This issue of Health Reports is a list of health products, including reports and testimonies, issued by the General Accounting Office (GAO) over the past 5 years. Organized chronologically, the entries provide a title, report number, and issue date for each GAO health product. Reports and testimonies on the same topic may be combined into a single entry.

The first section—Recent GAO Products—summarizes reports and testimonies on selected health issues published from January through December 1992. The summaries are followed by a list of additional products published during the same period. The remainder of Health Reports is a list of health products published from January 1988 through December 1992 organized by subject areas as shown in the table of contents. As appropriate, entries have been cross-indexed and are included in more than one subject area. An order form to be placed on our mailing for Health Reports and an order form to request GAO products appear at the end of this document.
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preface</td>
<td>1</td>
</tr>
<tr>
<td>Recent GAO Products (Jan. - Dec. 1992)</td>
<td>4</td>
</tr>
<tr>
<td>Summaries of Selected Reports</td>
<td>4</td>
</tr>
<tr>
<td>List of Additional GAO Health Products Issued Between January and December 1992</td>
<td>16</td>
</tr>
<tr>
<td>Health Financing and Access</td>
<td>24</td>
</tr>
<tr>
<td>Medicare and Medicaid</td>
<td>29</td>
</tr>
<tr>
<td>Public Health and Education</td>
<td>38</td>
</tr>
<tr>
<td>Health Quality and Practice Standards</td>
<td>42</td>
</tr>
<tr>
<td>Long-Term Care and Aging</td>
<td>46</td>
</tr>
<tr>
<td>Substance Abuse and Drug Treatment</td>
<td>48</td>
</tr>
<tr>
<td>Military and Veterans Health Care</td>
<td>52</td>
</tr>
<tr>
<td>Employee and Retiree Health Benefits</td>
<td>60</td>
</tr>
<tr>
<td>Other Health Issues</td>
<td>63</td>
</tr>
<tr>
<td>Environmental Impact on Health</td>
<td>63</td>
</tr>
<tr>
<td>Food and Drug Administration</td>
<td>64</td>
</tr>
<tr>
<td>Medical Malpractice</td>
<td>66</td>
</tr>
</tbody>
</table>

Page 2

GAO/HRD-93-66 Health Reports
Occupational Safety and Health 67
Prescription Drugs 68
Research 69
Social Security Disability 69
Miscellaneous 70

Appendixes
Appendix I: Major Contributors 74
Form for Mailing List 75
Order Form 77

Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADMS</td>
<td>Alcohol, Drug Abuse and Mental Health Services</td>
</tr>
<tr>
<td>ADP</td>
<td>automatic data processing</td>
</tr>
<tr>
<td>AIDS</td>
<td>acquired immunodeficiency syndrome</td>
</tr>
<tr>
<td>CDC</td>
<td>Centers for Disease Control</td>
</tr>
<tr>
<td>CHAMPUS</td>
<td>Civilian Health and Medical Program of the Uniformed Services</td>
</tr>
<tr>
<td>CPI</td>
<td>Consumer Price Index</td>
</tr>
<tr>
<td>DOD</td>
<td>Department of Defense</td>
</tr>
<tr>
<td>ERISA</td>
<td>Employee Retirement Income Security Act of 1974</td>
</tr>
<tr>
<td>EPA</td>
<td>Environmental Protection Agency</td>
</tr>
<tr>
<td>FDA</td>
<td>Food and Drug Administration</td>
</tr>
<tr>
<td>GAO</td>
<td>General Accounting Office</td>
</tr>
<tr>
<td>HCFA</td>
<td>Health Care Financing Administration</td>
</tr>
<tr>
<td>HHS</td>
<td>Department of Health and Human Services</td>
</tr>
<tr>
<td>HIV</td>
<td>human immunodeficiency virus</td>
</tr>
<tr>
<td>HMO</td>
<td>health maintenance organization</td>
</tr>
<tr>
<td>JCAHO</td>
<td>Joint Commission on Accreditation of Healthcare Organizations</td>
</tr>
<tr>
<td>MRI</td>
<td>Magnetic Resonance Imaging</td>
</tr>
<tr>
<td>MSP</td>
<td>Medicare secondary payer</td>
</tr>
<tr>
<td>NAIC</td>
<td>National Association of Insurance Commissioners</td>
</tr>
<tr>
<td>NIH</td>
<td>National Institutes of Health</td>
</tr>
<tr>
<td>NMDP</td>
<td>National Marrow Donor Program</td>
</tr>
<tr>
<td>OSHA</td>
<td>Occupational Safety and Health Administration</td>
</tr>
<tr>
<td>PRO</td>
<td>peer review organization</td>
</tr>
<tr>
<td>RBRVS</td>
<td>Resource-Based Relative Value Scale</td>
</tr>
<tr>
<td>USDA</td>
<td>United States Department of Agriculture</td>
</tr>
<tr>
<td>VA</td>
<td>Department of Veterans Affairs</td>
</tr>
<tr>
<td>WIC</td>
<td>Special Supplemental Food Program for Women, Infants, and Children</td>
</tr>
</tbody>
</table>
Recent GAO Products
(Jan. - Dec. 1992)

Summaries of Selected Reports

骨髓移植：国家项目大大增加了潜在捐赠者的池子（报告，11月4日，1992年，GAO/HRD-92-11）。

1989年12月至1992年4月期间，更大的和更种族和种族多样化的捐赠者的池子在国家骨髓捐赠者项目（NMDP）注册处帮助提高了找到匹配捐赠者的几率的几率，病人的稀有类型。新捐赠者通常只部分地被提供，因为只有很小一部分捐赠者被联系起来进行完全的类型化。在完全类型化捐赠者的过程中，可能花费几个月，患者可能会恶化并死亡或发展重大并发症。患者的搜索潜在捐赠者的成本主要由私人或公共保险覆盖。NMDP正参与由NIH和他人关于影响移植的关键问题的正在进行的研究工作。NMDP开始在其计划中整合初步研究发现。

妇女健康：FDA需确保更多的药物测试研究。

虽然FDA指导药物制造商建议他们对代表患者群体进行药物试验，但FDA并未定义"代表"。妇女在临床试验中包括在所有药物中，但在那些试验中被普遍地低估。然而，有足够多的妇女来检测药物中性别相关的差异。药物制造商通常不分析试验数据来确定女性对药物的反应是否与男性不同。

处方药物：公司在美国通常收费比加拿大高。

制造商的价格给批发商的相同的处方药物通常在美国比在加拿大高。价格差异主要是由于加拿大联邦和省级政府采取的行动来控制药物价格，并非由于制造商的成本在两国之间的任何差异。采用加拿大规定在美国的含义在争论中。不清楚这样的规定将如何影响制造商开发创新药物产品的能力。

HHS approved an amendment to Connecticut’s Medicaid plan that allows the state to implement a long-term care insurance plan sponsored by the Robert Wood Johnson Foundation, because it had no grounds for disapproving the plan. GAO believes HHS’s decision is a reasonable interpretation of the law (Title XIX of the Social Security Act). Concerning the federal role in protecting consumers, there are no federal consumer protection standards for long-term care insurance.


Many employers are facing rapidly increasing health insurance premiums and are frustrated by their unsuccessful efforts to contain health care costs. Firms most vulnerable to rising health costs are those whose health insurance plans offer extensive benefits and cover a large number of retirees or dependents; those whose workers are older, less healthy, or earning higher incomes; those with relatively few workers; and those in high health-cost areas. Individual firms can do little to lower their health care costs, because they cannot readily change their size, location, or employee demographics.


Weaknesses in Health Care Financing Administration (HCFA) oversight of contractor review activities, exacerbated by inadequate and inconsistent funding for payment safeguards, makes Medicare vulnerable to losses. HCFA’s lack of vigilance over contractors’ payment safeguard activities has left program funds inadequately protected from loss and waste. Overseeing Medicare’s payment safeguard activities has been a challenge to HCFA due to the program’s complex administrative structure. Loose payment controls and certain Medicare payment policies permit excessive reimbursement rates and contribute to the oversight problem.

Hospital Costs: Adoption of Technologies Drives Cost Growth (Report, Sept. 9, 1992, GAO/HRD-92-120).

From 1980 through 1989, hospital costs increased 63 percent after adjusting for inflation. Whereas the impact of each of the contributing factors cannot be quantified precisely, the single most important was the
rapid adoption of new medical technology. Acquired immunodeficiency syndrome (AIDS) and the costs of malpractice insurance were not major reasons for hospital cost growth in the 1980s. Although administrative costs played a larger role, its contribution could not be precisely calculated with existing data.


States have taken a leadership role in devising strategies to expand access to health insurance and contain the growth of health costs. A difficult hurdle to overcome, however, is the restrictions imposed by the preemption clause of the Employee Retirement Income Security Act of 1974 (ERISA). This clause effectively prevents states from exercising control over all employer-provided insurance. Hawaii is the only state with an exemption, in part because its law requiring employer-provided health insurance took effect before ERISA was enacted. Other states have tried to move toward coverage of all their citizens within ERISA's constraints. Some state initiatives have been more narrowly focused, creating programs to assist specific groups. State budgetary constraints, however, have limited these programs to serving a small fraction of the uninsured population.


The case study of the rolling labs scheme illustrates the vulnerability of Medicare and other health insurers to health care fraud. Investigators believe that this scheme, initially rooted in the Medicare program, is the largest case of health care fraud ever identified. Since the early 1980s, the scheme grew to involve hundreds of physicians and numerous medical laboratories and an estimated $1 billion in fraudulent claims to public and private insurers. The report highlights some of the lessons learned by health insurers in their efforts to address fraud.


GAO examined recent price increases for 29 widely used drug products purchased by pharmacies and the Department of Veterans Affairs (VA). From 1985 to 1991, prices for nearly all of the products increased more than the three consumer price indexes. During this period, the maximum
price increase for each product generally exceeded 100 percent, with some prices increasing more than 200 percent. During this same period, the all item Consumer Price Index (CPI) increased by 26.2 percent, the medical care CPI increased by 56.3 percent, and the prescription drug CPI increased by 67 percent.


The fraudulent reselling of prescription drugs is a prevalent type of Medicaid fraud that state Medicaid agencies are beginning to address more actively. A common fraud scheme involves "pill mills"—that is, a doctor's office, clinic, or pharmacy whose principal business is the illegal diversion of prescription drugs. Officials in 21 states cite such drug diversion as a major problem. Pill mills remain particularly resistant to enforcement efforts. Recent state initiatives offer considerable potential for overcoming stumbling blocks, curbing diversion, and recovering financial losses.


The size of the health care sector and sheer volume of money involved make it an attractive target for fraud and abuse. Profiteers are able to stay ahead of those who pay claims, in part, because of the obstacles to preventing and pursuing dishonest practices. Once detected, fraud is expensive and slow to pursue. The two federal agencies significantly involved in pursuing health care fraud cite resources as a problem. Because of the complexity involved in overcoming structural issues, GAO asked the Congress to consider establishing a national commission to develop comprehensive solutions to health insurance fraud and abuse.


Prescription drug monitoring programs save investigators' time and improve their productivity by providing information that allows them to identify potential cases of drug diversion. Prescription drug monitoring programs were not designed to measure their effect on reducing health care costs; however, 2 of the 10 states have reduced state Medicaid prescription drug costs by an estimated $27 million over 2 years and $440,000 for 1 year. Claims by medical, pharmaceutical, and patient organizations that prescription drug monitoring programs adversely affect
Recent GAO Products
(Jan. - Dec. 1992)

a physician’s ability to practice medicine or compromise patient care or confidentiality have not been sustained.


The durable medical equipment fee schedules established under the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) resulted in both Medicare and its beneficiaries paying more than they would have under the former system. For the high-volume items we reviewed, 1989 Medicare costs increased 17 percent. When revisions in the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508) are fully implemented, Medicare payments will return to the same level that would have been incurred under the former system.


VA has made significant progress since 1982 toward ensuring that female veterans have equal access to health care as male veterans. However, some problems remain in caring for female veterans. Physical examinations, including cancer screening, continue to be sporadic. VA medical centers are inadequately monitoring in-house mammography programs to ensure compliance with American College of Radiology quality standards.

Medicaid: Factors to Consider in Managed Care Programs (Testimony, June 29, 1992, GAO/T-HRD-92-43).

Medicaid is being severely strained by the continuing rise in the size of its population and cost. At the same time, there is general unhappiness with the traditional fee-for-service Medicaid program. Federal and state policy makers are turning to managed care as a possible way of getting better access and quality for the money they spend. Our previous reviews of Medicaid managed care programs have identified problems with access to care, quality of services, and oversight of provider financial reporting, disclosure, and solvency. Results from our current review in Oregon, however, indicate that concerns about these problems can be lessened through improved oversight and appropriate safeguards.

Although nearly all elderly persons had health insurance coverage through Medicare, poor elderly persons (1) were less likely to have private health insurance coverage to supplement Medicare, (2) spent a much higher percentage of their income on out-of-pocket health care expenses for noninstitutional care, and (3) were more likely to suffer from acute and chronic conditions than were nonpoor elderly persons. Moreover, only about 1 in 3 poor elderly persons were enrolled in Medicaid—the nation's health insurance program for the poor.


GAO and others have identified significant problems with long-term care insurance policies and the standards that govern them. GAO has also identified problems with insurance companies selling long-term care insurance to low-income people. The National Association of Insurance Commissioners (NAIC) has developed model standards for long-term care insurance. Consumers, however, are still vulnerable to considerable risks because (1) many states and insurance companies have not adopted all the NAIC standards, (2) NAIC standards do not sufficiently address several features of long-term care insurance that have important consequences for consumers, and (3) low-income people who purchased this expensive insurance may be covered by a government program such as Medicaid.


Oregon's Medicaid managed care program has avoided many of the problems identified in other states. The current program, while generally sound, could be improved by (1) insuring that efforts to improve child health screening services receive high priority, (2) revising its client satisfaction surveys, (3) intensifying its oversight of health plan solvency, and (4) requiring better financial information from the plans. Regarding the proposed demonstration, GAO is concerned that Oregon may not be able to recruit enough managed care providers within the first year to
ensure access to health services for the quickly expanding managed care population.


States are not ensuring that noncustodial parents provide health insurance for their children, even when such insurance is available through the noncustodial parents' employers. We estimate that the states and the federal government can save at least $122 million in medical expenditures annually if noncustodial parents provide health insurance that is available through their employment. Two main problems limit the effectiveness of state enforcement efforts: (1) federal laws lack specificity, permitting wide variability in the laws and practices states have adopted to enforce medical support, and (2) employers with health plans covered by ERISA that self-insure can exclude noncustodial parent's children from coverage.


HCFA could reduce Medicare expenditures on certain durable medical equipment by developing more detailed coverage criteria that give carriers a clear, well-defined, objective basis for paying or denying claims. To save additional Medicare funds, HCFA could also develop medical necessity certification forms for equipment subject to unnecessary payments.


GAO reported in Screening Mammography: Low-Cost Services Do Not Compromise Quality (Jan. 10, 1990, GAO/HRD-90-32) that many screening mammography providers surveyed lacked the quality assurance programs needed to ensure safe and accurate mammograms for women. GAO also identified a need for strong federal standards to assure the quality of screening mammography. The Congress required the Secretary of HHS to establish quality standards for mammography providers serving the Medicare population. Of significant concern, however, are the 30 million women not eligible for Medicare who should obtain regular screening and are not necessarily protected by federal quality standards.

In fiscal year 1990, VA spent approximately $1.3 billion to operate and maintain its mental health care programs and facilities. None of the four VA psychiatric hospitals GAO visited are effectively collecting and using quality assurance data on a consistent basis to identify and resolve quality-of-care problems in the psychiatric and medical care they are providing. GAO recommends that the Secretary of Veterans Affairs require the Chief Medical Director to: (1) define treatment goals, provide guidance on the evaluation of these goals, and ensure program reviews to evaluate the attainment of the goals; and (2) hold each hospital director responsible for making certain that identified medical and psychiatric quality-of-care problems are thoroughly examined and corrective actions are taken.

Childhood Immunization: Opportunities to Improve Immunization Rates at Lower Cost (Testimony, June 1, 1992, GAO/HRD-92-36).

Childhood immunization is one of the most effective means of health promotion and disease prevention. It could avert the costs of treatment for preventable diseases and save as much as $14 for every $1 invested. Yet GAO found that the average preschool full immunization rate among the states was 59 percent in 1990. According to the Centers for Disease Control (CDC), only about one-third of all urban preschool children are fully immunized. States told GAO that funding for purchasing and distributing CDC contract vaccines is a major barrier. Furthermore, implementing a system to handle, store, and distribute vaccines requires additional spending and also expands states' traditional public health role.


This fact sheet provides information on services, eligibility, and program interrelationships for seven programs that fund the delivery of health services to low-income women and children. The programs are the Preventive Health and Health Services block grant; Maternal and Child Health block grant; Early and Periodic Screening, Diagnosis, and Treatment portion of Medicaid; Childhood Immunization Program; Childhood Lead Poisoning Prevention; Community Health Centers; and Migrant Health Centers. GAO found that requirements for interprogram coordination were not well defined.

In some localities, Medicare's technical component payments for Magnetic Resonance Imaging (MRI) do not reflect the lower costs per scan now being achieved through faster scanning and higher machine utilization. Current payment levels are based, in part, on the charges allowed by local Medicare contractors in the mid-1980s. The 1991 payment levels in some localities were more than twice as high as in others, reflecting wide geographic disparities in the historical allowed charges. Medicare should base its payments on the costs incurred by high-volume, efficient facilities to reduce Medicare program expenditures and to discourage providers from adding excess capacity to the health care system.


GAO's work in recent years suggests that HCFA may need to exercise more active oversight over its contractors. Investigations into allegations of fraud and abuse and recovery of mistaken payments have not been adequate. Funding for Medicare's program safeguards has not kept pace with the growth in claims volume. GAO believes that HCFA must take a more active stance to hold contractors accountable for their performance in program administration.


GAO found that most states have proposed or already implemented programs to try to expand small business employees' access to health insurance coverage. Many of these initiatives have been adopted within the past 2 years, but the early indications are that they have led to only modest gains in the number of firms offering health insurance. This is largely because costs have not been reduced sufficiently to induce small firms to offer health insurance.

Weaknesses within the health insurance system allow unscrupulous health care providers to cheat insurance companies and programs out of billions of dollars annually. Repairing the system’s weaknesses presents a dilemma to policymakers: on the one hand, safeguards must be adequate for prevention, detection, and pursuit; on the other, they must not be unduly burdensome or intrusive for policyholders, providers, insurers, and law enforcement officials. GAO has asked the Congress to consider establishing a national health care fraud commission as a way to unite the efforts of public and private payers and to build consensus among representatives of divergent viewpoints.


In fiscal year 1990, VA spent approximately $1.3 billion to operate and maintain its mental health care programs and facilities. None of the four VA psychiatric hospitals GAO visited are effectively collecting and using quality assurance data on a consistent basis to identify and resolve quality-of-care problems in the psychiatric and medical care they are providing. GAO recommends that the Secretary of Veterans Affairs require the Chief Medical Director to: (1) define treatment goals, provide guidance on the evaluation of these goals, and ensure program reviews to evaluate the attainment of the goals; and (2) hold each hospital director responsible for making certain that identified medical and psychiatric quality-of-care problems are thoroughly examined and corrective actions are taken.


GAO evaluated HCFA’s proposed regulation that governs the review of accrediting organizations. GAO found that HCFA’s evaluation of the Community Health Accreditation Program’s ability to assure that home health agencies adhere to Medicare conditions of participation was inadequate. Moreover, several areas cited in HCFA’s proposed regulation governing the deeming of accrediting organizations were not effectively evaluated.

Medicaid: Factors to Consider in Expanding Managed Care Programs (Testimony, Apr. 10, 1992, GAO/T-92-26).

Medicaid is being severely strained by the continued rise in the size of its population and cost. Federal and state policy makers are turning to
managed care as a possible way to obtain better access to higher quality services for the money spent. Preliminary results from our review of the Oregon managed care program indicate that previously identified problems in Chicago health maintenance organizations that involve access to care, service quality, provider disclosure, provider solvency, and provider oversight can be lessened through appropriate oversight and adequate safeguards. Client advocates give the Oregon program high marks.


When the value of prevention is not quantified, legislators cannot easily factor it into their budgetary decisionmaking. To help quantify the value of prevention, GAO developed and tested a framework to analyze the costs and benefits associated with early intervention efforts. Using the Special Supplemental Food Program for Women, Infants, and Children (wic) as a test case, GAO concludes that providing wic benefits to pregnant women more than pays for itself within a year. GAO also found that the formula used to distribute wic funds to the states does not adequately consider the number of eligible persons in states.


Rapidly growing costs and inaccessibility of health care for a growing share of our population have generated a consensus that the U.S. health care system needs significant change. The challenge is to find a better way to manage and finance the U.S. system while preserving high-quality, innovative medical care. GAO work suggests that common themes in successful health care programs include (1) universal coverage, (2) a uniform system for managing payment of providers, and (3) expenditure targets or caps for major categories of providers and services. GAO is beginning to assess the health care system in Rochester, New York, which appears to be more successful than most in controlling the twin problems of rapidly rising costs and constricting access to health insurance.

Medicare: Over $1 Billion Should Be Recovered From Primary Health Insurers (Report, Feb. 21, 1992, GAO/HRD-92-52).

Medicare contractors have significant backlogs of mistaken payments for Medicare beneficiaries that are unrecovered from primary health insurers.
Medicare contractors recently surveyed by HCFA reported backlogs of over $1 billion in Medicare that were mistakenly paid. These backlogs could increase as a result of (1) a recently initiated HCFA effort to identify additional primary insurers, and (2) contractors’ research of previously paid beneficiary claims. Millions of dollars may be lost due to an HHS regulation that limits the time a contractor has to initiate recovery on a claim after it identifies a primary insurer. Collections of Medicare secondary payer (MSP) program mistaken payments far exceed carriers’ cost of recovery. Medicare contractors advised HCFA that inadequate MSP funding is the reason for backlogs of mistaken payments.


In most states, per capita spending on personal health care is near the U.S. average of $2,255 per capita in 1990. Many states with higher spending levels are concentrated in the Northeast, Midwest, and Far West, while many states with lower per capita spending are in the South and Rocky Mountain regions. Differences among states result largely from factors that state governments can do little to control. Most state differences in per capita personal health spending result from variations in personal income, health care services’ capacity (including the number of physicians and hospital and nursing home beds), the concentration of hospital services in urban areas, and health status.


Arbitration and no-fault programs are alternatives to litigation. Fifteen states have specific statutes on medical malpractice arbitration. Virginia and Florida enacted statutes authorizing no-fault programs to resolve certain birth-related injury claims. Michigan is the only state that (1) has a method to make patients aware of the arbitration option and (2) established a program to implement its statute’s requirements. But even in Michigan, relatively few malpractice claims have been filed for arbitration compared with those filed for litigation. At least two private sector health maintenance organizations (HMOs), covering over 6 million enrollees, have mandated the use of arbitration to resolve malpractice claims. Also, a demonstration project in Maine has established standards of care in four specialties. Starting in 1992, those participating physicians who follow the standards may be protected from litigation. However, Maine officials expect the legality of the approach to be challenged.
<table>
<thead>
<tr>
<th>List of Additional GAO Health Products Issued Between January and December 1992</th>
</tr>
</thead>
<tbody>
<tr>
<td>VA Health Care: Closure and Replacement of the Medical Center in Martinez, California (Report, Dec. 1, 1992, GAO/HRD-93-15).</td>
</tr>
</tbody>
</table>
Recent GAO Products 
(Jan. - Dec. 1992)


Recent GAO Products
(Jan. - Dec. 1992)


Resource-Based Relative Value Scale (RBRVS) and Administrative Costs (Letter, July 13, 1992, GAO/HRD-92-38R).


Medicaid: Factors to Consider in Managed Care Programs (Testimony, June 29, 1992, GAO/T-HRD-92-43).

VA Health Care: Copayment Exemption Procedures Should Be Improved (Report, June 24, 1992, GAO/HRD-92-77).


Recent GAO Products
(Jan. - Dec. 1992)


HHS Staff for Board and Care Issues (Letter, Apr. 1, 1992, GAO/HRD-92-29R).


Defense Health Care: Efforts to Address Health Effects of the Kuwait Oil Well Fires (Report, Jan. 9, 1992, GAO/HRD-92-50).

Health Financing and Access


Health Insurance: A Profile of the Uninsured in Ohio and the Nation (Report, Aug. 30, 1988, GAO/HRD-88-83).


Medicare and Medicaid


Resource-Based Relative Value Scale (RBRVS) and Administrative Costs (Letter, July 13, 1992, GAO/HRD-92-38R).


Medicaid: Factors to Consider in Managed Care Programs (Testimony, June 29, 1992, GAO/HRD-92-43).


Medicaid: Oregon’s Managed Care Program and Implications for Expansions (Report, June 19, 1992, GAO/HRD-92-80).


Medicare: Contractor Oversight and Funding Need Improvement (Testimony, May 21, 1992, GAO/HRD-92-52).

Medicaid: Factors to Consider in Expanding Managed Care Programs (Testimony, Apr. 10, 1992, GAO/HRD-92-26).


Medicare: Over $1 Billion Should Be Recovered From Primary Health Insurers (Report, Feb. 21, 1992, GAO/HRD-92-52).


Medicare and Medicaid


Quality of Care Provided Medicaid Recipients by Chicago-Area HMOs (Testimony, Sept. 14, 1990, GAO/HRD-90-54).


Medicaid: Sources of Information on Mental Health Services (Report, May 7, 1990, GAO/HRD-90-100).


Medicare: Cutting Payment Safeguards Will Increase Program Costs (Testimony, Feb. 28, 1989, GAO/T-HRD-89-6).


Internal Controls: Need to Strengthen Controls Over Payments by Medicare Intermediaries (Report, Nov. 14, 1988, GAO/HRD-89-8).

Medicare PROS: Extreme Variation in Organizational Structure and Activities (Report, Nov. 8, 1988, GAO/PEMD-89-7FS).


Controlled Substances: Medicaid Data May Be Useful For Monitoring Diversion (Report, Aug. 1, 1988, GAO/HRD-88-111).


Medicare: Improving Quality of Care Assessment and Assurance (Report, May 2, 1988, GAO/PEMD-88-10).


Medicare: Contractor Services to Beneficiaries and Providers (Report, Mar. 16, 1988, GAO/HRD-88-76BR).

Medicare: Management of Risk-Based HMO Program (Testimony, Mar. 10, 1988, GAO/T-HRD-88-10).

Medicare: Hospital Payment Rates Should Be Revised to Assure Reasonableness and Equity (Testimony, Mar. 1, 1988, GAO/T-HRD-88-9).

Medicare: Number of Rural Hospitals Terminating Participation Since the Program Began (Report, Jan. 29, 1988, GAO/HRD-88-46).


Childhood Immunization: Opportunities to Improve Immunization Rates at Lower Cost (Testimony, June 1, 1992, GAO/T-HRD-92-36).


Indian Health Service: Funding Based on Historical Patterns, Not Need (Report, Feb. 21, 1991, GAO/HRD-91-5).


Mental Health: Prevention of Mental Disorders and Research on Stress-Related Disorders (Report, Sept. 12, 1989, GAO/HRD-89-97).


Health Care: Nine States' Experiences With Home Care Waivers (Report, July 14, 1989, GAO/HRD-89-95).

Health Care: Children's Medical Services Programs in 10 States (Report, July 14, 1989, GAO/HRD-89-81).


Public Health: Centers for Disease Control Staffing for AIDS and Other Programs (Report, Apr 27, 1989, GAO/HRD-89-65).


Issues Concerning CDC's AIDS Education Programs (Testimony, June 8, 1988, GAO/T-HRD-88-18).


Health Quality and Practice Standards

Utilization Review: Information on External Review Organizations

Health Care: Reduction in Resident Physician Work Hours Will Not Be Easy to Attain

Home Health Care: HCFA Properly Evaluated JCAHO's Ability to Survey Home Health Agencies

AIDS: CDC's Investigation of HIV Transmissions by a Dentist

Medical Technology: For Some Cardiac Pacemaker Leads, the Public Health Risks Are Still High

Health Care: Most Community and Migrant Health Center Physicians Have Hospital Privileges

Screening Mammography: Federal Quality Standards Are Needed

Home Health Care: HCFA Evaluation of Community Health Accreditation Program Inadequate

Cross Design Synthesis: A New Strategy for Medical Effectiveness Research

Medical Technology: Quality Assurance Needs Stronger Management Emphasis and Higher Priority

VA Health Care: Compliance With Joint Commission Accreditation Requirements Is Improving

Breast Cancer, 1971-91: Prevention, Treatment, and Research

Screening Mammography: Quality Standards Are Needed in a Developing Market

Health Care: Actions to Terminate Problem Hospitals From Medicare Are Inadequate


Health Care: Limited State Efforts to Assure Quality of Care Outside Hospitals (Testimony, Apr. 29, 1991, GAO/T-HRD-91-20).


Health Quality and Practice Standards

Health Care: Limited State Efforts to Assure Quality of Care Outside Hospitals (Report, Jan. 30, 1990, GAO/HRD-90-33).


VA Health Care: Efforts to Assure Quality of Care in State Homes (Report, Nov. 27, 1989, GAO/HRD-90-40).


Health Care: Initiatives in Hospital Risk Management (Report, July 18, 1989, GAO/HRD-89-79).


Medicare: Improving Quality of Care Assessment and Assurance (Report, May 2, 1988, GAO/PEMD-88-10).

The Use of Breakthrough Treatments for Seven Types of Cancer (Report, Jan. 25, 1988, GAO/PEMD-88-12BR).
Long-Term Care and Aging


Long-Term Care Insurance: Risks to Consumers Should Be Reduced (Testimony, Apr. 11, 1991, GAO/HRD-91-14).
Aging Issues: Related GAO Reports and Activities in Fiscal Year 1990

Long-Term Care Insurance: Proposals to Link Private Insurance and

Respite Care: An Overview of Federal, Selected State and Private
Programs (Report, Sept. 6, 1990, GAO/HRD-90-125).

Nursing Homes: Admission Problems for Medicaid Recipients and

VA Health Care: Improvements Needed in Nursing Home Planning (Report,

Aging Issues: Related GAO Reports and Activities in Fiscal Year 1989

In-Home Services for the Elderly: Cost Sharing Expands Range of Services

Long-Term Care Insurance: State Regulatory Requirements Provide

Respite Care: Insights on Federal, State, and Private Sector Involvement
(Testimony, Apr. 6, 1989, GAO/T-HRD-89-12).

Board and Care: Insufficient Assurances That Residents’ Needs Are

Aging Issues: Related GAO Reports and Activities in Fiscal Year 1988

Long-Term Care for the Elderly: Issues of Need, Access, and Cost (Report,
Nov. 28, 1988, GAO/HRD-89-4).


Drug Education: School-Based Programs Seen as Useful but Impact Unknown (Report, Nov. 28, 1990, GAO/HRD-91-27).


HHS Cannot Currently Measure States' Programs in Meeting the Prompt Treatment Goal for Intravenous Drug Users (Testimony, Apr. 30, 1990, GAO/T-HRD-90-25).


Substance Abuse and Drug Treatment

Controlled Substances: Medicaid Data May Be Useful for Monitoring Diversion (Report, Aug. 1, 1988, GAO/HRD-88-111).


Employee Drug Testing (Testimony, Apr. 21, 1988, GAO/T-GGD-88-14).


Military and Veterans Health Care


VA Health Care: Closure and Replacement of the Medical Center in Martinez, California (Report, Dec. 1, 1992, GAO/HRD-93-15).


VA Health Care: Demonstration Project Concerning Future Structure of Veterans' Health Program (Testimony, Aug. 11, 1992, GAO/HRD-92-34).


Military and Veterans Health Care


VA Health Care: Copayment Exemption Procedures Should be Improved (Report, June 24, 1992, GAO/HRD-92-77).


Defense Health Care: Efforts to Address Health Effects of the Kuwait Oil Well Fires (Report, Jan. 9, 1992, GAO/HRD-92-50).


VA Health Care: Actions in Response to VA's 1989 Mortality Study (Report, Nov. 27, 1990, GAO/HRD-91-26).


VA Health Care: Better Procedures Needed to Maximize Collections From Health Insurers (Report, Apr. 6, 1990, GAO/HRD-90-64).


VA Health Care: Medical Centers Need to Improve Collection of Veterans' Copayments (Report, Mar. 28, 1990, GAO/HRD-90-77).


VA Health Care: Veterans' Concerns About Services at Wilmington, Delaware, Center (Report, Feb. 8, 1990, GAO/HRD-90-55BR).


VA Health Care: Assessment of Surgical Services at Two Medical Centers in the Southwest (Report, Dec. 14, 1989, GAO/HRD-90-6).

VA Health Care: Efforts to Assure Quality of Care in State Homes (Report, Nov. 27, 1989, GAO/HRD-90-40).

Defense Health Care: Patients' Views on Care They Received (Report, Sept. 13, 1989, GAO/HRD-89-137).


VA Health Care: Veterans' Demand for Outpatient Care (Report, May 31, 1989, GAO/HRD-89-70).


Implementation of the CHAMPUS Reform Initiative (Testimony, Apr. 18, 1989, GAO/T-HRD-89-17).


VA Health Care: Language Barriers Between Providers and Patients Have Been Reduced (Report, Mar. 9, 1989, GAO/HRD-89-40).

Military Child Care: Extensive, Diverse, and Growing (Report, Mar. 8, 1989, GAO/HRD-89-3).


DOD Health Care: Pediatric and Other Emergency Room Care (Report, Sept. 28, 1988, GAO/HRD-88-113).


Changes in the Delivery of Selected Mental Health Services at Veterans Administration Medical Centers (Testimony, July 14, 1988, GAO/T-HRD-88-22).


Defense Health Care: Reimbursement of Hospitals Not Meeting CHAMPUS Copayment Requirements (Report, June 1, 1988, GAO/HRD-88-102).


Use of Information Technology in Hospitals (Testimony, May 24, 1988, GAO/T-IMTEC-88-4).


VA/DOD Health Care: Further Opportunities to Increase the Sharing of Medical Resources (Report, Mar. 1, 1988, GAO/HRD-88-51).


<table>
<thead>
<tr>
<th>Report Title</th>
<th>Date</th>
<th>GAO/HRD-92-#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Benefits: Financing Health Benefits of Retired Coal Miners</td>
<td>July 22, 1992</td>
<td>130FS</td>
</tr>
<tr>
<td>Federal Health Benefits Program: Open Season Processing Timeliness</td>
<td>July 8, 1992</td>
<td>122BR</td>
</tr>
<tr>
<td>Information on Federal Health Benefits Costs</td>
<td>June 23, 1992</td>
<td>18R</td>
</tr>
<tr>
<td>Federal Health Benefits Program</td>
<td>May 4, 1992</td>
<td>1IR</td>
</tr>
<tr>
<td>Federal Health Benefits Program: Stronger Controls Needed to Reduce</td>
<td>Mar. 11, 1992</td>
<td>20</td>
</tr>
<tr>
<td>Administrative Costs</td>
<td>Feb. 12, 1992</td>
<td>27</td>
</tr>
<tr>
<td>Employee Benefits: States Need Labor's Help Regulating Multiple Employer</td>
<td>Mar. 10, 1992</td>
<td>40</td>
</tr>
<tr>
<td>Welfare Arrangements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hired Farmworkers: Health and Well-Being at Risk</td>
<td>Feb. 14, 1992</td>
<td>46</td>
</tr>
<tr>
<td>Federal Health Benefits Program: Stronger Controls Needed to Reduce</td>
<td>Feb. 12, 1992</td>
<td>27</td>
</tr>
<tr>
<td>Administrative Costs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>States Need More Department of Labor Help to Regulate Multiple Employer</td>
<td>Sept. 17, 1991</td>
<td>47</td>
</tr>
<tr>
<td>Welfare Arrangements and Correct Problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Benefits: Effect of Bankruptcy on Retiree Health Benefits</td>
<td>Aug. 30, 1991</td>
<td>115</td>
</tr>
<tr>
<td>Veterans' Benefits: VA Needs to Verify Medical Expenses Claimed by Pension</td>
<td>July 29, 1991</td>
<td>94</td>
</tr>
<tr>
<td>Beneficiaries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Farmworkers Face Gaps in Protection and Barriers to Benefits</td>
<td>July 17, 1991</td>
<td>40</td>
</tr>
<tr>
<td>Fraud and Abuse: Stronger Controls Needed in Federal Employees Health</td>
<td>July 16, 1991</td>
<td>95</td>
</tr>
<tr>
<td>Benefits Program</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Employee Benefits: Companies' Retiree Health Liabilities Large, Advance Funding Costly (Report, June 14, 1989, GAO/HRD-89-51).


Federal Health Benefits Program (Testimony, May 24, 1989, GAO/GGD-89-26).


Other Health Issues

Environmental Impact on Health


Food and Drug Administration


Nonprescription Drugs: Over the Counter and Underemphasized (Testimony, Apr. 8, 1992, GAO/PEMD-92-5).


Other Health Issues


Food Tampering: Legal Authority Adequate to Deal with Threats (Report, Oct. 31, 1990, GAO/HRD-91-20).

Food Tampering: FDA's Actions on Chilean Fruit Based on Sound Evidence (Report, Sept. 6, 1990, GAO/HRD-90-164).


Medical Devices: The Public Health at Risk (Testimony, Nov. 6, 1989, GAO/PEMD-90-2).

Other Health Issues


Occupational Safety and Health


Other Health Issues


Prescription Drugs


Other Health Issues

Research


Mental Health: Prevention of Mental Disorders and Research on Stress-Related Disorders (Report, Sept. 12, 1989, GAO/HRD-89-97).


Biomedical Research: Issues Related to Increasing Size of NIH Grant Awards (Report, May 6, 1988, GAO/HRD-88-90BR).


Social Security Disability


Other Health Issues


Miscellaneous


<table>
<thead>
<tr>
<th>Other Health Issues</th>
</tr>
</thead>
</table>
Laboratory Accreditation: Requirements Vary Throughout the Federal

ADP Modernization: Health Care Financing Administration's Software

Hospital Construction: Financial Information on HUD's Section 242
Hospital Mortgage Insurance Program (Report, Dec. 22, 1988,
GAO/HRD-89-14).

Transition Series: Health and Human Services Issues (Report, Nov. 1988,
GAO/OCG-89-10TR).

Cancer Treatment: National Cancer Institute's Role in Encouraging the

Financial Management: Continued Top Management Support Needed to

Inspectors General: Compliance With Professional Standards by the HHS

Financial Management: Continued Top Management Support Needed to

Minority Representation: Efforts of the Alcohol, Drug Abuse, and Mental
Health Administration (Report, May 13, 1988, GAO/HRD-88-49).

Debt Collection: More Aggressive Action Needed to Collect Debts Owed
Appendix I

Major Contributors

Human Resources Division, Washington, D.C.

Sibyl L. Tilson, Assignment Manager
David W. Bieritz, Evaluator-in-Charge
La Toria E. Allen, Production Assistant
Form for Mailing List

To be placed on the Health Reports mailing list:

Please complete the following:

Name __________________________________________

Organization __________________________________

Address ______________________________________

This form may be sent to

Janet Shikles, Director
U.S. General Accounting Office
NGB/Health Financing & Policy Issues
441 G Street, N.W.
Washington, D.C. 20548

The information can also be submitted by calling (202) 512-7119 or by faxing (202) 336-6642.
To order GAO's health reports:

The first copy of each GAO report is free. Additional copies are $2 each. Orders should be sent to the following address, accompanied by a check or money order made out to the Superintendent of Documents, when necessary. Orders for 100 or more copies to be mailed to a single address are discounted 25 percent.

U.S. General Accounting Office
P.O. Box 6015
Gaithersburg, MD 20877

Orders may also be placed by calling (202) 512-6000.

Orders for single copies only may be faxed to (301) 258-4066.

Name

Address

Report Number

Title

Quantity