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Health Reports is a list of health products, including reports and testimonies, issued by the General Accounting Office (GAO) over the past 2 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 June through October 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 October 1990 through October 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 list for Health Reports and an order form to request GAO products appear at the end of this document.
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<td>ADMS</td>
<td>Alcohol, Drug Abuse and Mental Health Services</td>
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<td>ADP</td>
<td>automatic data processing</td>
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<td>AIDS</td>
<td>acquired immunodeficiency syndrome</td>
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<td>CDC</td>
<td>Centers for Disease Control</td>
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<td>CHAMPUS</td>
<td>Civilian Health and Medical Program of the Uniformed Services</td>
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<td>CPI</td>
<td>Consumer Price Index</td>
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<td>DOD</td>
<td>Department of Defense</td>
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<td>ERISA</td>
<td>Employee Retirement Income Security Act of 1974</td>
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<td>FDA</td>
<td>Food and Drug Administration</td>
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<td>GAO</td>
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<td>HCFA</td>
<td>Health Care Financing Administration</td>
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<tr>
<td>HHS</td>
<td>Department of Health and Human Services</td>
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<tr>
<td>HIV</td>
<td>human immunodeficiency virus</td>
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<tr>
<td>HMO</td>
<td>health maintenance organization</td>
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<tr>
<td>NAIC</td>
<td>National Association of Insurance Commissioners</td>
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<td>OSHA</td>
<td>Occupational Safety and Health Administration</td>
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<tr>
<td>PRO</td>
<td>peer review organization</td>
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<tr>
<td>USDA</td>
<td>Department of Agriculture</td>
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<td>VA</td>
<td>Department of Veterans Affairs</td>
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<td>WIC</td>
<td>Special Supplemental Food Program for Women, Infants, and Children</td>
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Manufacturers' prices to wholesalers for identical prescription drugs are typically higher in the United States than in Canada. The price differences are largely attributable to actions taken by Canada's federal and provincial governments to restrain drug prices, not to any differences in manufacturers' costs in the two countries. The implications of adopting Canadian regulations in the United States are in dispute. It is not clear how such regulations would affect manufacturers' ability to develop innovative drug products.


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.

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, their contribution could not be precisely calculated with existing data.


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 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.

**Elderly Americans: Health, Housing, and Nutrition Gaps Between the Poor**
and Nonpoor (Report, June 24, 1992, GAO/PEMD-92-29). Testimony on same
topic (June 24, 1992, GAO/PEMD-92-10).

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.

**Long-Term Care Insurance: Actions Needed to Reduce Risks to**
Consumers (Testimony, June 23, 1992, GAO/HRD-92-44). Reports on same

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.

**Medicaid: Oregon’s Managed Care Program and Implications for**

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) ensuring 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 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 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 Health Care Financing Administration (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 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.

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 the states' traditional public health role.


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.


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

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


VA Health Care: Efforts to Improve Pharmacies' Controls Over Addictive Drugs (Testimony, June 10, 1992, GAO/HRD-92-38).


Health Financing and Access


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


Health Financing and Access


Managed Care: Oregon Program Appears Successful but Expansion Should Be Implemented Cautiously (Testimony, Sept. 16, 1991, GAO/HRD-91-48).


Medicare and Medicaid


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).


Contractor Oversight and Funding Need Improvement (Testimony, May 21, 1992, GAO/HRD-92-32).
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-92-62).


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


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


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

Health Quality and Practice Standards


Aging Issues: Related GAO Reports and Activities in Fiscal Year 1990


VA Health Care: Demonstration Project Concerning Future Structure of Veterans' Health Program (Testimony, Aug. 11, 1992, GAO/HRD-92-96).


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


Military and Veterans Health Care


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).
Employee and Retiree Health Benefits


Other Health Issues

Food and Drug Administration


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

Medical Malpractice


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Occupational Safety and Health


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Miscellaneous


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