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Preface

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.

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Abbreviations

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

Recent GAO Products

(Jan. - Dec. 1992)

Summaries of Selected Reports

Bone Marrow Transplants: National Program Has Greatly Increased Pool of Potential Donors (Report, Nov. 4, 1992, GAO/HRD-93-11).

Between December 1989 and April 1992, the larger and more racially and ethnically diverse pool of donors on the National Marrow Donor Program (NMDP) Registry helped improve the odds of finding a matching donor for patients who have rarer tissue types. New donors are usually only partially typed, because only a small portion of donors are ever contacted for full-typing. During the process of fully typing donors, which can take several months, patients may deteriorate and die or develop major complications. The patients' costs of searching for potential donors are mostly covered by private or public insurance. NMDP is participating in research conducted by NIH and others on key issues affecting transplants using unrelated donors. NMDP is beginning to incorporate preliminary research findings in its program.

Women's Health: FDA Needs to Ensure More Study of Gender Differences in Prescription Drug Testing (Report, Oct. 29, 1992, GAO/HRD-93-17).

Although FDA guidance to drug manufacturers recommends that they test new drugs on representative patient populations, FDA does not define "representative." Women were included in clinical trials for all the drugs in our survey but were generally underrepresented in those trials. There were, however, enough women to detect gender-related differences in response for most drugs in our survey. Often drug manufacturers do not analyze trial data to determine if women's responses to a drug differed from those of men.

Prescription Drugs: Companies Typically Charge More in the United States Than in Canada (Report, Sept. 30, 1992, GAO/HRD-92-110).

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.

Long-Term Care Insurance Partnerships (Letter, Sept. 25, 1992,
GAO/HRD-92-44R).

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.

Employer-Based Health Insurance: High Costs, Wide Variation Threaten
System (Report, Sept. 22, 1992, GAO/HRD-92-125).

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.

Health Insurance: Medicare and Private Payers Are Vulnerable to Fraud
and Abuse (Testimony, Sept. 10, 1992, GAO/T-HRD-92-56).

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.

State Health Care Reform: Federal Requirements Influence State Reforms (Testimony, Sept. 9, 1992, GAO/T-HRD-92-55). Report on same topic (June 16, 1992, GAO/HRD-92-70). Testimony on same topic (June 9, 1992, GAO/T-HRD-92-40).

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.

Medicare: One Scheme Illustrates Vulnerabilities to Fraud (Report, Aug. 26, 1992, GAO/HRD-92-76).

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.

Prescription Drugs: Changes in Prices for Selected Drugs (Report, Aug. 24, 1992, GAO/HRD-92-128).

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.

Medicaid Prescription Drug Diversion: A Major Problem, But State Approaches Offer Some Promise (Testimony, July 29, 1992, GAO/T-HRD-92-48).

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.

Health Insurance: More Resources Needed to Combat Fraud and Abuse (Testimony, July 28, 1992, GAO/T-HRD-92-49).

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: States Can Readily Identify Illegal Sales and Use of Controlled Substances (Report, July 21, 1992, GAO/HRD-92-115).

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.

Medicare: Program and Beneficiary Costs Under Durable Medical Equipment Fee Schedules (Report, July 7, 1992, GAO/HRD-92-78).

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 Health Care for Women: Despite Progress, Improvements Needed (Testimony, July 2, 1992, GAO/T-HRD-92-33). Testimony on same topic (June 19, 1992, GAO/T-HRD-92-42). Report on same topic (Jan. 23, 1992, GAO/HRD-92-23).

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.

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/T-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/T-HRD-92-44). Reports on same topic (Mar. 27, 1992, GAO/HRD-92-66 and Dec. 26, 1991, GAO/HRD-92-14). Testimony on same topic (May 20, 1992, GAO/T-HRD-92-31).

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 Expansions (Report, June 19, 1992, GAO/HRD-92-89).

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.

Medicaid: Ensuring That Noncustodial Parents Provide Health Insurance Can Save Costs (Report, June 17, 1992, GAO/HRD-92-80).

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.

Durable Medical Equipment: Specific HCFA Criteria and Standard Forms Could Reduce Medicare Payments (Report, June 12, 1992, GAO/HRD-92-64).

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.

Screening Mammography: Federal Quality Standards Are Needed (Testimony, June 5, 1992, GAO/T-HRD-92-39).

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.

VA Health Care: The Quality of Care Provided by Some VA Psychiatric Hospitals Is Inadequate (Testimony, June 3, 1992, GAO/T-HRD-92-37). Report on same topic (Apr. 22, 1992, GAO/HRD-92-17).

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/T-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.

Federally Funded Health Services: Information on Seven Programs Serving Low-Income Women and Children (Report, May 28, 1992, GAO/HRD-92-73FS).

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.

Medicare: Excessive Payments Support the Proliferation of Costly Technology (Report, May 27, 1992, GAO/HRD-92-59).

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.

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

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.

Access to Health Insurance: State Efforts to Assist Small Businesses (Report, May 14, 1992, GAO/HRD-92-90). Testimony on same topic (May 14, 1992, GAO/T-HRD-92-30).

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.

Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse (Report, May 7, 1992, GAO/HRD-92-69). Testimony on same topic (May 7, 1992, GAO/T-HRD-92-29).

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.

VA Health Care: The Quality of Care Provided by Some VA Psychiatric Hospitals Is Inadequate (Report, Apr. 22, 1992, GAO/HRD-92-17).

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.

Home Health Care: HCFA Evaluation of Community Health Accreditation Program Inadequate (Report, Apr. 20, 1992, GAO/HRD-92-93).

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-HRD-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.

Early Intervention: Federal Investments Like WIC Can Produce Savings
(Report, Apr. 7, 1992, GAO/HRD-92-18).

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.

Health Care: Problems and Potential Lessons for Reform (Testimony, Mar. 27, 1992, GAO/T-HRD-92-23).

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.

Health Care Spending: Nonpolicy Factors Account for Most State Differences (Report, Feb. 13, 1992, GAO/HRD-92-36).

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.

Medical Malpractice: Alternatives to Litigation (Report, Jan. 10, 1992, GAO/HRD-92-28).

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.

List of Additional GAO Health Products Issued Between January and December 1992

Removal of Breast Implants (Letter, Dec. 7, 1992, GAO/HRD-93-5R).

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

Utilization Review: Information on External Review Organizations
(Report, Nov. 24, 1992, GAO/HRD-93-22FS).

Health Care: Reduction in Resident Physician Work Hours Will Not Be
Easy to Attain (Report, Nov. 20, 1992, GAO/HRD-93-24BR).

Veterans' Benefits: Availability of Benefits in American Samoa (Report,
Nov. 18, 1992, GAO/HRD-93-16).

Home Health Care: HCFA Properly Evaluated JCAHO's Ability to Survey
Home Health Agencies (Report, Oct. 26, 1992, GAO/HRD-93-33).

Trauma Care Reimbursement: Poor Understanding of Losses and
Coverage for Undocumented Aliens (Report, Oct. 15, 1992, GAO/PEMD-93-1).

Defense Health Care: Physical Exams and Dental Care Following the
Persian Gulf War (Report, Oct. 15, 1992, GAO/HRD-93-5).

Occupational Safety and Health: Uneven Protections Provided to
Congressional Employees (Report, Oct. 2, 1992, GAO/HRD-93-1).

AIDS: CDC's Investigation of HIV Transmissions by a Dentist (Report,
Sept. 29, 1992, GAO/PEMD-92-31).

VA Health Care: Use of Private Providers Should Be Better Controlled
(Report, Sept. 28, 1992, GAO/HRD-92-109).

Integrating Human Services: Linking At-Risk Families With Services More
Successful Than System Reform Efforts (Report, Sept. 24, 1992,
GAO/HRD-92-108).

Medicare: HCFA Monitoring of the Quality of Part B Claims Processing
(Testimony, Sept. 23, 1992, GAO/T-PEMD-92-14).

Medical Technology: For Some Cardiac Pacemaker Leads, the Public
Health Risks Are Still High (Report, Sept. 23, 1992, GAO/PEMD-92-20).

Social Security: Racial Difference in Disability Decisions Warrants Further Investigation (Testimony, Sept. 22, 1992, GAO/T-HRD-92-41). Report on same topic (Apr. 21, 1992, GAO/HRD-92-56).

VA Health Care: Verifying Veterans' Reported Income Could Generate Millions in Copayment Revenues (Report, Sept. 15, 1992, GAO/HRD-92-159).

VA Health Care: VA Did Not Thoroughly Investigate All Allegations by the Froelich Trust Group (Report, Sept. 4, 1992, GAO/HRD-92-141).

Cancer Treatment: Actions Taken to More Fully Utilize the Bark of Pacific Yews on Federal Land (Report, Aug. 31, 1992, GAO/RCED-92-231).

Occupational Safety and Health: Improvements Needed in OSHA's Monitoring of Federal Agencies' Programs (Report, Aug. 28, 1992, GAO/HRD-92-97).

Food Safety and Quality: USDA Improves Inspection Program for Canadian Meat, But Some Concerns Remain (Report, Aug. 26, 1992, GAO/RCED-92-250).

D.C. Government: District Medicaid Payments to Hospitals (Report, Aug. 24, 1992, GAO/GGD-92-138FS).

Operation Desert Storm: Full Army Medical Capability Not Achieved (Report, Aug. 18, 1992, GAO/NSIAD-92-175).

VA Health Care: Offsetting Long-Term Care Costs by Adopting State Copayment Practices (Report, Aug. 12, 1992, GAO/HRD-92-96).

VA Health Care: Demonstration Project Concerning Future Structure of Veterans' Health Program (Testimony, Aug. 11, 1992, GAO/T-HRD-92-53).

Nuclear Health and Safety: Mortality Study of Atmospheric Nuclear Test Participants Is Flawed (Report, Aug. 10, 1992, GAO/RCED-92-182).

Recombinant Bovine Growth Hormone: FDA Approval Should Be Withheld Until the Mastitis Issue Is Resolved (Report, Aug. 6, 1992, GAO/PEMD-92-26).

Women's Health Information: HHS Lacks an Overall Strategy (Testimony, Aug. 5, 1992, GAO/T-HRD-92-51).

VA Health Care: Inadequate Controls Over Scarce Medical Specialist Contracts (Testimony, Aug. 5, 1992, GAO/T-HRD-92-50). Report on same topic (July 29, 1992, GAO/HRD-92-114).

Food Safety and Quality: FDA Strategy Needed to Address Animal Drug Residues in Milk (Report, Aug. 5, 1992, GAO/RCED-92-209).

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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

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