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Human Resources Division



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# Health Reports







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## PREFACE

The July 1993 issue of 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 March through June 1993. This section is followed by a list of additional products published during the same period and then a section listing summaries of most frequently requested health reports. The remainder of Health Reports is a list of health products published from July 1991 through June 1993 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 is on page 46 of this report. An order form to request GAO products is on page 47.

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Abbreviations

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| ADMS | Alcohol, Drug Abuse and Mental Health Services |
| ADP | automatic data processing |
| AIDS | acquired immunodeficiency syndrome |
| CDC | Centers for Disease Control and Prevention |
| CHAMPUS | Civilian Health and Medical Program of the Uniformed Services |
| DC | District of Columbia |
| DOD | Department of Defense |
| DOE | Department of Energy |
| 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 |
| HealthPASS | Philadelphia Accessible Services System |
| HHS | Department of Health and Human Services |
| HIV | human immunodeficiency virus |
| HMO | health maintenance organization |
| IHS | Indian Health Service |
| JCAHO | Joint Commission on Accreditation of Healthcare Organizations |
| MRI | Magnetic Resonance Imaging |
| OSHA | Occupational Safety and Health Administration |
| RBRVS | Medicare Resource-Based Relative Value Scale |
| SSA | Social Security Administration |
| USDA | United States Department of Agriculture |
| VA | Department of Veterans Affairs |
| WIC | Special Supplemental Food Program for Women, Infants, and Children |

## RECENT GAO PRODUCTS
## (March - June 1993)

### SUMMARIES OF SELECTED REPORTS

Hospital Sterilants: Insufficient FDA Regulation May Pose a Public Health Risk (Report, June 14, 1993, GAO/HRD-93-79).

EPA and FDA acted correctly in halting the sale of Sporicidin Cold Sterilizing Solution and other products that are disinfectants in December 1991. Although FDA took proper action against Sporicidin International, its overall regulation of other manufacturers of hospital sterilants and disinfectants has been inadequate. In this regard, only a few sterilant and disinfectant manufacturers have registered their products with FDA, and few of the hundreds have been authorized for marketing by FDA, as required by law.

Private Health Insurance: Wide Variation in State Insurance Departments' Regulatory Authority (Testimony, May 27, 1993, GAO/T-HRD-93-25).

GAO discussed how state insurance departments regulate health insurance, the resources they commit to these efforts, and the implications that health care reform could have on state insurance departments' roles and responsibilities. The departments' authority extends over only part of the market and varies widely among states. Past GAO studies have raised serious questions about the effectiveness of states' efforts to monitor insurer financial solvency. In our current survey, GAO found wide variations in states' practices and procedures for approving premium rates and policy forms. Any health reform plan adopted should clearly specify expectations for the departments in enforcing whatever new requirements may be imposed on health insurers.

Medical Malpractice: Experience with Efforts to Address Problems (Testimony, May 20, 1993, GAO/T-HRD-93-24).

The states and the private sector have initiated a number of efforts to address the problems associated with an inefficient and inequitable compensation system and the adverse effects on the way physicians practice medicine. Four of these efforts currently receiving considerable attention are (1) risk management at the Harvard medical institutions, (2) the use of practice guidelines in Maine, (3) alternatives to litigation in several states and some health maintenance organizations, and (4) no-fault approaches in Virginia and Florida. Any reform of the malpractice system should address the issues of (1) reducing the incidence of negligent care, (2) fairly compensating individuals injured through medical negligence, and (3) dealing with the complexities involved in

efforts to enhance the overall quality of care provided in the United States.

Medicare: Renal Facility Cost Reports Probably Overstate Costs of Patient Care (Report, May 18, 1993, GAO/HRD-93-70).

GAO randomly selected 30 Medicare audits of 124 dialysis facility cost reports and found that the audits were incomplete and poorly done. If the audits had been adequately performed, additional costs would probably have been disallowed and removed from the cost reports. This would have resulted in a further reduction of the median cost per treatment. Cost report data show that vertically integrated firms (those that own manufacturing, pharmacy, and dialysis facilities) and horizontally integrated firms (those that own a group of dialysis facilities) provided dialysis treatments at a substantially lower cost than nonintegrated firms (those that own only one dialysis facility).

Medicaid: HealthPASS--An Evaluation of a Managed Care Program for Certain Philadelphia Recipients (Report, May 7, 1993, GAO/HRD-93-67).

GAO reviewed certain aspects of the Philadelphia Accessible Services System (HealthPASS), and found that (1) women who seek pregnancy-related care are receiving quality services, but they did not avail themselves of this care early or often enough, (2) premature and low birth weight babies were delivered with great frequency by both HealthPASS and fee-for-service providers, (3) some HealthPASS providers were not furnishing children required and timely preventive care services, and (4) enrollment of eligible HealthPASS members in the Special Supplemental Food Program for Women, Infants, and Children (WIC) is no greater than the enrollment of eligible Medicaid fee-for-service women and children.

Organ Transplants: Increased Effort Needed to Boost Supply and Ensure Equitable Distribution of Organs (Report, Apr. 22, 1993, GAO/HRD-93-56). Testimony on same topic (Apr. 22, 1993, GAO/T-HRD-93-17).

In assessing the organ allocation and procurement system, GAO found that existing practices raise questions as to equity of organ allocation decisions. The lack of an adequate measure of organ procurement effectiveness hinders efforts to monitor and improve organ procurement. Although the National Organ Procurement and Transplantation Network has improved the procurement and allocation of organs for transplant, further improvements are needed.

Medicare: Physicians Who Invest in Imaging Centers Refer More Patients for More Costly Services (Testimony, Apr. 20, 1993, GAO/T-HRD-93-14). Report on same topic (May 27, 1992, GAO/HRD-92-59).

Freestanding diagnostic imaging centers have proliferated in many parts of the country and are also among the most popular types of physician-owned joint ventures. Referral practices for diagnostic imaging varied among the medical specialties. GAO's study of diagnostic imaging referral practices provides further evidence that physician investment in medical facilities is associated with more frequent referral to those facilities and higher health care costs.

Indian Health Service: Basic Services Mostly Available; Substance Abuse Problems Need Attention (Report, Apr. 9, 1993, GAO/HRD-93-48).

GAO reviewed the availability of health care services to American Indians and Alaska Natives residing in five Indian Health Service (IHS) areas--Aberdeen, Alaska, California, Navajo, and Portland. While they differed greatly in the way they delivered health care services, the five areas reported generally similar availability of basic clinical services. Service units officials generally identified alcohol and substance abuse services as their greatest unmet health need. IHS lacks data on alcoholism rates among Indians and the effectiveness of current prevention and treatment programs. Without such data, IHS is hard pressed to develop effective strategies that maximize the use of its limited resources.

Medicare Secondary Payer Program: Identifying Beneficiaries With Other Insurance Coverage Is Difficult (Testimony, Apr. 2, 1993, GAO/T-HRD-93-13).

Beginning in 1980, the Congress enacted a number of laws making Medicare the secondary payer for most beneficiaries covered under employer-sponsored group health insurance. These amendments have reduced Medicare costs by billions of dollars. Medicare has had problems recouping funds from other insurers when it discovers that it has mistakenly paid for the services for which another insurer was liable. GAO believes opportunities exist to identify a more efficient and less costly approach to identify Medicare secondary payer activities.

Medicaid: The Texas Disproportionate Share Program Favors Public Hospitals (Report, Mar. 30, 1993, GAO/HRD-93-86).

GAO found that use of the Texas disproportionate share program formula favors public hospitals that receive a relatively large

amount of state and local revenue. The formula does not give full credit to hospitals' charity care that is not tax supported--such as that provided by some private hospitals. Four other states--Florida, Louisiana, Michigan, and Virginia--reviewed by GAO have established qualifying formulas which include a measure of charity care provided to low-income patients.

Childhood Immunization: Opportunities to Improve Immunization Rates at Lower Cost (Report, Mar. 24, 1993, GAO/HRD-93-41). Testimony on same topic (June 1, 1992, GAO/T-HRD-92-36).

Most state Medicaid programs could save money if low-cost vaccines acquired through Centers for Disease Control and Prevention (CDC) contracts were made available to all health care providers administering vaccinations to poor children. Savings on vaccine costs, however, will do little to improve preschool immunization levels unless funds are provided for educating parents and tracking and following up on the immunization status of children to help ensure that preschool children receive timely immunizations. Most states do not systematically carry out these three activities.

Needle Exchange Programs: Research Suggests Promise as an AIDS Prevention Strategy (Report, Mar. 23, 1993, GAO/HRD-93-60).

The Yale University forecasting model, which GAO found to be credible, estimated a 33 percent reduction in new HIV infections among New Haven, Connecticut, needle exchange program participants over one year. Despite the potential of such programs as an AIDS prevention strategy, HHS is currently restricted from using certain funds to directly support the funding of exchange programs. Only three of nine needle exchange programs reviewed by GAO had published results showing changes in needle sharing behaviors based on strong evidence. Two of these three programs reported a reduction in needle sharing while a third reported an increase. Five programs found that injection drug use did not increase among users; four reported no increase in frequency of injection and one found no increase in the prevalence of use.

Medicaid: Outpatient Drug Costs and Reimbursements for Selected Pharmacies in Illinois and Maryland (Report, Mar. 18, 1993, GAO/HRD-93-55FS).

Nine pharmacies in Illinois and Maryland received about 19 percent more Medicaid reimbursement for selected drugs than the total amount paid for these drugs by the pharmacies. For the Illinois pharmacies, the amount by which reimbursements exceeded purchase costs ranged from 10 to 23 percent. For the Maryland pharmacies, the range was from 11 to 34 percent.

Medicaid: States Turn to Managed Care to Improve Access and Control Costs (Report, Mar. 17, 1993, GAO/HRD-93-46). Testimony on same topic (Mar. 17, 1993, GAO/T-HRD-93-10).

Most states are rapidly developing or expanding their managed care programs. States choosing managed care for their Medicaid programs report facing difficult implementation issues. Medicaid managed care plans have had mixed results in improving access to care, assuring the quality of services, and saving money. States moving to managed care are under increasing pressure to monitor access and quality of services to ensure that providers' medical decisions are not compromised by financial incentives.

Health Insurance: Remedies Needed to Reduce Losses From Fraud and Abuse (Testimony, Mar. 8, 1993, GAO/T-HRD-93-8).

Health insurance experts estimate that fraud and abuse contribute to some 10 percent of the $800-plus billion currently spent on health care. Overcoming obstacles, which frustrate insurers' efforts to prevent or detect and pursue cases involving fraudulent or abusive billing, will require systematic collaboration by insurers, law enforcement agents, regulators, and providers, on problems involving health insurance fraud and abuse. Resource constraints add to the problems of pursuing health care fraud.

## LIST OF ADDITIONAL GAO HEALTH PRODUCTS ISSUED BETWEEN MARCH AND JUNE 1993

Medical Readiness Training: Limited Participation by Army Medical Personnel (Report, June 30, 1993, GAO/NSIAD-93-205).

Federal Health Care: Increased Information Sharing Could Improve Service, Reduce Costs (Report, June 29, 1993, GAO/IMTEC-93-33BR).

Overhead Costs: Unallowable and Questionable Costs Charged to Medicare by Hospital Corporation of America (Testimony, June 23, 1993, GAO/T-NSIAD-93-16).

VA Health Care: Delays in Awarding Major Construction Contracts (Report, May 26, 1993, GAO/HRD-93-101).

VA Health Care: Problems in Implementing Locality Pay for Nurses Not Fully Addressed (Report, May 21, 1993, GAO/HRD-93-54).

DOD Health Care: Further Testing and Evaluation of Case-Managed Home Care Is Needed (Report, May 21, 1993, GAO/HRD-93-59).

VA Health Care: Enforcement of Federal Ethics Requirements at VA Medical Centers (Testimony, May 19, 1993, GAO/T-HRD-93-22). Reports on same topic (May 12, 1993, GAO/HRD-93-39S and Apr. 30, 1993, GAO/HRD-93-39).

Massachusetts Long-Term Care (Letter, May 17, 1993, GAO/HRD-93-22R).

Safety and Health: Key Independent Oversight Program at DOE Needs Strengthening (Report, May 17, 1993, GAO/RCED-93-85).

Medicaid: Data Improvements Needed to Help Manage Health Care Program (Report, May 13, 1993, GAO/IMTEC-93-18).

Defense Health Care: Lessons Learned From DOD's Managed Health Care Initiative (Testimony, May 10, 1993, GAO/T-HRD-93-21).

Defense Health Care: Additional Improvements Needed to CHAMPUS's Mental Health Program (Report, May 6, 1993, GAO/HRD-93-34).

Veterans' Health Care: Potential Effects of Health Care Reforms on VA's Major Construction Program (Testimony, May 6, 1993, GAO/T-HRD-93-19).

Veterans' Affairs: Establishing Patient Smoking Areas at VA Facilities (Report, May 3, 1993, GAO/HRD-93-104).

Automated Medical Records: Leadership Needed to Expedite Standards Development (Report, Apr.30, 1993, GAO/IMTEC-93-17).

Social Security: Rising Disability Rolls Raise Questions (Testimony, Apr. 22, 1993, GAO/T-HRD-93-15).

Cataract Surgery: Patient-Reported Data on Appropriateness and Outcomes (Testimony, Apr. 21, 1993, GAO/T-PEMD-93-3). Report on same topic (Apr. 20, 1993, GAO/PEMD-93-14).

FDA Premarket Approval: Process of Approving Lodine as a Drug (Report, Apr. 12, 1993, GAO/HRD-93-81).

Social Security: SSA's Processing of Continuing Disability Reviews (Testimony, Apr. 9, 1993, GAO/T-HRD-93-9).

Public Health Service: Evaluation Set-Aside Has Not Realized Its Potential to Inform the Congress (Report, Apr. 8, 1993, GAO/PEMD-93-13).

Long-Term Care Case Management: State Experiences and Implications for Federal Policy (Report, Apr. 6, 1993, GAO/HRD-93-52).

Veterans' Health Care: Potential Effects of Health Financing Reforms on Demand for VA Services (Testimony, Mar. 31, 1993, GAO/T-HRD-93-12).

DOD Mental Health Review Efforts (Letter, Mar. 31, 1993, GAO/HRD-93-19R).

Medicaid Formula Alternatives (Letter, Mar. 31, 1993, GAO/HRD-93-18R). Letter on same topic (Mar. 2, 1993, GAO/HRD-93-17R).

Management of VA: Improved Human Resource Planning Needed to Achieve Strategic Goals (Report, Mar. 18, 1993, GAO/HRD-93-10).

Veterans' Health Care: Potential Effects of Health Reforms on VA Construction (Testimony, Mar. 3, 1993, GAO/T-HRD-93-7).

VA Health Care: Selection of a Planned Medical Center in East Central Florida (Report, Mar. 1, 1993, GAO/HRD-93-77). Letter on same topic (June 2, 1993, GAO/HRD-93-23R).

## MOST FREQUENTLY REQUESTED HEALTH REPORTS

Health Care: Rochester's Community Approach Yields Better Access, Lower Costs (Report, Jan. 29, 1993, GAO/HRD-93-44).

Rochester, New York, has succeeded in keeping health care costs lower than costs in other communities without sacrificing its residents' access to care. Rochester residents are more likely to have health insurance than populations of other cities and the nation. Rochester's system is distinguished by the interaction of several factors, beginning with a long history of community-based health planning. These planning initiatives have included limiting the expansion of hospital capacity, implementing global budgeting that capped total hospital revenues, and controlling the diffusion of medical technology.

Emergency Departments: Unevenly Affected by Growth and Change in Patient Use (Report, Jan. 4, 1993, GAO/HRD-93-4).

Nationwide emergency department patient caseloads grew dramatically from 1985 through 1990. Growth was concentrated among patients whose medical care is often not reimbursed, such as the uninsured and Medicaid patients in some states. This disproportionate growth may make it more difficult for hospitals to absorb or offset losses due to unreimbursed emergency department patient care costs. Nationwide patterns of caseload growth, payer mix, and timeliness of care conceal substantial variations in emergency department conditions among hospitals.

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.

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.

Access to Health Care: States Respond to Growing Crisis (Report, 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: 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.

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.

Health Care Spending Control: The Experience of France, Germany, and Japan (Report, Nov. 15, 1991, GAO/HRD-92-9). French and German translations available (Nov. 15, 1991, GAO/HRD-92-9ES). Testimony on same topic (Nov. 19, 1991, GAO/T-HRD-92-12).

France, Germany and Japan achieve near-universal health insurance coverage. This report describes these countries' health insurance and financing method, their policies intended to restrain health care spending increases, and the effectiveness of these policies. While GAO does not endorse the specific health systems in the reviewed countries, their strengths and weaknesses could be instructive in helping resolve U.S. health care problems.

U.S. Health Care Spending: Trends, Contributing Factors, and Proposals for Reform (Report, June 10, 1991, GAO/HRD-91-102). French and German translations available (June 10, 1991, GAO/HRD-91-102). Testimony on same topic (Apr. 17, 1991, GAO/T-HRD-91-16).

This report contains testimony presented to the House Committee Ways and Means on April 17, 1991, on health care costs in the United States as well as on long-term strategies for reform of the U.S. health care system.

Canadian Health Insurance: Lessons for the United States (Report, June 4, 1991, GAO/HRD-91-90). Testimony on same topic (June 4, 1991, GAO/T-HRD-91-35).

If the universal coverage and single-payer features of the Canadian system were applied in the United States, the savings in administrative costs alone would be more than enough to finance insurance coverage for the millions of Americans who are currently uninsured. There would be enough left over to permit a reduction, or possibly even the elimination, of copayments and deductibles. With the authority and responsibility to oversee the system as a whole, as in Canada, the single payer could potentially constrain the growth in long-run health care costs. Canadians have few problems with access to primary care services. The Canadian method of controlling hospital costs has limited the use of expensive, high technology diagnostic and surgical procedures.

## HEALTH FINANCING AND ACCESS

Organ Transplants: Increased Effort Needed to Boost Supply and Ensure Equitable Distribution of Organs (Report, Apr. 22, 1993, GAO/HRD-93-56). Testimony on same topic (Apr. 22, 1993, GAO/T-HRD-93-17).

Health Insurance: Remedies Needed to Reduce Losses From Fraud and Abuse (Testimony, Mar. 8, 1993, GAO/T-HRD-93-8).

Major Issues Facing a New Congress and a New Administration (Testimony, Jan. 8, 1993, GAO/T-OCG-93-1).

Health Insurance: Legal and Resource Constraints Complicate Efforts to Curb Fraud and Abuse (Testimony, Feb. 4, 1993, GAO/T-HRD-93-3). Report on same topic (May 7, 1992, GAO/HRD-92-69). Testimony on same topic (May 7, 1992, GAO/T-HRD-92-29).

Health Care: Rochester's Community Approach Yields Better Access, Lower Costs (Report, Jan. 29, 1993, GAO/HRD-93-44).

Emergency Departments: Unevenly Affected by Growth and Change in Patient Use (Report, Jan. 4, 1993, GAO/HRD-93-4).

Transition Series: Health Care Reform (Report, Dec. 1992, GAO/OCG-93-STR).

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

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

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

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

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

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).

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

Access to Health Care: States Respond to Growing Crisis (Report, June 16, 1992, GAO/HRD-92-70). Testimony on same topic (June 9, 1992, GAO/T-HRD-92-40).

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

Access to Health Insurance: States Attempt to Correct Problems in Small Business Health Insurance Market (Report, May 14, 1992, GAO/HRD-92-90). Testimony on same topic (May 14, 1992, GAO/T-HRD-92-30).

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).

Insurer Failures: Life/Health Insurer Insolvencies and Limitations of State Guaranty Funds (Testimony, Apr. 28, 1992, GAO/T-GGD-92-15). Report on same topic (Mar. 19, 1992, GAO/GGD-92-44).

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

Maternal and Child Health: Block Grant Funds Should be Distributed More Equitably (Report, Apr. 2, 1992, GAO/HRD-92-5).

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

Insurer Failures: Life/Health Insurer Insolvencies and Limitations of State Guaranty Funds (Report, Mar. 19, 1992, GAO/GGD-92-44).

Small Group Market Reforms: Assessment of Proposals to Make Health Insurance More Readily Available to Small Businesses (Letter, Mar. 12, 1992, GAO/HRD-92-27R).

Medigap Insurance: Insurers Whose Loss Ratios Did Not Meet Federal Minimum Standards in 1988-89 (Report, Feb. 28, 1992, GAO/HRD-92-54).

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

Budget Issues: 1991 Budget Estimates: What Went Wrong (Report, Jan. 15, 1992, GAO/OCG-92-1).

Hispanic Access to Health Care: Significant Gaps Exist (Report, Jan. 15, 1992, GAO/PEMD-92-6). Testimony on same topic (Sept. 19, 1991, GAO/T-PEMD-91-13).

Health Care Spending Control: The Experience of France, Germany, and Japan (Report, Nov. 15, 1991, GAO/HRD-92-9). French and German translations available (Nov. 15, 1991, GAO/HRD-92-9ES). Testimony on same topic (Nov. 19, 1991, GAO/T-HRD-92-12).

Off-Label Drugs: Reimbursement Policies Constrain Physicians in Their Choice of Cancer Therapies (Report, Sept. 27, 1991, GAO/PEMD-91-14).

States Need More Department of Labor Help to Regulate Multiple Employer Welfare Arrangements and Correct Problems (Testimony, Sept. 17, 1991, GAO/T-HRD-91-47).

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

Rural Hospitals: Closures and Issues of Access (Testimony, Sept. 4, 1991, GAO/T-HRD-91-46). Reports on same topic (Feb. 15, 1991, GAO/HRD-91-41), (June 19, 1990, GAO/HRD-90-134), (June 12, 1990, GAO/HRD-90-67).

Nonprofit Hospitals: Better Standards Needed for Tax Exemption (Testimony, July 10, 1991, GAO/T-HRD-91-43). Report on same topic (May 30, 1990, GAO/HRD-90-84). Testimony on same topic (June 28, 1990, GAO/T-HRD-90-45).

Private Health Insurance: Problems Caused by a Segmented Market (Report, July 2, 1991, GAO/HRD-91-114). Testimony on same topic (May 2, 1991, GAO/T-HRD-91-21).

## MEDICARE AND MEDICAID

Overhead Costs: Unallowable and Questionable Costs Charged to Medicare by Hospital Corporation of America (Testimony, June 23, 1993, GAO/T-NSIAD-93-16).

Medicare: Renal Facility Cost Reports Probably Overstate Costs of Patient Care (Report, May 18, 1993, GAO/HRD-93-70).

Medicaid: Data Improvements Needed to Help Manage Health Care Program (Report, May 13, 1993, GAO/IMTEC-93-18).

Medicaid: HealthPASS--An Evaluation of a Managed Care Program for Certain Philadelphia Recipients (Report, May 7, 1993, GAO/HRD-93-67).

Screening Mammography: Higher Medicare Payments Could Increase Costs Without Increasing Use (Report, Apr. 22, 1993, GAO/HRD-93-50).

Medicare: Physicians Who Invest in Imaging Centers Refer More Patients for More Costly Services (Testimony, Apr. 20, 1993, GAO/T-HRD-93-14). Report on same topic (May 27, 1992, GAO/HRD-92-59).

Medicare Secondary Payer Program: Identifying Beneficiaries With Other Insurance Coverage Is Difficult (Testimony, Apr. 2, 1993, GAO/T-HRD-93-13).

Medicaid Formula Alternatives (Letter, Mar. 31, 1993, GAO/HRD-93-18R). Letter on same topic (Mar. 2, 1993, GAO/HRD-93-17R).

Medicaid: The Texas Disproportionate Share Program Favors Public Hospitals (Report, Mar. 30, 1993, GAO/HRD-93-86).

Childhood Immunization: Opportunities to Improve Immunization Rates at Lower Cost (Report, Mar. 24, 1993, GAO/HRD-93-41). Testimony on same topic (June 1, 1992, GAO/T-HRD-92-36).

Medicaid: Outpatient Drug Costs and Reimbursements for Selected Pharmacies in Illinois and Maryland (Report, Mar. 18, 1993, GAO/HRD-93-55FS).

Medicaid: States Turn to Managed Care to Improve Access and Control Costs (Report, Mar. 17, 1993, GAO/HRD-93-46). Testimony on same topic (Mar. 17, 1993, GAO/T-HRD-93-10).

Medicare: Funding and Management Problems Result in Unnecessary Expenditures (Testimony, Feb. 17, 1993, GAO/T-HRD-93-4).

Medicaid: Changes in Drug Prices Paid by HMOs and Hospitals Since Enactment of Rebate Provisions (Report, Jan. 15, 1993, GAO/HRD-93-43).

High-Risk Series: Medicare Claims (Report, Dec. 1992, GAO/HR-93-6).

Medicare: Millions in End-Stage Renal Disease Expenditures Shifted to Employer Health Plans (Report, Dec. 31, 1992, GAO/HRD-93-31).

District of Columbia: Barriers to Medicaid Enrollment Contribute to Hospital Uncompensated Care (Report, Dec. 29, 1992, GAO/HRD-93-28).

Medicaid: Disproportionate Share Policy (Letter, Dec. 22, 1992, GAO/HRD-93-3R).

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

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