
April 2002

**RETIRED COAL
MINERS' HEALTH
BENEFIT FUNDS**

**Financial Challenges
Continue**



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<p>Abstract</p> <p>In 1992, certain retired coal miners and their spouses and dependents more than 100,000 individuals in all faced a potential decrease in their employment-related health insurance coverage or loss of such coverage altogether. Some former employers had stopped mining coal or gone out of business, so they were no longer contributing to the United Mine Workers of America (UMWA) retiree benefit funds. To ensure that these individuals would continue to receive the health benefits specified in previous collective bargaining agreements reached with coal companies, often gained in exchange for lower pensions, the Congress enacted the Coal Industry Retiree Health Benefit Act of 1992 (Coal Act).¹ The Coal Act replaced the existing UMWA retiree health benefit funds with the Combined Benefit Fund (CBF) and the 1992 Benefit Plan collectively referred to in this report as the Funds.² The act specified how each fund would be financed by the coal miners former employers and other sources to cover the health care costs not paid for by Medicare. In 2001, there were about 55,000 beneficiaries in the CBF and about 6,000 in the 1992 Benefit Plan. The health plans are administered by the United Mine Workers of America Health and Retirement Funds (UMWAF).</p>		
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Contents

Letter	1
Results in Brief	3
Background	5
Along Some Dimensions, the Funds' Benefits Are More Generous than Those Offered by Major Manufacturers or Companies with Unionized Labor Forces	12
The Funds' Beneficiaries Have Higher Health Care Costs than Comparable Beneficiaries	18
The Funds' Trustees Have Implemented a Number of Cost Control Initiatives	21
Concluding Observations	22
Comments from the UMWA Health and Retirement Funds and Our Evaluation	23

Related GAO Products	25
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Tables	
Table 1: Selected Features of the Funds' Health Plans Compared with Health Plans Offered to Salaried Workers and Retirees in Manufacturing Companies and Plans Offered to Unionized Hourly Workers and Retirees	13
Table 2: Comparison of the Funds' Outpatient Prescription Drug Benefit with Benefits Offered by Selected Retiree Health Plans in Manufacturing Companies, 2000	17

Figures	
Figure 1: Health Care Expenditures for the Funds' Medicare-Eligible Beneficiaries and Comparable Medicare Beneficiaries with Employer-Sponsored Health Insurance, 1999	19

Abbreviations

AML	Abandoned Mine Reclamation fund
BCOA	Bituminous Coal Operators Association
CBF	Combined Benefit Fund
CMS	Centers for Medicare and Medicaid Services
HCFA	Health Care Financing Administration
PBM	pharmacy benefits manager
SNF	skilled nursing facility
SSA	Social Security Administration
UMWA	United Mine Workers of America
UMWAF	United Mine Workers of America Health and Retirement Funds



United States General Accounting Office
Washington, DC 20548

April 18, 2002

The Honorable Don Nickles
United States Senate

Dear Senator Nickles:

In 1992, certain retired coal miners and their spouses and dependents—more than 100,000 individuals in all—faced a potential decrease in their employment-related health insurance coverage or loss of such coverage altogether. Some former employers had stopped mining coal or gone out of business, so they were no longer contributing to the United Mine Workers of America (UMWA) retiree benefit funds. To ensure that these individuals would continue to receive the health benefits specified in previous collective bargaining agreements reached with coal companies, often gained in exchange for lower pensions, the Congress enacted the Coal Industry Retiree Health Benefit Act of 1992 (Coal Act).¹ The Coal Act replaced the existing UMWA retiree health benefit funds with the Combined Benefit Fund (CBF) and the 1992 Benefit Plan—collectively referred to in this report as the Funds.² The act specified how each fund would be financed by the coal miners' former employers and other sources to cover the health care costs not paid for by Medicare. In 2001, there were about 55,000 beneficiaries in the CBF and about 6,000 in the 1992 Benefit Plan. The health plans are administered by the United Mine Workers of America Health and Retirement Funds (UMWAF).

Since 1997, the CBF has incurred annual operating deficits. Although the Congress has made special appropriations to keep the CBF solvent, these

¹Pub L. No. 102-486, Tit. XIX, Subtit. C, 106 Stat 2776, 3036 (codified at 26 U.S.C. §§ 9701-9722 (1994)).

²The 1950 UMWA Benefit Plan and the 1974 UMWA Benefit Plan were merged to create the CBF, which continued coverage for retirees receiving benefits from either of the two plans. The 1992 Benefit Plan was created to serve (1) individuals who, on February 1, 1993, were eligible but not receiving benefits as of July 20, 1992, and who had retired by September 30, 1994, and (2) subsequent retirees eligible under the previous plans whose former employers stopped providing health care coverage or had gone out of business. The CBF and the 1992 Benefit Plan are alike in most respects except for how they are financed. The comments in this report generally apply to both funds. When a distinction must be drawn between the two funds each one is identified by name.

actions have not addressed the CBF's long-term financial challenges.³ Health care spending has risen faster than contributions to the CBF, and financial difficulties have been compounded by court decisions that have reduced the per beneficiary premium paid by the coal miners' former employers and relieved some companies of the responsibility for paying premiums for certain beneficiaries.⁴ Consequently, actuarial projections indicate that annual revenue shortfalls are expected to continue.

In contrast to the CBF, the 1992 Benefit Plan has not incurred ongoing deficits. The 1992 Benefit Plan has a different financing structure and premiums paid by coal companies are adjusted each year to meet the expected health care costs of covered beneficiaries. From 1997 through 2002, these premiums rose by 47 percent to keep pace with increases in per capita health care spending.⁵

To help the Congress consider long-term solutions to the Funds' financial challenges, you asked us to examine (1) how the Funds' health benefits compare to benefits offered by other retiree plans, (2) how the health care costs of the Funds' beneficiaries compare to the costs of other retiree groups, and (3) the efforts of the Funds' officials to control costs.⁶ To conduct our study, we compared the benefit packages the Funds offered in 1999 to the benefit packages certain major manufacturing companies

³Had the Congress not made a special appropriation to keep the fund solvent, there would have been an annual operating deficit of about \$53.4 million in 2001.

⁴Under the Coal Act, the CBF also assumed responsibility for the death benefits coverage previously provided by the pension plans it replaced. These benefits amounted to \$7.8 million in 2000. Expenditure figures are reported for the fund's fiscal year.

⁵Under the Coal Act, the 1992 Benefit Plan is financed by a combination of two premiums charged to signatory coal companies. The references in this report to 1992 Benefit Plan premiums refer to the per beneficiary premium, which the trustees set to reflect the expected per beneficiary cost of health care for the coming year. The other premium is calculated and charged to coal companies to ensure that there are sufficient funds to cover the costs of individuals in the plan whose companies no longer offered health care benefits or who could not be assigned to specific companies.

⁶We addressed questions concerning fund financing in three previous letters: U.S. General Accounting Office, *Analysis of the Administration's Proposal to Ensure Solvency of the United Mine Workers of America Combined Benefit Fund*, [GAO/AIMD-00-267R](#) (Washington, D.C.: Aug. 15, 2000), *Financial and Legal Issues Facing the United Mine Workers of America Combined Benefit Fund*, [GAO/AIMD-00-280R](#) (Washington, D.C.: Aug. 15, 2000), and *Additional Information Related to Analysis of the Administration's Proposal to Ensure Solvency of the United Mine Workers of America Combined Benefit Fund*, [GAO/AIMD-00-308R](#) (Washington, D.C.: Aug. 31, 2000).

offered and those offered to a sample of unionized hourly workers.⁷ Because 89 percent of the Funds' beneficiaries are eligible for Medicare, we compared the health care costs for these individuals to the health care costs of other, demographically similar Medicare beneficiaries covered by employer-sponsored insurance. We also interviewed the Funds' managers and their contractors, officials from the Health Care Financing Administration (HCFA),⁸ and coal company representatives about the financing and operations of the Funds. We performed our work from October 2000 through March 2002 in accordance with generally accepted government auditing standards.

Results in Brief

The Funds' health care benefits package requires relatively less cost sharing by beneficiaries and provides more extensive coverage of some services than benefit packages offered by the major manufacturing companies and companies with unionized workforces that we examined, but overall, the extent of coverage is generally comparable. For hospital care and physician services, which comprise the majority of health care spending, the Funds' coverage is similar to that offered by the majority of manufacturing companies and to other unionized hourly workers. However, unlike many retirees in the comparison companies, the Funds' beneficiaries do not pay premiums for their health care coverage and beneficiaries' annual out-of-pocket expenses for covered services are capped at \$150 per family. In contrast, the typical unionized hourly worker is liable for \$1,750 for covered services. The Funds' beneficiaries receive somewhat more comprehensive coverage for skilled nursing facility (SNF) care than other retirees from manufacturing companies. The Funds require a relatively low copayment of \$5 for each covered prescription and cap this required cost sharing at \$50 per year, although beneficiaries may be liable for additional amounts if they use brand name drugs instead of generic equivalents or use brand name drugs not on a list specified by the

⁷See Hewitt Associates, LLC, *Salaried Employee Benefits Provided by Major U.S. Employers in 1999—Manufacturing* (Lincolnshire, Ill.: 2000) and *Hourly Employee Benefits Provided by Major U.S. Employers, 1999* (Lincolnshire, Ill.: 2000). The manufacturing study included information from 513 companies, while the hourly employee benefits study included information from 126 employers with union employees.

⁸On July 1, 2001, the name of the Health Care Financing Administration (HCFA) was changed to the Centers for Medicare and Medicaid Services. In this report, we continue to refer to HCFA where our findings apply to the organizational structure and operations associated with that name.

Funds. In contrast, beneficiaries in a sample of manufacturing companies we contacted are responsible for \$1,000 or more in prescription drug costs.

The cost of health care for the Funds' beneficiaries in 1999 was about 29 percent higher (\$2,163 per person) than for demographically similar Medicare beneficiaries with employer-sponsored insurance. Approximately 62 percent of this difference (\$1,345) reflects higher spending on Medicare-covered services, while the remaining 38 percent (\$818) reflects higher spending on benefits not covered by Medicare, such as outpatient prescription drug coverage. However, the Funds' beneficiaries may also use more services because of their relatively poor health. Compared to demographically similar retirees, the Funds' beneficiaries report poorer health status and thus their greater use of hospital care, physician services, and SNF care may, in part, reflect greater needs.

The Funds' trustees believe the beneficiaries of the CBF and the 1992 Benefit Plan are entitled to the level of benefits established through prior bargaining agreements and consequently, their numerous cost containment initiatives have focused on the efficient management of health care services and on obtaining lower prices from their health care providers. The Funds' officials said they have attempted to control costs largely through approaches that do not reduce or limit the benefits for beneficiaries, do not increase beneficiary cost sharing requirements, or that have a minimal impact on beneficiaries. For example, the Funds' officials initiated case and disease management programs, implemented claims review procedures designed to avoid payment of inappropriate claims, hired a pharmacy benefits manager (PBM) to help control their outpatient prescription drug costs, solicited competitive bids to obtain better prices for durable medical equipment, and negotiated for their providers to accept Medicare rates as payment in full for all the Funds' beneficiaries.

In comments on a draft of this report, the Funds' officials stressed that in comparing their plans and beneficiaries with other plans and populations, it is important to have a full appreciation of the history behind the 1992 Coal Act and the tradeoffs coal miners made to secure their health benefits. The Funds' officials also noted that they have implemented a wide range of managed care and cost containment initiatives and have realized substantial savings for the Funds and for Medicare and the U.S. Treasury.

Background

The Coal Act established beneficiary eligibility requirements, a standard for covered benefits, and separate boards of trustees to oversee the CBF and the 1992 Benefit Plan. For both funds, the act requires coal companies to pay premiums for beneficiaries and their dependents, but the annual premium amount, the method for adjusting the premium each year, and other financing arrangements are quite different for each fund. Since the Funds were established in 1993, coal companies have challenged several provisions of the law. Court decisions in favor of former employers have reduced the premium contributions paid by the companies to the CBF. Although the CBF's financing was originally expected to be adequate, the CBF has incurred an annual operating deficit in each year since 1997, prompting Congress to make special appropriations in 1999 and 2000 to maintain its solvency. In contrast, the 1992 Benefit Plan has had an annual operating deficit in only one year (2000) since its inception.⁹

The Funds' Beneficiaries

The Coal Act limited coverage under the Funds to retired coal miners, their spouses and dependents who were eligible for benefits under former UMWA retiree benefit plans. There were approximately 115,000 beneficiaries in 1993. The number of beneficiaries has declined each year as individuals died and dependent minors reached 22 years of age and no longer qualified for coverage (the current population is declining by approximately 9 percent per year). In 2001, the Funds provided health benefits to about 61,000 beneficiaries. Approximately 70 percent of beneficiaries are female and the median age is over 78. Most of the Funds' beneficiaries are eligible for Medicare (89 percent) and others are from 55 to 64 years of age and nearing eligibility (7 percent).

Most of the Funds' beneficiaries (62 percent) live in rural or nonmetropolitan urban areas. More than three quarters of the beneficiaries live in five states: West Virginia (32 percent), Pennsylvania (19 percent), Kentucky (12 percent), Virginia (8 percent), and Ohio (6 percent). In 2000, the median income of the Funds' beneficiaries (\$17,100) was similar to the median income of all Medicare beneficiaries (\$18,000).

⁹The 2001 financial statements were not available during the time we were preparing this report.

Health Care Benefits

The Coal Act specified that “to the maximum extent feasible,” the Funds’ coverage be “substantially the same as” the coverage provided under the UMWA retiree health plans they replaced, provided that premium income is sufficient to cover payment rates to providers.¹⁰ Thus, the Funds’ benefit packages reflect the outcome of prior agreements between UMWA and coal companies. The benefits include coverage for inpatient and outpatient hospital care, physician services, prescription drugs, home health services, SNF care, mental health care, and durable medical equipment such as ventilators and wheelchairs.

All of the Funds’ beneficiaries receive the same package of benefits regardless of their entitlement status (retiree, spouse, or dependent) or their eligibility for Medicare. For Medicare-eligible beneficiaries, the Funds pay Medicare’s required cost sharing (coinsurance, copayments, and deductibles) in addition to the cost of services included in the Funds’ benefit packages but not covered by Medicare, such as outpatient prescription drugs. Except for required copayments, the Funds pay the entire cost of covered services provided to beneficiaries who are not eligible for Medicare.

Operations and Financing

There are separate boards of trustees for the CBF and for the 1992 Benefit Plan. The Coal Act stipulates that the CBF board consist of one individual designated by the Bituminous Coal Operators Association (BCOA) to represent employers in the coal mining industry, one individual jointly designated by the three employers with the greatest number of assigned beneficiaries, two individuals designated by UMWA, and three persons selected by the other board members.¹¹ UMWA and BCOA each appoint two members to the board of the 1992 Benefit Plan. Some individuals serve as trustees for both the CBF and the 1992 Benefit Plan.

The Coal Act established the Funds’ initial and ongoing financing structures. Both funds receive annual revenues from coal company premiums and Medicare payments.¹² However, the CBF also received an

¹⁰26 U.S.C. §§ 9701-9722 (1994).

¹¹The Coal Act specifies that the three employers must not be signatories to the 1988 National Bituminous Coal Wage Agreement.

¹²The Funds also receive a small amount of their revenues from other sources, such as income from the pursuit of delinquencies owed the merged plans, from the Department of Labor for black lung related care, and interest income from investments.

initial transfer of assets from the 1950 UMWA Pension Plan,¹³ and has received some of the accumulated interest from the Abandoned Mine Reclamation fund (AML) since 1996.¹⁴ Together, these revenues pay for health care expenses and the associated administrative costs of the health plans, which include the cost of third-party contracts for claims processing and utilization review, general overhead, and legal representation in lawsuits brought by and against the Funds.¹⁵

Company Premiums

The Coal Act requires certain coal and other companies to pay premiums on behalf of beneficiaries who are covered by the 1992 Benefit Plan or the CBF.¹⁶ However, the 1992 Benefit Plan and the CBF differ in how the annual premium amount is determined and the extent to which coal companies are responsible for beneficiaries. For the 1992 Benefit Plan, the Coal Act allows the premiums to be adjusted annually to cover changes in the cost of providing benefits. The trustees have historically set the premiums so that revenues will meet projected annual expenditures. Thus, premium adjustments reflect changes in medical prices or beneficiaries' use of medical services. For 2002, the annual premium was about \$4,437, or about 38 percent higher than the CBF annual premium.

The Coal Act assigns financial responsibility for paying premiums to each eligible retiree's most recent coal industry employer.¹⁷ If an employer has

¹³The Coal Act transferred \$210 million (13 percent of assets) from the UMWA 1950 Pension Plan to the CBF in three transactions of \$70 million each from February 1, 1993, to October 1, 1994. These assets were then used to finance the health care benefits under the Coal Act, instead of pensions. Actuarial estimates produced for the BCOA place the value of forgone pensions due to this transfer at \$743 per year for retired miners and \$248 per year for widows.

¹⁴The Surface Mining Control and Reclamation Act of 1977, Pub. L. No. 95-87, 91 Stat. 445, established the AML primarily to fund cleanups of abandoned mine land. The Coal Act specified that accumulated AML interest could be used to pay the health care costs of those beneficiaries for whom the CBF did not receive premiums from coal companies. AML moneys are not used for the 1992 Benefit Plan.

¹⁵The Funds' representatives said that administrative costs were roughly 4 percent of CBF expenses from 1993 through 2000.

¹⁶Following the Supreme Court's decision in *Eastern Enterprises v. Apfel*, 524 U.S. 498 (1998), some employers have been relieved of their financial responsibilities.

¹⁷This employer must be a signatory to the 1988 National Bituminous Coal Wage Agreement.

gone out of business, or the premium cannot otherwise be collected, the cost of affected 1992 Benefit Plan beneficiaries is shared by other coal companies that were signatories to a prior agreement between the industry and UMWA and that have either current or potentially eligible beneficiaries under the 1992 Benefit Plan.

For the CBF, the Coal Act specifies a method for determining the premium to be paid by a company for each of its retirees and eligible dependents, and how the premium is updated. The premium is based on the cost of providing benefits under the UMWA's retiree health plan during the period between July 1, 1991 through June 30, 1992. It is increased each year by the percentage change in general medical prices as measured by the medical component of the consumer price index. In 2002, the annual premium was about \$2,725.

The Social Security Administration (SSA) was charged with determining which company is financially responsible for each CBF beneficiary. In some cases, SSA was not able to assign a beneficiary to a responsible company. This occurred, for example, when a beneficiary's former employer had gone out of business. In 2001, about 71 percent of CBF beneficiaries were assigned to companies that were responsible for paying premiums on their behalf. The CBF did not receive premium payments from coal companies or their successors for the 29 percent of beneficiaries who were unassigned.

Transfers of Accumulated Interest from the AML

The Coal Act allows for transfers of accumulated interest from the AML, a federal fund financed by levies on coal extraction, to cover the projected costs of the CBF's unassigned beneficiaries. Since 1996, transfers of interest from the AML to the CBF have helped to pay for costs associated with assigned beneficiaries. In 1999 and 2000, Congress made special appropriations to keep the CBF solvent. The AML moneys have not been used to support the 1992 Benefit Plan.

Medicare Payments

The Funds are participants in a Medicare demonstration project that places them at financial risk for the cost of Medicare-covered services delivered to eligible beneficiaries. The extent of the Funds' financial risk varies by type of service. The Funds assume partial risk for the cost of Medicare's part A benefits that include coverage for inpatient hospital services and skilled nursing facility care. Annual spending for these

services is compared to an expenditure target. If spending was less than the targeted amount, the difference is shared between the Funds and Medicare according to a predetermined formula. The same formula specifies how the cost of any spending in excess of the targeted amount is to be shared. The Funds assume full financial risk for the cost of Medicare-covered part B benefit that cover physician, hospital outpatient, and certain other services. Medicare pays the Funds a fixed monthly payment per beneficiary, known as a capitation payment, that is projected to cover the cost of these services.¹⁸ If the Funds' spending on these services for eligible beneficiaries is less than Medicare's capitation payments, the Funds may retain the difference. However, the Funds are financially responsible for any spending in excess of Medicare's capitation payments.

In recent years, the Funds spent less on Medicare-covered services than the combined total of the annual expenditure target and capitation payments from Medicare. In 1999, for example, this difference amounted to approximately \$16 million, of which \$4.4 million was retained by the Funds and \$11.6 million was retained by Medicare. The Funds can use these retained moneys to help pay for services and items not covered by Medicare, such as outpatient prescription drugs.

On July 1, 2001, the Centers for Medicare and Medicaid Services (CMS) renewed the demonstration project for an additional 3 years. At the same time, CMS agreed to include a new component in the demonstration project that will provide the Funds with additional revenue to help cover the cost of outpatient prescription drugs. Under the terms of the new demonstration component, Medicare will pay the Funds an amount equal to 27 percent of their expenditures on outpatient prescription drugs for Medicare-eligible beneficiaries. CMS estimates that the new demonstration component will result in an additional \$135 million in Medicare payments to the Funds during the 3-year period.

¹⁸The annual spending targets and capitation payment amounts are calculated from the Funds' per capita cost of providing Medicare-covered services in a specified base year updated by changes in the Medicare program's per capita spending since that year.

Impact of Legal Challenges

Court decisions in several lawsuits brought by coal companies have reduced the premium revenues available to the CBF and contributed to the financing challenge it faces.¹⁹ The cost of legal representation has also increased the CBF's annual administrative costs. Since 1992, companies have filed over 50 lawsuits challenging specific aspects of the Coal Act's implementation. One lawsuit challenged SSA's calculation of the initial premium rate. As a result of the court decision in that case, premiums charged to companies were reduced by approximately 10 percent.²⁰ In other lawsuits, companies have challenged some of SSA's beneficiary assignment decisions. The effect of one Supreme Court decision was to reduce companies' financial responsibilities thereby increasing the number of unassigned beneficiaries.²¹ Another case changed the status of several thousand beneficiaries from assigned to unassigned.²² The CBF will receive no further premiums from coal companies for all living beneficiaries who are now unassigned as a result of these cases, and transfers from the AML will have to increase to cover the health care costs of these additional unassigned beneficiaries. Furthermore, the CBF will need to refund the premiums it previously collected on behalf of any affected beneficiaries.

Discrepancy between Cost and Revenue Growth

The rise in health care expenditures during the 1990s, which prompted many private employers to reduce the health insurance benefits they provided to their employees or to require larger contributions from beneficiaries, also affected the expenditures of the Funds. From 1994 through 2000 the per capita cost of the CBF's beneficiaries rose by 53 percent, an average annual increase of 7.3 percent, and the per capita costs of the 1992 Benefit Plan beneficiaries, who tend to be younger than CBF beneficiaries, increased by 28 percent, an average annual increase of 4.2 percent. Part of the rise in cost was due to higher medical prices.

¹⁹For information on legal challenges, see U.S. General Accounting Office, *Financial and Legal Issues Facing the United Mine Workers of America Combined Benefit Fund*, [GAO/AIMD-00-280R](#) (Washington, D.C.: Aug. 15, 2000).

²⁰*National Coal Association vs. Chater*, 81 F.3d 1077 (11th Cir. 1996).

²¹*Eastern Enterprises v. Apfel*, 524 U.S. 498 (1998)

²²*Dixie Fuel Co. v. Comm'r of Soc. Sec.*, 171 F.3d 1052 (6th Cir. 1999, *petition for rehearing denied*, 1999 U.S. App. Lexis 16997 (6th Cir. July 7, 1999).

However, overall increases in the use of medical services and increases in the use of outpatient prescription drugs and other expensive services also pushed up per beneficiary costs. Although Medicare per capita costs rose by 26 percent during this period, in part due to rising utilization, the trend may have been magnified in the CBF because it serves a closed, and therefore aging, population. Per capita costs would be expected to grow faster among CBF beneficiaries relative to Medicare beneficiaries because older individuals tend to use more medical services than younger individuals and because the cost of outpatient prescription drugs, which are not covered by Medicare, have risen faster than other components of health care spending during this period.

Unlike premiums in the 1992 Benefit Plan, CBF premiums have not kept pace with increases in the cost of services not covered by Medicare. The CBF premium update adjustment specified in the Coal Act only reflects changes in medical prices, which rose at an average annual rate of 3.6 percent from 1994 to 2000 while per capita spending increased at twice that rate. To date, Medicare payments have been sufficient to cover the cost of providing Medicare-covered services in both the CBF and the 1992 Benefit Plan because annual updates to Medicare's payments reflect underlying changes in both prices and use of services. Similarly, AML funding for the non-Medicare costs of the CBF's unassigned beneficiaries is based on projected costs and takes into account expected changes in both utilization and prices.

Along Some Dimensions, the Funds' Benefits Are More Generous than Those Offered by Major Manufacturers or Companies with Unionized Labor Forces

In four areas—premium contributions, annual deductible, the cap on beneficiary out-of-pocket expenses, and coverage for SNF care—the Funds' benefits are more generous than those benefits typically offered to retirees and workers by major manufacturing companies or to unionized hourly workforces in other companies.²³ In addition, most aspects of the Funds' outpatient prescription drug coverage are more generous than the coverage provided by other benefit plans. However, many features of the Funds' health plans are similar to those offered in the comparison plans. In particular, the Funds' coverage for hospital and physician services, which account for the majority of health care spending, is comparable to the coverage provided by the other plans. (Table 1 compares selected benefits of the Funds' plans with those in plans offered to workers in manufacturing companies and to unionized hourly workers.) Eligibility requirements for retiree health plan coverage by the Funds are similar to those of other manufacturing employers. The Funds' beneficiaries can qualify for retiree health benefits at age 62 with 5 years of service, or at age 55 with 10 years of service.²⁴ Most retiree plans require a similar combination of minimum age and years of service to qualify for retiree health benefits.²⁵

²³We compared the Funds' benefits with those offered to retired and active workers in 513 large manufacturing companies and 126 companies with unionized hourly workers that participated in a survey on benefits conducted by Hewitt Associates, LLC. Details on active workers' health benefit packages are reported here because similar information was not available for some dimensions of retirees' benefit packages. According to a representative of Hewitt Associates, the health benefit packages offered to retirees are typically comparable to, or somewhat less generous than, the benefit packages offered to active workers. Data on unionized companies include both manufacturing and nonmanufacturing companies.

²⁴Disabled workers can become eligible for pensions and health benefits under other conditions.

²⁵Age, years of service, or some combination of the two was required for eligibility for almost all of the employers with unionized hourly workers who responded to the survey conducted by Hewitt Associates, LLC.

Table 1: Selected Features of the Funds' Health Plans Compared with Health Plans Offered to Salaried Workers and Retirees in Manufacturing Companies and Plans Offered to Unionized Hourly Workers and Retirees

Plan Feature	Feature included in the CBF and the 1992 Benefit Plan	Percentage of plans offered to salaried workers and retirees in manufacturing companies with feature (n=513)	Percentage of plans offered to unionized hourly workers and retirees with feature (n=126)
Retirees age 65 and older			
Retiree premium contribution			
No contribution required	✓	8	39
Contribution required, amount varies by pay, service, age, or other factor		10	19
Fixed contribution required		82	42
Total		100	100
Employer subsidy of premium			
Subsidized, no defined limit	✓	51	65
Subsidized, defined limit		41	31
No subsidy		8	4
Total		100	100
Retirees less than 65 years old			
Retiree premium contribution			
No contribution required	✓	4	30
Contribution required, amount varies by pay, service, age, or other factor		10	20
Fixed contribution required		86	50
Total		100	100
Employer subsidy of premium			
Subsidized, no defined limit	✓	54	51
Subsidized, defined limit		38	41
No subsidy		8	8
Total		100	100
Beneficiaries who have not retired			
Deductible			
No deductible	✓	48	59
Deductible		52	41
Total		100	100
Cap on employee out-of-pocket expenditures ^a			
Included	✓	NA	73
Not included		NA	5
Not needed; plan pays 100 percent		NA	22
Total		NA	100

Plan Feature	Feature included in the CBF and the 1992 Benefit Plan	Percentage of plans offered to salaried workers and retirees in manufacturing companies with feature (n=513)	Percentage of plans offered to unionized hourly workers and retirees with feature (n=126)
Hospital room and board coverage^a			
100 percent of reasonable and customary charges, no limit on days	✓	39	52
100 percent of reasonable and customary charges, with limitations on days		3	9
Less than 100 percent of reasonable and customary charges		59	39
Total		100^b	100
Hospital copayment or separate deductible^a			
No copayment or separate deductible	✓	86	88
Separate per admission copayment/deductible		11	11
Separate per day copayment/deductible		2	1
Other		1	-
Total		100	100
Surgical coverage^a			
100 percent of reasonable and customary charges	✓	39	57
Less than 100 percent		61	43
Total		100	100
Physician office visit coverage^a			
100 percent coverage with no copayment		5	8
100 percent coverage with copayment	✓	52	55
Less than 100 percent coverage		43	37
Total		100	100

NA: Data not available

^aInformation based on beneficiaries seeking care from a provider participating in the plan.

^bPercentages do not add to 100 due to rounding.

Source: *UMWA Combined Benefit Fund Plan Document* (www.umwafunds.org, downloaded on December 12, 2001), *UMWA 1992 Benefit Plan Plan Document* (www.umwafunds.org, downloaded on December 12, 2001), Hewitt Associates, LLC, *Salaried Employee Benefits Provided by Major U.S. Employers in 1999—Manufacturing*, and Hewitt Associates, LLC, *Hourly Employee Benefits Provided by Major U.S. Employers, 1999*.

Retiree premium contribution. The Funds' beneficiaries do not pay a premium beyond that required for Medicare part B, the optional part of Medicare. According to a study by Hewitt Associates, 61 percent of unionized companies require retired unionized hourly workers to pay a health insurance premium.²⁶ A related study found that more than 92 percent of major manufacturing companies require retirees from salaried jobs to pay a health insurance premium.²⁷

Deductible. The Funds' beneficiaries are not responsible for an annual deductible. Beginning with the first covered service used, the Funds pay all but the copayment. In contrast, the average annual deductible for workers in large manufacturing companies is more than \$260 for individuals and more than \$615 for families.

Cap on beneficiary out-of-pocket expenses. The Funds' beneficiaries are responsible for copayments on each service used, up to an annual amount of \$100 per family, excluding prescription drugs. Additional out-of-pocket expenses for covered prescription drugs are capped at \$50 per family per year. The total cap of \$150 is substantially less than the median cap of over \$1,750 in plans offered to other unionized hourly workers.

SNF coverage. The Funds' beneficiaries are eligible for SNF care with no cost-sharing requirement and no limit on the number of covered days.²⁸ In contrast, most employer-sponsored retiree plans do not offer SNF care. Those that do typically restrict the number of days covered, require cost sharing, or both.

²⁶Hewitt Associates, LLC, *Hourly Employee Benefits Provided by Major U.S. Employers, 1999*.

²⁷Hewitt Associates, LLC, *Salaried Employee Benefits Provided by Major U.S. Employers in 1999–Manufacturing*.

²⁸The care must be deemed medically appropriate and be consistent with Medicare's SNF coverage criteria. Medicare covers most necessary SNF services, including room and board, nursing care, and ancillary SNF services such as drugs, laboratory tests, and physical therapy for up to 100 days of each benefit period. Beneficiaries must meet certain qualifying conditions such as having prior hospitalization and paying a copayment beginning with the 21st day (\$99 per day in 2001). There is no limit to the number of benefit periods a beneficiary may have.

Outpatient prescription drug benefit. The Funds' beneficiaries pay a \$5 copayment per prescription and their annual out-of-pocket costs for covered prescription drugs are capped at \$50. In contrast, many plans offered by manufacturing companies do not have deductibles but require beneficiaries to pay higher cost sharing requirements with no cap on out-of-pocket costs.²⁹ (See table 2.) Some plans require beneficiaries to pay 20 percent of the cost of each prescription while others use multitiered copayment schedules that may, for example, require \$5 for generic drugs, \$10 to \$15 for brand name drugs included in the health plan's formulary, and \$20 or more for nonformulary brand name drugs.³⁰ Furthermore, 14 of the 17 companies we contacted that cover prescription drugs do not cap retirees' out-of-pocket costs for outpatient prescription drugs.

²⁹We surveyed a randomly selected subset of 25 automotive, energy, oil, mining, and metals/steel companies that responded to the 1999 Hewitt survey of the manufacturing industry.

³⁰In general, a formulary is a list of drugs that, in most circumstances, a health insurer prefers that physicians prescribe. The formulary includes drugs that the insurer has deemed to be effective and suppliers may have favorably priced for the insurer.

Table 2: Comparison of the Funds' Outpatient Prescription Drug Benefit with Benefits Offered by Selected Retiree Health Plans in Manufacturing Companies, 2000

Plan Feature	Feature included in the CBF and the 1992 Benefit Plan	Number of comparison plans with feature^a (n=25)
Prescription drug benefit		
No benefit		8
Benefit offered	✓	17
Drug deductible (annual)		
None	✓	12
\$50		1
More than \$50		4
Cap on beneficiary out-of-pocket drug expenses		
Cap on costs	✓ ^b	3
No cap on costs		14
Generic drug substitution incentive policy		
Mandatory substitution	✓	5
Voluntary/differential pricing ^c		10
Voluntary/equal pricing for generics and brands		2

^aComparison companies are a randomly selected subset of automotive, energy, oil, mining, and metals/steel companies that responded to the 1999 Hewitt survey of the manufacturing industry.

^bThe Funds cap beneficiary out-of-pocket drug costs at \$50 annually, although beneficiaries may pay an additional amount if they use brand names instead of generics or nonpreferred brand names for certain classes of drugs. The amount was higher (\$1,000 to \$2,000) for the comparison companies whose plans had caps.

^cVoluntary/differential pricing includes multitiered pricing with lower copayments for generics than for brand name drugs.

Source: *UMWA Combined Benefit Fund Plan Document* (www.umwafunds.org, downloaded on December 12, 2001), *UMWA 1992 Benefit Plan Plan Document* (www.umwafunds.org, downloaded on December 12, 2001), and GAO survey of 25 manufacturing companies' retiree health plans.

However, the Funds' prescription drug benefit is more restrictive than those of some other retiree benefit plans, in that it generally limits coverage to generic versions of prescription drugs when generic versions are available. The Funds pay the entire cost of a drug, with the exception of the copayment, if a beneficiary uses a generic version of a prescription drug when one is available, unless his or her physician submits a written justification specifying that a particular brand is necessary. If the request is approved, the beneficiary is not charged an additional amount for the brand name product. Typically, about 40 such requests are received each month and about 30 percent of them are approved. Without approval, the

Funds' beneficiaries who use brand name drugs instead of generic equivalents, or who use off-formulary brand names instead of ones included on the formulary, must pay the full difference in price between the preferred and nonpreferred drug. This amount does not count toward the beneficiary's \$50 annual cap on prescription drug expenditures. Only 5 of the 17 companies we contacted that cover prescription drugs have similar mandatory generic drug use policies.

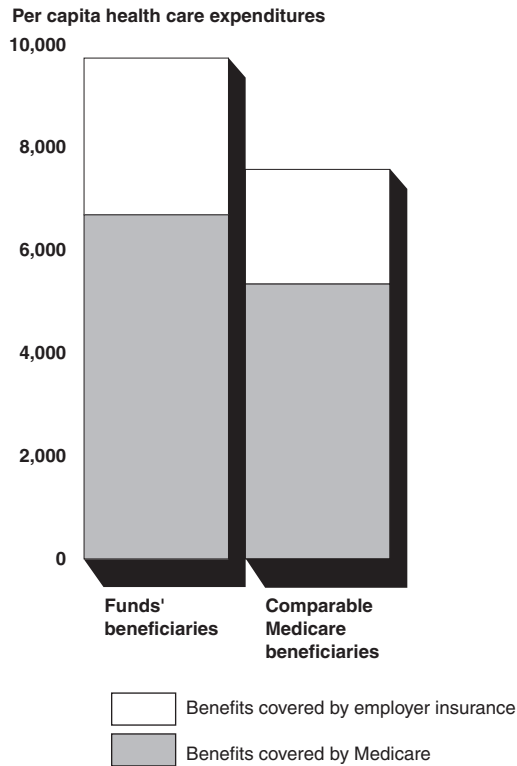
The Funds' Beneficiaries Have Higher Health Care Costs than Comparable Beneficiaries

The average annual health care cost of the Funds' beneficiaries is approximately 29 percent higher than the average cost of demographically similar Medicare retirees with employer-provided insurance.³¹ The Funds' beneficiaries also tend to use more health care services than Medicare beneficiaries of the same age and sex. The Funds' beneficiaries appear to be in relatively poorer health, which may explain the differences in cost and service use.

In 1999, the Funds spent an average of \$9,732 on each beneficiary who was eligible for Medicare. This was \$2,163, or 29 percent, higher than the estimated average health care cost of Medicare beneficiaries who live in the same counties where the Funds' beneficiaries live, have similar demographic characteristics, and have employer-provided supplemental insurance. (See figure 1.) Approximately \$1,345 (62 percent) of the \$2,163 estimated cost differential is associated with increased use of Medicare-covered services while the remaining \$818 (38 percent) is associated with additional benefits, such as prescription drug coverage, that are covered by the Funds.

³¹A third fund, the 1993 Benefit Plan, was established through collective bargaining between UMWA and BCOA. In March 2000, it covered approximately 2,000 beneficiaries. Because some UMWA data were reported collectively for the CBF, the 1992 Benefit Plan, and the 1993 Benefit Plan, the estimated cost per beneficiary is based on a joint analysis of all three funds.

Figure 1: Health Care Expenditures for the Funds' Medicare-Eligible Beneficiaries and Comparable Medicare Beneficiaries with Employer-Sponsored Health Insurance, 1999



Note: Estimates reflect costs of Medicare beneficiaries who live in counties where beneficiaries of the Funds live and are adjusted to reflect differences between Medicare beneficiaries and the beneficiaries of the Funds in characteristics such as age, sex, Medicaid eligibility, current labor force participation, and whether or not they are living in institutions.

Source: GAO analysis of CMS's and the Funds' data.

The beneficiaries of the Funds who are eligible for Medicare generally use more health care services than do similar Medicare beneficiaries nationwide. In 1999, the beneficiaries of the Funds had 22 percent more physician office visits, 51 percent more days in SNFs, 91 percent more days in the hospital, and 55 percent more days in hospice care than the

national average for Medicare beneficiaries of the same age and sex.³² However, the Funds' beneficiaries' use of home health care was substantially below the average home health utilization rate among demographically similar Medicare beneficiaries.³³

The health status of the Funds' beneficiaries may explain some of the observed differences in health care costs and utilization. In 1999, the average beneficiary in the Funds reported his or her health status as fair or good. That same year, the average Medicare beneficiary with similar demographic characteristics reported his or her health status as good or very good.³⁴ Several studies have found that individuals who report poorer health tend to use substantially more services than individuals who report better health.³⁵ Thus, it is likely that some of the higher costs and utilization associated with the Funds' beneficiaries is a result of their relatively poorer health. The Funds' low cost-sharing requirements provide few financial barriers to care, which may also contribute to the cost differential. However, we cannot determine how much of the cost and utilization difference is attributable to health status differences, local practice patterns, or differences in benefit packages and cost sharing arrangements.

³²The Funds beneficiaries' utilization rates may resemble local practice patterns more closely than they reflect national averages. For example, about 32 percent of the Funds' beneficiaries live in West Virginia—a state where the number of inpatient days per thousand for Medicare beneficiaries is 15 percent higher than the national average.

³³The comparison group of Medicare beneficiaries was similar to the Funds' Medicare-eligible beneficiaries in terms of age, sex, Medicaid eligibility, labor force participation, and whether or not they were living in institutions.

³⁴We obtained self-reported health status information on Medicare beneficiaries from the Medicare Current Beneficiary Survey. In a February 2001 survey of the Funds' beneficiaries, 57 percent of the respondents aged 65 and older reported their health status as "fair" or "poor." Comparable information from the 2001 Medicare Current Beneficiary Survey was not available during the time we were preparing this report.

³⁵For example, see Arlene S. Bierman, Thomas A. Bubolz, Elliott S. Fisher, and John H. Wasson, "How Well Does a Single Question about Health Predict the Financial Health of Medicare Managed Care Plans?" *Effective Clinical Practice*, Volume 2, Number 2 (Philadelphia: American College of Physicians, March/April 1999).

The Funds' Trustees Have Implemented a Number of Cost Control Initiatives

The Funds' trustees have stated that they are firmly committed to preserving the "benefits that were promised and guaranteed" to the retired miners and therefore their cost control efforts largely focus on making the Funds a more efficient manager and prudent purchaser of health care services.³⁶ While many private employers have responded to rising health care costs by requiring their beneficiaries to contribute more to the cost of health insurance, either through higher premiums or increased copayments and deductibles, the trustees have chosen to make relatively few changes that would affect the Funds' beneficiaries' out-of-pocket expenses.³⁷

According to the Funds' representatives, the trustees have tried to deliver services more efficiently and negotiate lower prices from providers and suppliers. The Funds' efficiency initiatives include a disease and case management program and the management of medical service use through prepayment claims and utilization review. Beneficiaries with health conditions such as diabetes or congestive heart failure receive care coordinated by the Funds' disease management program. To help prevent unnecessary spending, the third-party administrator that processes the Funds' claims reviews billing patterns to identify potential billing abuses or inappropriate payments and has also instituted other program integrity safeguards.

The Funds' efforts at being a prudent purchaser of care include a competitive bidding program for durable medical equipment suppliers, a range of initiatives designed to help control spending for prescription drugs, and arrangements with hospitals and physicians providers to accept Medicare rates as payments in full for all beneficiaries, including those who are not eligible for Medicare. The Funds have solicited competitive bids for durable medical equipment in an effort to obtain better pricing and have reduced the number of suppliers nationwide from several hundred to six. The Funds' PBM, which administers the prescription drug benefit, has established a formulary, mandated the use of generic drugs

³⁶According to the Funds' representatives, the trustees view the Coal Act's requirement that, "to the maximum extent feasible," the coverage under both the CBF and the 1992 Benefit Plan be "substantially the same" as coverage under the UMWA plans they replaced as a restriction on their ability to increase beneficiary cost sharing or to reduce covered services.

³⁷See U.S. General Accounting Office, *Retiree Health Benefits: Employee-Sponsored Benefits May Be Vulnerable to Further Erosion*, [GAO-01-374](#) (Washington, D.C.: May 1, 2001).

when available, implemented a preferred product program, negotiated discounts, and initiated mail order pharmacy services. The Funds claim that these cost control efforts collectively have achieved millions of dollars in savings per year.

The Funds' officials have tried to maintain the established level of benefits and cost sharing for their beneficiaries even while health care costs have risen. For example, neither the copayments nor the cap on out-of-pocket expenditures for the Funds' beneficiaries have been adjusted for inflation or otherwise modified since they were established.³⁸ The Funds' beneficiaries face no cost sharing after they reach their annual \$100 cap on out-of-pocket expenses for covered services (\$150 including outpatient prescription drugs). In contrast, other employers have reduced coverage for prescription drugs or other benefits, shifted retirees into managed care plans, or stopped offering retiree health benefits altogether in response to recent health care cost increases.

Concluding Observations

From 1994 through 2000, the per capita health care costs of the CBF's beneficiaries increased by 53 percent while those of the 1992 Benefit Plan's beneficiaries increased by 28 percent. The Funds' officials have taken steps to help control the cost growth. The Funds' officials contend, however, that statutory requirements pertaining to coverage impede their ability to require beneficiaries to pay more for their health care. To cover rising health care costs, the 1992 Benefit Plan has increased the premiums charged to coal companies. This option is not available to the CBF because the Coal Act ties annual premium updates to a formula that accounts for inflation, but not to changes in the use of health care services. Consequently, Congress has had to provide the CBF with additional money in recent years to close the gap between its costs and revenues. These annual shortfalls are expected to continue into the future as the CBF's beneficiaries grow older and require more medical services.

³⁸In comparison, the Medicare inpatient deductible increased approximately 19 percent from 1992 through 2000.

Comments from the UMWA Health and Retirement Funds and Our Evaluation

In written comments on a draft of this report, the Funds³⁹ emphasized the importance of the history of the Coal Act in understanding the Funds' operations, provided additional detail on the health status of their beneficiary population, and stressed the breadth and success of their cost control efforts. The Funds also pointed out technical issues that we have incorporated, where appropriate.

The Funds' officials stressed that comparisons of their plans and beneficiaries with other plans and populations are misleading without a full appreciation of the history behind the 1992 Coal Act and the characteristics of their beneficiary population. Specifically, they emphasized that coal miners traded lower pensions for better health care benefits in their labor contracts. The Funds' comments cited the 1990 Coal Commission Report conclusion that "retired miners are entitled to the health care benefits that were promised and guaranteed them and that such commitments must be honored." They noted that the Funds' beneficiaries have already contributed significantly to their health care benefits through the shifting of assets from their pension plans. The Funds stated that any comparisons of benefits with other groups are inappropriate because the plans' benefits are a culmination of their history.

The Funds also said that cost comparisons are misleading because their population is sicker than comparably aged men and women. Finally, the Funds emphasized their record of success in implementing a wide range of managed care and cost containment programs and claimed that these initiatives have realized substantial savings for the Funds and for Medicare and the U.S. Treasury.

We acknowledge that the retired coal miners traded lower pensions for the promise of future health care benefits, and that this may be an important consideration when interpreting our benefit comparisons with packages offered by other manufacturing companies and companies with significant numbers of unionized workers. Our analysis finds that the Funds' plans are generally comparable, but more generous in some dimensions and less so in others. Our cost comparison adjusts for all the demographic information used by Medicare to calculate the average cost per

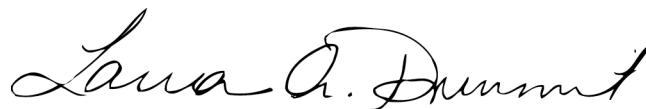
³⁹The Funds forwarded the draft to, and received comments, from BCOA, UMWA, and the three coal companies with the largest number of assigned beneficiaries. Our response addresses the comments from all of these organizations.

beneficiary, and acknowledges the differences in self-reported health status. Finally, as we have noted in the report, the Funds' officials have adopted numerous cost-cutting initiatives and have a history of achieving savings against their Medicare targets.

As we agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution of it until 30 days from the date of this letter. We will then send copies of this report to the UMW Health and Retirement Funds and other interested parties. We will also make copies available to others upon request.

If you or your staff have any questions about this report, please call me at (202) 512-7119 or James C. Cosgrove, assistant director, at (202) 512-7029. Other major contributors to this report include Jim S. Hahn and Richard M. Lipinski.

Sincerely yours,

A handwritten signature in black ink that reads "Laura A. Dummit". The signature is written in a cursive, flowing style.

Laura A. Dummit
Director, Health Care—Medicare Payment Issues

Related GAO Products

Medigap: Current Policies Contain Coverage Gaps, Undermine Cost Control Incentives, [GAO-02-533T](#). Washington, D.C.: Mar. 14, 2002.

Retiree Health Insurance: Gaps in Coverage and Availability, [GAO-02-178T](#). Washington, D.C.: Nov. 1, 2001.

Retiree Health Benefits: Employee-Sponsored Benefits May Be Vulnerable to Further Erosion, [GAO-01-374](#). Washington, D.C.: May 1, 2001.

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