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PATIENT PROTECTION AND AFFORDABLE CARE ACT

Concentration, Plan Availability and Premiums, and Enrollee Experiences in Health Insurance Markets Since 2014

Statement of John E. Dicken
Director, Health Care

GAO-17-383T

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PATIENT PROTECTION AND AFFORDABLE CARE ACT

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GAO Highlights

Highlights of GAO-17-383T, a testimony before the Subcommittee on Health Care, Benefits, and Administrative Rules, Committee on Oversight and Government Reform, House of Representatives

Why GAO Did This Study

PPACA contained provisions, many of which took effect in 2014, that could affect how issuers determine health insurance coverage and premiums and how they market their plans. For example, PPACA prohibits issuers from denying coverage or varying premiums based on consumer health status or gender. PPACA also requires health plans to generally be marketed based on metal tiers (bronze, silver, gold, and platinum), which allows consumers to compare the relative value of each plan. It also required the establishment of health insurance exchanges in each state, through which consumers can compare and select from among participating health plans.

This testimony describes (1) private health-insurance market concentration and issuer participation from 2011 through 2014, the year by which key PPACA provisions took effect, (2) health plans and premiums available to individuals in 2014 and 2015, and (3) the experience of enrollees that obtained coverage through the exchanges from 2014 through 2016. It is based on three GAO reports issued in 2015 and 2016. For these reports, GAO examined data from the Centers for Medicare & Medicaid Services (CMS); reviewed published research; and interviewed stakeholders, including experts and officials from CMS and five states—Colorado, Indiana, Montana, North Carolina, and Vermont—that varied in geography and whether the state or CMS offered the exchange.

View GAO-17-383T. For more information, contact John E. Dicken at (202) 512-7114 or dickenj@gao.gov.

What GAO Found

GAO issued three reports in 2015 and 2016 on the early impact of the Patient Protection and Affordable Care Act (PPACA) on private health insurance markets.

Market Concentration

- In a 2016 report, GAO examined enrollment in private health-insurance plans in the years leading up to and through 2014, the first year of the exchanges established by PPACA, and found that in all years analyzed, markets were concentrated among a small number of issuers in most states.
- Beginning in 2014, enrollment in PPACA exchange plans was generally more concentrated among a few issuers than was true for the overall markets.

Plan Availability and Premiums

- In a 2015 report, GAO examined the availability of health plans for individual market consumers and found that they generally had access to more health plans in 2015 than in 2014.
- In both years, most consumers in 28 states for which GAO had sufficiently reliable data had 6 or more plans from which to choose in three of the four health plan metal tiers (bronze, silver, and gold).
- The range of premiums available to consumers varied considerably by state, and in most states the costs for the minimum and median premiums for silver plans increased from 2014 to 2015. In both years, the lowest cost plans were typically available on an exchange.
- More recent analyses by the Department of Health and Human Services found that in 2017 all consumers continued to have multiple plan options, and that premiums for exchange plans increased more in 2017 compared to the annual increases for these plans since 2014.

Enrollee Experiences

- In a 2016 report, GAO examined national survey data to examine satisfaction of exchange enrollees. GAO found that, from 2014 through 2016, most enrollees who obtained their coverage through an exchange reported being satisfied overall with their plans.
- In 2015 and 2016, the satisfaction that exchange enrollees reported with their plans was either somewhat lower than or similar to that of enrollees in employer-sponsored plans.
- Exchange enrollees reported varying degrees of satisfaction with specific aspects of their plans, including coverage and plan affordability.
- Stakeholders GAO interviewed and literature GAO reviewed revealed some concerns about exchange enrollee experiences that were generally consistent with longstanding concerns in the private health insurance market—including concerns about affordability of out-of-pocket expenses and difficulties understanding coverage terminology.

Chairman Jordan, Ranking Member Krishnamoorthi, and Members of the Subcommittee:

I am pleased to be here today to discuss findings of several recent GAO reports on the effects of the Patient Protection and Affordable Care Act (PPACA) on health insurance markets, including insurer availability, variation in premiums, and enrollee satisfaction.[1]

According to the most recently available Census Bureau estimates, over 189 million Americans under the age of 65 obtained health coverage from private health insurance plans in 2015.[2] Private health insurance is sold through individual and group markets. Group market participants generally obtain health insurance coverage through a group health plan, usually offered by an employer—small employers purchase insurance from the small-group market and large employers purchase from the large-group market.[3] Americans without access to group health coverage, such as those with employers that do not offer health coverage, may choose to purchase it directly from an insurer through the individual market. All three markets (individual, small-group, and large-group) have historically been highly concentrated—that is, a small number of issuers in a market enrolled a significant portion of the people in that market.[4]

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[1]Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010) ("HCERA"). In this report, references to PPACA include any amendments made by HCERA.

[2]Census Bureau, *Health Insurance Coverage in the United States: 2015* (Washington, D.C.: September 2016).

[3]For group health plan purposes, federal law defines a small employer as having an average of 1 to 50 employees on business days during the preceding calendar year and employing at least 1 employee on the first day of the plan year; however, states may instead elect to define the term as an employer having an average of 1 to 100 employees on business days during the preceding calendar year. See 42 U.S.C. §§ 300gg-91(e), 18024(b).

[4]GAO, *Private Health Insurance: Concentration of Enrollees among Individual, Small Group, and Large Group Insurers from 2010 through 2013,* GAO-15-101R (Washington, D.C.: Dec. 1, 2014).

We use the term "issuer" when referring to the insurance entities that are licensed by a state to engage in the business of insurance in that specific state.

As you know, PPACA contained a number of provisions that could affect private health insurance markets, many of which took effect for plan years beginning in 2014. For example, it changed how insurers determine health insurance coverage and premiums and how they market their plans, such as by prohibiting insurers from denying coverage to individuals and from varying premiums based on consumer health status or gender and established limits on premium variation based on age, geographic location, and other factors. In addition, PPACA established requirements for the benefits that must be covered by health plans—referred to as essential health benefits—and required insurers to market their plans according to defined categories based on the extent to which the plans would be expected to cover the costs of enrollees' medical care.

PPACA also required the establishment of health insurance exchanges in each state beginning in 2014—marketplaces through which consumers can compare and select health insurance coverage from among all the health plans participating in the state exchange. These plans are known as qualified health plans (QHP). Some states have established their own exchanges—referred to as state-based exchanges. In states that have not done so, consumers have access to a federally facilitated exchange (FFE). For 2017, 17 states were operating a state-based exchange and 34 states were using the FFE. In general, plans available on either type of exchange are also available for sale outside of the exchange, in that the consumer could work directly with an insurer to purchase a plan without using their state's exchange. However, PPACA provided incentives for many consumers to use the exchange instead of purchasing plans directly from an insurer. For example, certain consumers are eligible for tax credits to help them pay their premiums, but only if they purchase a QHP through the exchange. In addition, the exchanges are required to carry out certain consumer assistance functions that may facilitate individuals' selection of and enrollment in exchange coverage. The combination of all of these provisions allows consumers to use the exchanges to directly compare the health insurance plans available to them based on premium costs, benefits covered, and plan generosity.[5] According to the Department of Health and Human Services (HHS), enrollments in the exchanges have increased every year since 2014, with about 11 million individuals having purchased health plans through the exchanges in 2016, up from about 7 million in 2014.

[5]We refer to the expected impact of the design of plan coverage on enrollee cost sharing as a plan's "generosity." A plan whose enrollees would incur lower out-of-pocket costs is more generous than one whose enrollees would incur higher costs.

This testimony describes (1) private health-insurance market concentration and issuer participation in the individual, small-group, and large-group markets from 2011 through 2014, the years leading up to and through the first year that key PPACA provisions took effect; (2) the numbers of health plans and ranges of health plan premiums available to individuals during the first 2 years of exchange operation (2014 and 2015); and (3) enrollee experiences with QHPs obtained through the exchanges during the first 3 years of exchange operation (2014 through 2016).

My comments are primarily based on three reports we issued in 2015 and 2016.[6] For these reports, we primarily examined data from the Centers for Medicare & Medicaid Services (CMS), within HHS, and previously published research. For our 2016 report on private health-insurance market concentration and issuer participation, we analyzed data from 2011 through 2014, the first year of PPACA exchanges, to see how market concentration and issuer participation in 2014 compared to earlier years. We used 2011 through 2014 Medical Loss Ratio datasets and 2014 Unified Rate Review data that issuers are required to report annually to CMS. For our 2015 report on the numbers of health plans and ranges of health plan premiums available to individuals in 2014 and 2015, we also analyzed data from CMS. Comparisons across years were conducted at both the state and the county level for states that had sufficiently reliable data in both years—including comparisons of plans offered either on or off an exchange in 28 states (1,886 counties), and comparisons of plans offered only on an exchange for 38 states (2,613 counties). For our 2016 report on enrollee experiences with QHPs obtained through the exchanges during the first years of exchange operation, we performed a search of research databases to identify relevant literature published from January 1, 2014, through April 30, 2016. Among other things, we identified and reviewed the results of five national surveys of QHP enrollees who obtained their coverage through the exchanges. We interviewed stakeholders, including officials from CMS and five states—Colorado, Indiana, Montana, North Carolina, and Vermont—that varied geographically and by whether the state or CMS

[6]GAO, *Private Health Insurance: In Most States and New Exchanges, Enrollees Continued to be Concentrated among Few Issuers in 2014*, GAO-16-724 (Washington, D.C.: Sept. 6, 2016); GAO, *Private Health Insurance: The Range of Premiums and Plan Availability for Individuals in 2014 and 2015*, GAO-15-687 (Washington, D.C.: Aug. 10, 2015); and GAO, *Patient Protection and Affordable Care Act: Most Enrollees Reported Satisfaction with Their Health Plans, Although Some Concerns Exist*, GAO-16-761 (Washington, D.C.: Sept. 12, 2016).

offered the exchange. Each report includes a full description of our scope and methodology. For the purpose of this testimony, we also present more recent data on issuer participation, plan availability, and premium options in the exchanges that were published by HHS in 2016.[7]

We conducted the work upon which this statement is based in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

PPACA required the establishment of individual health insurance exchanges, as well as small business exchanges, within each state by 2014.[8] PPACA does not require issuers to offer plans through these exchanges, but instead generally relies on market incentives to encourage issuer participation. Issuers seeking to offer a health plan in an individual exchange or small business exchange must first have that plan approved by the exchange in the state. We previously reported that most of the largest issuers holding the majority of the market in the 2012 individual and small-group markets participated in the 2014 exchanges, although most of the numerous smaller issuers in those markets did not.[9] In addition, some issuers that participated in the 2014 individual or small business exchanges had not participated in that respective market in 2012. While some of these issuers had previously provided coverage in other markets in 2012, other issuers were newly established through the federally supported Consumer Oriented and Operated Plans (CO-OP) program.[10]

[7]HHS Office of the Assistant Secretary for Planning and Evaluation, *Health Plan Choice and Premiums in the 2017 Health Insurance Marketplace* (Washington, D.C.: Oct. 24, 2016).

[8]States may establish separate individual and small business exchanges or a single exchange to serve both individuals and small employers.

[9]GAO, *Patient Protection and Affordable Care Act: Largest Issuers of Health Coverage Participated in Most Exchanges, and Number of Plans Available Varied*, GAO-14-657 (Washington, D.C: Aug. 29, 2014).

[10]PPACA established a program to foster the creation of consumer-governed, not-for-profit issuers of health coverage—referred to as CO-OPs—that would provide additional coverage options in the individual and small-business exchanges. For 2014, 23 CO-OPs receiving federal loans offered coverage through the exchanges.

As I mentioned above, PPACA also changed, as of 2014, how insurers determine health insurance premiums and how consumers shop for health insurance plans. As part of this, PPACA required that health plans be marketed based on information that helps consumers compare the relative value of each plan. Specifically, plans must be marketed by specific categories—including four “metal” tiers of coverage (bronze, silver, gold, and platinum)—that reflect out-of-pocket costs that may be incurred by an enrollee.[11] These changes occurred at the same time that PPACA required the establishment of health insurance exchanges for each state, through which consumers could compare and select from among QHPs. Finally, beginning January 1, 2014, premium tax credits and cost-sharing subsidies became available under PPACA for qualified individuals who purchased QHPs sold through an exchange.[12]

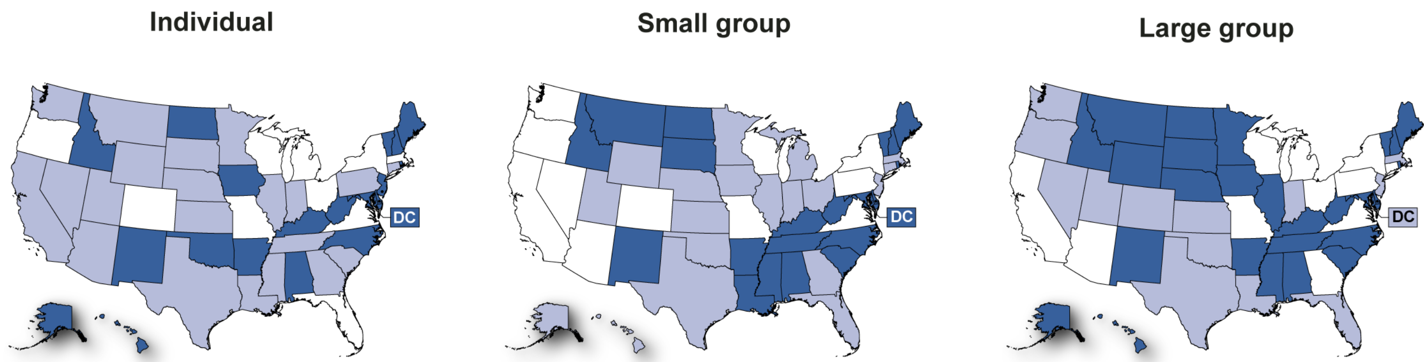
Health-Insurance Markets Remained Concentrated in Most States in 2014, While Issuer Participation Generally Decreased from the Prior Year

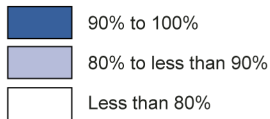
In 2016, we examined enrollment in private health-insurance plans in the years leading up to and through 2014, the first year of the exchanges established by PPACA, and found that in each year, markets were concentrated among a small number of issuers in most states. On average, in each state, 11 or more issuers participated in each of three types of markets—individual, small group, and large group—from 2011 through 2014. However, in most states, the 3 largest issuers in each market had at least an 80 percent share of the market during the period. (See fig. 1.) Not all issuers in the individual and small group markets participated in the exchanges in 2014, and several exchanges had fewer than 3 participating issuers. Enrollment through the exchanges was generally more concentrated among a few issuers than was true for the individual and small group markets overall in 2014.

[11]The metal tier designation categorizes plans by their actuarial value, which reflects the amount out of pocket costs that may be incurred by an enrollee. Bronze plans (with an actuarial value of 60 percent) tend to have the lowest premiums but leave consumers subject to the highest out-of-pocket costs when they receive health care services, while platinum plans (with an actuarial value of 90 percent) tend to have the highest premiums and the lowest out-of-pocket costs. In addition to these metal tiers, catastrophic plans are available for certain individuals who are exempt from the requirement to have minimum essential coverage. Catastrophic plans’ actuarial value must be lower than that of a bronze plan.

[12]Premium tax credits may be used to reduce monthly premiums, and cost-sharing subsidies decrease out-of-pocket expenses such as deductibles and copays.

Figure 1: Market Share for the Three Largest Issuers, by Market in 2014

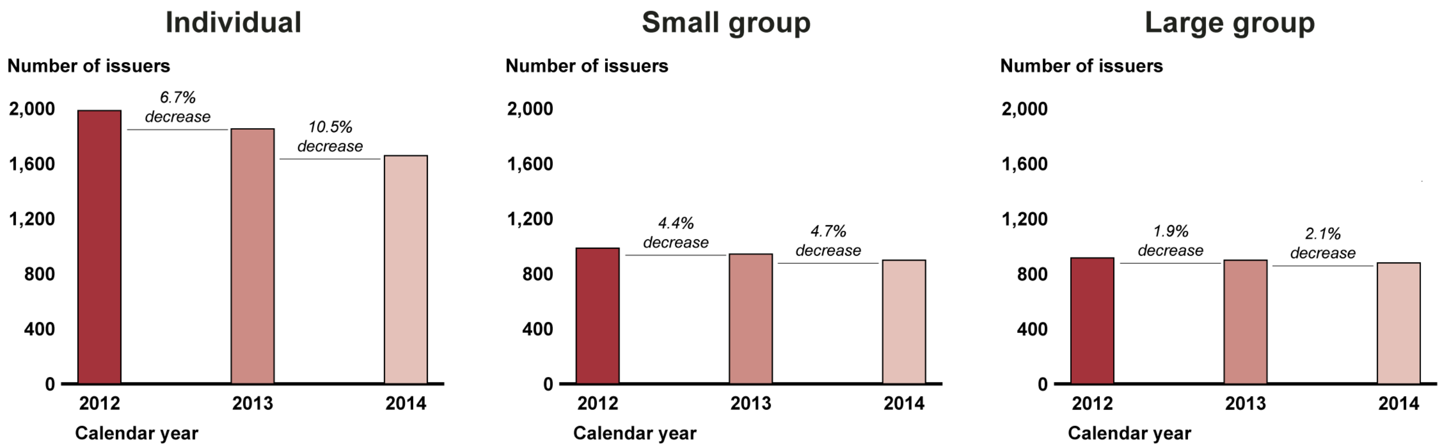




Sources: GAO analysis of data from the Centers for Medicare & Medicaid Services (data); Map Resources (map). | GAO-17-383T

For our examination of issuer participation in the first year of the exchanges, we reported that fewer issuers participated in most state health insurance markets in 2014 compared to 2013, though exiting issuers generally had small market shares in that prior year. Specifically, we found that from 2013 to 2014, the number of issuers participating in individual markets decreased in 46 states, while fewer states' small-group and large-group markets had decreased participation (28 and 22 states, respectively). (See fig. 2.) However, across the three types of markets, those issuers exiting each state market before 2014 generally had less than 1 percent of the market in the prior year. There were also issuers that newly entered state markets in 2014. Their market shares in 2014 varied across the three types of markets, with some newly entering issuers in the individual market capturing a market share of over 10 percent. Most newly entering issuers in 2014 participated in the exchanges and they generally had a larger share of the enrollment sold through the exchanges than through the overall markets. In addition, some newly entering issuers captured a majority of their exchange market, with CO-OPs having a higher proportion.

Figure 2: Total Number of Issuers Participating in the Individual, Small-Group, and Large-Group Markets across All States, 2012-2014



Source: GAO analysis of data from the Centers for Medicare & Medicaid Services. | GAO-17-383T

Since 2014, there have been additional changes to the number of issuers entering and exiting the individual and small group markets. For example, most of the CO-OPs that offered coverage in the exchanges in 2014 have since discontinued offering coverage.[13] In addition, in an analysis of data from exchanges in states that used the FFE and state-based exchanges, where available, HHS has since reported that the number of issuers offering health plans through the exchanges decreased from 2016 to 2017, reflecting multi-state withdrawals by a few large insurers.[14]

[13]We found that as of January 2016, 12 of the 23 CO-OPs that offered coverage in 2014 had since discontinued offering coverage. For additional information on the CO-OPs, see GAO, *Private Health Insurance: Federal Oversight, Premiums, and Enrollment for Consumer Operated and Oriented Plans in 2015,* GAO-16-326 (Washington, D.C.: Mar. 10, 2016).

[14]HHS Office of the Assistant Secretary for Planning and Evaluation, *Health Plan Choice and Premiums in the 2017 Health Insurance Marketplace* (Washington, D.C.: Oct. 24, 2016).

Consumers in the Individual Market Had Access to More Plans in 2015 than 2014, with Varying Premiums in Both Years

In 2015, we reported that individual market consumers generally had access to more health plans in 2015—a year after the initial implementation of key PPACA provisions—than in 2014. Consumers in most of the counties analyzed in the 28 states for which we had sufficiently reliable data for plans offered either on or off an exchange had six or more plans from which to choose in three of the four health plan metal tiers (bronze, silver, and gold) in both 2014 and 2015. The percentage of counties with six or more plans in those metal tiers increased from 2014 to 2015. Specifically, in 2014, six or more bronze-, silver-, and gold-tier plans were available to consumers in the individual market (either on or off an exchange) in at least 95 percent of the 1,886 counties and were available on an exchange in at least 59 percent of the 2,613 of the counties for which we had sufficiently reliable data for plans offered on an exchange. In 2015, the percentage of these same counties with six or more bronze-, silver-, and gold-tier plans available in the individual market increased to 100 percent, and at least 71 percent had six or more of these plans available on an exchange. (See table 1.)[15]

Table 1: The Percentages of Counties in Which Various Numbers of Health Plans Were Offered to Individual Market Consumers, by Market Category and Metal Tier, 2014 and 2015

Market category	Metal tier	Percentage of counties in 2014			Percentage of counties in 2015		
		No plans available	Between 1 and 5 plans available	6 or more plans available	No plans available	Between 1 and 5 plans available	6 or more plans available
All plans (available on or off exchange)[a]	Bronze	0%	3%	97%	0%	0%	100%
	Silver	0	3	97	0	0	100
	Gold	0	5	95	0	0	100
	Platinum	9	31	60	1	15	84
Plans available on an exchange[b]	Bronze	0	20	80	0	12	88
	Silver	0	20	80	0	6	94
	Gold	0	41	59	0	29	71
	Platinum	46	48	7	31	63	6

Source: GAO analysis of Center for Consumer Information and Insurance Oversight data. | GAO-17-383T

Note: Figures may not total 100 across rows within each year due to rounding.

[a]Includes data for plans in the 1,886 counties in the 28 states for which we had sufficiently reliable data on plans whether or not they were sold through an exchange.

[b]Includes data for plans in the 2,613 counties in the 38 states for which we had sufficiently reliable data on plans sold through exchanges.

[15]Consumers had fewer options regarding platinum-tier plans, although the availability of platinum plans generally also increased from 2014 to 2015.

In our 2015 report, we also found that premiums varied among states and counties, the lowest cost plans were typically available on an exchange, and in most states premiums increased from 2014 to 2015. Specifically, we found that:

- The range of premiums available to consumers in 2014 and 2015 varied among the states and counties we analyzed. For example, in Arizona, the premium for the lowest-cost silver plan option for a 30-year-old in 2015 was $147 per month, but in Maine, the lowest-cost silver plan for a 30-year-old in 2015 was $237. We also found that the range of premiums—from the lowest to highest cost—differed considerably by state. For example, in Rhode Island, 2015 premiums for silver plans available to a 30-year-old either on or off an exchange ranged from a low of $217 per month to a high of $285 per month, a difference of 32 percent. By contrast, in Arizona, 2015 premiums for these plans ranged from a low of $147 per month to a high of $545 per month, a difference of 270 percent.
- The lowest cost plans were typically available on an exchange. Specifically, in both years, taking into account plans available through an exchange and those only available off an exchange, the lowest cost plans were available through an exchange in most of the 1,886 counties we analyzed in the 28 states.
- In most states, the costs for the minimum and median premiums for silver plans increased from 2014 to 2015. For example, in the 28 states included in our analysis, from 2014 to 2015 the minimum premiums for silver plans available to a 30-year-old increased in 18 states, decreased in 9 states, and remained unchanged in 1 state. At the county level, we found that premiums for the lowest cost silver option available for a 30-year-old increased by 5 percent or more in 51 percent of the counties in the 28 states.

While our 2015 report examining the numbers of health plans and ranges of health plan premiums available to individuals in 2014 and 2015 was our most recent examination of these two issues, HHS has examined more recent data.[16] For example, in 2016, HHS reported that despite a decline in the number of issuers participating in the FFE from 2016 to 2017, all consumers were able to choose among various plan options for

[16]HHS Office of the Assistant Secretary for Planning and Evaluation, *Health Plan Choice and Premiums in the 2017 Health Insurance Marketplace* (Washington, D.C.: Oct. 24, 2016).

2017, although the options for about 21 percent of consumers were among choices of plans offered by a single insurer. HHS also conducted analyses focused on the premiums for the second-lowest cost silver plan in states that used the FFE and estimated that average premiums for these plans increased more between 2016 and 2017 (25 percent) than in previous years (2 percent between 2014 and 2015, and 7 percent between 2015 and 2016).[17]

Available Data Show That Most Early QHP Enrollees Expressed Satisfaction with Their Plans in 2014 through 2016, Despite Some Concerns

In 2016, we reported that most enrollees who obtained their coverage through the health insurance exchanges were satisfied overall with their QHP during the first few years that exchanges operated, according to national surveys of QHP enrollees. For example, most QHP enrollees who obtained their coverage through the exchanges reported overall satisfaction with their plans in 2014 through 2016, according to three national surveys that asked this question. One survey found that most 2015 enrollees re-enrolled in 2016 with the same insurer, and often with the same plan offered by that insurer, and another survey reported that most re-enrollees expressed satisfaction with their QHP. The surveys reported that QHP enrollees' satisfaction with their plans was either somewhat lower than, or was similar to, that of those enrolled in employer-sponsored health insurance in 2015 and 2016. To varying degrees, QHP enrollees expressed satisfaction with specific aspects of their plan, including their coverage and choice of providers, and with plan affordability.

We also interviewed stakeholders—including experts, state departments of insurance, and others—and reviewed literature for our 2016 report. These interviews and the literature revealed some concerns about QHP enrollee experiences that were similar to longstanding concerns in the private health insurance market. For example, according to these experts, some enrollees found it too expensive to pay for their out-of-pocket expenses before reaching their deductibles and have reported concerns about affording care or have been deterred from seeking care. Some enrollees have also faced difficulties understanding their QHP's coverage terminology and others have faced problems accessing care after enrollment, according to stakeholders and literature we reviewed.

[17]The second lowest-cost silver plan has significance because PPACA's premium tax credits are calculated based on the premiums for these plans.

Chairman Jordan, Ranking Member Krishnamoorthi, and Members of the Subcommittee, this concludes my statement. I look forward to answering any questions that you may have.

GAO Contact and Staff Acknowledgments

For questions about this statement, please contact John E. Dicken at (202) 512-7114 or dickenj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement.

Individuals making key contributions to this statement include John E. Dicken, Director; Gerardine Brennan and William Hadley, Assistant Directors; and Kristen J. Anderson, LaKendra Beard, Sandra George, and Laurie Pachter.

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