



Testimony

Before the Subcommittee on Health,
Committee on Energy and Commerce,
House of Representatives

For Release on Delivery
Expected at 10:15 a.m. ET
December 3, 2014

CHILDREN'S HEALTH INSURANCE

Cost, Coverage, and Access Considerations for Extending Federal Funding

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GAO Highlights

Highlights of [GAO-15-268T](#), a testimony before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives

Why GAO Did This Study

Without health insurance coverage, children are less likely to obtain routine medical or dental care, establish a relationship with a primary care physician, and receive immunizations or treatment for injuries and chronic illnesses. As such, Congress faces important decisions about the future of CHIP. PPACA extended federal funding for CHIP through fiscal year 2015, and Congress will be deciding whether to act to extend that funding.

States can operate CHIP as a separate program, include CHIP-eligible children in their Medicaid programs, or use a combination of the two approaches. If funding for CHIP runs out after 2015, children in CHIP-funded Medicaid programs will remain in Medicaid. For the 5.3 million children in separate CHIP programs, beginning in October 2015, PPACA requires that if a state's CHIP funding is insufficient to cover all CHIP-eligible children, the state must establish procedures to ensure that they are screened for Medicaid eligibility, and, if not eligible, enroll them in QHPs certified as comparable to CHIP.

This testimony is based on prior work conducted from February 2011 through November 2013, and highlights relevant GAO findings on cost, coverage, and access in CHIP.

View [GAO-15-268T](#). For more information, contact Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov.

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CHILDREN'S HEALTH INSURANCE

Cost, Coverage, and Access Considerations for Extending Federal Funding

What GAO Found

Over the last 17 years, the State Children's Health Insurance Program (CHIP)—a federal-state program that provides coverage to about 8 million low-income children—has played an important role in providing health insurance coverage for children who would otherwise be uninsured. The Patient Protection and Affordable Care Act (PPACA) created alternative coverage options with the establishment of subsidized coverage—through a premium tax credit and cost-sharing subsidies—offered through health insurance exchanges, however, there remain important considerations related to cost, coverage, and access when determining the ongoing need for the CHIP program.

- **Cost.** In 2013, GAO found that consumer costs in CHIP plans were lower than under the benchmark plans selected by states as models for the benefits that would be offered by qualified health plans (QHP) through exchanges in 2014. For example, when comparing CHIP plans in five states with separate CHIP programs to state benchmark plans, GAO found that the CHIP plan in the states typically did not require the payment of deductibles, while all five states' benchmark plans did. Similarly, the amount of any applicable cost-sharing was almost always less for CHIP plans and the difference was particularly pronounced for physician visits, prescription drugs, and outpatient therapies. PPACA provisions, which seek to standardize QHP costs and reduce cost-sharing for certain individuals, could narrow the cost gap. GAO's work also suggests that some children transitioning out of CHIP would not be eligible for the premium tax credit because they have a parent with employer-sponsored health coverage that is considered affordable under Internal Revenue Service regulations.
- **Coverage.** GAO's prior work from 2013 found that coverage was generally similar in separate CHIP and benchmark plans, though some variation exists. GAO also found that in contrast to CHIP plans where dental benefits are included, in some states, dental coverage is optional through exchanges and may be offered as a stand-alone dental plan. GAO found that families choosing such coverage could face higher costs. Further, in the current landscape of coverage options, many children eligible for CHIP, Medicaid, or the premium tax credit will have different eligibility than their parents, which can create complex scenarios of coverage for families. In 2012, GAO estimated that 21 percent of children eligible for CHIP, Medicaid, or the premium tax credit under PPACA would have different eligibility than their parents.
- **Access.** GAO's prior work found that CHIP enrollees generally reported having access to health care at rates comparable to children with private insurance, with some exceptions. In 2013, GAO's analysis of national survey data indicated that CHIP enrollees reported positive responses regarding their ability to obtain care, and the proportion of positive responses was generally comparable to those with Medicaid or with private insurance.

Chairman Pitts, Ranking Member Pallone, and Members of the Subcommittee:

I am pleased to be here today to discuss the extension of federal funding for the State Children's Health Insurance Program (CHIP). Established in 1997, CHIP finances health insurance for over 8 million children whose household incomes are above the threshold for Medicaid eligibility.¹ Since the inception of this joint federal-state program, the percentage of uninsured children nationwide has fallen by half, although the uninsured rate for children varies considerably among states.² Without health insurance coverage, children are less likely to obtain routine medical or dental care, establish a relationship with a primary care physician, and receive immunizations or treatment for injuries and chronic illnesses. The Centers for Medicare & Medicaid Services (CMS) within the Department of Health and Human Services (HHS) oversees CHIP, while states design, manage, and administer the operations of their individual CHIP programs. States administer CHIP under broad federal requirements, and the programs vary, for example, in the services covered, costs to individuals and families, and eligibility requirements.

Congress faces important decisions about the future of CHIP. Congress has appropriated federal CHIP funding at various times since the creation of the program. Most recently, the Patient Protection and Affordable Care Act (PPACA) appropriated federal CHIP funding through federal fiscal year 2015.³ Congress will decide whether to act to extend funding in the future. In the near term, PPACA requires that, if CHIP funding for a state is insufficient to cover all CHIP-eligible children, beginning in October 2015—the month after which federal funding for CHIP is scheduled to

¹Medicaid is a joint federal-state program that finances health insurance coverage for certain categories of lower-income individuals, including children. Most states' CHIP eligibility levels are between 200 and 300 percent of the federal poverty level (FPL), with the highest eligibility level being 400 percent of the FPL.

²The percent of uninsured children was 13.9 in 1997 and 6.6 percent in the first three months of 2014. See Cohen, R.A, Martinez, M.E. *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January-March 2014*. National Center for Health Statistics. (September 2014). Available from: <http://www.cdc.gov/nchs/nhis/releases.htm>.

³Pub. L. No. 111-148, § 10203, 124 Stat. 119, 927 (2010). In this testimony, references to PPACA include any amendments made by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010), unless otherwise indicated.

end—the state must establish procedures to ensure that the children who are not covered by CHIP are screened for Medicaid eligibility.⁴ If ineligible for Medicaid, children are to be enrolled in a qualified health plan (QHP), which are plans offered by private issuers through health insurance exchanges established as required by PPACA.⁵ While all QHPs must meet certain requirements related to what services are covered and the value of coverage, the QHPs for children transitioning out of CHIP must be certified by the Secretary of HHS as offering benefits and imposing cost-sharing for children in a manner that is at least comparable to the covered services and cost-sharing protections provided under the state’s CHIP plan. If the Secretary finds that no exchange plans are comparable to CHIP, states are not required to seamlessly transition children from CHIP to exchange coverage, though families may obtain such coverage on their own. Children transitioning from CHIP to exchange coverage may be eligible for the advance health insurance premium tax credit (referred to as the premium tax credit) and for cost-sharing subsidies established through PPACA to offset the cost of insurance purchased through state exchanges by eligible families.⁶ Over the longer term, PPACA also requires states to maintain eligibility levels for children in CHIP and Medicaid. That requirement ends after fiscal year 2019, which means that under current law, in fiscal year 2020, some states could choose to eliminate their programs even if federal funds were available.

My statement today will draw from past GAO work examining the Medicaid and CHIP programs to identify important issues regarding

⁴Although federal appropriations for the program will end on September 30, 2015, any unexpended amounts allotted to the states in fiscal year 2015 will be available for expenditure through September 30, 2016.

⁵PPACA requires the establishment of health insurance exchanges (referred to as exchanges) in each state—marketplaces where eligible individuals can compare and select among QHPs offered by participating private issuers of health coverage. QHPs provide a package of essential health benefits—including coverage for specific service categories, such as ambulatory care, prescription drugs, and hospitalization.

⁶Eligibility for the premium tax credit is limited to individuals with household incomes between 100 and 400 percent FPL. In addition, to be eligible for the premium tax credit, an individual cannot have access to public insurance such as Medicaid or CHIP (except for a child in a state with insufficient CHIP funds for eligible children) or to affordable employer-sponsored health insurance that provides a minimum value. Eligibility for the cost-sharing subsidies, which aim to reduce out-of-pocket costs for deductibles, co-payments, and other costs, is for individuals and families with household incomes of up through 250 percent FPL.

whether to extend federal funding for CHIP beyond fiscal year 2015. In particular, my remarks will address considerations related to cost, coverage, and access in CHIP.

My statement is based on reports we issued from February 2011 through November 2013.⁷ For this work, to compare costs and coverage for consumers in separate CHIP plans and the benchmark plans that serve as models for QHP benefits,⁸ we reviewed Evidence of Coverage documents from separate CHIP plans and benchmark plans from five states. To describe access to care for children in CHIP compared to others with Medicaid, private insurance, or without insurance, we analyzed nationwide data from HHS's Medical Expenditure Panel Survey (MEPs) from 2007 through 2010. The reports cited in this statement each provide detailed information on our scope and methodology. The work upon which this statement is based was conducted 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

With CHIP programs, states cover children in families whose household incomes are too high to qualify for Medicaid. Most states' CHIP eligibility levels are between 200 and 300 percent of the federal poverty level (FPL). States typically cover a broad array of services in their CHIP

⁷See GAO, *Medicaid and CHIP: Given the Association between Parent and Child Insurance Status, New Expansions May Benefit Families*, [GAO-11-264](#) (Washington, D.C.: Feb. 4, 2011); *Medicaid and CHIP: Most Physicians Serve Covered Children but Have Difficulty Referring Them for Specialty Care*, [GAO-11-624](#) (Washington, D.C.: June 30, 2011); *Children's Health Insurance: Opportunities Exist for Improved Access to Affordable Insurance*, [GAO-12-648](#) (Washington, D.C.: June 22, 2012); and *Children's Health Insurance: Information on Coverage of Services, Costs to Consumers, and Access to Care in CHIP and Other Sources of Insurance*, [GAO-14-40](#) (Washington, D.C.: Nov. 21, 2013).

⁸To prepare for the offering of QHPs through exchanges in 2014, HHS asked states to select benchmark health plans—plans intended as models for the benefits that would be offered through QHPs—by December 26, 2012. To offer coverage starting in 2014, individual market and small group market insurance plan issuers were required to offer QHPs that were substantially equal to their state's benchmark plan. We compared coverage under CHIP and benchmark plans to establish baseline information.

programs, for example, routine check-ups, immunizations, emergency services, and certain dental services. With respect to costs to consumers, CHIP premiums and cost-sharing may not exceed minimum amounts as defined by law. States may vary CHIP premiums and cost-sharing based on income and family size, as long as cost-sharing for higher-income children is not lower than for lower-income children. Federal laws and regulations also impose additional limits on premiums and cost-sharing for children in families with incomes at or below 150 percent FPL. In all cases, no cost-sharing can be required for preventive services—defined as well-baby and well-child care, including age-appropriate immunizations and pregnancy-related services. In addition, states may not impose premiums and cost-sharing, in the aggregate, that exceeds 5 percent of a family's total income for the length of the child's eligibility period in CHIP.⁹

States can operate CHIP as a separate program, include CHIP-eligible children in their Medicaid programs (referred to as a CHIP-funded Medicaid expansion), or use a combination of the two approaches. Eligible children in a CHIP-funded Medicaid expansion are entitled to coverage because Medicaid is an entitlement. There is no individual entitlement to coverage under separate CHIP programs. If funding for CHIP runs out after fiscal year 2015, those children enrolled in CHIP-funded Medicaid expansions—2.5 million children across 32 states and the District of Columbia in fiscal year 2013—will remain in Medicaid.¹⁰ For the 5.3 million children across 39 states in separate CHIP programs, PPACA requires that the state must establish procedures to ensure that the children who are not covered by CHIP are screened for Medicaid eligibility and, if determined ineligible for Medicaid, are enrolled into a QHP in an exchange in that state that has been certified by the Secretary of HHS as comparable to CHIP.

⁹This annual cumulative cost-sharing maximum applies to all services with cost-sharing requirements, irrespective of the number of children in the family that are enrolled in CHIP.

¹⁰For children that remain in Medicaid, the state is to receive reimbursement based on the federal matching rate for the state's Medicaid program rather than the CHIP rate, which under PPACA is to increase by 23 percentage points to nearly 100 percent from fiscal years 2016 through 2019. The federal government matches state Medicaid service expenditures based on a statutory formula known as the Federal Medical Assistance Percentage (FMAP). The FMAP depends on each state's per capita income and may range from 50 to 83 percent.

Cost, Coverage, and Access Are Important to Consider in Deciding whether to Extend Federal CHIP Funding

Over the last 17 years, CHIP has played an important role in providing health insurance coverage for low-income children who would otherwise be uninsured. While the introduction of the premium tax credit and cost-sharing subsidies for coverage through health insurance exchanges could provide an alternative coverage option for some of these children, there are important considerations related to cost, coverage, and access when determining the ongoing need for the CHIP program.

Cost considerations

Our prior work suggests that consumer costs under state benchmark plans, which were used as models for QHP benefits, would be higher than in CHIP, due to higher cost sharing and premiums. For example, in 2013, when comparing CHIP plans in five states with separate CHIP programs to state benchmark plans, we found that the CHIP plan in the states we reviewed typically did not include deductibles, while all five states' benchmark plans did.¹¹ Similarly, when cost-sharing applied, the amount was almost always less for CHIP plans, and the cost difference was particularly pronounced for physician visits, prescription drugs, and outpatient therapies.¹² For example, depending on income, the copayment for primary care and specialist physician visits ranged from \$2 to \$10 per visit for one state's CHIP enrollees, but was \$30 and \$50 per visit, respectively, for benchmark plan enrollees. PPACA provisions, which seek to standardize QHP costs and reduce cost-sharing for certain individuals, could narrow the cost gap we identified, but will vary by consumers' income level and plan selection.¹³ Our analysis of premium data also suggested that CHIP premiums were likely lower than benchmark plans, with some enrollees in three states paying no premiums and most enrollees across all five states paying less than \$200 a year. For families that qualify for a premium tax credit, premium contributions for those covered under the QHP will be limited to anywhere from 2 percent to 9.5 percent of the family's annual income; we estimated

¹¹The five states were Colorado, Illinois, Kansas, New York, and Utah. See [GAO-14-40](#).

¹²We have work underway that is examining a comparison of costs and coverage in separate CHIP plans and QHPs in selected states.

¹³Effective January 1, 2014, PPACA provides for cost-sharing subsidies for individuals and families with household incomes up through 250 percent of FPL to reduce out-of-pocket costs for deductibles, co-payments, and other costs.

that in 2014 those premium contributions would range from \$471 to \$8,949 for a family of four.

Further, our work suggests that some children transitioning out of CHIP would not be eligible for the premium tax credit because they have a parent with employer-sponsored health coverage that is considered affordable under Internal Revenue Service (IRS) regulations. With regard to affordability, IRS standards consider the cost of self-only coverage offered by the employer rather than the cost of family coverage. In 2012, we estimated that about a half million uninsured low-income children would be ineligible for the premium tax credit under these IRS standards, because they had access to affordable employer-sponsored coverage.¹⁴ Further, we estimated that without CHIP-funded Medicaid expansion or separate CHIP programs, an additional 1.9 million children who would otherwise be eligible for CHIP would be considered to have access to affordable insurance under the IRS standards for affordability.¹⁵

Coverage considerations

Our prior work suggests that coverage was generally similar in CHIP and benchmark plans, though some variation exists. In 2013, we found that the separate CHIP and benchmark plans we reviewed in five states were generally similar in terms of the services on which they imposed day, visit, or dollar limits.¹⁶ For example, the plans we reviewed were similar in that they typically did not impose any such limits on ambulatory patient services, emergency care, preventive care, or prescription drugs, but commonly did impose limits on outpatient therapies and pediatric dental, vision, and hearing services.¹⁷ One notable difference between CHIP and benchmark plans we reviewed was the frequency by which they limited home- and community-based health care services. While the benchmark plans in four states imposed day or visit limits on these services, only one state's CHIP plan did so.

¹⁴See [GAO-12-648](#).

¹⁵Our analysis did not identify the percentage of these children estimated to be in CHIP-funded Medicaid expansions and separate CHIP programs.

¹⁶See [GAO-14-40](#).

¹⁷One state's CHIP plan specified limits on rehabilitative services received in an inpatient setting, but not the number of days allowed for an inpatient admission.

Another consideration around coverage in CHIP and through exchanges is in coverage of dental services. CHIP covers dental services, but such coverage is optional for families seeking coverage on the exchange in some states. Families obtaining coverage through exchanges are provided a choice with regard to health plans, which may include some that cover pediatric dental and others that do not, along with the option to purchase a stand-alone dental plan. In 2013, before the exchanges were fully in place, we reported that exchange officials in three states told us that some families may face confusion in obtaining the appropriate amount of pediatric dental coverage. Now that exchanges are in place, our ongoing work is obtaining data on the types of plans in which families have enrolled, including stand-alone dental plans. As we found in 2013, a cost consideration for families is that stand-alone dental plans have out-of-pocket maximum costs that are in addition to the QHP maximum costs. For 2014, the out-of-pocket maximum costs for stand-alone dental plans offered in some states' exchanges were \$700 for a plan with one child or \$1,400 for a plan with two or more children. For example, a family with an annual income of \$53,663,¹⁸ that enrolls their two children in a stand-alone dental plan that is in addition to their QHP, would be subject to a total out-of-pocket maximum cost of \$11,800.

In the current landscape of coverage options, many children eligible for CHIP, Medicaid, or the premium tax credit will have different eligibility than their parents, which can create complex scenarios of coverage for families. Eligibility can vary within households because low- to moderate-income adults with household incomes greater than 133 percent of FPL will typically be ineligible for any assistance or will be eligible for the premium tax credit rather than Medicaid or CHIP, while children in some of these households will be eligible instead for Medicaid or CHIP. As one example, a family of three in Oregon could begin the year eligible for Medicaid. If the father gained part-time employment, the household income could increase such that the parents would no longer be eligible for Medicaid but would be eligible for the premium tax credit and cost-sharing subsidies and the child would become eligible for CHIP.

In 2012, we estimated that 21 percent of children eligible for Medicaid, CHIP, or the premium tax credit under PPACA would have different

¹⁸For a family of four in 2014, an annual income of \$53,663 equates to 225 percent of the FPL in the 48 contiguous states and the District of Columbia.

eligibility from their parents as of the beginning of the year, and an additional 9 percent would encounter that situation due to an income fluctuation during the course of the year.¹⁹ This could lead to breaks in children's coverage and, potentially, negative implications for health outcomes given the strong association between a parent's and a child's health insurance status. For example, in 2011, we found that children were more likely to be insured when their parents were insured, and that there is a strong association between a parent's health insurance status—whether they are privately insured, publicly insured, or uninsured—and a child's health insurance status.

Access considerations

Our prior work suggests that CHIP enrollees generally reported having access to care at rates comparable to children with private insurance, with some exceptions. In 2013, our analysis of national survey data indicated that CHIP enrollees reported positive responses regarding their ability to obtain care, and the proportion of positive responses was generally comparable to those with Medicaid or with private insurance.²⁰ For example, at least 88 percent of CHIP enrollees reported they had a usual source of care and usually or always got the care they needed. When compared with respondents with other sources of insurance, the proportion of CHIP enrollees with positive responses to these questions were, for most questions, comparable to respondents with Medicaid or with private insurance—that is, within 5 percentage points. In addition, in 2011, we found that most physicians were enrolled in Medicaid and CHIP and serving children covered by these programs. On the basis of our 2010 national survey of physicians, we estimated 78 percent of primary and specialty care physicians were enrolled as Medicaid and CHIP providers and serving children covered by these programs.²¹

Access to specialty care in CHIP may be more limited than in private insurance. In analyzing national survey data in 2013, we found that the proportion of CHIP enrollees with positive responses to the question

¹⁹A child's eligibility for CHIP, Medicaid, and the premium tax credit can change over time as his or her household income fluctuates. For example, a child who begins the year eligible for the premium tax credit may become eligible for CHIP if household income declines during the year. See [GAO-12-648](#).

²⁰See [GAO-14-40](#).

²¹See [GAO-11-624](#).

about the ability to obtain specialty care was roughly comparable to respondents with private insurance.²² However, in 2011, we found that the physicians we surveyed experienced much greater difficulty referring children in Medicaid and CHIP to specialty care, compared to privately insured children. We also found that the percentage of specialty care physicians who accepted all new children with private insurance was about 30 percent higher than the percentage of those who accepted all children in Medicaid and CHIP.

The findings of our 2011 and 2013 studies predated the introduction of QHPs sold through exchanges. As such, little is known about the comparability of provider networks for CHIP versus QHPs purchased through exchanges and the effects on access to care. Knowing more about the potential differences in provider networks is important for understanding the possible disruptions in care that could lead to negative health outcomes for children moving from CHIP to QHPs.

In conclusion, Congress, HHS, and the states will be faced with making important decisions regarding the future of CHIP. In the short term, Congress will be deciding whether to extend federal funding for CHIP beyond fiscal year 2015. In the longer term, states and Congress will face decisions about the role of CHIP in covering children once states are no longer required to maintain eligibility standards in fiscal year 2020.

Chairman Pitts, Ranking Member Pallone, and Members of the Subcommittee, this concludes my prepared statement. I would be pleased to respond to any questions that you may have at this time.

GAO Contact and Staff Acknowledgments

For further information about this statement, please contact Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Susan Barnidge, Assistant Director; Priyanka Sethi Bansal; Sandra George; Drew Long; and Rachel Svoboda were key contributors to this statement.

²²About 81 percent of CHIP enrollees responded positively to the question about the ability to obtain specialty care compared to 87 percent of respondents with private insurance. We considered responses to be comparable if they were within 5 percentage points.

Related GAO Products

Children's Health Insurance: Information on Coverage of Services, Costs to Consumers, and Access to Care in CHIP and Other Sources of Insurance. [GAO-14-40](#). Washington, D.C.: November 21, 2013.

Medicaid and CHIP: Considerations for Express Lane Eligibility. [GAO-13-178R](#). Washington, D.C.: December 5, 2012.

Children's Health Insurance: Opportunities Exist for Improved Access to Affordable Insurance. [GAO-12-648](#). Washington, D.C.: June 22, 2012.

Pre-Existing Condition Insurance Plan: Comparison of Implementation and Early Enrollment with the Children's Health Insurance Program. [GAO-12-62R](#). Washington, D.C.: November 10, 2011.

Medicaid and CHIP: Most Physicians Serve Covered Children but Have Difficulty Referring Them for Specialty Care. [GAO-11-624](#). Washington, D.C.: June 30, 2011.

Medicaid and CHIP: Reports for Monitoring Children's Health Care Services Need Improvement. [GAO-11-293R](#). Washington, D.C.: April 5, 2011.

Medicaid and CHIP: Given the Association between Parent and Child Insurance Status, New Expansions May Benefit Families. [GAO-11-264](#). Washington, D.C.: February 4, 2011.

Medicaid and CHIP: Enrollment, Benefits, Expenditures, and Other Characteristics of State Premium Assistance Programs. [GAO-10-258R](#). Washington, D.C.: January 19, 2010.

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