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21ST CENTURY

**Addressing Long-Term
Fiscal Challenges Must
Include a Re-examination of
Mandatory Spending**

Statement of David M. Walker
Comptroller General of the United States



Mr. Chairman, Representative Spratt, and Members of the Committee:

I appreciate this opportunity to talk with you about the need to look at entitlement and other mandatory spending programs in light of our nation's long-term fiscal outlook and the challenge it poses for the budget and oversight processes.

As I have said many times before, meeting our nation's large, growing, and structural fiscal imbalance will require a three-pronged approach:

- restructuring existing entitlement programs,
- reexamining the base of discretionary and other spending, and
- reviewing and revising existing tax policy, including tax expenditures,¹ which can operate like mandatory spending programs.

Before I turn to the major driver of the long-term spending outlook—rising health care costs combined with known demographic trends—I'd like to step back and take a broader view of the need to reexamine and reconsider what the federal government does, how it does it, and who does it. We are in the first decade of the 21st century but the basis and design for many of the federal government's activities date from before I was born.

In our report entitled *21st Century Challenges: Reexamining the Base of the Federal Government*,² we presented illustrative questions for policy makers to consider as they carry out their responsibilities. These questions look across major areas of the budget and federal operations including discretionary and mandatory spending, and tax policies and programs. We hope that this report, among other things, will be used by various congressional committees as they consider which areas of government need particular attention and reconsideration. You will, of course, also

¹ Tax expenditures result in forgone revenue for the federal government due to preferential provisions in the tax code, such as exemptions and exclusions from taxation, deductions, credits, deferral of tax liability, and preferential tax rates. These tax expenditures are often aimed at policy goals similar to those of federal spending programs; existing tax expenditures, for example, are intended to encourage economic development in disadvantaged areas, finance postsecondary education, and stimulate research and development. See GAO, *Government Performance and Accountability: Tax Expenditures Represent a Substantial Federal Commitment and Need to Be Reexamined*, [GAO-05-690](#) (Washington, D.C.: Sept. 23, 2005).

² GAO, *21st Century Challenges: Reexamining the Base of the Federal Government*, [GAO-05-325SP](#) (Washington, D.C.: February 2005).

receive more specific proposals, some of them will be presented within comprehensive agendas—the President’s Budget released last week is just one very prominent example.

Our report provides examples of the kinds of difficult choices the nation faces with regard to discretionary spending; mandatory spending, including entitlements; as well as tax policies and compliance activities. It is, I think, important to recognize that tax policies and programs financing the federal budget can be reviewed not only with an eye toward the overall level of revenue provided to fund federal operations and commitments, but also the mix of taxes and the extent to which the tax code is used to promote overall economic growth and broad-based societal objectives. In practice, some tax expenditures are very similar to mandatory spending programs even though they are not subject to the appropriations process or selected budget control mechanisms. As we reported last September, tax expenditures represent a significant commitment and are not typically subjected to review or reexamination.

Mandatory spending programs—like tax expenditures—are governed by eligibility rules and benefit formulas, which means that funds are spent as required to provide benefits to those who are eligible and wish to participate. Since Congress and the President must change substantive law to change the cost of these programs, they are relatively uncontrollable on an annual basis. Moreover, as we reported in a 1994 analysis, their cost cannot be controlled by the same “spending cap” mechanism used for discretionary spending.³

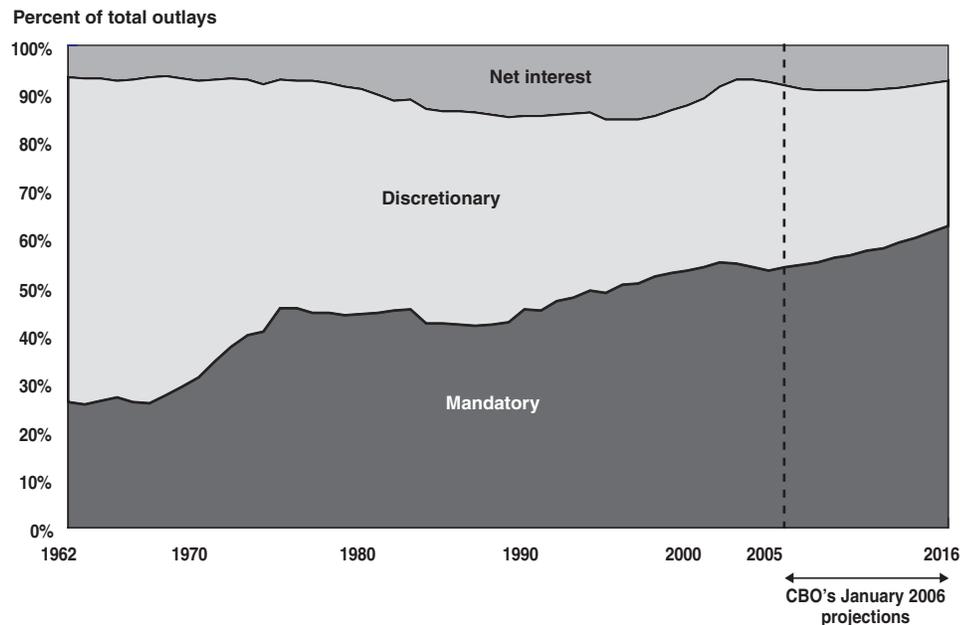
By their very nature mandatories limit budget flexibility.⁴ As figure 1 shows, mandatory spending has grown as a share of the total federal budget. For example, mandatory spending has grown from 27 percent before the creation of Medicare and Medicaid to 42 percent in 1985 to 54 percent last year. (Total spending not subject to annual appropriations—mandatory spending and net interest—has grown from 56 percent in 1985 to 61 percent last year.) Under both the Congressional Budget Office

³ GAO, *Budget Policy: Issues in Capping Mandatory Spending*, [GAO/AIMD-94-155](#) (Washington, D.C.: July 18, 1994).

⁴ Similarly tax expenditures may limit flexibility on the revenue side; there is a tradeoff between tax rates and revenue lost through tax expenditures. In order to raise a given amount of federal revenue, tax rates must be raised higher than they otherwise need to be due to revenue losses from tax expenditures.

baseline estimates and the President's Budget, this spending would grow further.

Figure 1: Federal Spending for Mandatory and Discretionary Programs



Source: OMB and CBO.

Note: Projections assume discretionary spending grows with inflation after 2006.

While the long-term fiscal outlook is driven by Medicare, Medicaid and Social Security, it does not mean that all other mandatory programs should be “given a pass.” As we have noted elsewhere, reexamination of the “fit” between government programs and the needs and priorities of the nation should be an accepted practice.⁵ So in terms of budget flexibility—the freedom of each Congress and President to allocate public resources—we cannot ignore mandatory spending programs even if they do not drive the aggregate.

⁵GAO-05-325SP.

While some might suggest that mandatory programs could be controlled by being converted to discretionary or annually appropriated programs, that seems unlikely to happen. If we look across the range of mandatories we see many programs have objectives and missions that contribute to the achievement of a range of broad-based and important public policy goals such as providing a floor of income security in retirement, fighting hunger, fostering higher education, and providing access to affordable health care. To these ends, these programs—and tax expenditures—were designed to provide benefits automatically to those who take the desired action or meet the specified eligibility criteria without subjecting them to an annual decision regarding spending or delay in the provision of benefits such a process might entail.

Although mandatory spending is not amenable to “caps,” that does not mean that mandatory programs should be permitted to be on autopilot and grow to an unlimited extent. Since the spending for any given entitlement or other mandatory program is a function of the interaction between the eligibility rules and the benefit formula—either or both of which may incorporate exogenous factors such as economic downturns—the way to change the path of spending for any of these programs is to change those rules or formulas. We recently issued a report on “triggers”—some measure which, when reached or exceeded, would prompt a response connected to that program.⁶ By identifying significant increases in the spending path of a mandatory program relatively early and acting to constrain it, Congress may avert much larger and potentially disruptive financial challenges and program changes in the future.

A trigger is a measure and a signal mechanism—like an alarm clock. It could trigger a “soft” response—one that calls attention to the growth rate or the level of spending and prompts special consideration when the threshold or target is breached. Two examples of soft responses that could be triggered include requiring the relevant agency to prepare a report analyzing why the trigger was tripped and/or requiring the President to submit a proposal to change the path or explain why he thinks it should remain unchanged. The Medicare program already contains a “soft” response trigger: The President is required to submit a proposal for action to Congress if the Medicare Trustees determine in 2 consecutive years that the general revenue share of Medicare spending is projected to exceed 45

⁶GAO, *Mandatory Spending: Using Budget Triggers to Constrain Growth*, GAO-06-276 (Washington, D.C.: Jan. 31, 2006).

percent during a 7-year period.⁷ Each year the Social Security and Medicare Trustees test for program financial adequacy over the next 10 years. The results of the test are included in the respective Trustees' reports to Congress, in which they note that failure to meet this test is an indication that action is needed. A few Social Security reform proposals have taken this further by including language requiring Presidential and Congressional action if the Social Security Board of Trustees determines that the balance ratio of either of the Social Security trust funds will be zero for any calendar year during the succeeding 75 years.⁸ Given the complexity and controversy associated with reforming entitlements, commissions might be one means to come up with possible triggers appropriate to the specific programs.

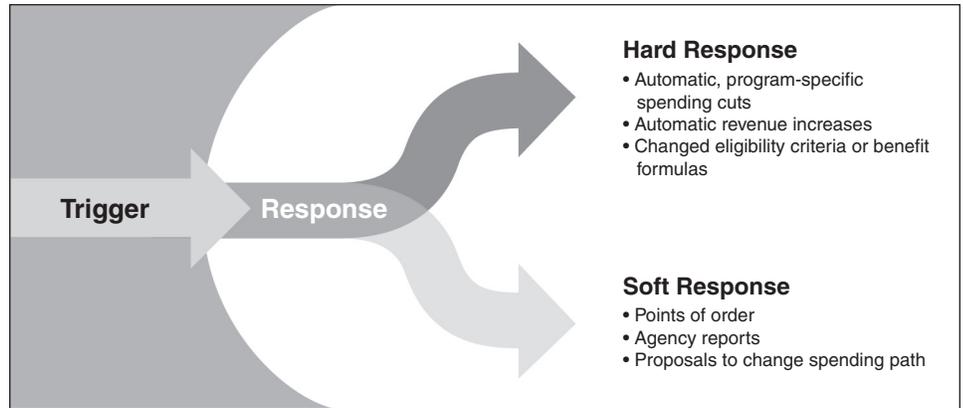
Soft responses can help in alerting decision makers of potential problems but they do not ensure that action to decrease spending or increase revenue is taken. With soft responses, the fiscal path continues unless Congress and the President take action. In contrast, a trigger could lead to "hard" responses requiring a predetermined, program-specific action to take place, such as changes in eligibility criteria and benefit formulas, automatic revenue increases, or automatic spending cuts. With hard responses, spending is automatically constrained, revenue is automatically increased, or both, unless Congress takes action to override. For example, this year the President's Budget proposes to change the Medicare trigger from solely "soft" to providing a "hard" (automatic) response if Congress fails to enact the President's proposal.⁹ Figure 2 below illustrates the conceptual differences between hard and soft responses of a budget trigger.

⁷For the purpose of the Medicare trigger, general revenue is defined as the difference between Medicare program outlays and dedicated Medicare financing sources. Dedicated Medicare financing sources are defined as Hospital Insurance (HI) payroll taxes, the HI share of income taxes on Social Security benefits, state transfers for Part D prescription drug benefits, premiums paid under Parts A, B, and D, and any gifts received by the trust funds.

⁸Recently, this provision was included in the Bipartisan Retirement Security Act of 2005, H.R. 440, 109th Cong. § 14 (2005).

⁹The response now would include a sequester if the Congress did not act on the President's proposal. The proposed sequester would result in a four-tenths of a percent reduction in all payments to providers beginning in the year the threshold is exceeded. Each year the shortfall continues to occur the reduction would grow by an additional four-tenths of a percent. We have not yet analyzed how this would work.

Figure 2: Conceptual Differences between Hard and Soft Responses



Source: GAO analysis.

In our recent report on mandatory spending triggers, we discussed the kinds of responses that might be triggered and the importance of program-specific design. Proposed changes in underlying benefits structure and design of a mandatory program can be considered in the context both of the factors that drive the growth of that program and the specific goals and objectives of the program. For example, some mandatorics are intended to have a countercyclical effect; any triggered response in these programs would have to be designed not to interfere with that function. Its design, therefore, would have to be sensitive to whether growth comes because the program is, in fact, working as an automatic stabilizer.

Both near- and long-term perspectives should be considered in the design of triggers. For some programs, it might be appropriate to tie the trigger to historical data—for example, to see whether spending growth was greater than some historical average or path. For programs that expose the government to long-term commitments, it might be more appropriate to tie the trigger to projections of future spending. For “contributory” programs that represent a long-term commitment of future earmarked resources, such as Social Security, one appropriate measure could be the actuarial projections of the 75-year outlook. Some similar approach might be used for programs like pension or health insurance.

Any discussion to create triggered responses and their design must recognize that unlike controls on discretionary spending, there is some tension between the idea of triggers and the nature of entitlement and other mandatory spending programs. These programs—as with tax

provisions such as tax expenditures—were designed to provide benefits based on eligibility formulas or actions as opposed to an annual decision regarding spending. This tension makes it more challenging to constrain costs and to design both triggers and triggered responses. At the same time, with only about one-third of the budget under the control of the annual appropriations process, considering ways to increase transparency, oversight, and control of mandatory programs must be part of addressing the nation’s long-term fiscal challenges.

Before I turn to the largest driver of our long-term challenge—rising health care costs—let me note that the idea of triggers need not only apply to spending. The revenue side of the budget should also be addressed. If, for example, one option to cover the increased costs of a mandatory spending program was a premium increase or tax increase, it would serve to increase public visibility and could make the American people more aware of how much they are paying for services. More directly analogous to mandatory spending programs is the extensive use of tax incentives, rather than direct spending authority, to address various social objectives. As we reported in September 2005,¹⁰ the sum of revenue loss estimates associated with tax expenditures—such as tax exclusions, credits, and deductions—was nearly \$730 billion in 2004.¹¹ Under the most recent estimates, this has risen to more than \$775 billion in 2005.

Let me be clear that in suggesting application of this analysis to tax expenditures I am not addressing the appropriate level of taxation as a share of GDP. Whatever level of revenue is deemed appropriate, tax expenditures that seek to achieve programmatic or policy goals should—like other federal programs or activities—be reviewed to determine their effectiveness, continued relevance, affordability, and sustainability. Tax expenditures have a significant effect on overall tax rates—in that, for any given level of revenue, overall tax rates must be higher to offset the revenue forgone through tax expenditures—as well as the budget and fiscal flexibility. They also contribute to the growing complexity of the federal tax system. Many tax expenditures operate like mandatory spending programs and generally are not subject to reauthorization. Such tax expenditures are embedded in the tax system. They are not subject to

¹⁰See [GAO-05-690](#).

¹¹Summing the individual tax expenditure estimates is useful for gauging the general magnitude of the federal revenue involved, but it does not take into account possible interactions between individual provisions.

a performance test and are off the radar screen for the most part. This is a concern from a budgetary standpoint because taxpayer dollars committed to fund these expenditures do not compete in the annual appropriations process and are effectively “fully funded” before any discretionary spending is considered. The analysis we have applied to spending would also be useful in examining tax expenditures.

Federal Health Care Spending Drives the Long-Term Fiscal Challenge

Among mandatory spending programs—and indeed tax expenditures—the health area is especially important because the long-term fiscal challenge is largely a health care challenge. Contrary to public perceptions, health care is the biggest driver of the long-term fiscal challenge. While Social Security is important because of its size, health care spending is both large and projected to grow much more rapidly.

Our most recent simulation results illustrate the importance of health care in the long-term fiscal outlook as well as the imperative to take action. Simply put, our nation’s fiscal policy is on an imprudent and unsustainable course. These long-term budget simulations show, as do those published last December by the Congressional Budget Office (CBO),¹² that over the long term we face a large and growing structural deficit due primarily to known demographic trends and rising health care costs and lower federal revenues as a percentage of the economy. Continuing on this unsustainable fiscal path will gradually erode, if not suddenly damage, our economy, our standard of living, and ultimately our national security. Our current path also will increasingly constrain our ability to address emerging and unexpected budgetary needs and increase the burdens that will be faced by future generations.

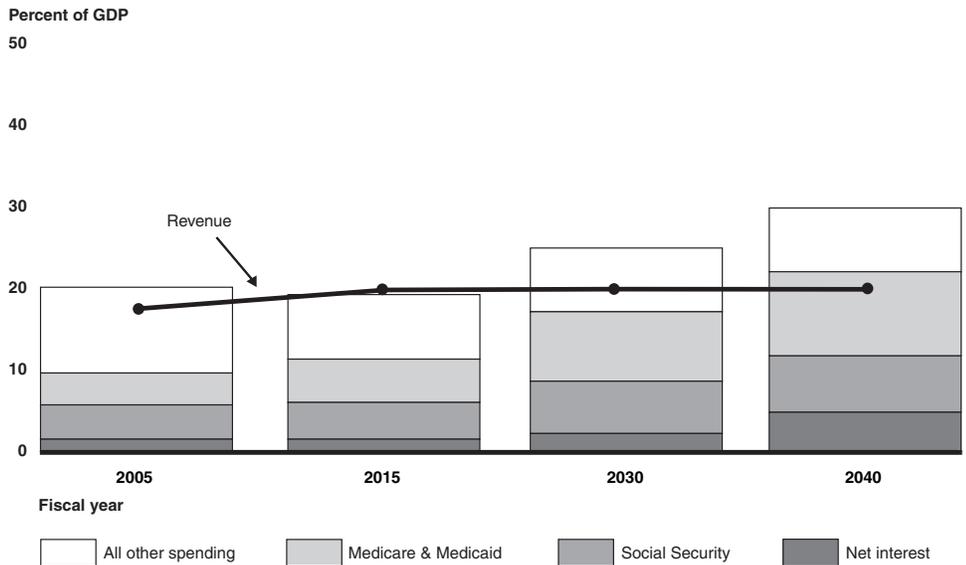
Figures 3 and 4 present our long-term simulations under two different sets of assumptions. In figure 3, we start with CBO’s 10-year baseline—constructed according to the statutory requirements for that baseline.¹³ Consistent with these requirements, discretionary spending is assumed to grow with inflation for the first 10 years and tax cuts scheduled to expire are assumed to expire. After 2016, discretionary spending is assumed to grow with the economy, and revenue is held constant as a share of GDP at the 2016 level. In figure 4, two assumptions are changed: (1) discretionary

¹² CBO, *The Long-Term Budget Outlook* (Washington, D.C.: December 2005).

¹³ CBO, *The Budget and Economic Outlook: Fiscal Years 2007 to 2016* (Washington, D.C.: January 2006).

spending is assumed to grow with the economy after 2006 rather than merely with inflation, and (2) all expiring tax provisions are extended. For both simulations, Social Security and Medicare spending is based on the 2005 Trustees' intermediate projections, and we assume that benefits continue to be paid in full after the trust funds are exhausted. Medicaid spending is based on CBO's December 2005 long-term projections under mid-range assumptions.

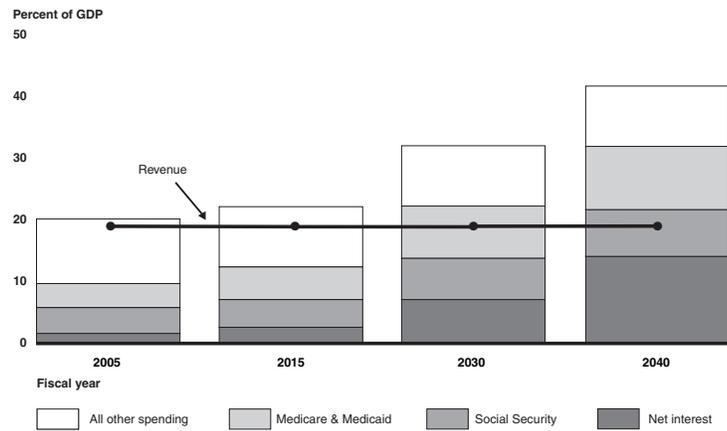
Figure 3: Composition of Spending as a Share of GDP under Baseline Extended



Source: GAO's January 2006 analysis.

Note: In addition to the expiration of tax cuts, revenue as a share of GDP increases through 2016 due to (1) real bracket creep, (2) more taxpayers becoming subject to the alternative minimum tax (AMT), and (3) increased revenue from tax-deferred retirement accounts. After 2016, revenue as a share of GDP is held constant.

Figure 4: Composition of Spending as a Share of GDP Assuming Discretionary Spending Grows with GDP after 2006 and All Expiring Tax Provisions Are Extended



Source: GAO's January 2006 analysis.

Note: This includes certain tax provisions that expired at the end of 2005, such as the increased AMT exemption amount.

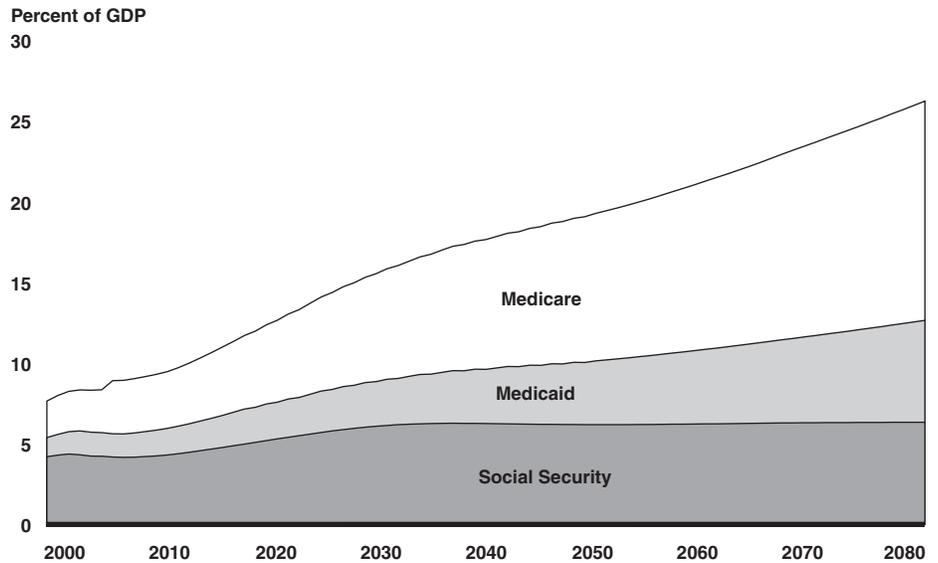
As these simulations illustrate, absent significant policy changes on the spending and/or revenue side of the budget, the growth in mandatory spending on federal retirement and especially health entitlements will encumber an escalating share of the government's resources. Indeed, when we assume that all the temporary tax reductions are made permanent and discretionary spending keeps pace with the economy, our long-term simulations suggest that by 2040 federal revenues may be adequate to pay only some Social Security benefits and interest on the federal debt. Neither slowing the growth in discretionary spending nor allowing the tax provisions to expire—nor both together—would eliminate the imbalance. Although revenues will be part of the debate about our fiscal future, assuming no changes to Social Security, Medicare, Medicaid, and other drivers of the long-term fiscal gap would require at least a doubling of taxes—and that seems highly implausible. Economic growth is essential, but we will not be able to simply grow our way out of the problem. The numbers speak loudly: our projected fiscal gap is simply too great. Closing the current long-term fiscal gap would require sustained economic growth far beyond that experienced in U.S. economic history since World War II. Tough choices are inevitable, and the sooner we act the better.

Accordingly, substantive reform of the major health programs and Social Security is critical to recapturing our future fiscal flexibility. Ultimately, the nation will have to decide what level of federal benefits and spending it wants and how it will pay for these benefits. Our current fiscal path will increasingly constrain our ability to address emerging and unexpected budgetary needs and increase the burdens that will be faced by future generations. Continuing on this path will mean escalating and ultimately unsustainable federal deficits and debt that will serve to threaten our future national security as well as the standard of living for the American people.

The aging population and rising health care spending will have significant implications not only for the budget, but also the economy as a whole. Figure 5 shows the total future draw on the economy represented by Social Security, Medicare, and Medicaid. Under the 2005 Trustees' intermediate estimates and CBO's 2005 long-term Medicaid estimates under mid-range assumptions, spending for these entitlement programs combined will grow to 15.7 percent of gross domestic product (GDP) in 2030 from today's 8.4 percent. It is clear that, taken together, Social Security, Medicare, and Medicaid represent an unsustainable burden on future generations.

Furthermore, most of the long-term growth is in health care. While Social Security in its current form will grow from 4.3 percent of GDP today to 6.4 percent in 2080, Medicare's burden on the economy will quintuple—from 2.7 percent to 13.8 percent of the economy—and these projections assume a growth rate for Medicare spending that is below historical experience! As figure 5 shows, unlike Social Security which grows larger as a share of the economy and then levels off, within this projection period we do not see Medicare growth abating. Whether or not the President's Budget proposals on Medicare are adopted, they should serve to raise public awareness of the importance of health care costs to both today's budget and tomorrow's. This could serve to jump start a discussion about appropriate ways to control the major driver of our long-term fiscal outlook—health care spending.

Figure 5: Social Security, Medicare, and Medicaid Spending as a Percent of GDP



Source: GAO analysis based on data from the Office of the Chief Actuary, Social Security Administration, Office of the Actuary, Centers for Medicare and Medicaid Services, and the Congressional Budget Office.

Note: Social Security and Medicare projections are based on the intermediate assumptions of the 2005 Trustees' Reports. Medicaid projections are based on CBO's January 2006 short-term Medicaid estimates and CBO's December 2005 long-term Medicaid projections under mid-range assumptions.

As noted, unlike Social Security, Medicare spending growth rates reflect not only a burgeoning beneficiary population, but also the escalation of health care costs at rates well exceeding general rates of inflation. The growth of medical technology has contributed to increases in the number and quality of health care services. Moreover, the actual costs of health care consumption are not transparent. Consumers are largely insulated by third-party payers from the cost of health care decisions.

The health care spending problem is particularly vexing for the federal budget, affecting not only Medicare and Medicaid but also other important federal health programs, such as for our military personnel and veterans. For example, Department of Defense health care spending rose from about \$12 billion in 1990 to about \$30.4 billion in 2004—in part, to meet additional demand resulting from program eligibility expansions for military retirees, reservists, and the dependents of those two groups and for the increased needs of active duty personnel involved in conflicts in

Iraq, Bosnia, and Afghanistan. Expenditures by the Department of Veterans Affairs have also grown—from about \$12 billion in 1990 to about \$26.8 billion in 2004—as an increasing number of veterans look to federal programs to supply their health care needs.

The challenge to rein in health care spending is not limited to public payers, however, as the phenomenon of rising health care costs associated with new technology exists system-wide. This means that addressing the unsustainability of health care costs is also a major competitiveness and societal challenge that calls for us as a nation to fundamentally rethink how we define, deliver, and finance health care in both the public and the private sectors. A major difficulty is that our current system does little to encourage informed discussions and decisions about the costs and value of various health care services. These decisions are very important when it comes to cutting-edge drugs and medical technologies, which can be incredibly expensive but only marginally better than other alternatives. As a nation, we are going to need to weigh unlimited individual wants against broader societal needs and decide how responsibility for financing health care should be divided among employers, individuals, and government. Ultimately, we may need to define a set of basic and essential health care services to which every American is ensured access. Individuals wanting additional services, and insurance coverage to pay for them, might be required to allocate their own resources. Clearly, such a dramatic change would require a long transition period—all the more reason to act sooner rather than later.

In recent years, policy analysts have discussed a number of incremental reforms that take aim at moderating health care spending, in part by unmasking health care's true costs. (See fig. 6 for a list of selected reforms.) Among these reforms is to devise additional cost-sharing provisions to make health care costs more transparent to patients. Currently, many insured individuals pay relatively little out of pocket for care at the point of delivery because of comprehensive health care coverage—precluding the opportunity to sensitize these patients to the cost of their care.

Figure 6: Selected Reforms Aimed at Moderating Health Care Spending

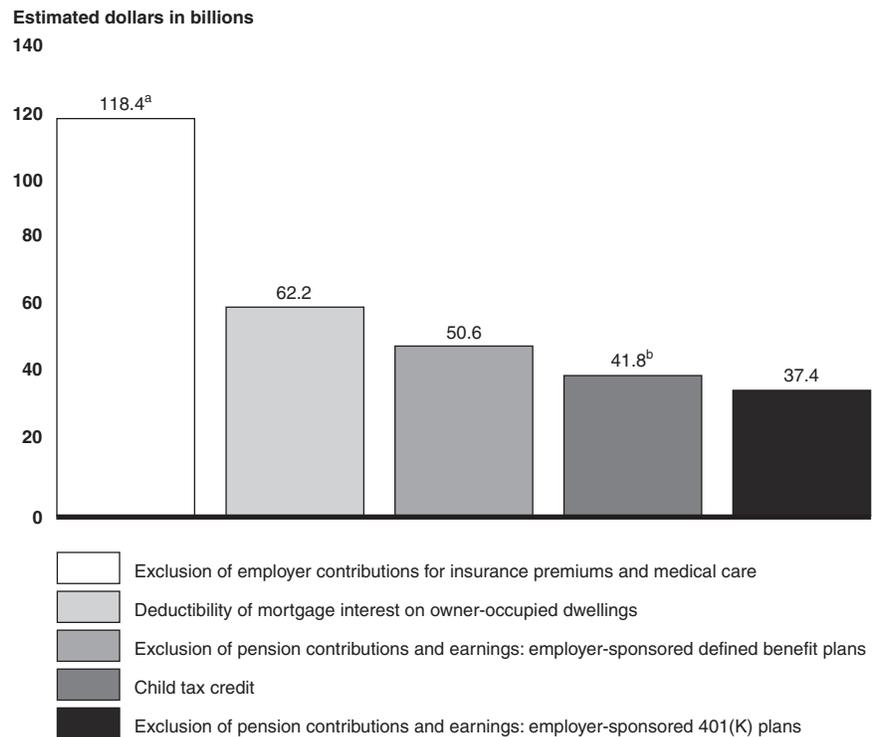
- Develop a set of national practice standards to help avoid unnecessary care, improve outcomes, and reduce litigation.
- Encourage case management approaches for people with expensive acute and chronic conditions to improve the quality and efficiency of care delivered and avoid inappropriate care.
- Foster the use of information technology to increase consistency, transparency, and accountability in health care.
- Emphasize prevention and wellness care, including nutrition.
- Leverage the government's purchasing power to control costs for prescription drugs and other health care services.
- Revise certain federal tax preferences for health care to encourage the more efficient use of appropriate care.
- Create an insurance market that adequately pools risk and offers alternative levels of coverage.
- Develop a core set of basic and essential services with supplemental coverage being available as an option but at a cost. Use the Federal Employees Health Benefits Program (FEHBP) model as a possible means to experiment and see the way forward.
- Limit spending growth for government-sponsored health care programs (e.g., percentage of the budget and/or the economy).

Source: GAO

Other steps include reforming the policies that give tax preferences to insured individuals and their employers. These policies permit the value of employees' health insurance premiums to be excluded from the calculation of their taxable earnings and exclude the value of the premium from the employers' calculation of payroll taxes for both themselves and employees. Tax preferences also exist for health savings accounts and other consumer-directed plans. These tax exclusions represent a significant source of forgone federal revenue and work at cross-purposes to the goal of moderating health care spending. As figure 7 shows, in 2005 the tax expenditure responsible for the greatest revenue loss was that for

the exclusion of employer contributions for employees' insurance premiums and medical care.

Figure 7: Health Care Was the Nation's Top Tax Expenditure in Fiscal Year 2005



Source: Office of Management and Budget (OMB), *Analytical Perspectives, Budget of the United States Government, Fiscal Year 2007*.

Note: "Tax expenditures" refers to the special tax provisions that are contained in the federal income taxes on individuals and corporations. OMB does not include forgone revenue from other federal taxes such as Social Security and Medicare payroll taxes.

^aIf the payroll tax exclusion were also counted here, the total tax expenditure for employer contributions for health insurance premiums would be about 50 percent higher or \$177.6 billion.

^bThis is the revenue loss and does not include associated outlays of \$14.6 billion.

Another area conducive to incremental change involves provider payment reforms. These reforms are intended to induce physicians, hospitals, and other health care providers to improve on quality and efficiency. For example, studies of Medicare patients in different geographic areas have found that despite receiving a greater volume of care, patients in higher use areas did not have better health outcomes or experience greater satisfaction with care than those living in lower use areas. Public and

private payers are experimenting with payment reforms designed to foster the delivery of care that is proven to be both clinically and cost effective. Ideally, identifying and rewarding efficient providers and encouraging inefficient providers to emulate best practices will result in better value for the dollars spent on care. The development of uniform standards of practice could lead to ensuring that people with chronic illnesses, a small but expensive population, received more and cost-effective and patient-centered care while reducing unwarranted medical malpractice litigation.

The problem of escalating health care costs is complex because addressing federal programs such as Medicare and the federal-state Medicaid program will need to involve change in the health care system of which they are a part—not just within federal programs. This will be a major societal challenge that will affect all age groups. Because our health care system is complex, with multiple interrelated pieces, solutions to health care cost growth are likely to be incremental and require a number of extensive efforts over many years. In my view, taking steps to address the health care cost dilemma system-wide puts us on the right path for correcting the long-term fiscal problems posed by the nation's health care entitlements.

I have focused today on health care because it is a driver of our fiscal outlook. Indeed, health care is already putting a squeeze on the federal budget.

Health care is the dominant but not the only driver of our long-term fiscal challenge. Today it is hard to think of our fiscal imbalances as a big problem: the economy is healthy and interest rates seem low. We, however, have an obligation to look beyond today. Budgets, deficits, and long-term fiscal and economic outlooks are not just about numbers: they are also about values. It is time for all of us to recognize our stewardship obligation for the future. We should act sooner rather than later. We all must make choices that may be difficult and unpleasant today to avoid passing an even greater burden on to future generations. Let us not be the generation who sent the bill for its consumption to its children and grandchildren.

Thank you Mr. Chairman, Mr. Spratt, and members of the Committee for having me today. We at GAO, of course, stand ready to assist you and your colleagues as you tackle these important challenges.

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