

GAO

Report to the Chairman, Special
Committee on Aging, U.S. Senate

December 1994

AGING ISSUES

Related GAO Reports and Activities in Fiscal Year 1994





United States
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Washington, D.C. 20548

**Health, Education, and
Human Services Division**

B-259318

December 29, 1994

The Honorable David H. Pryor
Chairman, Special Committee on Aging
United States Senate

Dear Mr. Chairman:

This report was prepared in response to the Committee's November 25, 1994, request for a compilation of our fiscal year 1994 products and ongoing work regarding older Americans and their families.

GAO's work in aging reflects the continuing importance of federal programs for older Americans. The Census Bureau has estimated that there are over 33 million older Americans today, and, by the year 2020, that number will exceed 53 million. Because the elderly are one of the fastest growing segments of today's society, the Congress faces many issues involving income security and health policy in which the federal government will play an important role. These issues range from demographic changes affecting the traditional structure and role of the family to financing and provision of health care, long-term care, Social Security, and pensions.

Our work during fiscal year 1994 covered a range of issues, including federal government activities in employment, health care, housing, income security, and veterans' issues. Some federal programs such as Social Security and Medicare are directed primarily at older Americans. Other federal programs target older Americans as one of several groups served, such as Medicaid or federal housing programs. We have organized the summaries of our fiscal year 1994 reports and related products accordingly.

In the appendixes, we describe four types of GAO activities that relate to older Americans:

- reports on policies and programs directed primarily at older Americans (see app. I),
- reports on policies and programs that affect older Americans as one of several target groups (see app. II),
- congressional testimonies on issues related to older Americans (see app. III), and
- ongoing work on issues related to older Americans (see app. IV).

The issues addressed by these products and ongoing work are presented in table 1. The table shows that health and income security were the leading issues addressed among reports focused primarily on older Americans. Health and veterans were the leading issues that affected both older Americans and other groups.

Table 1: GAO Activities Relating to the Elderly in Fiscal Year 1994

Issue	Reports focused on the elderly	Reports with elderly as one of several target groups	Testimonies	Ongoing work as of 9/30/94
Employment	0	2	0	0
Health	16	20	13	26
Housing	0	7	1	0
Income Security	10	6	8	8
Social Services	3	1	0	0
Veterans	0	17	5	21
Other	1	6	1	0
Total	30	59	28	55

Appendix I provides summaries of 30 issued reports on policies and programs directed primarily at older Americans. We include in this section reviews of health, income security, social services, and other issues.

Appendix II provides summaries of 59 reports in which older Americans were one of several target groups for specific federal policies. Many of these policies are generally financed in conjunction with services to other populations. For example, Medicaid finances nursing homes and other types of long-term care, as well as medical care for poor persons of all ages.

Appendix III describes 28 testimonies given during fiscal year 1994 on subjects focused on older Americans. We testified most often on health issues.

In appendix IV, we have listed 55 studies related to older Americans that were ongoing as of September 30, 1994.

As arranged with your office, we are sending copies of this report to interested congressional committees and subcommittees. Copies will also be made available to others on request.

This report was prepared under the direction of Jane L. Ross, Director, Income Security Issues, who may be reached at (202) 512-7215 if you have any questions. Other major contributors are listed in appendix V.

Sincerely yours,

A handwritten signature in cursive script that reads "Janet L. Shikles".

Janet L. Shikles
Assistant Comptroller General

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Abbreviations

AOA	Administration on Aging
CalPERS	California Public Employees' Retirement System
CDC	Centers for Disease Control and Prevention
DI	Disability Insurance
DOD	Department of Defense
ERISA	Employee Retirement Income Security Act of 1974
FDA	Food and Drug Administration
FTC	Federal Trade Commission
HCA	Hospital Corporation of America
HCFA	Health Care Financing Administration
HMO	health maintenance organization
HUD	Department of Housing and Urban Development
ISSRA	individual Social Security retirement accounts
LSD	lysergic acid
NASD	National Association of Securities Dealers
NYSE	New York Stock Exchange
OASI	Old Age and Survivors Insurance
OBRA-90	Omnibus Budget Reconciliation Act of 1990
OMB	Office of Management and Budget
PBGC	Pension Benefit Guaranty Corporation
PHS	Public Health Service
PWBA	Pension and Welfare Benefits Administration
SEC	Securities and Exchange Commission
SSA	Social Security Administration
SSI	Supplemental Security Income
VA	Department of Veterans Affairs

Fiscal Year 1994 GAO Reports on Issues Primarily Affecting Older Americans

During Fiscal Year 1994, GAO issued 30 reports on issues primarily affecting older Americans. Of these, 16 were on health, 10 on income security, 3 on social services, and 1 on other issues.

Health Issues

Health Insurance for the Elderly: Owning Duplicate Policies Is Costly and Unnecessary
(GAO/HEHS-94-185, Aug. 3, 1994)

Owning multiple health insurance policies to supplement Medicare is both costly and unnecessary. GAO estimated that about 3 million elderly Medicare beneficiaries paid about \$1.8 billion in 1991 for policies that probably involved duplicate coverage. Many of these people had supplemental coverage through employer-sponsored plans. About 500,000 other Medicare beneficiaries who were also eligible for Medicaid because of limited incomes spent about \$190 million on unnecessary supplemental insurance. Although retirees with employer-sponsored coverage generally do not need to buy a Medigap policy, many employers with retiree health plans are increasing cost-sharing or tightening eligibility requirements. Such changes may make an employer-sponsored plan less attractive. In addition, the employer may terminate the plan. Federal Medigap requirements provide a one-time "open season" for people to buy Medigap insurance, regardless of health status, within 6 months of enrolling in Medicare part B. If a retiree's employer-sponsored plan is changed or canceled after the open season, the retiree has lost the guaranteed access to a Medigap plan. To alleviate this potential problem, the Congress would have to revise the law.

Long-Term Care Reform: States' Views on Key Elements of Well-Designed Programs for the Elderly
(GAO/HEHS-94-227, Sept. 6, 1994)

The state agencies agree widely on the key components of well-designed programs for the elderly. State agencies believe that an elderly person's ability to perform activities of daily living is the best way to identify persons with the greatest need for services, although states do not uniformly define such activities. To determine service needs, state agencies generally agree that case/care management, a standard assessment instrument, and involvement of the elderly person in the process are most useful. State agencies report that the largest number of severely disabled elderly persons need nonmedical services, such as personal care. State agencies agree that a variety of cost control methods are effective, although there is less consensus about which specific methods work best. Regarding the private-sector role in long-term care, state agencies believe that the private-sector role could probably reduce

government costs, and government interventions might spur private-sector activity.

Long-Term Care: Other Countries Tighten Budgets While Seeking Better Access (GAO/HEHS-94-154, Aug. 30, 1994)

In the United States, the number of people age 65 and older will exceed 20 percent of the total population by the year 2030, up from 12.5 percent in 1990. Public and private spending for long-term care has risen dramatically during the past decade—exceeding \$100 billion in fiscal year 1993—and is projected to continue this upward trend. At the same time, there is considerable consumer dissatisfaction with the cost of and access to this care. To varying degrees, other countries also face aging populations, cost pressures, and service delivery problems. This report reviews the provision of long-term care in Canada, Germany, Sweden, and the United Kingdom. GAO examines (1) the financing and cost-containment measures these countries use to control public spending for long-term care and (2) administrative and delivery approaches the countries use to expand the range of and access to services.

Long-Term Care: Private Sector Elder Care Could Yield Multiple Benefits (GAO/HEHS-94-60 Jan. 31, 1994)

Today, about 6 million older Americans need help living at home because of their disabilities. The demand for this kind of assistance is expected to increase significantly in the future, with upwards of 10 million persons needing help by 2020. Most disabled elderly receive this care from family members and friends, primarily women. Yet greater geographic dispersion of families, smaller family sizes, and the large numbers of women who work outside the home are straining the ability of caregivers. Some companies are responding to the needs of their workers with policies and programs, known as “elder care,” to help ease work and caregiving conflicts. This report evaluates (1) the extent and nature of company practices now offered to help employees who look after the elderly, (2) planned changes in these practices, and (3) the potential of company practices to further support informal caregivers.

Long-Term Care: Status of Quality Assurance and Measurement in Home and Community-Based Services (GAO/PEMD-94-19 Mar. 31, 1994)

This report examines how quality is ensured and measured in home and community-based long-term care services for elderly persons with disabilities. These services range from skilled nursing services to help with activities such as bathing, dressing, shopping, and meal preparation. GAO answers the following questions: How is “quality” defined for home and community-based long-term care services? What measures are now being used to monitor or ensure quality?

**Long-Term Care: Support
for Elder Care Could
Benefit the Government
Workplace and the Elderly
(GAO/HEHS-94-64, Mar. 4,
1994)**

Today, about six million older Americans living at home need help with day-to-day activities, such as eating, bathing, shopping, and house cleaning. Most disabled elderly get all their care informally, from family members and friends, mainly women. Greater geographic dispersion of families, small families, and more women working outside the home are straining the ability of informal caregiving. Some private and public-sector employers are now providing assistance known as “elder care” to alleviate work and caregiving conflicts. This assistance may include leave policies, alternative work schedules, and referral services to help employees care for their elderly relatives. Little is known nationwide about the extent and content of elder care generally—and even less is known about elder care in government, which employs 18 million people or 15 percent of the workforce. This report evaluates (1) the extent and nature of government practices facilitating elder care; (2) planned changes in these practices; and (3) their potential to further support informal caregivers.

**Medicare and Medicaid:
Many Eligible People Not
Enrolled in Qualified
Medicare Beneficiary
Program (GAO/HEHS-94-52
Jan. 20, 1994)**

The Qualified Medicare Beneficiary Program pays many out-of-pocket expenses for Medicare recipients whose incomes are not quite low enough to qualify them for regular Medicaid benefits. The number of people enrolled has steadily increased since the program began in 1989, but a substantial portion of those eligible has yet to sign up—despite repeated efforts by government and advocacy groups to publicize the program. Many believe that people have not enrolled because of the perceived welfare stigma associated with means-tested programs and because of the complicated application process. Many also believe that authorizing the Social Security Administration (SSA) to make program eligibility determinations would help overcome these factors and boost enrollment. Although SSA might be able to increase enrollment, GAO believes that this concept should be tested before it is generally adopted. Finally, some state part A buy-in practices delay or preclude enrollment of Qualified Medicare Beneficiary Program and regular Medicaid beneficiaries in part A. This, in turn, can place some beneficiaries at a disadvantage relative to beneficiaries in other states.

**Medicare: Beneficiary
Liability for Certain
Paramedic Services May
Be Substantial
(GAO/HEHS-94-122BR,
Apr. 15, 1994)**

Volunteer ambulance companies often transport Medicare patients to hospitals. In some cases, the patient may require the services of a paramedic trained in advanced life support services. GAO found that Medicare contractors rely on states to certify ambulance companies for participation in the Medicare program, and states set their own certification requirements. Most volunteer ambulance companies do not

charge for their services or have their own paramedics. Medicare does not pay separately for paramedics, who are covered only if they are an integral part of the ambulance service. Although data are limited, GAO believes that the potential liability of Medicare beneficiaries for paramedic services may be substantial. For example, two providers of paramedic services in Connecticut charged Medicare patients in excess of \$600,000. The Health Care Financing Administration (HCFA) has tried to minimize this liability by allowing ambulance companies to submit a single bill to Medicare for both the ambulance and paramedic services. Because volunteer ambulance companies seldom bill for services, however, this arrangement may not help patients minimize their liability. HCFA officials have agreed to reexamine their policy but as of March 1994 had not yet reached a decision on this matter.

Medicare: Better Guidance Is Needed to Preclude Inappropriate General and Administrative Charges
(GAO/NSIAD-94-13, Oct. 15, 1993)

GAO found that \$1.1 million of \$2.6 million in administrative expenses claimed by the Hospital Corporation of America (HCA) in its Medicare cost report was either unallowable, questionable, or unsupported. In a recently completed review of administrative expenses and employee fringe benefit costs claimed by hospitals and corporate offices in their Medicare cost reports, the Inspector General at the Department of Health and Human Services found more than \$50 million in unallowable and questionable expenses. He concluded that a lack of explicit guidance in Medicare cost principles was at least a contributing factor to this problem. Similarly, the general nature of the Medicare cost principles was a major reason why HCA included inappropriate costs in its report. Medicare cost principles, for example, do not specifically address many of the costs that GAO questioned, such as liquor, flowers, gifts, entertainment, Christmas parties, and scholarships for employee children. In GAO's view, the cost principles contained in the Federal Acquisition Regulation and in Office of Management and Budget Circular A-21 provide useful guidance on allowable general and administrative expenses.

Medicare: Changes to HMO Rate Setting Method Are Needed to Reduce Program Costs
(GAO/HEHS-94-119, Sept. 2, 1994)

During the 1980s, the per capita costs of providing health care to the elderly under Medicare increased 59 percent, even after adjusting for inflation. To slow this cost spiral, the Congress allowed Medicare to contract with health maintenance organizations (HMO) under an alternative payment system. Medicare's traditional fee-for-service payment method created incentives for overuse of medical care because providers could boost their incomes by encouraging greater use of services. By contrast, HMOs receive an up-front fixed monthly fee for each patient's care instead

of a fee for each service. Government researchers and outside analysts, however, have claimed that HMOs can be more expensive than fee-for-service care. These analysts argue that beneficiaries enrolled in Medicare HMOs are healthier (and less costly to care for) than beneficiaries in the fee-for-service sector and that Medicare payments to HMOs do not fully reflect these differences in costs. In addition to this problem, industry representatives and other analysts claim that Medicare payment rates are too low in some areas and show unjustifiably wide variation across geographic boundaries. This report examines Medicare's HMO rate setting methodology to determine the existence and the magnitude of these problems and to review proposed solutions. Specifically, GAO discusses the impact of favorable selection and rate variation on the ability of the Medicare risk contract program to yield cost savings.

Medicare: Greater Investment in Claims Review Would Save Millions (GAO/HEHS-94-35, Mar. 2, 1994)

Given soaring U.S. health care costs and shrinking budgets for many government programs, the Congress is concerned that Medicare pay only for appropriate medical services without compromising the quality of care provided to beneficiaries. One of the several ways that Medicare ensures proper payments is through the medical review function performed by contractors—called carriers—who process and pay claims for physician services, diagnostic tests, and other Medicare part B services. Review activities are designed to prevent spending on inappropriate, medically unnecessary, or excessive services. This report assesses a HCFA demonstration that involves medical review operations at five carriers: three of these were given added management flexibility and funding to enhance their medical review function and two served as comparisons. This report discusses whether (1) the improved medical review activities at the demonstration carriers produced measurable savings or benefits to the claims process; (2) more medical review funding for other carriers would be cost-effective; and (3) HCFA's medical review oversight needs improvement.

Medicare: HCFA's Contracting Authority for Processing Medicare Claims (GAO/HEHS-94-171, Aug. 2, 1994)

Since 1966, HCFA has awarded most contracts to process claims under Medicare parts A and B without competition, has renewed them annually, and has compensated contractors on a cost-reimbursement basis. Periodically, the Congress has directed HCFA to experiment with other types of contracts to reduce administrative costs. Earlier experiments had mixed results, but current experiments indicate that different types of contracts may reduce costs. While HCFA's current authority provides opportunities to achieve administrative efficiencies, it may be useful for

the Congress to direct HCFA to evaluate new approaches that could lead to a more competitive environment. Any changes, however, should avoid problems that have occurred in the past. The role that the Blue Cross and Blue Shield Association (the national trade association for independent Blues plans) plays in coordinating part A contracting activities with individual Blues plans may limit the need for HCFA resources to perform these activities. However, HCFA has not evaluated the Association's performance since 1989, even though HCFA paid the Association over \$21 million during that period. In GAO's view, HCFA needs to regularly assess the Association's performance, just as it does for other contractors, to ensure that the Medicare program is being managed efficiently.

**Medicare: Impact of
OBRA-90's Dialysis
Provisions on Providers
and Beneficiaries**
(GAO/HEHS-94-65, Apr. 25,
1994)

To control soaring Medicare costs, the Congress has required that, in some cases, employer-sponsored group health plans covering Medicare beneficiaries pay medical claims before Medicare begins to foot the bill. Since 1981, such a requirement has been in place for patients with advanced kidney disease, which requires regular dialysis or a kidney transplant. The Omnibus Budget Reconciliation Act of 1990 (OBRA-90) extended the period during which these plans must pay before Medicare kicks in. The OBRA extension of the plans' obligation as primary payers has increased the amount that providers received for dialysis by an estimated \$41 million per year. This increase occurred because employer-sponsored plans generally paid dialysis providers more than the cost-based Medicare rates. Although the additional revenue is relatively small when viewed in the aggregate, boosting total provider revenues for dialysis by about 1.8 percent, it represents pure profit for providers. The extension should not affect most kidney disease patients' out-of-pocket expenses because provisions insulate patients with dual coverage from being singled out for increased out-of-pocket expenditures.

**Medicare: Inadequate
Review of Claims
Payments Limits Ability to
Control Spending**
(GAO/HEHS-94-42 Apr. 28,
1994)

Medicare overpayments of millions of dollars are being made because of inadequate safeguards by contractors who process Medicare claims and inattention by HCFA. Carriers use inaccurate or incomplete data in compiling statistical reports profiling doctors and other providers. Their focused reviews to identify irregular billing patterns and unusual spending trends suffer from HCFA's failure to spell out appropriate analysis methods and outcome measures. As a result, HCFA cannot be sure that Medicare carriers are systematically targeting providers or services that most warrant attention. Shortcomings in carriers' claims review activities exist, in part, because HCFA lacks meaningful requirements for—and the data

needed to measure—carriers’ postpayment review performance. Shortcomings also persist because funds earmarked for postpayment review have not kept pace with the growth in Medicare claims or as a percentage of the carriers’ overall administrative budget.

Medicare: Shared System Conversion Led to Disruptions in Processing Maryland Claims
(GAO/HEHS-94-66, May 23, 1994)

Since 1989, HCFA has tried to reduce administrative costs by urging Medicare contractors to share claims processing system software and hardware with other contractors. In October 1991, Blue Cross and Blue Shield of Maryland began using claims processing software developed by another contractor. For more than a year after the system conversion, Medicare payments to Maryland physicians were frequently late and often contained errors, resulting in unanticipated costs of more than \$5 million. The Maryland contractor has yet to realize any of the anticipated annual savings of more than \$600,000 in administrative costs. Poor management by Blue Cross and Blue Shield of Maryland and poor decisions by HCFA contributed to the contractor’s costly and turbulent shared system conversion. In particular, HCFA and the Maryland contractors did not allow enough time to plan the effort and scheduled the conversion during a period of Medicare program changes requiring major computer system modifications. The Maryland contractor’s experience provides valuable lessons for the future, especially given HCFA’s plan to convert the 14 systems that the contractor now uses to a single automated claims processing system. HCFA needs to ensure that planning and testing time for major system changes are adequate and not compromised by its desire to achieve administrative savings.

Medigap Insurance: Insurers’ Compliance With Federal Minimum Loss Ratio Standards, 1988-91
(GAO/HEHS-94-47, Feb. 7, 1994)

From 1988 through 1991, the market for Medicare supplemental insurance—commonly called Medigap—grew by more than 50 percent; premiums rose from about \$7 billion to \$11 billion. In the first half of this period, Medigap insurers’ loss ratios fell for both individual and group policies. Beginning in 1990, loss ratios rose, and the 1991 aggregate loss ratios were about at their 1988 levels—80 percent for policies sold to individuals and 90 percent for group policies. The loss ratios for individual policies represent a dramatic improvement from the early 1980s when the federal minimum standards became effective and aggregate loss ratios were about 60 percent. The premiums associated with companies whose aggregate loss ratios did not meet the federal minimum standards fell from \$388 million in 1988 to \$206 million 3 years later. Although this decline suggests that insurers’ compliance with the loss ratio standards improved during the 4-year period, some companies did not meet the minimum loss

ratio standards in every state in which they did business. The premiums collected by these companies steadily declined during the period, from \$126 million in 1988 to \$35 million in 1991.

Income Security Issues

D.C. Pension Benefits: Comparison With Selected State and Local Government Pension Plans (GAO/HRD-94-18, Nov. 4, 1993)

After surveying 40 public employee retirement plans, GAO concludes that the District of Columbia's retirement plans for police officers, firefighters, teachers, and judges generally provide benefits that are comparable to those offered by other public retirement plans. District police officers and firefighters receive pensions that are slightly higher (as a percent of final salary) than the average provided by similar plans, while District teachers' pensions are slightly lower. District judges' pensions are higher than the average of other plans. Any comparison of public pension plan benefits is complicated, however, because survivor benefits, disability benefits, and cost-of-living adjustment provisions vary among plans. The District's cost-of-living adjustment provision—retirement annuities are increased twice yearly by the full amount of the rise in the consumer price index—is more generous than provisions of other plans.

District's Workforce: Annual Report Required by the District of Columbia Retirement Reform Act (GAO/GGD-94-64, Mar. 31, 1994)

The federal government makes annual payments to the District of Columbia retirement fund for police officers and firefighters. To encourage the District government to control disability retirement costs, these payments must be reduced when the disability retirement rate exceeds a certain limit. GAO concludes that no reduction is required in the fiscal year 1995 payment to the fund.

Insurance Ratings: Comparison of Private Agency Ratings for Life/Health Insurers (GAO/GGD-94-204BR, Sept. 29, 1994)

Private rating agencies can play an important role in providing consumers with information about insurers' financial health. Concerns have arisen, however, about the usefulness of these ratings to consumers. This report (1) compares the rating systems of the five major raters of life/health insurers—A.M. Best, Duff & Phelps, Moody's, Standard and Poor's, and Weiss Research—over the period August 1989 to June 1992 and (2) determines which raters were first to report the vulnerability of financially impaired or insolvent insurers.

**Pension Plans: Stronger
Labor ERISA Enforcement
Should Better Protect Plan
Participants**
(GAO/HEHS-94-157, Aug. 8,
1994)

The Department of Labor's Pension and Welfare Benefits Administration (PWBA) is responsible for enforcing provisions of the Employee Retirement Income Security Act of 1974 (ERISA), the federal program to protect an estimated 200 million participants and beneficiaries of private pension and welfare plans, as well as the \$2.5 trillion in assets held by those plans. A review of Labor's enforcement program shows improvements since 1986, but also the need to strengthen enforcement by taking steps to ensure maximum use of investigative resources. PWBA has never evaluated its current enforcement strategy; such an evaluation is needed to determine whether PWBA is focusing on the right issues and whether the strategy produces the greatest results. In addition, PWBA has done little to assess the effectiveness of computer targeting programs developed to systematically select pension and welfare plans for investigation of potential fiduciary violations. The enforcement program also can be strengthened by increasing the use of penalties authorized by ERISA to deter plans from violating the law.

**Proposal to Strengthen
H.R. 3396**
(GAO/HEHS-94-181R,
June 24, 1994)

Pursuant to a congressional request, GAO provided information on options that would strengthen H.R. 3396. GAO noted that (1) H.R. 3396 would improve funding for many underfunded pension plans, (2) H.R. 3396 should be strengthened so that sponsors of poorly funded plans are required to contribute more than the ERISA minimum requirements, (3) the Pension Benefit Guaranty Corporation (PBGC) needs to determine what threshold defines a poorly funded plan so that the risks of benefit loss are reduced and plan contributions are increased, (4) PBGC believes that strengthening H.R. 3396 is unnecessary and that the minimum ERISA contribution will be sufficient to move plans to full funding, (5) funding mechanisms are needed to ensure that a plan's funding ratio will not fall too low because hidden liabilities can deteriorate a plan's funding rapidly, and (6) a reasonable threshold to define an underfunded plan would be 75 to 85 percent.

**Social Security
Administration: Risks
Associated With
Information Technology
Investment Continue**
(GAO/AIMD-94-143, Sept.
19, 1994)

SSA's proposed acquisition of intelligent workstations, that is, personal computers and local area networks, has not been driven by plans to identify how and where SSA can best use its new technology and other resources to handle increasing workloads and improve public service. SSA ultimately plans to introduce a system of more than 90,000 personal computers and 27,000 local area networks at a cost of billions of dollars. GAO has encouraged and supported recent SSA efforts to reengineer its disability determination process and set overall service delivery goals

because they are important steps in identifying future resource needs. However, national implementation of intelligent workstations and local area networks is proceeding independently of these initiatives and at risk because SSA has not adequately defined its technology needs.

**Social Security Disability:
Most of Gender Difference
Explained**
(GAO/HEHS-94-94, May 27,
1994)

Under the Social Security Disability Insurance Program, older women are allowed benefits at a lower rate than are older men. For example, in 1988, 39 percent of female applicants aged 55 to 64—compared with 50 percent of the male applicants of the same age—were allowed benefits. However, GAO found that this difference does not necessarily point to bias in the system. Rather, most of the difference could be explained by gender difference in impairments and demographic characteristics and by the rules for determining disability.

**Social Security Retirement
Accounts**
(GAO/HEHS-94-226R,
Aug. 12, 1994)

Pursuant to a congressional request, GAO reviewed proposed legislation to create a system of individual Social Security retirement accounts (ISSRA), focusing on the (1) implications of H.R. 306 on the retirement income of individuals and (2) key differences between H.R. 306 and the 1990 proposal. GAO noted that (1) ISSRA could be integrated with the Social Security benefit structure and, given favorable market conditions, could improve retirement incomes; (2) although both proposals include a 2-percent payroll tax diversion, H.R. 306 would deplete Social Security trust fund contingency reserves; (3) under the 1990 proposal, the ISSRA program would end when the projected Old Age and Survivors Insurance (OASI) cost rate would rise to equal the income rate, except for the accumulation and payment of interest; (4) H.R. 306 proposes a permanent ISSRA scheme that would require future payroll tax increases or benefit reductions; (5) since H.R. 306 does not provide for benefit reductions to account for the diversion of payroll tax revenues, individuals will generally receive a higher total retirement income; and (6) under H.R. 306, the ISSRA program would effectively become a mandatory defined contribution supplement to Social Security.

**Social Security: Sustained
Effort Needed to Improve
Management and Prepare
for the Future**
(GAO/HRD-94-22, Oct. 27,
1993)

Failure to meet the SSA's management challenges could have serious consequences. SSA provides benefits to about 47 million people today, and it will have to provide benefits and services to many more people in the future. The baby boomers are aging, and, beginning in 1995, Social Security earning and benefits statements will be required for all workers. SSA is already seeing the effects of a significant rise in disability cases, an

area already plagued by major processing delays. This third in a series of GAO reports examines SSA's current operations and its preparations for the future. GAO concludes that if SSA cannot establish the necessary long-range plans, efficiently manage computer-systems modernization, address workforce needs, and control its finances, it risks significant deterioration in its ability to serve the public efficiently and effectively. GAO summarized this report in testimony before the Congress; see Social Security Administration: SSA Needs to Act Now to Assure World-Class Service, by Jane L. Ross, Associate Director for Income Security Issues, before the Subcommittee on Social Security, House Committee on Ways and Means (GAO/T-HRD-94-46, Oct. 28, 1993).

Social Security: Trust Funds Can Be More Accurately Funded
(GAO/HEHS-94-48, Sept. 2, 1994)

Each year, the Social Security trust funds are credited with revenues derived from income taxes paid on Social Security benefits. But do they get the right amount? GAO reports that the Social Security trust fund's revenues could be increased by recognizing additional taxes identified through the Internal Revenue Service's (IRS) efforts to locate underreported taxable income and through better detection of underreported tax-exempt interest. Recognizing additional taxes identified by IRS could have boosted the trust funds by more than \$200 million in tax revenue and investment income for tax years 1984 to 1989. Further, data from the Federal Reserve and the Investment Company Institute indicate that taxpayers may have underreported an estimated \$7.2 billion in tax-exempt income on their 1989 tax returns.

Social Services Issues

Older Americans Act: Title III Funds Not Distributed According to Statute
(GAO/HEHS-94-37, Jan. 18, 1994)

The Administration on Aging's (AOA) method of allocating funds under title III of the Older Americans Act is inconsistent with the law's basic requirement that funds be distributed to states in a manner proportionate to their elderly populations. Funds must be allotted proportionally among the states except that no state is to receive less than the minimum set by law. AOA's current method of computing allotments ensures that the minimums are met but in a way that fails to achieve proportionality among states not subject to the minimum grant requirements. Among the distorting effects of AOA's method are that the amounts allotted per elderly person are not equal in similarly populated states, and states with more

rapidly growing elderly populations are underfunded. The required method avoids or minimizes both effects.

Older Americans Act: The National Eldercare Campaign
(GAO/PEMD-94-7, Feb. 23, 1994)

In April 1991, AOA launched a multiyear initiative called the National Eldercare Campaign. AOA used about \$14 million of \$26 million in title IV discretionary funds to support the campaign's various components. The largest portion of these funds went to a new community outreach effort, Project CARE. Under this national coalition-building demonstration program, each state was required to establish three local coalitions. At the end of 15 months, virtually all states had three local coalitions in place. A majority of coalitions had generated some resources, and about 70 percent of the coalitions were providing a service to the elderly. The campaign differs from earlier AOA initiatives in that it seeks to expand not only the Aging Network but also the resources available to them. Usually, AOA initiatives were of 12- to 24-months duration and limited to research, demonstration, and technical assistance. By the end of fiscal year 1992, about 200 coalitions had joined the Aging Network and had developed programs and services for the elderly. Although this is a significant change in both the mission and structure of the Aging Network, the success of this campaign ultimately depends upon the coalitions' ability to sustain themselves beyond the 3-year funding period.

Older Americans Act: Funding Formula Could Better Reflect State Needs
(GAO/HEHS-94-41, May 12, 1994)

In response to congressional concerns that current title III allocations do not fully reflect indicators of states' needs, GAO examined the interstate funding formula of the current Older Americans Act of 1965. This formula allocated more than \$770 million in federal title III dollars in fiscal year 1993 among the 50 states and the District of Columbia. GAO concludes that the Congress should modify the formula for distributing title III money to better target those elderly persons with the greatest social and economic needs. In this report, GAO (1) develops equity standards appropriate to evaluating the allocation of title III assistance to the states, (2) uses these standards to create alternative formulas under which funds might be distributed more equitably, (3) shows how each of the alternatives would redistribute funding among the states, and (4) explores ways of phasing in a new formula to moderate the degrees of funding changes in a single year.

Other Issues

Aging Issues: Related GAO Reports and Activities in Fiscal Year 1993 (GAO/HRD-94-73, Dec. 22, 1993)

GAO's work on aging issues reflects the continuing importance of federal programs for older Americans. The 1990 Census reported more than 31 million older Americans, and that number is expected to top 53 million by 2020. A multitude of public policy issues are linked to the graying of America. GAO's reports and testimony during 1993 addressed many of these subjects, including federal programs relating to employment, health care, housing, income security, and veterans affairs. This handy reference guide summarizes issued reports and testimony and lists jobs that were ongoing as of September 1993.

Fiscal Year 1994 GAO Reports on Issues Affecting Older Americans and Others

GAO issued 59 reports in fiscal year 1994 on policies and programs in which older Americans were one of several groups. Of these, 2 were on employment, 20 on health, 7 on housing, 6 on income security, 1 on social services, 17 on veterans, and 6 on other issues.

Employment Issues

EEOC's Expanding Workload: Increases in Age Discrimination and Other Charges Call for New Approach
(GAO/HEHS-94-32, Feb. 9, 1994)

The amount of time a person may have to wait for the Equal Employment Opportunity Commission (EEOC) to process a discrimination charge under the nondiscrimination laws could more than double and approach 21 months by fiscal year 1996. The current trend of a steadily increasing workload without commensurate increases in resources is expected to continue. Former and current EEOC officials and civil rights experts have suggested several options that they believe could improve the federal government's ability to enforce employment nondiscrimination laws. The one mentioned most often is increased use of alternative dispute resolution approaches, such as mediation. GAO recommends that the Congress convene a panel of experts to review this and other options for improvement. Because resources are scarce, EEOC officials doubt that EEOC will initiate substantially more systemic charges or litigate significantly under the nondiscrimination laws.

Employment Discrimination: How Registered Representatives Fare in Discrimination Disputes
(GAO/HEHS-94-17, Mar. 30, 1994)

To work in the security industry, registered representatives—mainly stockbrokers—must agree to submit any employment controversy, including discrimination disputes, to arbitration panels composed of neutral third parties. In recent years, the number of discrimination cases filed by registered representatives for arbitration at the New York Stock Exchange (NYSE) and the National Association of Securities Dealers (NASD) has remained low and relatively constant. Six discrimination cases were filed for arbitration with NYSE in 1990 and 14 in both 1991 and 1992. Between August 1990 and December 1992, NASD's New York Office and NYSE decided 18 discrimination cases. In 4 of the 10 cases involving financial awards, the monetary compensation was directly linked to discriminatory practices. Sex and age discrimination were cited most often in such cases. Some NYSE and NASD procedures for selecting arbiters need improvement. For example, NASD lacks written criteria for excluding potential arbiters with a history of disciplinary actions or regulatory infractions while working in the securities industry. In addition, NYSE and

NASD differ in their requirements for arbiter disclosure of criminal convictions. The Securities and Exchange Commission's (SEC) oversight of arbitration programs focuses on customer-firm disputes rather than on employee-employer disputes. Because SEC does not review discrimination cases during its inspection of arbitration programs, it does not know the extent to which discrimination cases are filed and whether the industry has fairly and impartially resolved them. In addition, SEC has not established a formal inspection cycle—a set time for conducting inspections of securities' arbitration programs—to ensure that all programs are inspected regularly. SEC also does not know whether the securities industry corrects problems flagged by its inspections.

Health Issues

Blue Cross and Blue Shield: Experiences of Weak Plans Underscore the Role of Effective State Oversight
(GAO/HEHS-94-71, Apr. 13, 1994)

The 1990 failure of Blue Cross and Blue Shield of West Virginia left thousands of people and many health care providers with millions of dollars in unpaid claims. More recently, congressional investigators uncovered serious financial problems as well as mismanagement at three other “Blues” plans and raised questions about the oversight of these plans by their boards of directors and state regulators. GAO found that 53 of 64 Blues plans are rated in fair to excellent condition by Weiss Research, Inc.—the only insurance rating agency doing such evaluations of Blues plans. The remaining 11 plans, which insure about one-quarter of all Blues subscribers, are rated as weak to very weak financially. Some plans were slow to respond to changing market conditions or made poor investment decisions, while others were put at a competitive disadvantage by rate-setting constraints and coverage requirements applicable only to Blues plans. In addition, weaknesses in oversight by plan boards of directors and state regulators allowed plans' financial problems to persist. The Blue Cross and Blue Shield Association, individual plans, and states have tried to remedy the problems of financially troubled plans, but it is too soon to tell how successful these efforts will be. Under health care reform, the role of state insurance regulators in monitoring the financial solvency of Blues plans and protecting subscribers' and providers' interest will become increasingly important and challenging. It is essential that state insurance regulators have the tools necessary to enforce new requirements on Blues plans and other health insurers.

**Cancer Survival: an
International Comparison
of Outcomes**
(GAO/PEMD-94-5, Mar. 7,
1994)

In comparing U.S. and Canadian survival rates for lung cancer, colon cancer, Hodgkin's disease, and breast cancer, GAO found that breast cancer patients lived longer after diagnosis in the United States than in Canada. The outcomes were mixed for the other types of cancer studied. Nine to 10 years after cancer was detected, the survival rates for U.S. patients were indistinguishable from (in the cases of colon cancer and Hodgkin's disease) or lower (in the case of lung cancer) than survival rates in Canada. One possible interpretation of these findings is that quality of care for breast cancer patients is better in the United States than in Canada and that for the three other cancers it is about the same. Other interpretations focus on differences in detection.

**Early Retiree Health:
Health Security Act Would
Shift Billions in Costs to
Federal Government**
(GAO/HEHS-94-203FS,
July 21, 1994)

The President's proposed Health Security Act would relieve private industry of much of the financial burden of providing health insurance to early retirees. This would shift billions of dollars in costs each year to the federal government. Today, about 9 million private-sector retirees and one-third of all private-sector workers are in company health plans with coverage for health care between retirement and age 65—when Medicare kicks in. If the Health Security Act is enacted, the federal government, beginning in 1998, would not only pick up the tab for early retirees' share of their health costs but would also pay the major portion of company costs. The federal government's share would be \$6 billion in the first year, growing to nearly three times that amount 3 years later. At the same time, companies would save \$11 billion in the first 3 years and would ultimately save over \$130 billion after 10 years.

**Health Care in Hawaii:
Implications for National
Reform (GAO/HEHS-94-68,
Feb. 11, 1994)**

For nearly 20 years, Hawaii has been a leader in the effort to achieve universal access to health insurance. It is the only state that requires employers to provide a minimum level of health insurance benefits to employees, and its public programs cover many residents lacking employment-based insurance. GAO makes several points. First, Hawaii's employer mandate did not have a harmful effect on small businesses. Second, although Hawaii's system of near-universal access has lowered health premiums, its per capita health care costs have risen at a rate similar to the national average. Third, Hawaii's experience suggests that an employer mandate by itself will not necessarily result in universal access to health care. GAO summarized this report in testimony before the Congress; see Health Care in Hawaii: Implications for National Reform, by Mark V. Nadel, Associate Director for National and Public Health Issues,

before the House Committee on Small Business (GAO/T-HEHS-94-123, Mar. 16, 1994).

**Health Care Reform:
“Report Cards” Are Useful
but Significant Issues Need
to Be Addressed
(GAO/HEHS-94-219, Sept.
29, 1994)**

As part of the debate over health care reform, the Congress is considering requiring health plans to provide prospective purchasers with information on the quality of care they furnish. Presumably, purchasers will use such “report cards” to compare health plans and choose one that provides the desired level of quality and price. Although report cards that compare the performance of competing health care plans could be a positive step in preserving quality and lowering costs, experts disagree about the type and amount of information to be published because such data may not be reliable or valid. Some experts believe that usable report cards can be produced within 2 to 5 years if the indicators are limited to those known to be valid and reliable. Others believe that it will be as long as 15 years before highly reliable and valid measures are developed. Several states and groups such as United HealthCare Corporation and Kaiser Permanente Northern California Region have already issued report cards on the care they furnish, but no studies have been done on the cards’ validity or reliability. To overcome obstacles to using report cards, most experts recommend that (1) the federal government standardize indicators and the formulas for calculating results and (2) an independent third party verify data before they are published.

**Health Care Reform:
Proposals Have Potential
to Reduce Administrative
Costs (GAO/HEHS-94-158,
May 31, 1994)**

Americans today receive health insurance from a multitude of sources, including more than 1,200 commercial insurers; 550 health maintenance organizations; 69 Blue Cross and Blue Shield plans; thousands of self-insured plans run by private employers; and government programs, such as Medicaid and Medicare. Many believe that the complexity of this insurance system contributes to the nation’s high per capita health care costs. One of the aims of health care reform is to enhance administrative efficiency. To the extent that reform simplifies insurance administration, it may be able to cut costs. Any savings in administrative expenses could be applied to other valuable ends, such as expanding access and improving quality. This report examines the administrative cost implications of alternative reform proposals, including a single-payer plan and three managed competition plans, and compares their administrative cost savings potential.

Health Care Reform:
Potential Difficulties in
Determining Eligibility for
Low-Income People
(GAO/HEHS-94-176,
July 11, 1994)

To obtain basic health care, more than 30 million people depended on Medicare in fiscal year 1992. Federal and state governments spent nearly \$120 billion to provide services to these people. However, millions of people with income below the poverty line are not now covered by Medicaid. Many of these who are potentially eligible do not apply, and many who apply are denied enrollment and remain uninsured. Because health care reform may expand coverage to many of the uninsured, some form of means testing may be required to determine eligibility. This report identifies the (1) reasons why people who may be potentially eligible for Medicaid are not being enrolled, (2) incentives hospitals have to facilitate enrollment of their patients in Medicaid, and (3) implications for eligibility determinations if health care reform is enacted.

Health Care: Antitrust
Enforcement Under
Maryland's Hospital
All-Payer System
(GAO/HEHS-94-81, Apr. 27,
1994)

One issue being raised in the debate over health care reform is how antitrust law should be applied to health care providers. Federal and state antitrust law seeks to prevent price fixing and predatory pricing and to ensure access to and quality of goods and services for consumers. Since 1974, Maryland has operated a rate-setting program that sets how much hospitals can charge for their services. Also, health care facilities operating in Maryland must obtain a certificate of need if they wish to change the type of services they provide or to make major capital expenditures. Because Maryland regulates hospital prices similar to the way in which public utilities are regulated, state antitrust concerns about hospital pricing are not an issue, and Planning Commission-approved mergers and joint actions by hospitals are exempt from the state's antitrust law. Also, to the extent that the state actively regulates hospitals, federal antitrust enforcement concerning such regulated activities may not be relevant under the Supreme Court's state action immunity doctrine. Other concerns about anticompetitive conduct and its possible harmful effect on the public may still be relevant and covered by federal or state antitrust law.

Health Care: Federal and
State Antitrust Actions
Concerning the Health
Care Industry
(GAO/HEHS-94-220, Aug. 5,
1994)

In response to a request to review antitrust enforcement actions involving hospitals by the Department of Justice and the Federal Trade Commission (FTC), GAO found that of 397 acute care hospital mergers reviewed by Justice and the FTC in the 13-year period of fiscal year 1981 through fiscal year 1993, less than 4 percent were challenged. For an additional 13 percent of these mergers, Justice or the FTC conducted a preliminary investigation and then allowed the mergers to go forward. The remaining 83 percent of cases involved no more than the required initial filing of

notice of proposed merger. Neither Justice nor the FTC has ever challenged a hospital joint venture. GAO also found that the hospital industry has actively sought enactment of state laws that would confer antitrust immunity to collaborative actions by hospitals, such as mergers, joint ventures, and sharing of patients and equipment. Since 1992, 18 states have enacted regulatory programs for state approval of hospital activities that can fall under antitrust statutes. Such state laws are sought because under the state action immunity doctrine established by the Supreme Court, certain anticompetitive conduct regulated by the states may be immune from federal antitrust enforcement action.

Health Insurance:
California Public
Employees' Alliance Has
Reduced Recent Premium
Growth (GAO/HRD-94-40,
Nov. 22, 1993)

As part of the ongoing debate over health care reform, policymakers have been weighing the pros and cons of alternative ways to purchase care. The administration's health care reform package and other recent reform proposals call for purchasing cooperatives to manage competition among health care plans. One frequently cited example of a successful purchasing cooperative is the California Public Employees' Retirement System (CalPERS), which negotiates health premiums for many public employees in California. This report analyzes CalPERS' effectiveness in controlling health care costs for its members. GAO (1) examines CalPERS' cost-containment record, (2) identifies factors that have contributed to the trend in its premium rates, (3) assesses the impact of CalPERS' cost-containment efforts on its members' benefits, and (4) discusses the applicability of its Health Benefits Program as a model of managed competition—a system under which large purchasing cooperatives contract with a variety of competing health plans on behalf of employers and individuals.

Health Professions
Education: Role of Title
VII/VIII Programs in
Improving Access to Care
Is Unclear
(GAO/HEHS-94-164, July 8,
1994)

During the past decade, the supply of nearly all health professionals has increased faster than has the population. For most health professions, however, data are unavailable to show whether this increased supply has meant more access to care in rural and underserved areas. For the two professions with the most data available—primary care physicians and general dentists—supply has increased in many rural areas but not in those urban and rural areas with the greatest shortages. GAO's findings are similar for minority recruitment: Although the number of minorities in the health professions is increasing, data are inconclusive about whether further increases will improve access to health care for underserved populations. Although nearly \$2 billion has been provided to 30 Title VII and VIII programs during the last 10 years, evaluations have not shown

that these programs have had a significant effect on changes in the supply, distribution, and minority representation of health professionals.

**Medicaid Long-Term Care:
Successful State Efforts to
Expand Home Services
While Limiting Costs
(GAO/HEHS-94-167,
Aug. 11, 1994)**

Because nearly one-third of the nation's Medicaid expenditures are now spent on long-term care (\$42 billion in 1993), GAO was asked to review the experience of states in expanding government-funded home and community-based services. GAO's review focused on Oregon, Washington, and Wisconsin. These three states have expanded home and community-based long-term care in part as a strategy to help control rapidly increasing Medicaid expenditures for institutional care. As they expanded home and community-based care, the three states restricted how large most of the programs can grow. Some restrictions were mandated by the federal government, which approves capacity limits on programs operated under Medicaid waivers. Other restrictions result from constrained state budgets. Despite these deliberate limits on program size, one impact of the shift to home and community-based care is that the three states have been able to provide services to more people with the dollars available, primarily because home and community-based care is less expensive per person than institutional care.

**Medicaid: Changes in Best
Price for Outpatient Drugs
Purchased by HMOs and
Hospitals
(GAO/HEHS-94-194FS,
Aug. 5, 1994)**

The Congress has tried to reduce Medicaid prescription drug costs by requiring drug manufacturers to give state Medicaid programs rebates for outpatient drugs. The rebates were based on the lowest or "best" prices that drug manufacturers charged other purchasers, such as health maintenance organizations (HMO) and hospitals. Concerns have been raised in the Congress that drug manufacturers might try to minimize the rebates to state Medicaid programs by increasing best prices and cutting best price discounts for drugs purchased by HMOs and others. This fact sheet (1) determines the changes in the best prices for the drugs bought by the HMOs and group purchasing organizations GAO studied; (2) determines the changes in the difference between the drugs' best prices and their average prices, known as the "best price discount;" and (3) compares the changes in the best prices with the changes in prices paid by the HMOs and the group purchasing organizations.

Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government (GAO/HEHS-94-133, Aug. 1, 1994)

Medicaid, which provides health insurance for qualified low-income persons, is jointly funded by the federal government and the states. Because of soaring health care costs during the past decade, states have been searching for new ways to help finance the \$125 billion Medicaid program. Some states are now using dubious financial arrangements to collect federal funds without committing their own matching amounts, thus increasing the share of Medicaid costs borne by the federal government. This report (1) examines the financial arrangements used by states to inflate the federal share of Medicaid program expenditures, (2) describes the various techniques that states use to obtain federal funds for their basic Medicaid and disproportionate share hospital programs, and (3) looks into whether states are using their federal matching funds to provide medical services to Medicaid patients.

Medical Malpractice: Maine's Use of Practice Guidelines to Reduce Costs (GAO/HRD-94-8, Oct. 25, 1994)

As part of a larger goal of reducing health care costs and improving medical care, Maine is testing an innovative medical malpractice reform initiative. Maine has incorporated into state law 20 practice guidelines for four specialties: anesthesiology, emergency medicine, obstetrics and gynecology, and radiology. This effort seeks to resolve malpractice claims by eliminating the need to litigate to establish the standard of care. Maine officials expect that the practice guidelines will decrease doctors' motivation to do medically unnecessary tests and will lower health care costs. Maine was able to incorporate the practice guidelines into law by (1) gaining broad involvement of those affected by the guidelines, (2) ensuring that those developing and choosing the guidelines were accountable to the public, and (3) protecting the physicians who use the guidelines in their practice. Specifically, the project was developed and is overseen by health care providers, payers, and consumers. To persuade Maine's doctors to participate in the project once it was developed, the project provides physicians complying with the guidelines a defense in future malpractice lawsuits. With these components, the majority of eligible doctors opted to participate in the project.

Medicare/Medicaid: Data Bank Unlikely to Increase Collections From Other Insurers (GAO/HEHS-94-147, May 6, 1994)

The Department of Health and Human Services has been directed to establish a data bank, beginning in February 1995, that would contain information on all workers, spouses, and dependents who are covered by employer-provided health insurance. The goal is to save millions by strengthening processes to (1) identify the approximately 7 million Medicare and Medicaid beneficiaries who have other health insurance coverage that should pay medical bills before Medicare and Medicaid

kicks in and (2) ensure that this insurance is appropriately applied to reduce Medicare and Medicaid costs. In GAO's view, however, the data bank will end up costing millions and likely achieve little savings. GAO believes that changes and improvements to existing activities would be a much easier, less costly, and thus preferable alternative to the data bank. This is largely because the data bank will result in an enormous amount of added paperwork for both the Health Care Financing Administration (HCFA) and the nation's employers. GAO summarized this report in testimony before the Congress; see Medicare/Medicaid: Data Bank Unlikely to Increase Collections From Other Insurers, by Leslie G. Aronovitz, Associate Director for Health Financing Issues, before the Senate Committee on Governmental Affairs (GAO/T-HEHS-94-162, May 6, 1994).

Medicare: Graduate
Medical Education
Payment Policy Needs to
Be Reexamined
(GAO/HEHS-94-33, May 5,
1994)

It is widely held that the United States is not training enough primary care physicians relative to types of physicians. In 1961, about half of all doctors were in primary care practice; if current trends continue, that number could drop to about 26 percent by 2020. At the same time, if health care reform establishes a delivery system that incorporates managed care, the need for primary care physicians will increase. The Medicare program is the primary vehicle through which the federal government helps finance physician training and education. Although data are limited, some researchers argue that hospitals are using Medicare funds to disproportionately underwrite the training of nonprimary care physicians at a time when more primary care physicians are needed. This report (1) describes how Medicare compensates hospitals for the costs of graduate medical education and (2) determines the extent of Medicare support for the graduate medical education of primary and nonprimary care physicians.

Medicare: Technology
Assessment and Medical
Coverage Decisions
(GAO/HEHS-94-195FS,
July 20, 1994)

Thousands of medical procedures, devices, and drugs are available for patient care in this country. Each year, public and private health care insurers make coverage decisions for these medical technologies. To make these decisions, insurers increasingly rely on formal technology assessments, which evaluate a technology's safety and effectiveness. In this fact sheet, GAO provides general information about the technology assessment resources and activities of the Public Health Service's (PHS) Agency for Health Care Policy and Research, HCFA's resources and processes for making Medicare coverage decisions, and HCFA's process for making hospital payments that account for the use of new technologies.

**Prescription Drugs:
Companies Typically
Charge More in the United
States Than in the United
Kingdom**
(GAO/HEHS-94-29, Jan. 12,
1994)

Drug manufacturers charge 60 percent more for 77 commonly prescribed, brand-name drugs in the United States than for the same medications in the United Kingdom. A total of 66 of the drugs were priced higher in the United States than in the United Kingdom; 47 of these were priced more than twice as high. Most of the differences in prescription drug prices between countries cannot be attributed to differences in manufacturers' costs. Instead, U.S.-U.K. drug price differences are mainly due to the lack of regulatory constraints in the United States. In the United Kingdom, the government health system—virtually the sole payer for prescription drugs—has an agreement with drug manufacturers that limits the profits that drug companies can earn on sales in the British Isles. Other factors may also work to lower drug prices in the United Kingdom. Pharmaceutical information is more widely available in the United Kingdom than in the United States, possibly enhancing price competition among drug manufacturers in the United Kingdom. U.K. doctors receive information on their own prescribing patterns and on the comparative prices and efficacy of drugs. The government can remove drugs from its list of reimbursable products if the manufacturers' prices for those drugs are considered excessive. Wholesalers and retailers can import brand-name drugs into the United Kingdom from elsewhere in Europe where drugs are cheaper.

**Public Health Services:
Agencies Use Different
Approaches to Protect
Public Against Disease and
Injury**
(GAO/HEHS-94-85BR,
Apr. 29, 1994)

The PHS conducts or supports national programs of health services delivery, disease prevention, health promotion, and biomedical research through eight agencies. Because agencies' programs often address the same diseases or conditions, the potential exists for duplication of effort. Congressional concerns have also been raised about the expansion of funding for the Centers for Disease Control and Prevention (CDC), which rose from \$587 million to about \$1.5 billion between fiscal years 1987 and 1992. Concerns have likewise been raised that the scope of CDC's programs and activities today extends well beyond the agency's early focus on communicable disease. GAO found that no PHS agency was duplicating another agency's public health activities in the programs GAO reviewed. Also, CDC's programs were appropriate considering the agency's legislative authority and its history of prevention and control efforts regarding chronic diseases and other health conditions. Public health experts GAO consulted support CDC's activities.

Housing Issues

Efforts to Assist the Homeless in San Antonio (GAO/RCED-94-238R, July 11, 1994)

Pursuant to a congressional request, GAO reviewed the role of McKinney Act programs in assisting the homeless in San Antonio. GAO noted that (1) although the homeless have had access to a range of low-income assistance programs since 1970, most of these programs were not targeted specifically toward the homeless; (2) before McKinney Act programs became available, emergency shelters were established by charitable organizations and health care was available through county facilities; (3) McKinney program funding has played a small but important role in San Antonio's homeless assistance efforts since 1987; (4) McKinney programs have improved existing emergency food and shelter programs, funded transitional housing, expanded health care services, helped link adult education programs with shelters, established mobile outreach services for the mentally ill and employment assistance for veterans, and improved coordination between local organizations and providers; (5) local service providers believe that their current resources are not sufficient to meet the special needs of the homeless; (6) service providers believe that San Antonio needs to increase the amount of transitional housing, employment training, literacy education, prenatal care for youths, substance abuse treatment, homeless prevention efforts, affordable housing for low-income persons, and high-paying jobs; and (7) San Antonio should seek new and creative ways to provide low-income housing, since affordable housing shortages contribute to homelessness in San Antonio.

Efforts to Assist the Homeless in Seattle (GAO/RCED-94-237R, July 11, 1994)

Pursuant to a congressional request, GAO reviewed the role of McKinney Act programs in assisting the homeless in Seattle. GAO noted that (1) homeless social service programs and emergency services have been available in Seattle for many years and are funded by local and state governments and private sources; (2) McKinney program funding has played an important role in Seattle's homeless assistance efforts since 1987; (3) McKinney programs have supplemented existing food and emergency shelter services, expanded employment and education programs, and funded transitional housing, health care services shelters, and mentally ill outreach programs; (4) although McKinney funds are provided to cities for food, shelter, health care, education, and employment programs targeted to the homeless, the current resources available are not meeting service demands; (5) service providers believe

that without McKinney program funds, health care outreach services, transitional housing, and education programs would be greatly reduced or discontinued; (6) local service providers believe that Seattle needs to increase the amount of affordable housing for low-income persons, funds for substance abuse programs, services targeted to youths, and its employment training, education, and homeless prevention efforts; and (7) Seattle should seek new and creative ways to provide low-income housing, since affordable housing shortages contribute to homelessness in Seattle.

Efforts to Assist the
Homeless in Baltimore
(GAO/RCED-94-239R,
July 11, 1994)

Pursuant to a congressional request, GAO reviewed the role of McKinney Act programs in assisting the homeless in Baltimore. GAO noted that (1) homeless emergency services have been available in Baltimore since the 19th century; (2) before McKinney Act programs became available, churches, missions, and private groups provided food and shelter services for the homeless; (3) since 1987, McKinney program funding has played an important role in Baltimore's efforts to assist the homeless; (4) McKinney programs have supplemented existing emergency food and shelter services, funded transitional housing and education programs for adults and children, expanded health care services, and established mobile outreach services for the mentally ill and a research demonstration project for homeless people with chronic mental illness and substance abuse problems; (5) service providers believe that without McKinney program funds, case management and health care outreach services, transitional housing, and adult education programs would be greatly reduced or discontinued; (6) local service providers believe that their current resources are not sufficient to meet the special needs of the homeless and that Baltimore needs to increase the amount of affordable housing, funds for substance abuse programs, and its homeless education and prevention efforts; and (7) Baltimore should seek new and creative ways to provide low-income housing, since affordable housing shortages contribute to homelessness in Baltimore.

Homelessness: McKinney
Act Programs Provide
Assistance but Are Not
Designed to Be the
Solution
(GAO/RCED-94-37, May 31,
1994)

The Stewart B. McKinney Homeless Assistance Act of 1987 established emergency food and shelter programs; programs providing longer term housing and supportive services; and programs designed to demonstrate effective approaches for providing the homeless with other services, such as physical and mental health, education, and job training. GAO evaluated the act's impact in Baltimore, Maryland; San Antonio, Texas; Seattle, Washington; and St. Louis, Missouri. This report discusses (1) what difference the McKinney Act programs have made in these cities' efforts to

help the homeless, (2) what problems the cities have experienced with McKinney Act programs, and (3) what directions the cities' programs for the homeless are taking and what gaps the McKinney Act programs may fill.

Homelessness: McKinney Act Programs and Funding Through Fiscal Year 1993
(GAO/RCED-94-107,
June 29, 1994)

GAO is required to report annually to the Congress on the status of programs authorized under the McKinney Act. This report provides updated program and funding information for fiscal years 1992 and 1993. It also provides information on the third reauthorization of the act. GAO discusses the legislative history of the act; describes each McKinney Act program, and identifies the funding provided under each program by state. GAO also briefly describes newly authorized assistance programs for the homeless and significant changes to existing McKinney Act programs that occurred during these two fiscal years.

Rental Housing: Use of Smaller Market Areas to Set Rent Subsidy Levels Has Drawbacks
(GAO/RCED-94-112,
June 24, 1994)

To ensure that needy families can live in adequate housing, the Department of Housing and Urban Development (HUD) provides rent subsidies to low-income households. This program, known as the Section 8 program, served more than one million households at a cost of about \$7 billion in 1992. The amount of rental assistance that a household receives varies depending on the household's market area. The size and nature of a market area can vary greatly: Entire states, large metropolitan areas, and medium-sized cities can all be considered market areas. In response to congressional concerns that these market areas are too broadly defined to permit rental assistance payments that reflect true market rents, this report determines (1) the effects of basing rent subsidy payments on smaller market areas, including any effects that doing so would have on recipient households' access to education and employment and (2) the extent to which payments made under the current program have an inflationary effect on the rental rates in surrounding areas. GAO also provides information on where Section 8 recipients lived and their proximity to key services and businesses. GAO based its analysis on the following four market areas: Oklahoma City, Oklahoma; Seattle, Washington; Washington, D.C.; and Wilmington, Delaware.

**Section 8 Rental Housing:
Merging Assistance
Programs Has Benefits but
Raises Implementation
Issues (GAO/RCED-94-85,
May 27, 1994)**

HUD runs two similar rental housing subsidy programs for low-income households—the section 8 certificate and voucher programs. These two programs, which local and state housing agencies operate for HUD, enable 1.3 million poor families to live in decent, affordable, privately owned housing. Although these programs are in many ways similar, several statutory and administrative differences can affect the housing subsidy that households receive. Over the past several years, GAO, the Vice President’s National Performance Review, and others have urged that the two programs be combined; legislation now before the Congress would accomplish that goal. This report examines (1) the benefits of a merger, (2) the major program differences that would need to be reconciled, (3) the effect of a merger on HUD’s budgeting and financial management, and (4) the effort needed to merge the two programs.

**Income Security
Issues**

**Social Security Disability:
SSA Quality Assurance
Improvements Can
Produce More Accurate
Payments
(GAO/HEHS-94-107, June 3,
1994)**

In 1993, the Social Security Administration’s (SSA) Disability Insurance program provided nearly \$35 million to 5.3 million disabled workers and their dependents and the Supplemental Security Income (SSI) program provided about \$24 billion to 6 million recipients. Although SSA runs these programs, state agencies determine whether claimants are disabled according to program rules. In recent years, disability benefit claims have soared, and the two programs have been unable to keep up with the high rate of claims submitted. In response to congressional concerns about the increasing workload pressures on the quality of disability determinations, this report evaluates (1) the reliability of SSA’s reported accuracy rates and (2) how well SSA’s quality assurance mechanism ensures the accuracy and consistency of state agencies’ disability determinations and minimizes erroneous payments.

**Social Security: Disability
Rolls Keep Growing, While
Explanations Remain
Elusive (GAO/HEHS-94-34,
Feb. 8, 1994)**

More people are applying for and being awarded Social Security disability benefits than ever before, and these beneficiaries are remaining on the disability rolls for longer periods of time. As a result, disability payments have burgeoned. Changes in beneficiary characteristics have accompanied this growth: the average age of new beneficiaries is now below 50, mental impairment awards to younger workers have risen substantially, and more and more new beneficiaries receive such low disability insurance (DI)

benefits that they get additional income from ssi. These low benefit levels suggest that the new beneficiaries had limited work histories. Higher unemployment probably contributes to increasing applications, and policy changes have produced changes in the numbers and types of beneficiaries. Quantitative data on the impact of these factors are lacking, however, and important questions remain. The upshot is that SSA's ability to predict future growth and change in the rolls is limited. Better information would also help SSA to determine whether improvements in program management are needed.

**Social Security: Increasing
Number of Disability
Claims and Deteriorating
Service (GAO/HRD-94-11,
Nov. 10, 1993)**

The administration SSA's disability programs has reached a crisis stage; service is poor and billions of dollars in payments will end up going to ineligible persons unless mandated continuing disability reviews are resumed. Claim backlogs and processing times for SSA's DI and SSI programs hit an all-time high in fiscal year 1992. The two programs have been unable to keep up with the high rate of claims for benefits, a trend that has continued into fiscal year 1993. Processing times have increased nearly 50 percent in recent years, and some states take more than 5 months to process claims. SSA has undertaken many short-term initiatives to keep up with claims—most significantly, the funding of overtime for disability determination services. According to administrators, staff are overworked and overtime is at record levels. SSA has also diverted staff from doing continuing disability reviews to processing initial claims. As a result, many ineligible persons are receiving program benefits at a cost of at least \$1.4 billion. These short-term initiatives have only slightly reduced pending claims and processing times. SSA also has several long-term initiatives under way to improve its disability programs; exactly how, when, and to what extent these initiatives will improve service is unknown at this point, however.

**Social Security: Major
Changes Needed for
Disability Benefits for
Addicts
(GAO/HEHS-94-128,
May 13, 1994)**

The number of addicts receiving disability benefits has grown substantially during the last 5 years—from fewer than 100,000 to about 250,000 today. The annual cost of providing benefits to addicts is about \$1.4 billion. The vast majority of addicts receiving disability benefits are either not in treatment or their treatment status is unknown. About 100,000 addicts have not been assigned a third-party or representative payee to manage their benefits. Consequently, SSA has no guarantee that these persons are not using their benefit checks to buy drugs or alcohol. Even in cases when payees have been assigned, their control over benefit payments is questionable; most of these payees are friends or relatives. Because

addicts may abuse, threaten, and pressure their payees, GAO believes that organizations would make better payees for addicts than friends or relatives. SSA needs to ensure that all disability benefit recipients are in treatment and that all addicts have a third-party or representative payee. Also, the Congress needs to consider expanding the treatment requirement to all addicts and restructuring the program to improve the payoff from treatment. GAO summarized this report in testimony before the Congress, *Social Security: Disability Benefits for Drug Addicts and Alcoholics Are Out of Control*, by Jane L. Ross, Director of Income Security Issues (GAO/T-HEHS-94-101, Feb. 10, 1994).

Social Security: Most Social Security Death Information Accurate but Improvements Possible
(GAO/HEHS-94-211, Aug. 29, 1994)

Nearly all the information based on reports of death that the SSA shares with other federal agencies is accurate. The accuracy of this information, which is provided to such agencies as the Departments of Defense, Veterans Affairs, and Labor, is essential to prevent or identify millions of dollars in overpayments by federal agencies to deceased persons and to avoid the erroneous termination of benefits. Fewer than 1 percent of the nearly 350,000 recorded deaths GAO reviewed were inaccurate. SSA can make its information more useful by taking action in four areas: the handling of cases erroneously terminated, processing of rejected death reports, providing information on nonbeneficiaries, and using feedback based on agency investigations of deaths.

Social Security: New Continuing Disability Review Process Could Be Enhanced
(GAO/HEHS-94-118, June 27, 1994)

SSA's new process for conducting continuing disability reviews relies on computer profiling and beneficiary self-reported data. Beneficiary self-reported data, when used with other key information SSA has, appear reliable for making decisions about when to do full medical examinations of beneficiaries scheduled for reviews. SSA has also taken steps to further assess the reliability of the self-reported data and plans to continually refine its use of computerized beneficiary data to better predict medical improvements and likely benefit terminations. The mailer process appears to be a significant step by SSA to make the review process more efficient and cost-effective. SSA needs to send out more mailers and conduct more full medical reviews of program beneficiaries. As SSA gains more experience with the mailer process and improves its ability to accurately identify beneficiaries with the greatest potential for medical improvement, it should do more full medical reviews of those persons to achieve the most effective use of agency resources. By focusing on beneficiaries with the greatest likelihood of improvement, SSA can save taxpayers millions of

dollars each year and help preserve the programs' integrity by removing ineligible persons from the rolls.

Social Services Issues

Americans With Disabilities Act: Challenges Faced by Transit Agencies in Complying With the Act's Requirements (GAO/RCED-94-58, Mar. 11, 1994)

The Americans With Disabilities Act prohibits discrimination on the basis of disability. The law requires transit systems to gradually make their buses and rail systems accessible to the disabled, including wheelchair users, and provide alternative transportation to those unable to use the transit systems' fixed-route service. Alternative transportation, called paratransit or door-to-door service, is generally provided by vans, minibuses, or taxis. This report (1) reviews the early experiences of transit agencies in phasing in the act's paratransit requirements and notes challenges to successful implementation, (2) provides information on transit agencies' projections of costs and time periods to implement the act's paratransit requirements, and (3) identifies variables affecting the reliability of projections and the magnitude of potential costs.

Veterans Issues

Disabled Veterans Programs: U.S. Eligibility and Benefit Types Compared With Five Other Countries (GAO/HRD-94-6, Nov. 24, 1993)

The United States offers benefits specifically for disabled veterans and their survivors in more program areas than any of the five other nations GAO studied—Australia, Canada, Finland, Germany, and the United Kingdom. Major differences exist, however, in the kinds of benefits offered, the eligibility requirements for benefits, and the methods used to compute benefits. Countries without special programs for disabled veterans often help these men and women through programs that serve the general population. In fact, Germany and the United Kingdom run most of their special veterans programs through general social service agencies rather than a separate veterans agency as in the United States, Australia, Canada, and Finland. Countries differ in the extent to which a veteran's disability must be service connected for the veteran to receive benefits. Most foreign countries require that a disability be closely related to the performance of military duty to qualify for disability benefits; no such link is required in the United States. The upshot is that the United States provides benefits for some disabilities that other countries do not. In a

July 1989 report (GAO/HRD-89-60), GAO recommended that the Congress consider tightening the U.S. criteria.

Health Security Act:
Analysis of Veterans'
Health Care Provisions
(GAO/HEHS-94-205FS,
July 15, 1994)

Reform of the nation's health care system to reduce the number of Americans who lack coverage of basic acute health care services could significantly reduce demand for such services in facilities administered by the Department of Veterans Affairs (VA). GAO reported in 1992 that if changes were not made in the VA health care system as part of health reform, VA hospitals could lose about 50 percent of their acute hospital workload and 44 percent of their outpatient workload. To assist the congressional Veterans' Affairs Committees, which will be considering legislation to fundamentally reform the VA health care system and veterans' health benefits, GAO prepared this fact sheet, which analyzes the veterans affairs provisions of the administration's proposed Health Security Act.

Homelessness: Demand for
Services to Homeless
Veterans Exceeds VA
Program Capacity
(GAO/HEHS-94-98, Feb. 23,
1994)

Veterans are generally believed to be about one-third of the homeless population in the United States; on any given night, up to 250,000 of an estimated 600,000 homeless persons living on the streets or in shelters may be veterans. Virtually all of these veterans are men, many of whom suffer from mental illness or drug and alcohol problems. The capacity of VA programs to serve these homeless veterans, however, falls far short of the demand for such services. Further, VA services for homeless veterans are nonexistent in many areas of the country. Every VA medical center is required to assess the needs of homeless veterans, determine the availability of VA and other services in its area, and establish plans to meet those needs in coordination with public and private providers. VA has not done these assessments and has yet to set specific target dates. If VA is to address the medical and social needs of homeless veterans nationwide, existing substance abuse, mental health, and housing programs will need to be substantially expanded and enhanced. VA may need to open new beds, hire more staff, contract with private providers of health care/housing, and either renovate buildings or allow private homeless groups to do so to provide temporary housing. In an era of tight federal budgets, however, increasing services for the homeless could force cutbacks in services to other veterans.

VA and the Health Security
Act (GAO/HEHS-94-159R,
May 9, 1994)

Pursuant to a congressional request, GAO reviewed the proposed Health Security Act, focusing on (1) the provisions that pertain directly to VA; (2) other provisions of the Health Security Act that pertain to veterans'

health care; and (3) a comparison of the health care services that would be covered under the Health Security Act with the health care services currently available to veterans. GAO noted that (1) the comprehensive benefits package under the proposed Health Security Act and the scope of care currently available to veterans are very extensive; (2) current VA benefits for mental health care, substance abuse treatment, dental treatment for children, and optometric treatment for children are more generous than those benefits proposed under the comprehensive benefits package; (3) VA currently provides for respite care and domiciliary care while the proposed Health Security Act does not; (4) the broad array of VA benefits is affected by complicated VA eligibility criteria; and (5) the proposed Health Security Act is more generous in regard to the broad category of outpatient services since it includes no limitations on outpatient care.

VA Health Care: A Profile of Veterans Using VA Medical Facilities in 1991 (GAO/HEHS-94-113FS, Mar. 29, 1994)

In 1993, the President proposed a major overhaul of the nation's health care system that would guarantee universal coverage to all Americans. For many veterans, this reform would allow them, for the first time, to choose between VA medical centers and other health care providers. Employment status and income levels are expected to be major factors affecting veterans' decisions. This fact sheet profiles veterans who, during 1991, used VA medical centers. It describes veterans' income, age, marital status, usage rates, disability status, employment, family size, and other characteristics. GAO collected this information using VA patient records and Internal Revenue Service tax records.

VA Health Care: Delays in Awarding Major Construction Contracts (GAO/HEHS-94-170, June 17, 1994)

For major construction projects costing \$3 million or more, the VA is required to award (1) construction document contracts by September 30 of the fiscal year in which funds are appropriated and (2) construction contracts by September 30 of the following fiscal year. VA is required to report to the Congress and to GAO on the projects that did not meet these time limits. VA's January 1994 letter to the Congress and GAO correctly identifies 15 projects that were required to but did not have construction document contracts or construction contracts awarded by September 30, 1993. GAO believes that the contracting delays for these projects do not constitute impoundments of budget authority under the Impoundment Control Act. In GAO's view, VA has shown no intent to refrain from using the funds appropriated. Information VA provided to GAO indicates that programmatic considerations caused the contracting delays. The reason cited most often for delays was changes in project scope or design. VA

expects to award 13 of the 17 required contracts for these 15 projects by September 30, 1994.

VA Health Care: Labor Management and Quality-of-Care Issues at the Salem VA Medical Center (GAO/HRD-93-108, Sept. 23, 1994)

In April 1993, the bodies of two patients were found on the grounds of the VA Medical Center in Salem, Virginia, and allegations were made about poor-quality patient care due to nursing shortages, employees' stress, and poor staff morale. GAO found that the center's new medical director is restoring both staff and public confidence in the facility's management and has started to deal with quality-of-care issues. He has addressed many of the labor-management issues confronting the facility and is trying to overcome nurse staffing shortages that have harmed the quality of care being provided. But more needs to be done. Nurse staffing shortages continue, medical records are incomplete, some psychiatrists are not seeing their patients regularly, and some psychiatrists and nurses are shirking essential duties, such as taking patient histories upon admission, assessing patient needs, and providing discharge planning before a patient is released. In addition, the center's quality assurance program could stand improvement. Management should ensure that this program objectively and systematically monitors and continuously improves the quality and appropriateness of services delivered.

VA Health Care: Medical Care Cost Recovery Activities Improperly Funded (GAO/HRD-94-2, Oct. 12, 1993)

Before 1990, the 158 medical centers run by the VA used medical care appropriations to finance the recovery of health care costs from veterans or third parties. In November 1990, the Congress established a Medical-Care Cost Recovery Fund to finance all recovery expenses related to collecting the cost of medical care and services provided by VA. This report examines whether medical centers were using only the fund to underwrite cost recovery activities. GAO also reviews VA's efforts to improve the efficiency of its recovery activities.

VA Health Care: Restructuring Ambulatory Care System Would Improve Services to Veterans (GAO/HRD-94-4, Oct. 15, 1994)

Veterans are experiencing lengthy delays when receiving medical care at the approximately 200 outpatient facilities run by the VA. Veterans often wait up to 3 hours before being examined by a doctor in VA's emergency/screening clinics. In addition, veterans wait an average of 8 to 9 weeks for an appointment in specialty clinics, such as those for cardiology or orthopedics. Inefficient operating procedures are the main cause of these delays. President Clinton has called for VA to compete with other providers in meeting the health care needs of veterans. To be a viable competitor, VA needs to quickly restructure its outpatient care delivery

system to provide more timely ambulatory services. The establishment of telephone assistance networks and appointment scheduling systems, for example, would help in the case of veterans with nonurgent conditions. GAO summarized this report in testimony before the Congress; see *Veterans Affairs: Service Delays at VA Outpatient Facilities*, by David P. Baine, Director of Federal Health Care Delivery Issues, before the Subcommittee on Oversight and Investigations, House Committee on Veterans Affairs (GAO/T-HRD-94-5, Oct. 27, 1993).

**VA Health Care:
Tuberculosis Controls
Receiving Greater
Emphasis at VA Medical
Centers (GAO/HRD-94-5,
Nov. 9, 1993)**

Lax infection-control practices and inadequate isolation rooms were behind the tuberculosis outbreak at the VA medical center in East Orange, New Jersey. Medical center staff did not consistently use appropriate procedures for isolating suspected or known tuberculosis patients. The center lacked a comprehensive employee-testing program to monitor the staff's exposure to active tuberculosis. Isolation rooms did not have proper airflow, and air exhausted from these rooms may have contaminated other areas in the medical center. Since the outbreak, the center has made major improvements in its infection-control practices, and VA plans to construct 19 isolation rooms at the center. VA has also tried to beef up tuberculosis controls at its other medical centers and is giving greater scrutiny to centers' tuberculosis-control programs and practices. According to a December 1992 VA survey, 10 medical centers each had more than 20 cases of tuberculosis; 6 of the 10 also had the highest numbers of AIDS cases.

**VA Health Care: VA
Medical Centers Need to
Improve Monitoring of
High-Risk Patients
(GAO/HRD-94-27, Dec. 10,
1993)**

After two patients were found dead on the grounds of a VA medical center, GAO investigated and found that "high-risk" patients—those unable to care for themselves—who wander away are a significant problem at 39 of 158 VA medical centers. In a recent 2-year period, more than 100 searches were conducted for high-risk patients at 20 VA medical centers. Patients leave their treatment settings without staff knowledge primarily when medical center staff (1) underestimate the potential for these patients to wander off without authorization or (2) fail to closely watch all high-risk patients while they are in the facility or on its grounds. During the same 2-year period, about 7,000 searches were conducted throughout the VA system for high-risk patients who were reported missing. About 99 percent of these patients were ultimately found unharmed; 34 were found dead and 19 injured. VA is working to develop search procedures for these high-risk patients who disappear without staff knowledge and approval. The goal is to find these persons before they leave the medical center grounds. But VA

also needs to do a better job of monitoring high-risk patients to prevent unauthorized departures in the first place. Further, VA can do more to locate unaccounted for patients.

**Veterans Benefits:
Redirected Modernization
Shows Promise**
(GAO/AIMD-94-26, Dec. 9,
1993)

In December 1992, the VA awarded the first of its planned three-stage modernization procurements. This 8-year contract was awarded to Federal Data Corporation with a maximum value of \$300 million. In response to congressional concerns about the benefits expected from this contract, this report discusses (1) the status of VA's business process redesign and its service improvement goals, (2) the validity of VA's cost estimates for the modernization, and (3) VA's contention that existing computer equipment failures were frequent and caused severe benefit service problems. In June 1993, VA and the Office of Management and Budget (OMB) agreed to redirect VA's modernization effort. This report also comments on the VA-OMB agreement.

**Veterans' Benefits: Lack of
Timeliness, Poor
Communication Cause
Customer Dissatisfaction**
(GAO/HEHS-94-179, Sept.
20, 1994)

In fiscal year 1993, the VA provided nearly \$19 billion in nonmedical benefits to veterans and their families. In 1993, GAO surveyed 1,400 recent applicants for VA nonmedical benefits nationwide. Although most applicants were satisfied with VA's services, more than one-third were unhappy with VA's handling of their claims. The time it takes VA to process claims was by far the greatest source of applicants' dissatisfaction. Communication with VA was another major concern for applicants. Many customers said that they were dissatisfied, whether the communications were by mail, by phone, or in person. For example, 40 percent of those who visited a VA office said that they did not get the information they needed. The need to resubmit documents to VA also inconvenienced applicants. GAO's study pointed out two other factors that may hold significant implications for VA's efforts to improve customer satisfaction. First, applicants whose claims were denied represented a significant portion—36 percent—of VA's customers. VA knows very little about who those applicants are, why their claims were denied, or what it could do to help these people. Second, 60 percent of VA customers received service from sources over which VA has no authority, such as state and county veterans offices and veterans service organizations.

Veterans' Benefits: Status of Claims Processing Initiative in VA's New York Regional Office
(GAO/HEHS-94-183BR, June 17, 1994)

The VA recognizes slow claims processing and poor customer service as critical concerns. Claims processing time is increasing as are claims backlogs. In 1993, more than 500,000 claims were pending in VA regional offices nationwide. One of the most highly publicized initiatives to reduce claims processing time and improve service to veterans and their families is the restructuring of the claims processing system in VA's New York Regional Office. In May 1993, the regional office began processing a quarter of its claims in a prototype unit. This new unit differs substantially from the traditional "assembly line" organization used by the rest of the New York office and most other VA regional offices. This briefing report determines (1) how the operation of the prototype unit differs from the traditional operation in New York, (2) how VA is assessing the effectiveness of the prototype and how the prototype's performance compares to the rest of the New York office's, and (3) what plans New York has for expanding the use of the prototype.

Veterans' Health Care: A Profile of Married Veterans Using VA Medical Centers in 1991
(GAO/HEHS-94-223FS, Aug. 26, 1994)

In a March 1994 report (GAO/HEHS-94-113FS), GAO profiled veterans who used medical centers run by the VA. That report focused on veterans' family incomes and showed how family income varied in relation to a range of characteristics, including employment status. This fact sheet examines married veterans, analyzing the percentage of family income attributable to veterans and spouses and comparing married veterans' incomes with those of single veterans. In addition, this fact sheet further refines veterans' employment status to differentiate between veterans receiving employee compensation and those with self-employment income.

Veterans' Health Care: Implications of Other Countries' Reforms for the United States
(GAO/HEHS-94-210BR, Sept. 27, 1994)

Reform of the nation's health care system would have a major impact on the VA health care system, one of the nation's largest direct delivery systems. Health care reform would give many uninsured and poor veterans the freedom to choose between VA and other health care providers. This would likely cause many veterans to leave the system unless it changes or VA benefits change to encourage those now in the system to stay or those outside the system to start using VA facilities. Without such changes, VA would likely lose nearly 50 percent of its acute hospital workload. This report studies changes in veterans health care systems and benefits in other countries that implemented universal health care systems. GAO limited its review to four countries—Australia, Canada, Finland, and the United Kingdom—that ran separate direct delivery systems for veterans when they instituted universal health care.

**Veterans' Health Care:
Most Care Provided
Through Non-VA Programs**
(GAO/HEHS-94-104BR,
Apr. 25, 1994)

When the VA health care system was established in 1930, neither public nor private health insurance programs were available to American veterans. With the subsequent growth of public and private health insurance programs, most veterans today have alternatives to VA health care. National health care reform could further reduce the number of veterans lacking health insurance. This briefing report determines (1) how many veterans are receiving services under other federal health programs and the cost of providing those services and (2) how many veterans using VA services are eligible to receive care under other federal programs.

Other Issues

**Americans With
Disabilities Act: Effects of
the Law on Access to
Goods and Services**
(GAO/PEMD-94-14,
June 21, 1994)

This report looks at the extent to which the Americans With Disabilities Act has improved the access for persons with disabilities to goods and services provided by businesses and state and local governments. Overall, GAO found steady improvement in both accessibility and awareness during the initial 15 months that the act was in effect. However, enough areas of concern remain to suggest a need for continuing educational outreach and technical assistance to business and government agencies covered by the act, as well as continued monitoring by the Congress.

**Budget Policy: Issues in
Capping Mandatory
Spending**
(GAO/AIMD-94-155,
July 18, 1994)

GAO examined whether implementation of a budgetary cap on mandatory entitlement spending is a practical way to control growth in mandatory programs. Although a spending cap on mandatory spending for federal entitlement programs would yield savings, a cap would have little, if any, effect on the long-term growth of these programs until the issues of eligibility and benefits, which drive up spending, are addressed.

**FDA User Fees: Current
Measures Not Sufficient
for Evaluating Effect on
Public Health**
(GAO/PEMD-94-26, July 22,
1994)

The Congress passed legislation in 1992 requiring the Food and Drug Administration (FDA) to charge fees for reviewing new drug applications to determine whether the drugs can be marketed in the United States. The fees collected are to be used to augment FDA resources devoted to reviewing new drug applications. This increase in resources, in turn, is intended to speed drug review and approval. GAO reviewed whether the data mandated by the law will be sufficient to evaluate how well the law has achieved its goal of getting drugs to patients sooner. GAO found that the existing reporting requirements of the user fee act, if satisfied, will

provide detailed information on one aspect of the drug review and approval process—the timeliness of FDA performance. However, because FDA performance is not the sole determinant of how long the process takes, these data alone will not be enough to evaluate how long it takes for drugs to become publicly available, and more data are needed.

**Federal Aid: Revising
Poverty Statistics Affects
Fairness of Allocation
Formulas**
(GAO/HEHS-94-165,
May 20, 1994)

Concerns have been raised in the Congress that revising counts of people in poverty by adjusting the official poverty line for geographic differences in the cost of living could significantly alter the allocation of federal aid to state and local governments. This report presents GAO's views on how such a revision could affect the fairness of the distribution of federal formula grants if such an adjustment were made. GAO concludes that adjusting poverty counts to reflect differences in the cost of living, if proven feasible, would bolster the federal government's ability to target federal aid to places with the greatest needs. GAO also believes that such a change should not be implemented in federal allocation formulas without first assessing the impact of the change on the fairness with which federal funding is allocated to states and localities. In a formula lacking an indicator of states' own funding capabilities, such a change by itself could increase inequities. In formulas that already adequately reflect states' funding capabilities, such a change would improve fairness.

**Health, Education,
Employment, Social
Security, Welfare, and
Veterans Reports**
(GAO/HEHS-94-233W, Sept.
1994)

This booklet lists GAO documents issued on government programs related to health, education, employment, Social Security, welfare, and veterans issues, which are primarily run by the Departments of Health and Human Service, Labor, Education, and Veterans Affairs. One section identifies reports and testimonies issued in the 2 months prior to September 1994 and summarizes key products. Another section lists all documents published during the past two years, organized chronologically by subject. Order forms are included.

**Status of Open
Recommendations:
Improving Operations of
Federal Departments and
Agencies** (GAO/OP-94-1,
Jan. 14, 1994)

In fiscal year 1993, GAO made more than 1,600 recommendations. This yearly report highlights the impact of GAO's work on everything from health care to transportation to international affairs. It also summarizes the key recommendations that have yet to be fully acted upon. For the first time, computer disks are being automatically included with the printed report. This hypertext software, which provides greater detail on all open recommendations, contains menu options that allow users to locate information easily.

Fiscal Year 1994 Testimonies Relating to Issues Affecting Older Americans

GAO testified 28 times before congressional committees during fiscal year 1994 on issues relating to older Americans. Of the testimonies, 13 were on health, 1 on housing, 8 on income security, 5 on veterans, and 1 on other issues.

Health Issues

Health Care in Hawaii: Implications for National Reform (GAO/T-HEHS-94-123, Mar. 16, 1994)

For nearly 20 years, Hawaii has been a leader in the effort to achieve universal access to health insurance. It is the only state that requires employers to provide a minimum level of health insurance benefits to employees, and its public programs cover many residents lacking employment-based insurance. GAO makes several points. First, Hawaii's employer mandate did not have a harmful effect on small businesses. Second, although Hawaii's system of near-universal access has lowered health premiums, its per capita health care costs have risen at a rate similar to the national average. Third, Hawaii's experience suggests that an employer mandate by itself will not necessarily result in universal access to health care.

Health Care Reform: Supplemental and Long-Term Care Insurance (GAO/T-HRD-94-58, Nov. 9, 1993)

Provisions of the Clinton administration's Health Security Act that deal with private long-term care insurance and supplemental health insurance address many of the problems that GAO has pointed out in the past. The act has detailed sections governing the content and marketing of such insurance, including disclosure standards that protect consumers from deceptive marketing practices, grievance procedures that allow policyholders to contest insurance company decisions, and sales commission standards that discourage questionable sales practices. In general, GAO believes that the administration's proposal contains the kinds of consumer protections that GAO has long advocated. Some problems, however, are not addressed. Specifically, the act will not protect consumers from the sale of duplicate policies or high-pressure sales techniques. It also does not address other kinds of supplemental insurance that cover specific diseases or conditions requiring hospitalization. Because of their limited, narrow coverage, such insurance may be unnecessary for many consumers.

**Health Care Reform:
Implications of Geographic
Boundaries for Proposed
Alliances**
(GAO/T-HEHS-94-108,
Feb. 24, 1994)

A common feature of many health reform bills is the creation of public or private health alliances that would seek to broaden coverage, pool risks, give consumers a choice of health care plans, and disseminate information on the costs and quality of plans. All the bills leave the establishment of alliance boundaries to the states. This testimony discusses (1) the provisions of major health reform bills concerning the configuration of alliance boundaries; (2) experiences of two states that have established entities similar to alliances; (3) features and procedures for creating a Metropolitan Statistical Area; and (4) issues relating to the potential effects of alliance boundaries on existing health markets, access to health care, and distribution of health care costs within a state. Concerns about the boundary provisions of the health reform proposals include the potential for gerrymandering, changing the provision and receipt of health care, segmenting high-risk groups, and isolating underserved areas.

**Health Care Reform: How
Proposals Address Fraud
and Abuse**
(GAO/T-HEHS-94-124,
Mar. 17, 1994)

Weaknesses within the current health insurance system allow unscrupulous health care providers to cheat insurance companies and programs out of billions of dollars annually. Fraud and abuse flourish in a health care system that collects little information on provider practices, encourages high profits at the expense of cost-effective care, and has ineffective laws and enforcement mechanisms to punish and recover money from those abusing the system. This testimony makes several recommendations aimed at overcoming these problems. Recent legislative proposals to reform the health care system, including the administration's proposal, address each of these elements to some extent.

**Long-Term Care Reform:
Program Eligibility, States'
Service Capacity, and
Federal Role in Reform
Need More Consideration**
(GAO/T-HEHS-94-144,
Apr. 14, 1994)

Passage of any long-term care reform legislation is merely the first step in a long journey toward meeting the nation's long-term care needs. Knowledge about determining long-term care needs and services, derived largely from the experience of innovative states, suggests that state flexibility is the best way to meet the diverse needs of individuals and communities. This flexibility requires a new, different federal role, largely one of partnership with the states in the design and management of programs. The administration's proposal would give states \$38 billion in federal funding each year for a new federal-state program of home and community-based services, to be phased in from 1996 to 2003. States will be given wide latitude to design and run programs to serve persons of all income ranges. The proposal would also liberalize Medicaid nursing home eligibility, provide tax credits to defray the costs of personal assistance for working persons with disabilities, and encourage and regulate private

long-term care insurance. If the administration's proposal is to be the blueprint for long-term care reform, the new federal role should be spelled out more clearly. More thought should also be given to developing state guidance on determining eligibility and to helping states with less capacity to use program funds wisely.

Long-Term Care:
Demography, Dollars, and
Dissatisfaction Drive
Reform
(GAO/T-HEHS-94-140,
Apr. 12, 1994)

The long-term care system has evolved in a patchwork fashion and is today comprises multiple programs that individuals find hard to access. Despite millions of dollars in outlays, the system often fails to meet the diverse needs of the disabled, and many believe that access to services could be improved with the same level of funding. This testimony focuses on three trends underlying the quest for reform. First, demographic changes make rising demand for long-term care inevitable across all ages, not just for the elderly. Second, spending will escalate sharply across all ages, not just for the elderly. Third, despite high costs, disabled persons are increasingly unhappy with available services and their ability to obtain them.

Long-Term Care: the Need
for Geriatric Assessment in
Publicly Funded Home and
Community-Based
Programs
(GAO/T-PEMD-94-20,
Apr. 14, 1994)

Because of advances in medicine and public health, Americans are living longer than ever before. Nearly one in every eight Americans was 65 years of age or older in 1990; by 2020, this ratio is expected to rise to one in five. To maintain their independence, many elderly people need daily help with routine activities, such as bathing, dressing, shopping, and meal preparation. Home and community-based long-term care for the elderly is today financed and run through a host of federal and state programs. This fragmentation can result in elderly persons being reevaluated every time they apply for a new program or pass a particular milestone, such as being discharged from a hospital. Despite this potential for redundancy, geriatric assessment is a potentially useful part of any program with frail elderly clients seeking community and home-based long-term care. This testimony discusses (1) what geriatric evaluation is and how it is used, (2) the extent to which it is available in public programs, (3) the professional requirements for persons who administer it, and (4) the pros and cons of standardizing the evaluation process.

**Managed Health Care:
Effect on Employers' Costs
Difficult to Measure
(GAO/T-HEHS-94-91,
Feb. 2, 1994)**

Although some "managed care" plans have the potential for delivering health care at lower cost, little empirical evidence exists showing that the use of these plans has contained employers' overall health care costs. Managed care refers to insurance plans that limit patients to a specific network of doctors and hospitals, control the use of services, and negotiate reimbursement with providers. Under this definition, about half of all insured workers are covered by managed care plans. GAO reviewed employers' experience with managed care and found that some managed care plans, by negotiating physician and hospital payments and controlling the use of services, can potentially hold down costs. Lower costs for these plans, however, may not translate into lower health care spending for employers due to enrollee differences and pricing policies. GAO also discovered that employees like many features of managed care plans but would rather not be limited in their choice of physicians.

**Medicaid: A Program
Highly Vulnerable to Fraud
(GAO/T-HEHS-94-106,
Feb. 25, 1994)**

The Medicaid program cost state and local governments more than \$150 billion in 1993 for health services and supplies. It is highly vulnerable to fraud because of its size, structure, target population, and coverage. The ensuing drain on program funds is hard to gauge, but state Medicaid officials believe it may be as high as 10 percent of program expenditures. Prescription drugs are a very appealing target. Schemes include pharmacists routinely adding medications to customers' orders and clinics inappropriately giving Medicaid recipients completed prescription forms, or scrips, that can be sold on the street to the highest bidder. Some pills costing 50 cents at the pharmacy have been resold for as much as \$85. Although states have been tackling Medicaid fraud with some success, the problem persists. Officials in many states say that most leads go unpursued, cases take too long to resolve, and penalties are light even for those convicted. Most say that a lack of resources hinders oversight, investigations, and prosecutions. GAO suggests that the Health Care Financing Administration (HCFA) take the lead and develop an overall strategy to guide states in their struggle against Medicaid fraud.

**Medicare Part B:
Inconsistent Denial Rates
for Medical Necessity
Across Six Carriers
(GAO/T-PEMD-94-17,
Mar. 29, 1994)**

GAO discovered large disparities in a probe of how many Medicare claims are being rejected for medical reasons in different parts of the country. The study looked at six carriers: California Blue Shield, California-Occidental, Illinois Blue Shield, Wisconsin Physician Services, North Carolina-Connecticut General, and South Carolina Blue Shield. In Southern California, for example, the insurance carrier handling Medicare claims rejects as medically unnecessary 54 of every 1,000 claims for

mammograms. In contrast, in Northern California, only three claims in 10,000 for the same procedure are turned down. GAO discovered (1) sizable differences among the carriers with respect to denial rates for the services screened for medical necessity; (2) that the number of services that carriers screened for medical necessity varied markedly; and (3) that the overall denial rate for medical necessity also differed among the six carriers reviewed. At one extreme, one carrier denied as few as one service per 1,000 allowed, while at the other extreme, another carrier denied 23 services per 1,000 allowed. Medicare is a national program under which beneficiaries in different geographic areas should be receiving similar benefits. Although it may be essential for Medicare to allow for local determination of medical policy, GAO concludes that this allowance, left to itself, results in inconsistent treatment of beneficiaries and providers.

Medicare/Medicaid: Data Bank Unlikely to Increase Collections From Other Insurers
(GAO/T-HEHS-94-162, May 6, 1994)

The Department of Health and Human Services has been directed to establish a data bank, beginning in February 1995, that would contain information on all workers, spouses, and dependents who are covered by employer-provided health insurance. The goal is to save millions by strengthening processes to (1) identify the approximately 7 million Medicare and Medicaid beneficiaries who have other health insurance coverage that should pay medical bills before Medicare and Medicaid kicks in and (2) ensure that this insurance is appropriately applied to reduce Medicare and Medicaid costs. In GAO's view, however, the data bank will end up costing millions and likely achieve little in the way of savings. GAO believes that changes and improvements to existing activities would be a much easier, less costly, and thus preferable alternative to the data bank. This is largely because the data bank will result in an enormous amount of added paperwork for both HCFA and the nation's employers.

Medicare: Adequate Funding and Better Oversight Needed to Protect Benefit Dollars
(GAO/T-HRD-94-59, Nov. 12, 1993)

Soaring expenditures for health care underscore the need for the government to fund and manage Medicare judiciously, but budget constraints have resulted in underfunding key program safeguards that control billions of dollars in benefit payments. In fiscal year 1993, Medicare cost \$146 billion, covered about 35 million beneficiaries, and processed nearly 700 million claims. Medicare has delegated much of the responsibility for program safeguards to a national network of some 80 claims processing and payment contractors. GAO testified that, given shortcomings in these safeguards, any cuts in Medicare's administration budgets should take into account their likely effect on benefit payments.

During the past 5 years, Medicare's program safeguards budget, on a per claim basis, has declined dramatically. The upshot is that opportunities to curb unnecessary Medicare expenditures are being lost. Strong evidence exists that with an adequately funded and managed safeguard program, Medicare could avoid millions of dollars in unnecessary expenditures. GAO believes that the Congress should continue to pursue modifying budget procedures so that Medicare's safeguard funding could be boosted without cutting spending elsewhere. GAO also believes that HCFA needs to develop an effective strategy to manage contractors' payment safeguard activities.

1993 German Health Reforms: Initiatives Tighten Cost Controls (GAO/T-HRD-94-2, Oct. 13, 1993)

Expensive new technologies, an aging population, administrative waste, structural inefficiencies, and unnecessary medical procedures have all fueled soaring health care costs in most industrialized nations. In 1993, Germany, concerned about sharp rises in health insurance premiums, began tightening its existing cost-control measures. The United States may find the German experience instructive because that nation provides coverage for nearly all its residents, guarantees a generous benefit package, and, like the U.S. system, relies mainly on employment-based financing. This testimony, which draws on a July 1993 GAO report (GAO/HRD-93-103), provides an overview of the German health care system, discusses problems leading up to the 1993 reforms, and presents some early results of these changes.

Housing Issues

Federally Assisted Housing: Condition of Some Properties Receiving Section 8 Project-Based Assistance Is Below Housing Quality Standards (GAO/T-RCED-94-273, July 26, 1994)

Physical conditions in the Section 8 assisted properties GAO visited ranged from very good to very poor. The properties in good physical condition show that the Section 8 program can work. Conditions in some properties, however, clearly violated the Department of Housing and Urban Development's (HUD) housing quality standards. In the distressed properties, families lived in units with leaking toilets and sinks, exposed electrical wiring, holes in walls and ceilings, broken air conditioners and smoke detectors, damaged and missing kitchen cabinets, and roach and rat infestation. Moreover, the landlords for some of these distressed properties collected rents that were higher than those for well-maintained apartments nearby. Although HUD has various enforcement tools to ensure that properties comply with its housing quality standards, including barring or suspending landlords from further participation in Section 8

programs and terminating housing assistance contracts, HUD has used these tools sparingly and inconsistently.

Income Security Issues

D.C. Pensions: Plans Consuming Growing Share of District Budget (GAO/T-HEHS-94-192, June 14, 1994)

The District of Columbia's overall financial status is being affected by the increasing demand on city revenues from its underfunded pension plans for police and fire fighters, teachers, and judges. In 1991 the District's contribution to these plans was about 8 percent of revenues, and unless remedial action is taken, the contribution could rise to about 15 percent of revenues by 2005. Pension costs are now running more than 50 percent of payroll and will grow to 70 percent after 2004. This testimony provides a brief historical overview of the unfunded liability in the District's pension plans; outlines the plans' current funding provisions; and discusses the effects of H.R. 3728, the District of Columbia Pension Liability Funding Reform Act of 1994, which seeks to eliminate the District's financial liability for these plans, as well as the responsibilities of the federal government, the District, and the plans' participants.

Social Security Administration: Many Letters Difficult to Understand (GAO/T-HEHS-94-126, Mar. 22, 1994)

The Social Security Administration (SSA) each year sends letters to more than 44 million people. To accommodate this extremely high volume, virtually the entire process is automated. SSA relies on these letters to officially notify individuals about their eligibility for benefits or adjustments SSA is making to their benefits. SSA has had long-standing problems communicating clearly in its letters. Although SSA's recently revised communication standards appear to be a positive step, they do not address problems such as illogically ordered information or missing details. GAO staff trained in accounting and the Social Security program examined a representative sample of 500 letters and found them hard to understand. GAO concludes that SSA needs to establish overall communication objectives, including identifying its customers' preferences and measuring progress toward achieving such objectives.

**Social Security
Administration: Major
Changes in SSA's Business
Processes Are Imperative**
(GAO/T-AIMD-94-106,
Apr. 14, 1994)

SSA's current disability determination process is extremely stressed, burdened with increasing workloads and enormous backlogs. SSA has turned to automation to improve operations, but these efforts have had only a minimal impact because they focused on automating existing processes that are inefficient. SSA's April 1994 proposal for redesigning the disability process is a credible proposal that would make the basic changes needed to realistically cope with disability determination workloads. The proposal, which combines top management leadership with the necessary staff and money, documents the existing disability determination problems and recommends a solution to dramatically change the process. As with any major reform, however, many implementation issues still need to be addressed, including new staffing and training demands, developing necessary automation requirements, and confronting the entrenched cultural barriers to changes.

**Social Security: Continuing
Disability Review Process
Improved, but More
Targeted Reviews Needed**
(GAO/T-HEHS-94-121,
Mar. 10, 1994)

GAO is encouraged SSA's efforts to make the continuing disability review process more efficient and cost-effective through the use of computer profiling and beneficiary self-reported data. GAO is concerned, however, that SSA continues to do too few continuing disability reviews, particularly for beneficiaries with the greatest likelihood of being removed from the disability rolls. In GAO's view, finding ways to provide SSA with more money to do the reviews is worthwhile.

**Social Security: Disability
Benefits for Drug Addicts
and Alcoholics Are Out of
Control**
(GAO/T-HEHS-94-101,
Feb. 10, 1994)

The number of drug addicts receiving Social Security disability benefits has soared in recent years; about 250,000 addicts now receive disability benefits at an annual cost of \$1.4 billion. Despite the fact that half of them qualify for benefits on the basis of their addiction alone, most addicts are not required to be in treatment. Finding qualified representative payees to manage addicts' benefits has been a long-standing problem for the SSA. Most payees are either friends or relatives. In the absence of tight controls, addicts are free to buy drugs and alcohol to maintain their addictions. GAO believes that organizational payees would be in a better position to provide the strict controls needed over benefit payments to addicts.

**Social Security: GAO's
Analysis of the Notch Issue**
(GAO/T-HEHS-94-236, Sept.
16, 1994)

GAO has been studying the "notch" issue for more than 8 years and has testified before the Congress many times. This testimony briefing covers the critical matters that GAO believes the Commission on the Social Security Notch Issue must deal with in addressing the notch issue in 1994. In summary, GAO concludes that retirees in the notch group who claim an

inequity are comparing themselves to a group of retirees who received benefits based on an overgenerous formula. If the Congress chooses to pursue legislation, it should consider several factors, particularly the cost of financing any legislation.

**Underfunded Pension
Plans: Federal
Government's Growing
Exposure Indicates Need
for Stronger Funding Rules
(GAO/T-HEHS-94-149,
Apr. 19, 1994)**

Sponsors of underfunded pensions are required by law to make additional contributions to their funds, but no evidence exists that the problem of underfunding has abated. The total underfunding in single-employer plans insured by the Pension Benefit Guaranty Corporation (PBGC) rose from \$31 billion in 1990 to more than \$50 billion in 1992. In a random sample of plans paying PBGC's variable rate premium, GAO discovered that only 40 percent of the plan sponsors subject to the law were making additional contributions in 1990, and the amount of additional contributions was less than 3 percent of the plans' underfunding. GAO found that the amounts sponsors were allowed to use to reduce their additional contributions were much larger than the unreduced additional contributions for some plans, suggesting that the design of the offset is flawed and needs to be changed. H.R. 3396 contains provisions to improve funding in underfunded plans, including a measure to correct the design flaw in the offset. Although it believes that the bill is a step in the right direction, GAO believes that the provisions of H.R. 3396 should be strengthened to ensure that sponsors of a greater percentage of underfunded plans make additional contributions.

**Underfunded Pension
Plans: Stronger Funding
Rules Needed to Reduce
Federal Government's
Growing Exposure
(GAO/T-HEHS-94-191,
June 15, 1994)**

Although the majority of pension plans insured by the PBGC are well funded, a significant minority are underfunded, and the level of underfunding in these plans has been growing in recent years. This growth increases PBGC's exposure, which refers to the size of its potential claims. This testimony makes three main points. First, current rules designed to ensure that sponsors of underfunded plans make additional contributions to better fund their plans are not working well. Second, provisions in the administration's proposed pension reform bill—S. 1780, the Retirement Protection Act of 1993—especially the revised offset design, should increase both the number of sponsors of underfunded plans that make additional contributions and the amount of those contributions. Third, GAO believes that the proposed funding provisions should be strengthened further to ensure that an even greater percentage of underfunded plan sponsors make additional contributions.

Veterans Issues

**VA Health Care for Women:
In Need of Continued VA
Attention**
(GAO/T-HEHS-94-114,
Mar. 9, 1994)

This testimony discusses the Department of Veterans Affairs' (VA) long-standing problems in meeting the health care needs of women veterans and the implications for VA's role in a reformed national health care system. VA has repeatedly stressed the need for delivering better service to women veterans and has issued guidance to its medical centers that responds to problems identified in a January 1992 GAO report. VA's greatest success has been in improving privacy for women veterans. VA has not, however, effectively monitored field facilities to ensure that they have actually improved service for women veterans. For example, even when medical centers submitted inadequate plans for improving breast cancer screenings, VA did not notify the medical centers of its findings. Under VA's health reform proposal, each veteran would be assigned a primary care physician. This step should improve the thoroughness of cancer screenings for women veterans. But real progress in improving service for women veterans depends on the leadership of individual VA medical center directors.

**VA Health Care Reform:
Financial Implications of
the Proposed Health
Security Act**
(GAO/T-HEHS-94-148,
May 5, 1994)

This testimony discusses the financial and policy implications of the veterans' health care provisions in the administration's proposed Health Security Act. GAO focuses on (1) veterans health coverage under VA and other federal programs; (2) factors that will likely affect the potential population of enrollees in VA health plans; (3) the potential costs associated with the expanded entitlement and supplemental benefits provisions of the Health Security Act; and (4) VA's ability to set realistic premiums and the implications of inaccurate premiums for cost, quality, and access to care for VA clients.

**Veterans Affairs: Service
Delays at VA Outpatient
Facilities**
(GAO/T-HRD-94-5, Oct. 27,
1993)

Veterans are experiencing lengthy delays when receiving medical care at the approximately 200 outpatient facilities run by the VA. Veterans often wait up to 3 hours before being examined by a doctor in VA's emergency/screening clinics. In addition, veterans wait an average of 8 to 9 weeks for an appointment in specialty clinics, such as those for cardiology or orthopedics. Inefficient operating procedures are the main cause of these delays. President Clinton has called for VA to compete with other providers in meeting the health care needs of veterans. To be a viable competitor, VA needs to quickly restructure its outpatient care delivery

system to provide more timely ambulatory services. The establishment of telephone assistance networks and appointment scheduling systems, for example, would help in the case of veterans with nonurgent conditions.

**Veterans' Health Care:
Veterans' Perceptions of
VA Services and Its Role in
Health Care Reform**
(GAO/T-HEHS-94-150,
Apr. 20, 1994)

GAO conducted a series of focus group meetings with veterans to explore their views on the current veterans health care system and the future role of the VA under health care reform. Among the topics discussed were the reasons and extent to which the veterans used VA health care services; their overall satisfaction with the care VA provides; the need to maintain a separate VA health care system; whether the VA health care system should be expanded to cover dependents; whether VA should set up managed care plans to compete with private-sector plans, and the potential competitiveness of VA plans; the factors they would consider in deciding whether to select a VA health plan; and improvements that would make VA a more competitive provider. The veterans expressed a wide range of opinions on these topics. Although their views may not be representative of the nation's 27 million veterans, many of the concerns expressed—such as the excessive waiting times and poor customer service—have been the focus of earlier GAO reports and congressional hearings.

**Veterans' Health Care:
Efforts to Make VA
Competitive May Create
Significant Risks**
(GAO/T-HEHS-94-197,
June 29, 1994)

GAO is undertaking several studies of the potential effects of health care reform on the VA health care system and options for restructuring veterans' health benefits. This testimony draws on the preliminary work of one of those studies and discusses (1) legal and structural barriers that could limit VA's ability to restructure its health care facilities into managed care plans and compete with private-sector health plans, (2) the extent to which the Health Security Act would overcome these barriers, and (3) the potential risks associated with efforts to make VA competitive with private-sector managed care plans competitive with private-sector managed care plans.

Other Issues

**Human Experimentation:
An Overview on Cold War
Era Programs**
(GAO/T-NSIAD-94-266,
June 29, 1994)

During World War II and the Cold War, the Defense Department (DOD) and other national security agencies conducted extensive radiological, chemical, and biological research programs. Precise information on the number of tests, experiments, and participants is unavailable and the exact numbers may never be known. However, GAO has identified hundreds of

experiments in which hundreds of thousands of people were used as test subjects. These experiments often involved hazardous substances, such as radiation, blister and nerve agents, biological agents, and lysergic acid (LSD). In some cases, basic safeguards to protect people were either not in place or were not followed. Some tests and experiments were done in secret, and others involved the use of people without their knowledge or consent or their full knowledge of the risks involved. The effects of the experiments are hard to determine. Although some participants suffered immediate injuries, and some died, in other instances health problems did not surface until 20 or 30 years later. It has proven difficult for participants in government experiments between 1940 and 1974 to pursue claims because little centralized information is available to prove participation or determine whether health problems resulted from the testing. Government experiments with human subjects continue today. For example, the Army uses volunteers to test new vaccines for malaria, hepatitis, and other exotic diseases. Since 1974, however, federal regulations have required (1) the formation of institutional review boards and procedures and (2) researchers to obtain informed consent from human subjects and ensure that their participation is voluntary and based on knowledge of the potential risks and benefits.

Ongoing GAO Work as of September 30, 1994, Relating to Issues Affecting Older Americans

At the end of fiscal year 1994, GAO had 55 ongoing assignments that affected older Americans. Of these, 26 were on health, 8 were on income security, and 21 were on veterans issues.

Health Issues

A Survey of Assessment Instruments in Medicaid Waiver Programs for Home and Community Based Long-Term Care

Adult Immunization Under Medicare

Assessing the Accuracy of Cholesterol Measurement

Cost and Quality of Hospital Care

Development of Formula and Program Alternatives to the Current Long Term Care Component of Medicaid

Disabled Medicare Beneficiaries' Ability to Obtain Durable Medical Equipment

HCFA Management of Medicare Medical Policies

Implementation of the "Patient Self-Determination" Provisions of OBRA'90

Inappropriate Prescription Drug Use Among the Elderly

Investigation of Inappropriate Medicare Billings for Rehabilitation Services to Nursing Home Residents

Long-Term Care Financing

Long-Term Care Populations

Long-Term Care Services

Loss Ratio Experience for Medigap Insurance in 1992

Medicare Claim Denials and Appeals Across Six Carriers

Medicare High Risk Report Follow-Up

Medicare's Use of Data to Monitor Performance of HMOS

Nursing Home Billing Abuses

Quality Assurance in Home Care

Recent Growth of Medicare Home Health Care

Review of Billing and Payment Procedures for Medical Supplies

Review of HUD's Hospital and Nursing Home Insurance Programs

Safeguards Against Inappropriate Use of Drugs in Nursing Homes

Study of Mergers and Alliances Between Pharmaceutical Manufacturers
and Pharmacy Benefit Management Companies

Supportive Services and Long-Term Care

Time Charges to Medicare for Anesthesia Services

Income Security Issues

Characteristics of 401(k) Plans and Their Participants

Federal Options for Funding DC Pension Plans for Fire, Police, and
Teachers

HRA4: 1995 Update of Pension Benefit Guaranty Corporation High Risk
Report

Public Pension Public Fund

Reasons for Caseload Growth in Supplemental Security Income

Social Security Administration: SSA's Transition to Independence

Social Security Administration: Office of Hearings and Appeals

Social Security Administration: SSA Services Provided to Employees

Veterans Issues

Adequacy of VA's Planning for the Reuse of the Orlando Naval Hospital

Availability of VA Health Care in Community-Based Settings

Evaluation of VA Direct Cost Comparison Studies

Evaluation of VA Medical Centers' Discharge Planning

Evaluation of VA Programs to Treat Veterans' Drug and Alcohol Dependency

How Well Is the Current VA Structure Meeting Health Care Needs of Veterans?

Nonveterans Use of VA Medical Centers

Preventing Needle-Stick and Sharp Injuries in VA

Prevention of Compensation and Pension Overpayments to Veterans and Their Survivors

Quality of Care: Factors Influencing Consumers' Decisions

Relationship Between Distance to VA Medical Centers and Use of VA Services

Review of the Quality of Care Provided in VA Hospital Based Nursing Homes

Review of VA's Selection of a Nursing Home Site in the Chesapeake Region

Study of VA Survivor's Benefits Program

Survey of Veterans Benefit Administration Interface with Other Entities

Types of Services Used by Medicare-Eligible Veterans

VA Albuquerque Medical Center's Lithotripsy Contracting Practices

VA Process for Evaluating Physicians Performance

Veterans' Compensation and Pension Claims Take Far Too Long to Process

Veteran's Perceptions Under Health Care Reform

**Appendix IV
Ongoing GAO Work as of September 30,
1994, Relating to Issues Affecting Older
Americans**

**What Barriers Could Affect VA's Plans to Implement a Managed Care
Program?**

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