United States General Accounting Office

GAO

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

March 1996

AGING ISSUES

Related GAO Reports and Activities in Fiscal Year 1995

GAO/HEHS-96-82

GAO

United States
General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-270776

March 6, 1996

The Honorable William S. Cohen
Chairman
The Honorable David H. Pryor
Ranking Minority Member
Special Committee on Aging
United States Senate

This report responds to the Committee's request for a compilation of our fiscal year 1995 products and ongoing work regarding programs and issues affecting older Americans and their families.

GAO's work in aging issues reflects the continuing importance of federal programs supporting older Americans. About 34 million Americans are age 65 and older, and by the year 2020 that number will exceed 52 million. Because the elderly represent one of the fastest growing segments of the country's population, the Congress faces many issues involving income security and health care 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 the financing and provision of health care, social security, and pensions.

Our work during fiscal year 1995 covered many issues, including federal government activities concerning 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. In the appendixes, we describe three types of GAO products and activities that relate to older Americans:

- reports and correspondence (see app. I),
- congressional testimonies (see app. II), and
- ongoing assignments (see app. III).

The issues addressed by these products and ongoing work are presented in table 1. The table shows that health, income security, and veterans issues were the areas most frequently addressed among our products focused on older Americans.

Table 1: GAO Activities Relating to the Elderly in Fiscal Year 1995

Elderly issues	Reports and correspondence	Testimonies	Ongoing work
Education and Employment	2	1	1
Health	33	20	29
Housing	2	0	0
Income Security	17	12	13
Veterans/Department of Defense	15	2	9
Related issues	3	0	0
Total	**72**	**35**	**52**

As arranged with your office, we are sending copies of this report to interested congressional committees. Copies also will be made available to others upon request. This report was prepared under the direction of Benjamin C. Ross, Evaluator-in-Charge, who may be reached at (202) 512-7260.

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Abbreviations

AEA	Adult Education Act
AFDC	Aid for Families With Dependent Children Program
CDC	Centers for Disease Control and Prevention
COLA	cost of living adjustment
DIC	Dependent and Indemnity Compensation Program
DOD	Department of Defense
DUR	drug utilization review
ERISA	Employee Retirement Income Security Act of 1974
FHA	Federal Housing Administration
HCFA	Health Care Financing Administration
HHA	home health agency
HHS	Department of Health and Human Services
HMO	health maintenance organization
HUD	Department of Housing and Urban Development
IHS	Indian Health Service
MIG	Medicare insured group
PBGC	Pension Benefit Guaranty Corporation
PPO	preferred provider organization
RMA	referral and monitoring agency
SCORE	Service Corps of Retired Executives Program
SSA	Social Security Administration
SSI	Supplemental Security Income
UMWA	United Mine Workers of America
USDA	Department of Agriculture
VA	Department of Veterans Affairs

Fiscal Year 1995 Reports and Correspondence on Issues Affecting Older Americans

During fiscal year 1995, GAO issued 72 reports on issues affecting older Americans. Of these, 2 were on education, 33 on health, 2 on housing, 17 on income security, 15 on veterans/DOD, and 3 on other related issues.

Education Issues

Adult Education: Measuring Program Results Has Been Challenging (GAO/HEHS-95-153, Sept. 8, 1995)

According to a recent national survey, nearly 90 million adults in the United States have difficulty writing a letter explaining an error on a credit card bill, using a bus schedule, or calculating the difference between the regular and sale price of an item. To address these deficient literary skills, Congress passed the Adult Education Act, which funds state programs to help adults acquire the basic skills needed for literate functioning, benefit from job training, and continue their education at least through high school. The most common types of instruction funded under the act's largest program—the State Grant Program—are basic education (for adults functioning below the eighth grade level), secondary education, and English as a second language. Because many clients of federal employment training programs need instruction provided by the State Grant Program, coordination among these programs is essential. Although the State Grant Program funds programs that address the educational needs of millions of adults, it has had difficulty ensuring accountability for results because of a lack of clearly defined program objectives, questionable validity of adult student assessments, and poor student data.

Adult Education Act (GAO/HEHS-95-65R, Feb. 16, 1995)

GAO provided information on the Adult Education Act (AEA) that focused on the (1) funding history of AEA; (2) changes that have taken place in the amount of services that the State-Administered Basic Grant Program provides; and (3) goals, targeted populations, and service recipients of the State-Administered Basic Grant Program. GAO noted that: (1) AEA funding increased from $100 million in fiscal year 1994, (2) enrollment in the State-Administered Basic Grant Program rose from approximately 377,000 participants in 1966 to almost 4 million participants in 1994, and (3) the purpose of AEA is to provide educational opportunities for adults who lack the necessary literacy skills to become a citizen and to be productive in their employment.

Health Issues

Community Health Centers: Challenges in Transitioning to Prepaid Managed Care (GAO/HEHS-95-138, May 4, 1995)

As states move to prepaid managed care to control costs and improve access for their Medicaid clients, the number of participating community health centers continues to grow. Medicaid prepaid managed care is not incompatible with health centers' mission of delivering health care to medically underserved populations. However, health centers face substantial risks and challenges as they move into these arrangements. Such challenges require new knowledge, skills, and information systems. Centers lacking expertise and systems face an uncertain future, and those in a vulnerable financial position are at even greater risk. Today's debate over possible changes in federal and state health programs heightens the concern over the financial vulnerability of centers participating in prepaid managed care. If this funding source continues to grow as a percentage of total health center revenues, centers must face building larger cash reserves while not compromising services to vulnerable populations. GAO summarized this report in testimony before Congress; see Community Health Centers: Challenges in Transitioning to Prepaid Managed Care, (GAO/T-HEHS-95-143, May 4, 1995), by Mark V. Nadel, Associate Director for Health Financing and Policy Issues, before the Senate Committee on Labor and Human Resources.

Durable Medical Equipment: Regional Carriers' Coverage Criteria Are Consistent With Medicare Law (GAO/HEHS-95-185, Sept. 19, 1995)

In November 1993, the Health Care Financing Administration (HCFA) began consolidating the work of processing and paying claims for durable medical equipment, prostheses, orthoses, and supplies at four regional carriers. Claims for such items had previously been processed and paid by local Medicare carriers. As part of the transition to regional processing, the four regional carriers developed coverage criteria for the items. GAO found that the final criteria adopted by the regional carriers are consistent with Medicare's national coverage policies and the law. GAO does not believe that the criteria have impeded disabled beneficiaries' access to needed durable medical equipment and other items. Also, in 1994 the regional carriers approved a similar percentage of service for durable medical equipment and other items for the disabled and aged Medicare beneficiaries, so there was no significant difference in access to durable medical equipment and other items between the two groups of beneficiaries.

Employer-Based Health Plans: Issues, Trends, and Challenges Posed by ERISA (GAO/HEHS-95-167, July 25, 1995)

As the movement for comprehensive federal health care reform has lost steam, the focus of reform has shifted to the states and the private market. States remain concerned about the growing number of people lacking health coverage and about financing health plans for poor people. Employers have become increasingly aggressive in managing their health plans and have adopted various managed care plans and innovative funding arrangements. However, the Employee Retirement Income Security Act of 1974 (ERISA) effectively blocks states from directly regulating most employer-based health plans, although it allows states to regulate health insurers. GAO found that nearly 40 percent of enrollees in employer-based health plans—44 million people—are in self-funded plans. The divided federal and state framework for regulating health plans produces a complex set of trade-offs for regulating health plans. Self-funded plans, which are exempt from state regulation under ERISA, provide employers greater flexibility to design a health benefits package that may have been less feasible to provide under state regulation. At the same time, however, states are unable to extend regulations, such as solvency standards, preexisting condition clause limits, and guaranteed issue and renewal requirements, even indirectly, to enrollees in these self-funded plans. GAO summarized this report in testimony before Congress; see Employer-Based Health Plans: Issues, Trends, and Challenges Posed by ERISA (GAO/T-HEHS-95-223, July 25, 1995), by Mark V. Nadel, Associate Director for National and Public Health Issues, before the Senate Committee on Labor and Human Resources.

Food Assistance Programs (GAO/RCED-95-115R, Feb. 28, 1995)

GAO reviewed the Department of Agriculture's (USDA) domestic food and nutrition assistance programs, focusing on those programs that target benefits to women, children, infants, the elderly, and the needy. GAO noted that (1) USDA food assistance programs constitute about 60 percent of the USDA budget and the Food Stamp Program accounts for more than one-half of those benefits; (2) 6 of the 14 USDA food programs target the groups reviewed; (3) participants' characteristics and the nature and level of benefits vary widely across the programs; (4) most of the programs have income eligibility criteria and some programs have additional criteria that individuals must meet to receive benefits; (5) benefit overlap is built into most of the programs, but it is not known how many persons participate in more than one program; (6) state and local governments and nonprofit organizations play a large role in distributing program benefits; (7) some USDA programs are similar to other agencies' assistance programs; (8) ineffective targeting of low-income people, burdensome administration, subsidizing providers rather than families, rising costs,

duplication of services, inequitable funding allocations, and unfunded mandates affect the distribution of food benefits; and (9) alternatives to reduce costs and streamline program operations include improving low-income targeting, consolidating multiple programs, reducing some programs' funding levels, and eliminating some ineffective programs.

HCFA's Approach to Evaluating Medicare Technology (GAO/AIMD-95-234R, Sept. 29, 1995)

GAO reviewed HCFA's approach to analyzing the benefits of commercial technology in the Medicare program. GAO noted that HCFA (1) is limiting its analysis of the benefits of commercial technology to determining whether Medicare contractors complied with existing payment controls and is using a flawed sampling methodology to select claims for review; (2) is attempting to verify the savings achievable through commercial systems without understanding how the systems operate; (3) believes that it cannot examine commercial systems without actually procuring a system; and (4) is failing to identify real monetary benefits of commercial detection systems in its analysis.

Health Care Reform: Considerations for Risk Adjustment Under Community Rating (GAO/HEHS-94-173, Sept. 22, 1994)

As part of the debate over health care reform, some have proposed prohibiting insurers from denying coverage or charging different premiums to persons on the basis of their health status. Under such a "community rating" system, an insurer would have to charge each potential beneficiary the same premium for a given insurance plan. However, community rating could create financial incentives for insurers to attract only healthy clients because these people would, on average, pay more in premiums than they generate in claims. Insurers' profits would depend more on the plan's ability to attract healthy beneficiaries and would be less responsive to efforts to deliver high-quality service at the lowest price. Risk adjustment can mitigate the undesirable effects of community rating on insurers' incentives. This report describes how the federal government's previous experience with risk adjustment is relevant to implementing risk adjustment under health care reform and identifies features of health care reform that could affect the ability to adequately adjust risk.

Health Care Shortage Areas: Designations Not a Useful Tool for Directing Resources to the Underserved (GAO/HEHS-95-200, Sept. 8, 1995)

Many Americans live in places where barriers exist to obtaining basic health care. These areas range from isolated rural locations to inner-city neighborhoods. In fiscal year 1994, the federal government spent about $1 billion on programs to overcome access problems in such locations. To be effective, these programs need a sound method of identifying the type of access problems that exist and focusing services on the people who need them. The Department of Health and Human Services (HHS) uses two main systems to identify such locales. One designates Health Professional Shortage Areas, the other Medically Underserved Areas. More than half of all U.S. counties fall into these two categories. GAO reviewed the two systems to determine (1) how well they identify areas with primary care shortages, (2) how well they help target federal funding to benefit those who are underserved, and (3) whether they are likely to be improved under proposals to combine them.

Health Insurance Portability: Reform Could Ensure Continued Coverage for Up to 25 Million Americans (GAO/HEHS-95-257, Sept. 19, 1995)

Although federal and state laws have improved the portability of health insurance, an individual's health care coverage could still be reduced when changing jobs. Between 1990 and 1994, 40 states enacted small group insurance regulations that include portability standards, but ERISA prevents states from applying these standards to the health plans of employers who self-fund. As a result, some in Congress have proposed broader national portability standards. GAO estimates that as many as 21 million Americans each year would benefit from federal legislation to ensure that workers who change jobs would not be subject to new health insurance plans that impose waiting periods or preexisting condition exclusions. In addition, as many as 4 million Americans who at some point have been unwilling to leave their jobs because they feared losing their health care coverage would benefit from national portability standards. Such a change, however, could possibly boost premiums, according to insurers.

HMO Enrollment Data (GAO/HEHS-95-159R, May 25, 1995)

GAO provided information on health maintenance organization (HMO) enrollment, focusing on the number of Medicare beneficiaries enrolled in risk-based HMOs. GAO noted that (1) between December 1993 and 1994, the percentage of Medicare beneficiaries enrolled in risk-based HMOs increased from 5.1 to 6.3 percent for a total of about 2.3 million beneficiaries; (2) although older beneficiaries had lower enrollment rates than the general Medicare population, they also increasingly joined risk-based HMOs; (3) between 1993 and 1994, the percentage of Medicare beneficiaries aged 75 and older enrolled in risk-based HMOs increased from 4.8 to 6.1 percent; and (4) the percentage of beneficiaries aged 85 and older

enrolled in risk-based HMOs increased from 3.9 to 4.7 percent between 1993 and 1994.

Hospital-Based Home Health Agencies (GAO/HEHS-95-209R, July 19, 1995)

GAO reviewed whether increased hospital ownership of home health agencies (HHA) has contributed to the growth in Medicare home health costs. GAO found that hospital-based HHA (1) generally care for beneficiaries with less chronic conditions and provide fewer visits to patients than all other types of HHA, except those run by the government and (2) apparently are not driving up Medicare costs any more than other types of HHA.

Indian Health Service: Improvements Needed in Credentialing Temporary Physicians (GAO/HEHS-95-46, Apr. 21, 1995)

Indian Health Service (IHS) facilities, which provide medical care to more than 1 million American Indians and Alaskan Natives, supplement their staffs with temporary physicians. But weak policies have led IHS to unknowingly hire doctors who have been disciplined for such offenses as gross and repeated malpractice and unprofessional conduct. IHS does not explicitly require verifying all active and inactive state medical licenses that a temporary physician may have. Further, most IHS facilities that have contracts with companies that supply temporary physicians do not require the companies to inform IHS of the status of all medical licenses a physician may hold. In addition, IHS facilities do not have a formal system for sharing information on temporary physicians who have worked within the IHS medical system. This report also discusses what happens when requested medical services are delayed.

Long-Term Care: Current Issues and Future Directions (GAO/HEHS-95-109, Apr. 13, 1995)

Today, an increasing number of Americans need long-term care. Unprecedented growth in the elderly population is projected for the twenty-first century, and the population age 85 and older—those most in need of long-term care—is expected to outpace the rate of growth for the entire elderly population. In addition to the dramatic rise in the elderly population, a large portion of the long-term care population consists of younger people with disabilities. The importance of long-term care was underscored by the 1994 congressional debate over health care reform and, more recently, by the "Contract with America," which proposed assistance such as tax deductions for long-term care insurance and tax credits for family caregiving. This report (1) defines what is meant by long-term care and discusses the conditions that give rise to long-term care need, how such need is measured, and which groups—young and old—require long-term care; (2) examines the long-term care costs that are

borne by federal and state governments as well as by families; (3) addresses strategies that states and foreign countries are pursuing to contain public long-term care costs; and (4) discusses predictions by experts on the future demand for long-term care.

Long-Term Care: Diverse, Growing Population Includes Millions of Americans of All Ages (GAO/HEHS-95-26, Nov. 7, 1994)

Contrary to popular perception, not all Americans needing long-term care are elderly or institutionalized. Of the 12 million Americans requiring such care, 5 million are working-age adults and about half a million are children; the vast majority—10 million—live at home or in community residential facilities. The long-term care needs of this population vary considerably, from around-the-clock nursing care to occasional assistance with household chores, such as cooking and house cleaning. The aging of the baby boom generation means that long-term care needs will increase well into the next century, as much as doubling among the elderly population in the next 25 years. Meaningful projections of the nation's future long-term care needs, however, are clouded by uncertainty about whether baby boomers will live longer, healthier lives than preceding generations and by a lack of good estimates on the future size of the nonelderly disabled population. Further, researchers believe that the number of younger disabled has grown in recent decades and will continue to do so, in part as a result of changing medical technology and other factors that may allow more low-birth-weight infants to reach childhood, for example, or more young adults to survive disabling accidents. The diverse ages, needs, and conditions of the long-term care population mean that greater flexibility is needed in the design and administration of programs to match the range of individual needs.

Medicaid Managed Care: More Competition and Oversight Would Improve California's Expansion Plan (GAO/HEHS-95-87, Apr. 28, 1995)

The Medicaid program was established to make health care more accessible to the poor. In many communities, however, beneficiaries' access to quality care is far from guaranteed. Too few doctors and other health care providers choose to participate in Medicaid because of low payment rates and administrative burdens. To address the access problem, as well as rising costs and enrollment in its $15 billion Medi-Cal program (which serves about 5.4 million beneficiaries), California intends to increase its reliance on managed care delivery systems. This report (1) describes California's current Medicaid managed care program, (2) reviews the state's oversight of managed care contractors with a focus on financial incentive arrangements and the provision of preventive care for children, (3) describes the state's plans for expansion, and

(4) identifies key issues the state will face as it implements the expanded program.

Medicaid: Restructuring Approaches Leave Many Questions (GAO/HEHS-95-103, Apr. 4, 1995)

Over the years, various proposals have been made to restructure the Medicaid program. One approach calls for providing federal block grants to the states and giving them increased responsibility for running the program. Under another proposal, Medicaid would be entirely funded and administered by the federal government. Yet another would split Medicaid into two programs, one encompassing acute and primary care and the other long-term care. This report compares the different restructuring approaches and discusses their implications for federal-state financing and administration of the program. GAO also provides information on the need to establish a federal "rainy day" fund if restrictions, such as block grants, are placed on federal revenues paid to states. GAO also provides the most recent data on the amount of federal Medicaid funds provided to each state.

Medicaid: Spending Pressures Drive States Toward Program Reinvention (GAO/HEHS-95-122, Apr. 4, 1995)

The $131 billion Medicaid program is at a crossroads. Between 1985 and 1993, Medicaid costs tripled and the number of beneficiaries rose by more than 50 percent. Medicaid costs are projected to rise to $260 billion, according to the Congressional Budget Office. Despite federal and state budgetary constraints, several states are pressuring to expand the program and enroll hundreds of thousands of new beneficiaries. The cost of expanded coverage, they believe, will be offset by the reallocation of Medicaid funds and the wholesale movement of beneficiaries into some type of managed care arrangement. This report examines (1) federal and state Medicaid spending, (2) some states' efforts to contain Medicaid costs and expand coverage through waiver of federal requirements, and (3) the potential impact of these waivers on federal spending and on Medicaid's program structure overall. The Comptroller General summarized this report in testimony before Congress; see Medicaid: Spending Pressures Drive States Toward Program Reinvention (GAO/T-HEHS-95-129, Apr. 4, 1995), by Charles A. Bowsher, Comptroller General of the United States, before the House Committee on the Budget.

Medicaid: Tennessee's Program Broadens Coverage but Faces Uncertain Future (GAO/HEHS-95-186, Sept. 1, 1995)

In early 1993, Tennessee predicted that increases in state Medicaid expenditures and the loss of tax revenues used to finance Medicaid would produce a financial crisis. To avert a financial crisis, control its Medicaid expenditures, and extend health insurance coverage to most state residents, Tennessee converted its Medicaid program into a managed care health program—TennCare—to serve both Medicaid recipients and uninsured persons. GAO found that although TennCare met its objectives of providing health coverage to many uninsured persons while controlling costs, concerns remain with respect to access to quality care and managed care performance. Specifically, questions have been raised about TennCare's rapid approval and implementation, lack of provider buy-in to the program, and delays in monitoring TennCare's access and quality of care. In addition, the soundness of the methodology for determining and the resulting adequacy of the program's capitation rates have been questioned. This report discusses (1) TennCare's basic design and objectives, (2) the degree to which the program is meeting these objectives, and (3) the experiences of TennCare's insurers and medical providers and their implications for TennCare's future.

Medicare: Allegations Against ABC Home Health Care (GAO/OSI-95-17, July 19, 1995)

In response to a congressional request, GAO investigated allegations against ABC Home Health Care, a home health agency, and its participation in Medicare's home health care program. In the Medicare program, providers may receive reimbursement for only those expenses that are reasonable in amount and related to patient care for eligible patients. Current and former employees told GAO that local ABC office managers directed them to alter records to make it appear that patients continued to need home health visits. Additionally, managers directed employees to continue visiting patients who, in the employees' opinions, did not qualify for home health care because they no longer met Medicare rules defining homebound status. ABC also reportedly charged Medicare for the cost of acquiring other HHAs by paying owners a small sum up front and the balance in the form of salary under employment agreements, a practice that is inconsistent with Medicare regulations for reimbursement. Finally, according to former employees, some managers directed employees to market ABC and its services with the intent of charging Medicare for costs that were not reimbursable. GAO has shared information concerning possible illegal activities with appropriate law enforcement authorities. GAO summarized this report in testimony before Congress; see Medicare: Allegations Against ABC Home Health Care (GAO/T-OSI-95-18, July 19, 1995), by Richard C. Stiener, Director, Office of Special Investigations, before the

Subcommittee on Health and Environment and the Subcommittee on Oversight and Investigations, House Commerce Committee.

Medicare: Antifraud Technology Offers Significant Opportunity to Reduce Health Care Fraud (GAO/AIMD-95-77, Aug. 11, 1995)

Medicare continues to suffer large losses each year due to fraud. Existing risks are sharply increased by the continual growth in Medicare claims—both in number and percentage processed electronically. Existing Medicare payment safeguards can be bypassed and apparently do not deter fraudulent activities. HCFA should be able to benefit by taking full advantage of emerging antifraud technology to better identify and prevent Medicare fraud. The number and types of Medicare fraud schemes perpetrated in South Florida may make that area the best place to test antifraud systems before nationwide use.

Medicare Claims: Commercial Technology Could Save Billions Lost to Billing Abuse (GAO/AIMD-95-135, May 5, 1995)

With an investment of only $20 million in off-the-shelf commercial software, Medicare could save nearly $4 billion over 5 years by detecting fraudulent claims by physicians—primarily manipulation of billing codes. On the basis of a test in which four commercial firms reprocessed samples of more than 20,000 paid Medicare claims, GAO estimates that the software could have saved $603 million in 1993 and $640 million in 1994. GAO estimates that because beneficiaries are responsible for about 22 percent of the payment amounts—mainly in the form of deductibles and copayments—Medicare could have saved them $134 million in 1993 and $142 million in 1994. The test results indicate that only a small portion of providers are responsible for most of the abuses: fewer than 10 percent of providers in the sample had miscoded claims. GAO summarized this report in testimony before Congress; see Medicare Claims Billing Abuse: Commercial Software Could Save Hundreds of Millions Annually (GAO/T-AIMD-95-133, May 5, 1995), by Frank W. Reilly, Director of Information Resources Management in the Health, Education, and Human Service Area, before the Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, Senate Committee on Appropriations.

Medicare: Excessive Payments for Medical Supplies Continue Despite Improvements (GAO/HEHS-95-171, Aug. 8, 1995)

In fiscal year 1994 alone, Medicare was billed more than $6.8 billion for medical supplies. Congressional hearings and government studies have shown that Medicare has been extremely vulnerable to fraud and abuse in its payments for medial supplies, especially surgical dressings. In one case discussed in congressional testimony in 1994, Medicare paid more than $15,000 in claims for a month's supply of surgical dressings for a single patient, apparently without reviewing the reasonableness of the claims

before payments. Until recently, medical suppliers had considerable freedom in choosing the Medicare contractors that would process and pay their claims. Some exploited this freedom by "shopping" for contractors with the weakest controls and highest payment rates. This report discusses the (1) circumstances allowing payment for unusually high surgical dressing claims and (2) adequacy of Medicare's internal controls to prevent paying such claims.

Medicare Hospital Payments (GAO/HEHS-95-158R, May 25, 1995)

GAO provided information on the growth in Medicare hospital payments, focusing on the annual payment growth rates for various types of hospitals. GAO noted that (1) while general inflation grew about 3.5 percent annually from 1984 through 1992, hospital payments per discharge grew at an annual rate of 5.4 percent; (2) major teaching hospitals averaged a 5.7 percent annual payment growth rate and nonteaching hospitals averaged a 5.3 percent annual payment growth rate; (3) hospitals receiving disproportionate share payments had a higher per discharge payment growth rate than hospitals not receiving such payments; (4) larger hospitals in both urban and rural settings had higher payment growth rates; (5) government-owned hospitals had higher payment growth rates than voluntary or proprietary hospitals; (6) increased payments did not necessarily translate to increased profits, since expenses were not accounted for; and (7) case complexity grew more rapidly among large urban and rural hospitals, which partially explains their higher payment growth rate.

Medicare: Increased HMO Oversight Could Improve Quality and Access to Care (GAO/HEHS-95-155, Aug. 3, 1995)

This report discusses problems that HCFA has had monitoring HMOs it contracts with to provide services to Medicare beneficiaries and ensuring that they comply with Medicare's performance standards. GAO found weaknesses in HCFA's quality assurance monitoring, enforcement measures, and appeal processes. Although HCFA routinely reviews HMO operations for quality, these reviews are generally perfunctory and do not consider the financial risks that HMOs transfer to providers. Moreover, HCFA collects virtually no data on services received through HMOs to enable it to identify providers who may be underserving beneficiaries. In addition, HCFA's HMO oversight has two other major limitations: enforcement actions are weak and the beneficiary appeal process is slow. HCFA's current regulatory approach of ensuring good HMO performance appears to lag behind the private sector. GAO summarized this report in testimony before Congress; see Medicare: Increased Federal Oversight of HMOs Could Improve Quality of and Access to Care (GAO/T-HEHS-95-229, Aug. 3, 1995), by

Sarah F. Jaggar, Director of Health Financing and Public Health Issues, before the Senate Special Committee on Aging.

Medicare Providers' Legal Expenses (GAO/HEHS-95-214R, July 18, 1995)

GAO provided information on Medicare reimbursement of providers' legal expenses, focusing on (1) the conditions that Medicare imposes on provider legal expense reimbursements and whether these conditions differ from those applied in other government contexts, (2) the amount Medicare spends on providers' legal expenses, and (3) whether Medicare providers have abused current provisions covering legal expense reimbursement. GAO noted that (1) HCFA has not specified the conditions under which legal fees are reimbursable; (2) Medicare decides whether providers' legal fees are reimbursable on a case-by-case basis; (3) the provisions for reimbursing Medicare providers' legal fees are more generous than those in other government contexts in that providers can be reimbursed by Medicare regardless of outcome and providers' legal expenses are not capped; (4) in 1994, 46 HHAs had a combined total of $6.5 million in legal expenses; and (5) HHAs are more likely to submit claims for Medicare reimbursement and to appeal denied cost adjustments, despite limited chances of success.

Medicare: Referrals to Physician-Owned Imaging Facilities Warrant HCFA's Scrutiny (GAO/HEHS-95-2, Oct. 20, 1994)

Because Florida had the only statewide information then available on doctors with a financial stake in imaging center joint ventures, GAO analyzed 1990 Medicare claims for imaging services ordered by physicians in that state. GAO found that Florida doctors with a financial interest in such centers ordered about $10 million more in Medicare-paid imaging services than other doctors in 1990. Florida physicians with imaging facilities in their offices, group practices, or other practice settings also had higher imaging rates compared with those of other physicians. HHS has not yet finalized the regulations and procedures needed to implement and enforce federal self-referral restrictions that would apply to doctors with a financial interest in joint ventures. Moreover, HCFA has no system to check physician-referral patterns to identify abusive overutilization of self-referrals.

Medicare Secondary Payer Program (GAO/HEHS-95-101R, Mar. 6, 1995)

GAO provided information on and suggested language for proposed legislation regarding the recovery of health care costs from private insurers where Medicare is the secondary payer. GAO noted that the (1) proposed legislation would give a clearer statutory basis for existing Medicare regulations on cost recovery from private insurers, which were

recently invalidated by a court ruling; (2) HHS is also preparing a legislative proposal to address this and other Medicare issues; (3) government may have to refund millions of dollars in past recoveries and forego future recoveries because of the court ruling; and (4) court ruling barred recoveries from third-party administrators and claims filed past the insurers' filing deadlines and before 1989.

Medicare Spending: Modern Management Strategies Needed to Curb Billions in Unnecessary Payments (GAO/HEHS-95-210, Sept. 19, 1995)

Medicare's vulnerability to billions in unnecessary payments stems from a combination of factors. First, Medicare pays higher than market rates for some services and supplies. For example, Medicare pays more than the lowest suggested retail price for more than 40 types of surgical dressings. Second, Medicare's anti-fraud-and-abuse controls do not prevent the unquestioned payment of claims for improbably high charges or manipulated billing codes. Third, Medicare's checks on the legitimacy of providers are too superficial to detect the potential for scams. Various health care management strategies help private payers avoid these problems, but Medicare generally does not use these strategies. The program's pricing methods and controls over utilization, consistent with health care financing and delivery 30 years ago, have not kept pace with major financing and delivery changes. GAO believes that a viable strategy for remedying the program's weaknesses would involve adapting the health care management approach of private payers to Medicare's public payer role. This strategy would include (1) more competitively developed payment rates, (2) enhanced fraud and abuse detection efforts through modernized information systems, and (3) more rigorous criteria for granting authorization to bill the program.

Medicare: Tighter Rules Needed to Curtail Overcharges for Therapy in Nursing Homes (GAO/HEHS-95-23, Mar. 30, 1995)

Nursing homes and rehabilitation centers are taking advantage of ambiguous payment rules and the lack of guidelines to bill Medicare at inflated rates for therapy services. State averages for physical, occupational, and speech therapists' salaries range from about $12 to $25 per hour, but Medicare has been charged upwards of $600 per hour. The extent of overcharging and its precise impact on Medicaid outlays are unclear; however, billing schemes uncovered in recent years suggest that the problem is nationwide and growing in magnitude. Extraordinary markups on therapy can result from providers exploiting regulatory ambiguity and weaknesses in Medicare's payment rules. Payment rules and procedures developed when the therapy industry was much smaller and less sophisticated have proved no match for increasingly complex business practices designed to generate increased Medicare revenue and

skirt program controls. Although the overbilling problem has been known since 1990, no action has been taken to close loopholes that allow payment for these overcharges.

Medigap Insurance: Insurers' Compliance With Federal Minimum Loss Ratio Standards, 1988-93 (GAO/HEHS-95-151, Aug. 23, 1995)

The Medigap market grew steadily from 1988 to 1993, from $7.3 billion to $12.1 billion. Medigap insurers' aggregate loss ratios were relatively stable during the first 4 years of that period. During the next 2 years, however, these ratios fell about 10 percent, to an aggregate 75 percent for individual policies and 85 percent for group policies. In 1991, 19 percent of Medigap policies failed to meet loss ratio standards; this rose to 38 percent by 1993. The premium dollars spent on such policies increased from $320 million in 1991 to $1.2 billion in 1993. If insurers had been required to give refunds or credits on substandard policies, as they will in the future, policyholders would have been due about $124 million during 1992 and 1993.

Michigan Financing Arrangements (GAO/HEHS-95-146R, May 5, 1995)

GAO provided information on Michigan's 1995 Medicaid funding arrangements. GAO noted that (1) Michigan has been among the most successful states in obtaining additional federal Medicaid funds; (2) since fiscal year 1991, Michigan has reduced its Medicaid costs by $1.8 billion due to a variety of financing partnerships with medical providers; (3) most federal matching funds paid to providers have been returned to the state, thus reducing state appropriations; (4) although federal legislation has curtailed certain financing practices, Michigan has found new ways to obtain federal matching funds, such as using provider donations to maximize federal funds and reduce state costs; (5) Michigan's use of intergovernmental transfers could reduce Medicaid costs by an additional $428 million in fiscal year 1995; (6) Michigan expects to obtain over $414 million in federal matching funds in fiscal year 1996; (7) Michigan should realize a net benefit of $196.5 million in fiscal year 1995 by adjusting nursing home and mental health Medicaid services payments; and (8) Michigan determined that it could make additional hospital outpatient payments of $40 million without exceeding what Medicare would pay for such services.

Patient Self-Determination Act: Providers Offer Information on Advance Directives but Effectiveness Uncertain (GAO/HEHS-95-135, Aug. 28, 1995)

Congress passed the Patient Self-Determination Act in 1990 to reinforce individuals' constitutional right to decide their final health care. The act requires health care providers to increase public awareness about the use of "advance directives"—a living will or health care power of attorney. An advance directive spells out how life-support decisions should be carried out should the patient become terminally ill and unable to communicate his or her wishes. This report provides information on the act's implementation and on the effectiveness of advance directives in ensuring patient self-determination. GAO looks at the extent to which (1) institutional health care providers and the federal government are complying with the act's provision, (2) the public uses advance directives to express their end-of-life treatment wishes, and (3) an advance directive affects a patient's desired care.

Prescription Drugs and the Elderly: Many Still Receive Potentially Harmful Drugs Despite Recent Improvements (GAO/HEHS-95-152, July 24, 1995)

The inappropriate use of prescription drugs is particularly hazardous for the elderly. Not only do they use more prescription drugs than any other age group, the elderly are more likely to take several drugs at once, increasing the likelihood of harmful drug reactions. Furthermore, the elderly do not eliminate drugs from their systems as efficiently as younger patients because of decreased liver and kidney function. GAO found that 17.5 percent of nearly 30 million noninstitutionalized Medicare recipients age 65 or older used at least one drug identified as generally unsuitable for elderly patients since safer alternative drugs exist. Inappropriate prescription drug use can result from doctors using outdated prescribing practices, pharmacists not doing drug utilization reviews, and patients not telling their doctors and pharmacists about all the drugs they are taking. Recent initiatives are seeking to address this problem. Federal and state efforts have encouraged the development and dissemination of detailed information on the effect of prescription drugs on the elderly, and the medical community is urging doctors to increase their knowledge of geriatrics and elderly clinical pharmacology. At the same time, drug utilization review systems now allow prescriptions to be screened before they are filled to identify potential problems, such as adverse drug interactions or inappropriate dosage levels. Changes in the health care delivery system may also help reduce inappropriate use of prescription drugs. For example, managed care plans, through the use of controls such as a "gatekeeper," could potentially improve the coordination of drug therapies for newly enrolled elderly patients.

Preventing Abusive Medicare Billing (GAO/HEHS-95-260R, Sept. 5, 1995)

GAO discussed its recommendations for preventing abusive Medicare billing and whether the recommendations can be implemented legislatively. GAO noted that (1) Medicare law could be amended to require HHS to establish the requirements recommended as well as a higher limit on the amount that Medicare will recognize as reasonable for therapy services; (2) expense claim limits could be set at the amount established under Medicare's part B fee schedules for therapy services; (3) establishing an upper limit would partially define billable units of service, since the procedure codes for occupational and speech therapy do not define the amount of time the codes cover; and (5) proposals have been made to require nursing homes to bill for the services provided to their residents, whether payment is sought from part A or part B fee schedules.

Housing Issues

HUD-Assisted Renters (GAO/RCED-95-167R, May 18, 1995)

GAO provided information on the Department of Housing and Urban Development's (HUD) rental assistance programs, focusing on the potential for assisted households to move toward or achieve economic self-sufficiency. GAO noted that based on samples of 1989 data (1) HUD-assisted renters' median age was 50 years, with 29 percent 34 years or younger, 36 percent between the ages of 35 and 64, and 35 percent 65 years or older; (2) the elderly and the disabled, who constituted about 49 percent of HUD-assisted households, had limited potential for achieving self-sufficiency; (3) 45 percent of assisted households had children, with 12 percent having three or more children; (4) about 55 percent of the households were headed by single parents; (5) single parents needed child care and other services to participate in training or employment programs; (6) about 36 percent of the heads of assisted households had graduated from high school, another 18 percent had 1 or more years of college, and 21 percent had fewer than 8 years of schooling; (7) at least 45 percent of HUD-assisted renters needed additional education or training to become self-sufficient; (8) the renters' median income was $7,320; (9) about 7 percent of the renters had incomes of $20,000 or more; (10) only 40 percent of the households reported income from wages or salaries; and (11) a 3-member family renting a 2-bedroom apartment would need an annual income ranging from $18,396 to $36,264 to become economically independent of the housing program.

HUD Management: Greater Oversight Needed of FHA's Nursing Home Insurance Program (GAO/RCED-95-214, Aug. 25, 1995)

HUD has insured private lenders against financial losses arising from defaults on mortgages for nursing homes and retirement service centers. Although HUD officials believe that the program has enabled the agency to assist populations or areas that are not well served by the private sector, GAO found that the nursing home program has not been targeted to specific populations or communities and that HUD does not collect or analyze information on whom the program is servicing. The Federal Housing Administration (FHA) has not completely assessed the financial performance of the nursing home and retirement service center programs. Available data indicate that the nursing home program has incurred losses of $187 million, adjusted for inflation, during its 35-year history. Additionally, FHA's fiscal year 1994 loan loss reserves anticipate future losses equivalent to about 19 percent of the $3.7 billion balance of nursing home loans in the portfolio as of September 1994. HUD data show that about 46 percent of the retirement service center's total portfolio of about $1.4 billion had defaulted and resulted in FHA insurance claims as of September 1994. GAO doubts whether HUD will be able to effectively manage the nursing home and retirement service center programs in the near future.

Income Security Issues

Combined Fund Update (GAO/HEHS-95-166R, May 25, 1995)

GAO reviewed the United Mine Workers of America (UMWA) Combined Benefit Fund, focusing on the fund's (1) beneficiaries, expenses, and revenues; and (2) Medicare reimbursement arrangements. GAO noted that (1) as of October 1, 1994, the fund had 96,700 beneficiaries, about three-quarters of whom were coal industry operators; (2) 29 firms terminated their contributions to the fund between October 1994 and March 1995, which necessitated the reassignment of 3,114 beneficiaries; (3) the fund had billed all operators about $162 million for fiscal year 1995 premiums; (4) the fund's Medicare per capita reimbursement rate was renegotiated and reduced for the year beginning July 1994, which makes it unlikely that future annual surpluses will occur; and (5) overall annual operating deficits are expected to begin in 1995, which would eliminate the current surplus by 2003.

Combined Fund Analysis (GAO/HEHS-95-230R, Aug. 4, 1995)

GAO reviewed two studies of the UMWA Combined Benefit Fund. GAO noted that (1) the consultants' models projected widely differing financial results for the UMWA Combined Benefit Fund; (2) the models' expense estimates for 1995 differed by about $16 million; (3) one of the models underestimated the UMWA fund's 1995 net expenses by approximately $3 million; (4) one consultant based its medical cost inflation assumptions on the Fund's past and current efforts to contain cost growth in prescription drugs; (6) the other consultant relied on the Medicare trust fund's projections of medical inflation and adjusted these estimates to reflect the Fund's past experiences; and (7) the later assumptions may be more reasonable and may be more accurate in predicting the Fund's status beyond 1995.

CSRS Funding (GAO/GGD-95-200R, Apr. 3, 1995)

GAO reviewed information on the funding status of the Civil Service Retirement System. GAO noted that (1) the system's unfunded liability is not a problem that needs to be fixed to avoid a steep increase in outlays from the Treasury or increases in the deficit and (2) there should be sufficient assets in the retirement fund to cover benefit payments to all current and future retirees.

D.C. Disability Retirement Rate (GAO/GGD-95-133, Mar. 31, 1995)

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 rates exceeds a certain limit. GAO concludes that no reduction is required in the fiscal year 1996 payment to the fund.

District Pensions: Federal Options for Sharing Burden to Finance Unfunded Liability (GAO/HEHS-95-40, Dec. 28, 1994)

With a total unfunded liability of about $5 billion in 1993, the three District of Columbia pension plans continued to be not as well-funded as 24 comparable state and local governmental pension plans. Under the funding method proposed by the District of Columbia Pension Liability Funding Reform Act of 1994 (H.R. 3728) and a companion District bill, about $1 billion in value today of contributions that the District would make under the existing law would be shifted to the federal government. However, because the approach would entail federal payments escalating at 5 percent per year through 2035, more of the burden of eliminating the unfunded liability would shift to future federal budgets and generations of federal taxpayers. In contrast, a constant annual federal payment of $102.1 million would shift less of the burden to future federal budgets and

taxpayers, cost the federal government a little less overall, and have the same effect as H.R. 3728 in stabilizing the District's contributions at about 45 percent of payroll while eliminating the liability. Other options with lower constant annual federal payments would also eliminate the liability, but the District's contributions would be higher. Also, under the District's act, its contributions for the first 3 years would be at the required minimum of $295.5 million. GAO notes that these payments would be about $58 million higher than the actuarially determined amounts.

Federal Retirement: Benefits for Members of Congress, Congressional Staff, and Other Employees (GAO/GGD-95-78, May 15, 1995)

The retirement benefits provided by the Civil Service Retirement System for Members of Congress are generally more generous than those provided for other federal employees. The major differences are found in the eligibility requirements for retirement and the formulas used to calculate benefits. The Member benefit formula applies to congressional staff, but they are covered by the general employee retirement eligibility requirements. Law enforcement officers and firefighters may retire earlier than general employees and are covered by a more generous benefit formula than are general employees. Under the Civil Service Retirement System, the provisions for air traffic controllers fall between those for law enforcement officers and firefighters and those for general employees. Many of the advantages afforded to Members of Congress and congressional staff under the Civil Service Retirement System were continued under the Federal Employees Retirement System, which covers workers hired in 1984 and thereafter. But under the Federal Employee Retirement System, provisions for law enforcement officers, firefighters, and air traffic controllers are very similar to provisions for Members. GAO summarized this report in testimony before Congress; see Congressional Retirement Issues, (GAO/T-GGD-95-165, May 15, 1995), by Johnny C. Finch, Assistant Comptroller General for General Government Programs, before the Subcommittee on Post Office and Civil Service, Senate Committee on Governmental Affairs.

Means-Tested Programs (GAO/HEHS-95-94R, Feb. 24, 1995)

GAO provided information on welfare reform proposals to simplify means-tested public assistance programs. GAO noted that (1) welfare services should be easily accessible by all who seek assistance; (2) there is no integrated strategy to unify these programs to address the interrelated needs of individuals and families; (3) despite efforts to better coordinate federal programs, conflicting requirements make it difficult for program staff to coordinate activities and share resources; and (4) program

integration could be facilitated by reducing or eliminating federal program barriers and reengineering the welfare delivery process.

PBGC (GAO/AIMD-95-225R, Aug. 24, 1995)

GAO reviewed the Pension Benefit Guaranty Corporation's (PBGC) accounting procedures and internal controls that warranted management's attention as of September 30, 1994. GAO noted that PBGC (1) used evidence about significant transactions that occurred after year-end in assessing its year-end contingent liabilities; (2) misclassified several pension plans based on their prior year classifications; (3) placed greater emphasis on bond ratings and debt-equity ratios in classifying pension plans; (4) had financial statements that did not disclose factors that represented high contingent liability risks; (5) did not adequately disclose the monetary effects that actuarial assumptions had on the amounts disclosed; (6) did not provide all available information about its efforts to recover amounts from sponsors of terminated plans in its financial statements; (7) incorrectly recorded its estimated losses; (8) did not provide adequate documentation in its Single Employer Program's Statement of Cash Flows; (9) inconsistently reviewed its financial assistance to multiemployer plans; (10) had yet to evaluate the effectiveness of its ratio screens in identifying troubled plans; (11) incorrectly listed 16 multiemployer plans as inactive in its Premium Processing System; (12) incorrectly allocated some of its losses to the Multiemployer Program; and (13) had not fully implemented its new computerized premium accounting system, disaster recovery plan, and software changes.

Pension COLAs (GAO/HEHS-95-219R, Aug. 11, 1995)

GAO provided information on the frequency and characteristics of cost-of-living adjustments (COLA) that retirees receive from public and private pension plans. GAO noted that (1) Social Security and federal pension plans incorporate automatic, annual COLA; (2) over half the states reporting to the Bureau of Labor Statistics provide automatic COLA annually, generally capped between 3 and 5 percent; (3) the remaining states mainly provide ad hoc COLA, although the number of states granting ad hoc COLA has gradually decreased since 1987, due to lower inflation; (4) ad hoc COLA in private pension plans occur less frequently than automatic COLA in the public sector and the plans often specify a maximum increase; (5) a number of factors, such as union negotiations, affect employers' decisions to provide COLA increases; (6) COLA provisions vary widely among industries, ranging from 3 percent of pension plans in the retail sector to over 60 percent in the transportation industry; and (7) ad

hoc adjustments to private sector pension benefits have declined in recent years from over 50 percent to under 10 percent of plans.

Private Pensions: Funding Rule Change Needed to Reduce PBGC's Multibillion Dollar Exposure (GAO/HEHS-95-5, Oct. 5, 1994)

In 1990, GAO flagged 17 federal program areas as high risk, including the Pension Benefit Guaranty Corporation (PBGC), which is plagued by a large and growing deficit and a large exposure to potential claims from underfunded plans. PBGC recently reported that underfunding in the single-employer defined-benefit plans it insures grew from $38 billion in 1991 to $53 billion in 1992—this despite more stringent funding requirements that the Pension Protection Act mandated for underfunded plans in 1987. GAO concludes that the current funding rules for underfunded plans are not working well. Despite the act's intent that funding in underfunded plans be improved, most sponsors of underfunded plans made no additional contributions to reduce underfunding in 1990. This is partly due to an unanticipated design flaw that yields offsets that are too large for many plans. In addition to describing the act's weaknesses in reducing underfunding, this report describes the potential impact of the proposed Pension Funding Improvement Act of 1993 and the administration's proposed Retirement Protection Act of 1993 on improving plan funding.

Service Corps of Retired Executives (GAO/RCED-95-127R, Mar. 10, 1995)

GAO provided information on the Small Business Administration's Service Corps of Retired Executives Program (SCORE), focusing on how SCORE (1) determines budget allocations for regional locations; (2) officials view the fairness of the allocations; and (3) meets the needs of rural communities. GAO noted that (1) SCORE regional budget allocations are based primarily on historical trends in actual expenditures; (2) SCORE officials stated that their areas receive a fair share of SCORE funds, given the small size of the total budget; and (3) to meet the needs of rural communities, SCORE uses approaches such as waiving the guidelines for the number of volunteers needed to start a chapter and using persons or funds from larger chapters to subsidize rural chapters.

Social Security Administration: Leadership Challenges Accompany Transition to an Independent Agency (GAO/HEHS-95-59, Feb. 15, 1995)

In 1994, Congress passed legislation making the Social Security Administration (SSA) an independent agency. As part of the transition, GAO was required to evaluate the interagency agreement for transferring personnel and resources from HHS to SSA. GAO concludes that the two agencies have developed an acceptable methodology for identifying the functions; personnel; and other resources, such as furniture and computer equipment, to be transferred to an independent SSA. They have also made good progress toward completing the initiatives necessary for SSA to be a fully functional independent agency by March 31, 1995. However, SSA will continue to face serious policy and management challenges, including the long-range shortfall in funds to pay future Social Security benefits. Also, questions have been raised by GAO and others about the future growth of the Disability Insurance program and recent increases in Supplemental Security Income (SSI) benefits.

SSI Disability Issues (GAO/HEHS-95-154R, May 11, 1995)

GAO provided information on several SSI issues related to (1) SSI outreach activities; (2) the status of continuing disability reviews involving interpreter fraud; (3) the function of referral and monitoring agencies (RMA) in overseeing the drug addict and alcoholic populations; and (4) the number of drug and alcohol addicts in treatment. GAO noted that (1) very few SSI outreach activities are targeted to drug addicts and alcoholics; (2) SSA has not requested funding for SSI outreach for fiscal years 1993 through 1996; (3) in two states, SSA continuing disability reviews are yielding a high rate of initial benefit terminations, of which about 60 percent have been appealed; (4) SSA is developing an interpreter database to understand the extent of the fraud problem; (5) RMAs assess beneficiaries' treatment needs, make treatment referrals, monitor beneficiaries' compliance with treatment, and report their compliance status to SSA; (6) RMAs do not conduct SSI outreach activities; (7) only 1 in 6 addicted beneficiaries are in required treatment, mainly due to the lack of RMA funding to monitor beneficiaries' treatment; and (8) in fiscal year 1996, the administration is requesting $195 million for RMA monitoring activities, which is a significant increase over 1990 through 1993 levels.

Supplemental Security Income: Growth and Changes in Recipient Population Call for Reexamining Program (GAO/HEHS-95-137, July 7, 1995)	The SSI program is the largest cash assistance program for the poor and one of the fastest growing entitlement programs; program costs have risen 20 percent annually during the last 4 years. SSI provides means-tested income support payments to aged, blind, or disabled persons. Last year, more than 6 million people received about $25 billion in federal and state benefits. In response to SSI's rapid growth, Congress passed legislation limiting drug addicts' benefits, and this year it is considering further restrictions for these recipients as well as for children and noncitizens. This report provides an overview of the SSI program and its recent history. Specifically, it examines factors contributing to caseload growth and changes in the characteristics of SSI recipients.
Welfare Benefits: Potential to Recover Hundreds of Millions More in Overpayments (GAO/HEHS-95-111, June 20, 1995)	Under welfare reform legislation being considered by Congress, resources for helping poor families may become increasingly limited—making it critical that only those who are eligible for benefits receive them. In 1992, benefit overpayments in three welfare programs—Aid to Families With Dependent Children (AFDC), Food Stamps, and Medicaid—totaled $4.7 billion, or about 4 percent of the total benefit paid. Moreover, nationwide recovery of these benefits was relatively low. This report discusses (1) what states are doing to recover benefit overpayments, what the more effective practices are, and what states could do better and (2) what the federal government could do to help states recover more overpayments.
Welfare Programs: Opportunities to Consolidate and Increase Program Efficiencies (GAO/HEHS-95-139, May 31, 1995)	The federal government provides billions of dollars in public assistance each year through an inefficient welfare system that is increasingly cumbersome for program administrators to manage and difficult for eligible clients to access. Program consolidation may be one strategy to reduce the inefficiency of the current system of overlapping and fragmented programs. This report (1) describes low-income families' participation in multiple welfare programs; (2) examines program inefficiencies, such as program overlap and fragmentation; and (3) identifies issues to consider in deciding whether and to what extent to consolidate welfare issues. Regardless of how the welfare system is restructured, ensuring that federal funds are used efficiently and that programs focus on outcomes remains important. Without a focus on outcomes, concerns and the effectiveness of welfare programs will not be adequately addressed.

Welfare Reform: Implications of Proposals on Legal Immigrants' Benefits (GAO/HEHS-95-58, Feb. 2, 1995)

GAO found that the percentage of immigrants receiving public assistance—specifically SSI or AFDC—is higher than the percentage of citizens receiving these benefits. Six percent of all immigrants receive benefits compared with 3.4 percent of all citizens. Most immigrant recipients live in four states: California, New York, Florida, and Texas; more than one-half of all immigrant recipients live in California. Between 1983 and 1993, the number of immigrants receiving SSI more than quadrupled, increasing from 151,000 to 683,000. During this period, immigrants grew from about 4 percent of all SSI recipients to more than 11 percent. As a percentage of all adult AFDC recipients, immigrants grew from about 5 percent to 8 percent. In all, immigrants received an estimated $3.3 billion in SSI benefits and $1.2 billion in AFDC benefits in 1993. Most immigrant recipients are lawful permanent residents or refugees, but other characteristics of immigrants receiving SSI and AFDC vary. For example, the number of immigrants receiving SSI aged benefits—available to those 65 years and older—has increased dramatically. According to the Congressional Budget Office, a welfare reform proposal now before Congress (H.R. 4) would save $9.2 billion from the SSI program and $1 billion from the AFDC program over 4 years. GAO estimates that 522,000 SSI recipients and 492,000 AFDC recipients would become ineligible for benefits under H.R. 4.

Veterans/DOD Issues

Defense Health Care: Issues and Challenges Confronting Military Medicine (GAO/HEHS-95-104, Mar. 22, 1995)

DOD's military health care system provides medical services and support both in peacetime and in war to members of the armed forces and their families, as well as to retirees and survivors. Post-Cold War planning scenarios, efforts to reduce the overall size of the military, federal budget cuts, and base closures and realignments have focused attention on the size of DOD's health care system, its makeup, how it operates, whom it serves, and whether its missions can be carried out in a more cost-effective way. This report describes the Military Health Services System, past problems faced by DOD as it ran the system and efforts to solve those problems, and the management challenges now confronting DOD. GAO summarized this report in testimony before Congress; see Defense Health Care: DOD's Managed Care Program Continues to Face Challenges (GAO/T-HEHS-95-117, Mar. 28, 1995), by David P. Baine, Director of Federal Health Care Delivery Issues, before the Subcommittee on Military Personnel, House Committee on National Security.

Defense Health Care: Problems With Medical Care Overseas Are Being Addressed (GAO/HEHS-95-156, July 12, 1995)

The American military presence in Europe has declined dramatically since 1989. The active duty population has been cut by 57 percent—from 332,000 to 138,000. At the same time, the military health services systems has also been substantially reduced. Many beneficiaries have expressed concern about their reduced access to health care from military medical facilities overseas and are dissatisfied with the care they receive from host nation providers. This report discusses (1) the availability of health care in military facilities, (2) any obstacles to providing that care, (3) the experiences of beneficiaries who have used host nation providers as an alternative to military health care, and (4) whether DOD is addressing service delivery problems and beneficiary concerns. To develop this information, GAO visited 15 military communities in Germany and northern Italy, where many of the beneficiary complaints about medical and dental care originated.

Proposed VA Hospital at Travis Air Base (GAO/HEHS-95-268R, Sept. 19, 1995)

GAO provided information on the proposed construction of a Department of Veterans Affairs (VA) hospital at Travis Air Force Base in Fairfield, California, focusing on (1) reasons that the project cost estimate was higher than VA originally proposed to Congress and (2) where veterans living in the Travis facility target area currently receive medical care. GAO noted that (1) the project cost estimate increased because VA believed it needed to construct and renovate more space than originally anticipated; (2) many veterans in the Travis target area currently receive hospital care at VA medical centers in the northern California and Nevada areas; and (3) although veterans' use of VA medical centers decreased in fiscal years 1992 and 1993, the reason for the decrease was unclear.

VA Clinic Funding (GAO/HEHS-95-273R, Sept. 19, 1995)

GAO provided information on how two VA medical centers financed their new free-standing primary care clinics to improve veterans' access to health care services. GAO noted that (1) the two centers have financed their four new clinics from savings derived from local management initiatives to improve operating efficiency; (2) the centers plan to open 10 more clinics over the next several years that will also be financed from other cost-saving initiatives; (3) the centers have contracted with predominantly rural clinics to provide primary care to veterans; (4) the yearly contract costs for the current and future clinics are expected to be less than $2 million; (5) cost savings have been derived from inpatient ward consolidations, patient utilization reviews, health education classes, service contract modifications, and staff reductions; and (6) the new

clinics are expected to reduce veterans' use of fee-for-service private care and reimbursements for travel expenses to VA medical facilities.

VA Health Care: Need for Brevard Hospital Not Justified (GAO/HEHS-95-192, Aug. 29, 1995)

VA assumed control of the former Naval Hospital in Orlando, Florida, in June 1995. VA plans to convert the hospital into a nursing home while continuing to operate an existing outpatient clinic. VA also plans to build a new hospital and nursing home in Brevard County, 50 miles from Orlando. GAO concludes that VA's conversion of the former Orlando Naval Hospital into a nursing home and construction of a new hospital and nursing home in Brevard County is not the most prudent and economical use of its resources. These construction projects are based on questionable planning assumptions that may result in the unneeded expenditure of federal dollars. Specifically, VA did not adequately consider the availability of hundreds of community nursing home beds and unused VA hospital beds as well as potential decreases in future demand for VA hospital beds. VA could achieve its goals in Central Florida by using existing capacity.

VA Health Care: Physician Peer Review Identifies Quality of Care Problems but Actions to Address Them Are Limited (GAO/HEHS-95-121, July 7, 1995)

Physicians peer review—physicians reviewing the work of other physicians—is crucial to ensuring that quality care is provided to patients. An essential element of peer review is management support for actions recommended by the peer review process. Without such support, peer review is meaningless because no action is taken on the peer reviewers' recommendations. This report examines the relationship between problem identification and problems resolution in VA physician peer review. GAO discusses (1) how the results of VA peer review are being used in reprivileging and disciplining doctors with performance problems; (2) what the impediments to effective peer review are; and (3) whether VA was taking steps to identify, follow up on, and report to state medical boards and the National Practitioner Data Bank on the actions of those physicians who are not performing in accordance with professional standards.

VA Health Care: Retargeting Needed to Better Meet Veterans' Changing Needs (GAO/HEHS-95-39, Apr. 21, 1995)

Many veterans have health care needs that are not adequately met through current health care programs, including VA's health care system. About one-third of the nation's homeless are veterans, nearly one-half of whom have serious mental problems, suffer from substance abuse, or both. The homeless have limited access to health care services and may not seek medical treatment. About 38 percent of male and 25 percent of female Vietnam veterans with Post Traumatic Stress Disorder have not sought

treatment. About 91,000 low-income, uninsured veterans with no apparent health care options indicated in a 1987 VA survey that they had never used VA health facilities because they were unaware that they were eligible or they had concerns about the quality or accessibility of VA health care. VA cannot adequately address many of these health care needs because (1) it relies primarily on direct delivery of health care services in VA facilities, (2) its complex eligibility and entitlement provisions limit the services that veterans can obtain from VA facilities, and (3) space and resource limitations prevent eligible veterans from obtaining covered services. This report presents several options for restructuring VA's health care system to enable it to better meet the health care needs of veterans.

VA Savings Options (GAO/HEHS-95-165R, May 18, 1995)

GAO reviewed several options to achieve budgetary savings in VA's health care system without adversely affecting the current level of services provided to low-income or disabled veterans. GAO noted that VA could achieve health care cost savings by (1) shifting care from VA hospitals to alternative settings, such as ambulatory care; (2) adopting state veterans' home charging policies; (3) authorizing estate recovery programs; (4) increasing copayments for health services; (5) reducing or eliminating care for veterans with high incomes; (6) delaying VA hospital construction projects; (7) increasing the use of community nursing homes as an alternative to new VA nursing homes; (8) strengthening veterans' income verification requirements; (9) changing VA dispensing practices for prescription drugs; (10) eliminating the dispensing of over-the-counter drugs; (11) recovering the full costs of services provided to nonveterans; (12) consolidating its mail service pharmacies; (13) consolidating underutilized services in nearby VA medical centers; (14) suspending locality-based pay adjustments; and (15) restructuring its ambulatory care system.

VA's Florida Network Planning (GAO/HEHS-95-160R, May 16, 1995)

GAO addressed a series of questions related to VA's acquisition and intended use of the Naval Hospital in Orlando, Florida. GAO noted that (1) the VA Integrated Planning Model is based upon veterans' ages, average lengths of hospital stays, and number of patients treated in selected medical services; (2) VA used its model to project veterans' inpatient, outpatient, and nursing home needs for the year 2005; (3) VA did not consider the number of VA hospitals per square mile per capita in making its construction planning decisions for Central Florida and significantly overestimated the number of hospital beds it would need in 1995; (4) it is unclear why Florida's hospital utilization rates are far below the national rates; (5) the veteran

population is expected to decline in Florida and the nation over the next 15 years, while the total population in these areas is expected to increase; (6) there are waiting periods for certain elective medical treatments in Central Florida VA hospitals due to staffing reductions; and (7) the VA Integrated Planning Model adequately accounts for the aging nature of the veteran population.

Veterans' Benefits: Basing Survivors' Compensation on Veterans' Disability Is a Viable Option (GAO/HEHS-95-30, Mar. 6, 1995)

In 1993, VA's Dependency and Indemnity Compensation (DIC) program paid benefits totaling $2.7 billion to about 276,000 surviving spouses of service members who had died on active duty and surviving spouses of some disabled veterans. These benefits were paid under the Veterans' Benefits Act of 1992, which changed the basis for DIC benefits from the military rank of the deceased service member or veteran to a flat rate for all surviving spouses. This report (1) estimates DIC recipients' total income and determines the kinds and the amounts of benefits received from other programs, (2) determines the financial impact on surviving spouses of the deaths of totally disabled veterans and of veterans who were receiving supplemental payments because they had multiple severe disabilities and could not care for themselves, and (3) assesses alternative ways to set DIC benefits.

Veterans' Benefits: Better Assessments Needed to Guide Claims Processing Improvements (GAO/HEHS-95-25, Jan. 13, 1995)

Slow claims processing and poor customer service have long been recognized as serious problems for VA. As early as 1990, VA began encouraging its regional offices to improve their claims processing system, but processing times and backlogs have increased rather than decreased. At the end of fiscal year 1994, nearly 500,000 claims awaited a VA decision. About 65,000 of these were initial disability compensation claims. On average during fiscal year 1994, veterans waited more than 7 months for their initial disability claims to be decided and, if approved, payments to begin; some waited much longer. This report discusses VA's current plans to change regional office claims processing and assesses VA's plans to determine the effectiveness of those changes.

Veterans' Benefits: Effective Interaction Needed Within VA to Address Appeals Backlog (GAO/HEHS-95-190, Sept. 27, 1995)

Veterans often wait months for VA to decide their compensation and pension claims. In addition, the 40,000 veterans who appeal VA's decisions each year wait much longer—more than 2 years for a final decision, according to agency officials. GAO found that VA's appeals process is increasingly bogged down, and the outlook for the future is not bright. Legislation and court ruling expanded veterans' rights but also expanded

VA's adjudication responsibilities. VA is having difficulty integrating these responsibilities into its already complex and unwieldy adjudication process. Since 1991, the number of appeals awaiting Board action has risen by 175 percent and the average processing time has increased by more than 50 percent. Studies by GAO, VA, and others have recommended the need for autonomous organizations in VA to work together to identify and resolve problems. Yet GAO found that problems continue to go unidentified and unresolved. Unless VA clearly defines its adjudication responsibilities, it will be unable to determine whether it has the resources to meet those responsibilities and whether new solutions may be needed, including laws amending VA's responsibilities or reconfiguring the department.

Veterans' Benefits: VA Can Prevent Millions in Compensation and Pension Overpayments (GAO/HEHS-95-88, Apr. 28, 1995)

Despite its responsibility to ensure accurate benefit payments, VA continues to overpay veterans and their survivors hundreds of millions of dollars in compensation and pension benefits each year. VA has the ability to prevent millions of dollars in overpayments but has not done so because it has not focused on prevention. For example, VA does not use available information, such as when beneficiaries will become eligible for Social Security benefits, to prevent the overpayments from occurring. Furthermore, VA does not systematically collect, analyze, and use information on the specific causes of overpayments that will help it target preventive efforts.

Veterans Compensation: Offset of DOD Separation Pay and VA Disability Compensation (GAO/NSIAD-95-123, Apr. 3, 1995)

DOD uses separation pay to induce people to serve in the military despite the risk of involuntary separation. Congress authorized special separation pay to minimize the use of involuntary separations in the ongoing force drawdown. Pay offsets prevent service members from receiving dual compensation for a single period of service. Repealing offsets for separation and disability pay would cost the federal government an estimated $435 million for those service members who separated during fiscal years 1995-99. A repeal would cost about $799 million if it was made retroactive to fiscal year 1992, when the special separation pay program began. Separation and disability pay offsets have not significantly undermined the voluntary separation incentive. According to DOD, the bulk of the drawdown since fiscal year 1992 has been accomplished through voluntary separations. DOD requires the services to inform separating service members about the offset.

Veterans' Health Care: Use of VA Services by Medicare-Eligible Veterans (GAO/HEHS-95-13, Oct. 24, 1994)

Medicare-eligible veterans make substantial use of VA services not extensively covered under Medicare. GAO found that many of these veterans turn to VA specifically to obtain such services, particularly prescription drugs, inpatient psychiatric care, and long-term nursing care. Also, many Medicare-eligible veterans who use VA health care facilities have lower incomes and less private insurance than those who rely solely on Medicare, suggesting that out-of-pocket costs may have influenced veterans to turn to VA for health care. Changes to Medicare or veterans health benefits made as a result of health care reform could significantly affect future demand for VA health care services. Medicare changes that would add benefits, such as outpatient prescription drugs, or reduce beneficiary cost sharing could lower demand for VA health care services. On the other hand, VA benefit changes, such as the elimination of restrictions on access to outpatient services, improved access to care, and expanded entitlement to free care, could boost demand for VA health care. Finally, the historic reluctance of Medicare beneficiaries to enroll in HMOs could reduce their willingness to enroll in VA health plans as long as traditional fee-for-service care remains available under Medicare.

Other Related Issues

Aging Issues: Related GAO Reports and Activities in Fiscal Year 1994 (GAO/HEHS-95-44, Dec. 29, 1994)

This report compiles GAO's fiscal year 1994 products and ongoing work on older Americans and their families. Because the elderly are one of the fastest growing segments of today's society, Congress faces a host of issues—ranging from demographic changes in the structure and role of the family to financing and provision of health care, Social Security, and pensions—in which the federal government will play an important role. This booklet summarizes 30 issued reports on policies and programs directed mainly at older Americans. Included in this section are reviews of health, income security, social services, and other topics. GAO also summarizes 59 reports in which older Americans were one of several groups targeted by federal policies. For example, Medicaid finances, nursing homes and other types of long-term care, along with medical care for poor persons of all ages. In addition, this booklet describes testimonies delivered during fiscal year 1994 on subjects affecting older Americans and lists 55 ongoing jobs related to older Americans.

Health, Education, Employment, Social Security, Welfare, and Veterans Reports (GAO/HEHS-95-261W, Sept. 1, 1995)

This booklet lists GAO documents 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 Services, Labor, Education, and Veterans Affairs. One section identifies reports and testimony issued during the past months and summarizes key products. Another section lists all documents published in the past year, organized chronologically by subject. Order forms are included.

High-Risk Report

High-Risk Series: Medicare Claims (GAO/HR-95-8, Feb. 1995)

In 1990, GAO began a special effort to identify federal programs at high risk of waste, fraud, abuse, and mismanagement. GAO issued a series of reports in December 1992 on the fundamental causes of the problems in the high-risk areas. This report on Medicare claims is part of the second series that updates the status of this high-risk area. Readers have the following three options in ordering the high-risk series: (1) request any of the individual reports in the series, including the Overview (HR-95-1), the Guide (HR-95-2), or any of the 10 issue area reports; (2) request the Overview and the Guide as a package (HR-95-21SET); or (3) request the entire series as a package (HR-95-20SET).

Fiscal Year 1995 Testimonies on Issues Affecting Older Americans

GAO testified 35 times before congressional committees during fiscal year 1995 on issues relating to older Americans. Of these testimonies, 1 was on employment, 20 on health, 12 on income security, and 2 on veterans issues.

Employment Issues

Department of Labor: Rethinking the Federal Role in Worker Protection and Workforce Development (GAO/T-HEHS-95-125, Apr. 4, 1995)

Although the Department of Labor has accomplished much over the years, its current approaches to worker protection are dated and frustrate both workers and employers. What is needed is greater service orientation, improved communication, greater access to compliance information, and expanded meaningful input into the standard-setting and enforcement processes. By developing alternative regulatory strategies that supplement and even replace its current labor-intensive compliance and enforcement approach, Labor can carry out its responsibilities in a less costly, more effective manner. Similarly, in the workforce development area, the government's job training effort consists of a patchwork of federal programs with similar goals, conflicting requirements, overlapping populations, and questionable outcomes. The roughly $20 billion appropriated in fiscal year 1995 for job training assistance to adults and out-of-school youth is disbursed to 15 agencies, including Labor, which supports 163 separate programs. This situation suggests that a major overhaul and consolidation of the programs is needed.

Health Issues

Community Health Centers: Challenges in Transitioning to Prepaid Managed Care (GAO/T-HEHS-95-143, May 4, 1995)

As states move to prepaid managed care to control costs and improve access for their Medicaid clients, the number of participating community health centers continues to grow. Medicaid prepaid managed care is not incompatible with health centers' mission of delivering health care to medically underserved populations. However, health centers face substantial risks and challenges as they move into these arrangements. Such challenges require new knowledge, skills, and information systems. Centers lacking expertise and systems face an uncertain future, and those in a vulnerable financial position are at even greater risk. Today's debate over possible changes in federal and state health programs heightens the concern over the financial vulnerability of centers participating in prepaid managed care. If this funding source continues to grow as a percentage of

total health center revenues, centers must face building larger cash reserves while not compromising services to vulnerable populations.

Employer-Based Health Plans: Issues, Trends, and Challenges Posed by ERISA (GAO/T-HEHS-95-223, July 25, 1995)

As the movement for comprehensive federal health care reform has lost steam, the focus of reform has shifted to the states and private market. States remain concerned about the growing number of persons lacking health coverage and about financing health plans for poor persons. Employers have become increasingly aggressive in managing their health plans and have adopted various managed care plans and innovative funding arrangements. However, ERISA effectively blocks states from directly regulating most employer-based health plans, although it allows states to regulate health insurers. GAO found that nearly 40 percent of enrollees in employer-based health plans—44 million people—are in self-funded plans. The divided federal and state framework for regulating health plans produces a complex set of trade-offs. Self-funded plans, which are exempt from state regulation under ERISA, provide employers greater flexibility to design a health benefits package that may have been less feasible to provide under state regulation. At the same time, however, states are unable to extend regulations, such as solvency standards, preexisting condition clause limits, and guaranteed issue and renewal requirements, even indirectly, to enrollees in these self- funded plans.

Health Insurance Regulation: National Portability Standards Would Facilitate Changing Health Plans (GAO/T-HEHS-95-205, July 18, 1995)

Many Americans face discontinuity in their health care coverage when they change employers, and others do not change jobs because of concerns about losing health care coverage. GAO surveyed the status of federal and state insurance reforms and the number of individuals who would be affected by legislation to establish national portability standards. GAO found that federal and state laws reflect steps taken to improve the portability of health insurance, but the possibility remains that an individual's coverage would be reduced when changing jobs because most private health plans still require waiting periods before making people with preexisting conditions fully eligible for coverage. On the basis of existing data on the number of people who change jobs and studies on the effect of health insurance on job mobility, GAO estimates that up to 21 million Americans would benefit from legislation waiving preexisting condition exclusions for individuals who have maintained continuous health care coverage.

Medicaid: Experience With State Waivers to Promote Cost Control and Access to Care (GAO/T-HEHS-95-115, Mar. 23, 1995)

Congress has begun reexamining the $131 billion Medicaid program—one of the fastest growing components of both federal and state budgets. In 1993, Medicaid cost nearly $100 billion more and served about 10 million more low-income residents than it did a decade ago. To contain exploding costs and enrollment, many states are seeking greater flexibility in implementing statewide Medicaid managed care programs. Currently, this flexibility is available only through the waiver authority established by section 1115 of the Social Security Act. Although many states have expressed interest in waivers, only four states have waivers in place. Two additional states have received federal approval, but their plans still must be ratified by state legislatures. States face significant challenges as they move from traditional fee-for-service systems into managed care. Specifically, the emphasis that states put on program implementation and oversight may affect whether states' managed care programs successfully contain costs while increasing access to quality health care.

Medicaid: Matching Formula's Performance and Potential Modifications (GAO/T-HEHS-95-226, July 27, 1995)

When the Medicaid program was established in 1965, a matching formula was developed to narrow differences likely to arise among Medicaid programs in wealthier and poorer states. By giving poorer states a higher federal match, it was believed that disparities would be reduced across states in (1) population groups and services covered in each state program and (2) the tax burden imposed by the financing of Medicaid relative to the size of the state's financial resources. GAO testified that the matching formula, with its reliance on per capita income as a measure of state wealth, has not significantly reduced wide differences in states' Medicaid programs or the tax burdens to support them. Large disparities persist in the coverage of population groups and types of services as well as in the burdens that state taxpayers bear in financing state programs. Modifying the formula could enhance the ability of federal payments to narrow program disparities.

Medicaid: Spending Pressures Drive States Toward Program Reinvention (GAO/T-HEHS-95-129, Apr. 4, 1995)

The $131 billion Medicaid program is at a crossroads. Between 1985 and 1993, Medicaid costs tripled and the number of beneficiaries rose by more than 50 percent. Medicaid costs are projected to rise to $260 billion, according to the Congressional Budget Office. Despite federal and state budgetary constraints, several states are pressuring to expand the program and enroll hundreds of thousands of new beneficiaries. The cost of expanded coverage, they believe, will be offset by the reallocation of Medicaid funds and the wholesale movement of beneficiaries into some type of managed care arrangement. This testimony examines (1) federal

	and state Medicaid spending, (2) some states' efforts to contain Medicaid costs and expand coverage through waiver of federal requirements, and (3) the potential impact of these waivers on federal spending and on Medicaid's program structure overall.
Medicaid: State Flexibility in Implementing Managed Care Programs Requires Appropriate Oversight (GAO/T-HEHS-95-206, July 12, 1995)	Requiring states to obtain waivers to broaden use of managed care may hamper their efforts to aggressively pursue cost-containment strategies. At the same time, because current program restrictions on managed care were designed to reinforce quality assurance, their absence requires the substitution of appropriate and adequate mechanisms to protect both Medicaid beneficiaries and federal dollars. Finally, the reinvestment of managed care savings to expand Medicaid coverage to several million additional persons suggests the need for up-front consultation with Congress because of (1) the heavier financial burden such 1115 waivers may place on the federal government and (2) the issue of whether the U.S. Treasury should benefit from those savings.
Medicaid: Statewide Section 1115 Demonstrations' Impact on Eligibility, Service Delivery, and Program Cost (GAO/T-HEHS-95-182, June 21, 1995)	The growth of Medicaid, which accounted for $142 billion in federal and state outlays in 1994, is outpacing even the growth of Medicare. This is happening at a time when states are feeling pressured financially and are seeking ways to care for their uninsured populations. In response, states are, one by one, reinventing their Medicaid programs, using the authority of section 1115 waivers. Named for section 1115(a) of the Social Security Act, these waivers free states from some Medicaid restrictions on the use of managed care delivery systems. They also allow states to expand Medicaid-financed coverage to persons not normally eligible for Medicaid. This testimony presents a detailed look at Medicaid's growing expenditures, describes states' efforts to obtain section 1115 waivers, and summarizes the expenditures forecast of programs operating with waivers.
Medicare: Adapting Private Sector Techniques Could Curb Losses to Fraud and Abuse (GAO/T-HEHS-95-211, July 19, 1995)	Medicare's loss of billions of dollars to fraud and abuse could be curbed by adopting such private sector techniques as competitive bidding, use of advanced software to detect gross overpayments, and preferred networks to better control costs. Medicare's losses stem from inappropriate pricing and inadequate scrutiny of claims for payments. Further, abusive and poorly qualified providers of medical services and supplies continue to participate in the program. These problems are not unique to Medicare. However, private payers are often able to react quickly, through a variety of management approaches, whereas Medicare's pricing methods and

controls over utilization, which were consistent with health care financing and delivery when the program started, have not been adapted to today's environment.

Medicare: Allegations Against ABC Home Health Care (GAO/T-OSI-95-18, July 19, 1995)

In response to a congressional request, GAO investigated allegations against ABC Home Health Care, an HHA, and its participation in the Medicare home health care program. In the Medicare program, providers may receive reimbursement for only those expenses that are reasonable in amount and related to patient care for eligible patients. Current and former employees told GAO that local ABC officer managers directed them to alter records to make it appear that patients continued to need home health visits. Additionally, managers directed employees to continue visiting patients who, in the employees' opinion, did not qualify for home health care because they no longer met Medicare rules defining homebound status. ABC also reportedly charged Medicare for the cost of acquiring other HHAs by paying owners a small sum up front and the balance in the form of salary under employment agreements, a practice that is inconsistent with Medicare regulations for reimbursement. Finally, according to former employees, some managers directed employees to market ABC and its services with the intent of charging Medicare for costs that were not reimbursable. GAO has shared information concerning possible illegal activities with appropriate law enforcement authorities.

Medicare Claims Billing Abuse: Commercial Software Could Save Hundreds of Millions Annually (GAO/T-AIMD-95-133, May 5, 1995)

With an investment of only $20 million in off-the-shelf commercial software, Medicare could save nearly $4 billion over 5 years by detecting fraudulent claims by physicians—primarily manipulation of billing codes. On the basis of a test in which four commercial firms reprocessed samples of more than 20,000 paid Medicare claims, GAO estimates that the software could have saved $603 million in 1993 and $640 million in 1994. GAO estimates that because beneficiaries are responsible for about 22 percent of the payment amounts—mainly in the form of deductibles and copayments—Medicare could have saved them $134 million in 1993 and $142 million in 1994. The test results indicate that only a small portion of providers are responsible for most of the abuses: fewer than 10 percent of providers in the sample had miscoded claims.

Medicare: High Spending Growth Calls for Aggressive Action (GAO/T-HEHS-95-75, Feb. 6, 1995)	The government faces strong obstacles to bringing Medicare expenditures under control. Broad-based payment system reforms have slowed overall spending, but Medicare growth rates remain higher than overall inflation. And although more reforms may be needed, their nature is the subject of much debate. There is less dispute, however, that Medicare pays too much for some services and supplies. Fiscal pressures have led private and state-government payers increasingly to negotiate discounts with providers and to manage the form and the volume of care. Medicare has not exercised its potential market power in similar fashion when buying some services, such as rehabilitation therapy. GAO suggests that the government change the reimbursement policies for these excessively costly services to ensure that it is acting as a prudent buyer. Also, greater vigilance over wasteful or inappropriate payments could better protect Medicare against fraudulent and abusive billings from providers.
Medicare: Increased Federal Oversight of HMOs Could Improve Quality of and Access to Care (GAO/T-HEHS-95-229, Aug. 3, 1995)	This testimony discusses problems that HCFA has had monitoring HMOs it contracts with to provide services to Medicare beneficiaries and ensuring that they comply with Medicare's performance standards. GAO found weaknesses in HCFA's quality assurance monitoring, enforcement measures, and appeal processes. Although HCFA routinely reviews HMO operations for quality, these reviews are generally perfunctory and do not consider the financial risks that HMOs transfer to providers. Moreover, HCFA collects virtually no data on services received through HMOs to enable HCFA to identify providers who may be underserving beneficiaries. In addition, HCFA's HMO oversight has two other major limitations: enforcement actions are weak and the beneficiary appeal process is slow. HCFA's current regulatory approach to ensuring good HMO performance appears to GAO to lag behind the private sector.
Medicare Managed Care: Enrollment Growth Underscores Need to Revamp HMO Payment Methods (GAO/T-HEHS-95-207, July 12, 1995)	Rapid growth in the number of Medicare beneficiaries in HMOs increases the urgency of correcting rate-setting flaws that result in unnecessary Medicare spending. By not tailoring its HMO capitation payment to how healthy or sick HMO enrollees are, HCFA cannot realize the savings that private-sector payers capture from HMOs. Two lessons can be learned from GAO's review of ways to fix Medicare's HMO capitation payments. First, a multipronged approach to rate setting makes sense. The large disparities in market conditions between states call for solutions keyed to market conditions. Second, with respect to achieving the promise of such initiatives, details matter. How these strategies are designed and implemented could mean the difference between success and failure. GAO

believes that in the short term, HCFA can overcome its capitation problem by introducing a better health status risk adjustor. HCFA should also promptly test competitive bidding and other promising approaches to setting HMO rates that reduce Medicare costs.

Medicare Managed Care: Program Growth Highlights Need to Fix HMO Payment Problems (GAO/T-HEHS-95-174, May 24, 1995)

Rapid growth in the number of Medicare beneficiaries enrolled in HMOs increases the urgency of correcting rate-setting flaws that undermine the cost-saving potential of managed care for Medicare. Medicare has paid HMOs much more than it would have paid traditionally more expensive fee-for-service providers. Two lessons can be learned from GAO's review of ways to fix Medicare's HMO capitation payments. First, a multipronged approach to rate setting makes sense. The large disparities in market conditions between states—from California to Maine—call for solutions keyed to market conditions. Second, with respect to achieving the promise of such initiatives, details matter. How these strategies are designed and implemented could mean the difference between success and failure. GAO believes that in the short term, HCFA can overcome its capitation rate problem by introducing a better health status risk adjuster. HCFA should also promptly test competitive bidding and other promising approaches to setting HMO rates that reduce Medicare costs.

Medicare: Modern Management Strategies Could Curb Fraud, Waste, and Abuse (GAO/T-HEHS-95-227, July 31, 1995)

Medicare's vulnerability to waste, fraud, and abuse stems from several factors: (1) higher than market rates for some services, (2) inadequate checks for detecting fraud and abuse, (3) superficial criteria for confirming the authenticity of providers billing the program, and (4) weak enforcement efforts. Various health care management techniques help private payers overcome these programs, but Medicare generally does not use these methods. The program's pricing methods and controls over utilization have not kept pace with financing and delivery changes during the past 30 years. To some extent, the predicament inherent in public programs—the uncertain line between adequate managerial control and excessive government intervention—helps explain the dissimilarity in the ways that Medicare and private health insurers run their respective "plans." GAO believes that a viable strategy for remedying the program's weaknesses involves adapting the health care management approach of private payers to Medicare's public payer role.

Medicare: Modern Management Strategies Needed to Curb Program Exploitation (GAO/T-HEHS-95-183, June 15, 1995)

Medicare's vulnerability to provider exploitation of its billing system stems from a combination of factors: (1) higher than market rates for some services, (2) inadequate checks for detecting fraud and abuse, (3) superficial criteria for confirming the authenticity of providers billing the program, and (4) weak enforcement efforts. Various health care management techniques help private payers avoid these problems, but Medicare generally does not use these techniques. The program's pricing methods and controls over utilization have not kept pace with changes in health care financing and delivery. To some extent, the predicament inherent in public programs—the uncertain line between adequate managerial control and excessive government intervention—helps explain the dissimilarity in the ways in which Medicare and private health insurers run their respective "plans." GAO believes that a viable strategy for remedying the program's weaknesses consists of adapting the health care management approach of private payers to Medicare's public payer role. This would entail (1) more competitively developed payment rates, (2) beefed-up fraud and abuse detection that uses modern information systems, and (3) more rigorous criteria for granting authorization to bill the program.

Medicare: Opportunities Are Available to Apply Managed Care Strategies (GAO/T-HEHS-95-81, Feb. 10, 1995)

Although the private sector quickly embraced managed care as an effective way to control the growth of health care costs, Medicare has moved more slowly. GAO believes that Medicare could benefit from the experience of the private sector and should test such managed care strategies as competitive bidding for HMOs. Using market power to negotiate with HMOs over price and increasingly over quality and the production of report-card-type information, large employers are becoming more prudent and sophisticated purchasers of health care. The particulars of these efforts may not be directly transferable to the federal government, but their goals of using incentive-based solutions to contain costs, guarantee quality, and inform consumers are worthy of consideration and testing.

Medicare: Rapid Spending Growth Calls for More Prudent Purchasing (GAO/T-HEHS-95-193, June 28, 1995)

Last year, federal spending for Medicare totaled $162 billion—more than $440 million a day. In March 1995, the Congressional Budget Office estimated that these outlays would approach $350 billion by 2002. In 2005, they could exceed $460 billion unless changes are made. This testimony discusses ways in which the Medicare program could avoid excessive or unnecessary spending. GAO examines areas of rapid spending growth and

ways to conserve program dollars—mainly by revising reimbursement policies and better controlling unwarranted use of services.

Medicare: Reducing Fraud and Abuse Can Save Billions (GAO/T-HEHS-95-157, May 16, 1995)

Medicare is overwhelmed in its efforts to keep pace with, much less stay ahead of, those bent on cheating the system. Various factors converge to create a particularly rich environment for profiteers. These include the following: (1) weak fraud and abuse controls to detect questionable billing practices, (2) few limits on those who may bill—companies using post office box numbers have qualified to bill the program for virtually unlimited amounts—and (3) overpayment for services. This testimony describes how providers exploit the system, why they are able to do so, and what steps Medicare has taken and what remains to be done to protect the program and the taxpayers against fraudulent reimbursement schemes and abusive billing practices.

Income Security Issues

Congressional Retirement Issues (GAO/T-GGD-95-165, May 15, 1995)

The retirement benefits provided by the Civil Service Retirement System for Members of Congress are generally more generous than those provided for other federal employees. The major differences are found in the eligibility requirements for retirement and the formulas used to calculate benefits. The Member benefit formula applies to congressional staff, but they are covered by the general employee retirement eligibility requirements. Law enforcement officers and firefighters may retire earlier than general employees and are covered by a more generous benefit formula than are general employees. Under the Civil Service Retirement System, the provisions for air traffic controllers fall between those for law enforcement officers and firefighters and those for general employees. Many of the advantages afforded to Members of Congress and congressional staff under the Civil Service Retirement System were continued under the Federal Employees Retirement System, which covers workers hired in 1985 and thereafter. But under the Federal Employee Retirement System, provisions for law enforcement officers, firefighters, and air traffic controllers are very similar to provisions for Members.

Disability Insurance: Broader Management Focus Needed to Better Control Caseload (GAO/T-HEHS-95-164, May 23, 1995)

Rising numbers of applicants for disability benefits have increased workloads at SSA and led to growing backlogs of claims. As a result, applicants are waiting longer to find out if they have been awarded benefits. Applicants wait almost 90 days to learn whether they have been awarded benefits, while persons who appeal their claims to SSA's administrative law judges wait more than a year. These long waits can impose substantial hardship on applicants, particularly those with limited incomes and no medical insurance. SSA has undertaken several short-term initiatives to address the backlog problem. It has also begun a long-term effort to redesign its disability determination process. GAO shares congressional concerns that these changes may sacrifice decisional accuracy for faster processing. SSA is also addressing its workload increases while dealing with substantial resource constraints. Nonetheless, SSA needs to focus more attention on terminating benefits for those who are no longer eligible and encouraging beneficiaries to return to work. SSA, now an independent agency, also needs to provide more data and advice to Congress on matters affecting disability insurance policy.

Federal Downsizing: The Administration's Management of Workforce Reductions (GAO/T-GGD-95-108, Mar. 2, 1995)

The Federal Workforce Restructuring Act of 1994 requires the federal government to eliminate about 270,000 positions between 1993 and 1999. To accomplish this downsizing without a reduction-in-force, the act allows federal agencies to offer buyouts to employees who agree to resign or retire by March 31, 1995. This testimony discusses (1) the administration's compliance with the act, including which positions are counted toward full-time-equivalent reductions and from what baseline, and whether savings from the reductions are being used to pay for the Violent Crime Control and Law Enforcement Act of 1994; (2) the targets of workforce downsizing; and (3) how the workforce reductions are being managed.

Federal Downsizing: The President's Fiscal Year 1996 Budget and Its Compliance With the Federal Workforce Restructuring Act of 1994 (GAO/T-GGD-95-105, Mar. 30, 1995)

GAO's analysis of the President's fiscal year 1996 budget shows that government agencies are well on their way to achieving the downsizing goals mandated by the Federal Workforce Restructuring Act. Although payroll savings will no doubt accrue from these reductions, some of the projected savings may be offset by costs associated with what agencies do with the work previously done by separated employees. To the extent that work is shifted to other employees, contracted out, or transferred to other agencies, downsizing's true savings to taxpayers may be reduced.

Federal Retirement Issues (GAO/T-GGD-95-111, Mar. 10, 1995)	This testimony focuses on ongoing GAO work on two issues involving federal employee retirement programs. First, GAO compares the retirement provisions for Members of Congress and congressional staff in the Civil Service Retirement System and the Federal Employees Retirement System with the provisions applicable to other employees covered by these systems. Second, GAO analyzes retirement programs in the private sector and state government.
Federal Retirement System Financing (GAO/T-GGD-95-197, June 28, 1995)	Federal retirement system financing is a complex issue. This testimony seeks to bring some perspective to the subject by describing how the government finances its retirement system and by describing the budget implications of the financing methods being used and possible changes to these methods. GAO concentrates on the Civil Service Retirement System and the Federal Employees Retirement System because they are the largest retirement programs for federal workers.
Means-Tested Programs: An Overview, Problems, and Issues (GAO/T-HEHS-95-76, Feb. 7, 1995)	Nearly 80 means-tested programs have been created over the years for low-income people. In fiscal year 1992, the federal government spent about $208 billion on these programs to meet the needs of poor Americans of all ages. The many means-tested programs are costly and difficult to administer. On the one hand, the programs sometimes overlap one another; on the other hand, they are often so narrowly focused that service gaps hinder clients. GAO notes that although advanced computer technology is essential to the programs operating efficiently, it is not being effectively developed or used. Due to their size and complexity, many of these programs are vulnerable to waste, fraud, and abuse. Moreover, the welfare system is often difficult for clients to use effectively. Finally, administrators have not articulated clear goals and objectives for some programs and have not collected data on how well the programs are working.
Overview of Federal Retirement Programs (GAO/T-GGD-95-172, May 22, 1995)	This testimony describes how the federal retirement systems work, the benefits they provide, and how they compare with private sector programs. GAO concentrates on the Civil Service Retirement System and the Federal Employees Retirement System because they are the largest retirement systems for federal civilian personnel. GAO describes the history of the two retirement systems and discusses four issues that are often raised in connection with federal retirement: (1) retirement eligibility provisions, (2) benefit formulas, (3) COLAs, and (4) system financing.

Social Security Disability: Management Action and Program Redesign Needed to Address Long-Standing Problems (GAO/T-HEHS-95-233, Aug. 3, 1995)

SSA has serious problems managing its disability insurance and SSI programs. First, the lengthy and complicated decision-making process results in untimely decisions, especially for those who appeal, and shows troubling signs of inconsistency. Second, SSA has a poor record of reviewing beneficiaries to determine whether they remain eligible for benefits and an even worse record of providing rehabilitation to help move people off the disability rolls and into employment. This reinforces the public perceptions that SSA pays disability benefits to persons who are not entitled to them. Third, SSA needs to make better decisions about work capacity to restore public confidence and to better serve beneficiaries. Although these problems are serious, solutions do exist. GAO believes that relatively quick action could be taken to reduce inconsistent decisionmaking, step up review of beneficiaries who may be able to return to work, and improve rehabilitation outcomes. In some cases, SSA has the authority to take action, in others, decisionmakers may need to rethink the goals and objectives of the disability programs.

Social Security: Federal Disability Programs Face Major Issues (GAO/T-HEHS-95-97, Mar. 2, 1995)

This testimony discusses the reasons for the tremendous growth in federal disability programs during the past 10 years, including program factors and social changes. GAO also comments on the impact of fraud and abuse on this growth and its effect on program integrity. In addition, GAO notes legislative reforms included in the Social Security Independence Act last year that tried to improve program integrity. Finally, GAO discusses weaknesses in SSA's efforts to return Disability Insurance and SSI beneficiaries to work.

Supplemental Security Income: Recent Growth in the Rolls Raises Fundamental Program Concerns (GAO/T-HEHS-95-67, Jan. 27, 1995)

This testimony discusses the growth of SSI rolls and changes in the characteristics of SSI recipients. Last year, SSA paid nearly $22 billion in federal benefit payments to about 6.3 million aged, blind, and disabled SSI recipients. Since 1986, payments have risen by $13.5 billion, more than doubling. Benefits for the disabled accounted for nearly 100 percent of this increase. Since 1986, the number of disabled SSI recipients under age 65 has increased an average of more than 8 percent annually, adding nearly 2 million younger recipients to the rolls, while the number of aged and blind recipients has remained level. The trend toward younger beneficiaries, coupled with low exit rates from the program, means that costs will continue to burgeon in the near term. Without a slowing in the growth of this younger population, SSI will become even more costly. Since 1991, three groups—disabled children, legal immigrants, and adults with mental problems—have accounted for nearly 90 percent of the SSI

caseload growth. Of the 2 million mentally disabled adults, roughly 100,000 are disabled mainly by drug addiction or alcoholism. The dramatic increases pose fundamental questions about eligibility standards, accountability, and program effectiveness.

Supplemental Security Income: Recipient Population Has Changed as Caseloads Have Burgeoned (GAO/T-HEHS-95-120, Mar. 27, 1995)

The SSI program provides means-tested income support payments to eligible aged, blind, or disabled persons. Last year, more than 6 million SSI recipients received nearly $22 billion in federal benefits and more than $3 billion in state benefits. SSI is one of the fastest growing entitlement programs, with program costs soaring 20 percent annually during the past 4 years. This testimony focuses on factors contributing to caseload growth, characteristics of SSI recipients, and ways to improve SSI.

Veterans/DOD Issues

VA Health Care: Challenges and Options for the Future (GAO/T-HEHS-95-147, May 9, 1995)

VA lags far behind the private sector in improving the efficiency of its hospitals. During the past decade, GAO has highlighted a series of management problems limiting VA's ability to (1) improve the efficiency and the effectiveness of its hospitals and (2) shift more of its inpatient care to less costly ambulatory settings. Although VA plans a major reorganization and other initiatives to improve its management capabilities, GAO remains concerned that some of the actions may not go far enough. Even if it improves the efficiency of its hospitals, VA is at a crossroads in the evolution of its health care system. The average daily workload in its hospitals dropped about 56 percent during the past 25 years, and further decreases are likely. At the same time, however, demand for outpatient care, nursing home care, and some specialized services is expanding, taxing VA's ability to meet veterans' needs. GAO concludes that a complete reevaluation of the VA health care system is needed. Absent such an effort, use of VA hospitals will likely continue to decline to a point at which VA's ability to provide quality care and support its secondary missions will be jeopardized.

VA Health Care: Issues Affecting Eligibility Reform (GAO/T-HEHS-95-213, July 19, 1995)

In this testimony GAO summarizes the results of a number of reviews that have detailed problems in administering VA's outpatient eligibility provisions; compared VA benefits and eligibility to those of other public and private health benefits programs; and assessed VA's role in a changing health care marketplace. In summary, veterans' eligibility for VA health

care has evolved over time both in terms of the types of veterans eligible for care and the services they are eligible to receive. VA has gone from a system primarily covering hospital care for veterans with war-related injuries to a system covering a wide array of hospital and other medical services for both wartime and peacetime veterans and both veterans with and without service-connected disabilities. VA now has multiple categories of veterans eligibility based on a number of factors.

Ongoing Work as of September 30, 1995, on Issues Affecting Older Americans

At the end of fiscal year 1995, GAO had 52 ongoing assignments that affected older Americans. Of these, 1 was on employment, 29 on health, 13 on income security, and 9 were on veterans issues.

Employment Issues

Survey of the Department of Labor's Administration of the Senior Community Services Employment Program (code 205270)

Health Issues

Alternative Methods of Payment in Medicare HMOs (code 101372)

Analysis of Factors That Determine Enrollment in Medicare HMOs (code 101374)

Assistance and Analyzing Formula Options for Allocating Medicaid Funds (code 118116)

Centers for Disease Control and Prevention (CDC) Public Health Block Grant (code 118106)

Enrollment Bias May Result in Overpayments to Medicare HMOs (code 101369)

Extent of Medical Underwriting in the Medical Supplemental Insurance Market (code 106429)

Federal Programming and State Innovations in Long-Term Services for Persons With Mental Retardation and Developmental Disabilities (code 101341)

Fraud and Abuse in Managed Health Care (code 101349)

HCFA Management of Medicare Medical Policies (code 101307)

Health Care Reform: States' Use of Medicaid Waivers to Expand Access (code 108200)

Implications of Limits on Hospital Lengths of Stay (code 108252)

Medicaid Prescription Abuse (code 600400)

Medicaid Prospective Drug Utilization Review (DUR) Impact (code 511188)

Medicare Billing Abuse (code 511194)

Medicare Managed Care: Access to Medical Specialist in HMOs and Preferred Provider Organizations (PPO) (code 108255)

Medicare Quality Assurance Strategies (code 101468)

Medicaid: State Accountability for Financial and Quality Issues in Managed Care Programs (code 101385)

Nursing Home Billing Abuses (code 101291)

Quality of Subacute Care in Medicare (code 101476)

Recent Growth of Medicare Home Health Care (code 106422)

Review of End Stage Renal Disease Medical Services (code 106416)

Review of Federal Oversight of Facilities for Persons With Mental Retardation or Developmental Disabilities (code 101342)

Review of HUD's Hospital and Nursing Home Mortgage Insurance Programs (code 108213)

Review of Implementation of Medicare Insured Group (MIG) Demonstration Projects (code 106426)

Review of Medicare Marketing Practices (code 101381)

Review of Rural Health Clinic Program (code 108254)

Review of State Medicaid Managed Care Programs for the Chronically Ill (code 101376)

Study of Medicare Managed Care Program Growth (code 101333)

Survey of Medicare Part B Appeal Process (code 106424)

Income Security Issues

Costs of Congressional Retirement Benefits (code 966651)

Comparison of the Features of All Retirement Systems for Federal Personnel (code 966678)

Effectiveness of SSI Matching (code 106800)

How Useful Are Personal Earnings and Benefits Estimate Statements to the Public? (code 105934)

Improving SSA's Customer Service (code 105933)

Public Supplemental Pensions (code 207442)

Preventing SSI Overpayments (code 105145)

Transfer of Resources in SSI (code 106801)

Social Security and SSA Death List (code 600402)

SSI Redetermination Process (code 106900)

SSA Overpayments Recoveries (code 106805)

State and Local Pension Plans (code 105686)

Women and Social Security (code 105678)

Veterans Issues

Hispanic Veterans (code 105741)

VA Disability Rating Schedule (code 105739)

VA Home Health Care (code 101454)

VA Major Construction Projects (code 406106)

VA Nursing Homes (code 101471)

VA Outpatient Clinic (code 406103)

VA's Community-Based Outreach (code 406077)

VA's Sale of Excess Service (code 406094)

VA's Vocational Rehabilitation Program (code 105744)

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