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Health
Education
Employment
Social Security
Welfare
Veterans

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Preface

The General Accounting Office (GAO), an arm of the Congress, was established to independently audit government agencies. GAO's Health, Education, and Human Services (HEHS) Division reviews the government's health, education, employment, social security, disability, welfare, and veterans programs administered in the Departments of Health and Human Services, Labor, Education, Veterans Affairs, and some other agencies.

This file contains selected key reports and testimonies issued by GAO on these programs in April and May 1995. These summaries were taken from Health, Education, and Human Services Division Reports, a monthly booklet which contains the following information:

- Most Recent GAO Products: This section identifies reports and testimonies issued during the past 2 months and provides summaries for selected key products

- Comprehensive 2-Year Listings: This section lists all products published in the last 2 years, organized chronologically by subject. When appropriate, products may be included in more than one subject area.

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Janet L. Shikles
Assistant Comptroller General

Contents

Abbreviations

AFDC	Aid to Families With Dependent Children
AIDS	acquired immunodeficiency syndrome
BLS	Bureau of Labor Statistics
CARE	Comprehensive AIDS Resources Emergency Act
CDC	Centers for Disease Control and Prevention
CDR	continuing disability review
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
DEA	Drug Enforcement Agency
DC	District of Columbia
DI	Disability Insurance
DOD	Department of Defense
DOE	Department of Energy
EEO	Equal Employment Opportunity
EEOC	Equal Employment Opportunity Commission
EMA	eligible metropolitan area
ERISA	Employee Retirement Income Security Act of 1974
ESEA	Elementary and Secondary Education Act
FDA	Food and Drug Administration
FSA	Family Support Act
GAO	General Accounting Office
GPRA	Government Performance and Results Act
HCFA	Health Care Financing Administration
HEAF	Higher Education Assistance Foundation, Department of Education

HEHS	Health, Education, and Human Services Division, GAO
HHS	De

Most Recent GAO Products (April - May 1995)

Health

Selected Summaries

Medicare: Reducing Fraud and Abuse Can Save Billions (Testimony, 5/16/95, GAO/T-HEHS-95-157).

Medicare is highly vulnerable to fraud and abuse. The program 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, including (1) weak fraud and abuse controls to detect questionable billing practices, (2) few limits on those who can bill, and (3) overpaying for services. These problems are exacerbated by a combination of factors involving the program's budget, management, and leadership. Despite some recent Health Care Financing Administration (HCFA) initiatives, solving these problems will require both greater investment in the people and technology needed to manage efforts to ensure that federal dollars are spent appropriately and more demanding standards for providers seeking authority to bill Medicare.

Medicare Managed Care: Program Growth Highlights Need to Fix HMO Payment Problems (Testimony, 5/24/95, GAO/T-HEHS-95-174).

GAO found that recent enrollment growth in Medicare health maintenance organizations (HMO) has been rapid, increasing the urgency of correcting rate-setting flaws that result in unnecessary Medicare spending. Because it does not tailor its HMO capitation payment to how healthy or sick HMO enrollees are, HCFA cannot realize the savings that private-sector payers are able to capture from HMOs. Although HCFA is planning demonstration projects to study ways to correct its HMO rate-setting method, results are likely to be years away. GAO believes that, in the short term, HCFA can mitigate its capitation rate problem by introducing a better health status risk adjuster. HCFA also should proceed promptly to test competitive bidding and other promising approaches to setting HMO rates that reduce Medicare costs. Given the recent acceleration in Medicare's HMO enrollment growth, GAO believes that correcting Medicare's HMO payment rate problems should become a HCFA priority.

Community Health Centers: Challenges in Transitioning to Prepaid Managed Care (Report, 5/4/95, GAO/HEHS-95-138). Testimony on same topic (5/4/95, GAO/T-HEHS-95-143).

In response to the changing health care environment, an increasing number of community health centers are participating in Medicaid prepaid managed care arrangements. While centers continue to serve vulnerable populations, prepaid managed care exposes the centers to significant financial risks. By 1993, almost one-half million community health center patients were covered by prepaid Medicaid managed care arrangements, an increase of 55 percent from 1991. Despite initial concerns that the centers' ability to provide services to vulnerable populations would be diminished, GAO found this was not the case in the 10 centers it visited, in part because the centers receive other revenues. While maintaining or expanding their medical and enabling services, all 10 health centers also improved their overall financial positions to some degree. However, even with improved overall financial positions, some health centers may be still vulnerable to financial difficulties.

Prescription Drug Prices: Official Index Overstates Producer Price Inflation (Report, 4/28/95, GAO/HEHS-95-90).

Recent research indicates that the producer price index for prescription drugs (PPI-Drugs) published by the Bureau of Labor Statistics (BLS), the official wholesale level index of U.S. drug prices, has overstated drug price increases substantially since at least 1984. This overstatement has three causes. First, before 1994, BLS used a market basket (sample) of drugs that underrepresented new and recently introduced drugs in the market. This sampling problem alone led PPI-Drugs to overstate drug inflation between 1984 and 1991 by an estimated 23 to 36 percent. Second, the index does not account for the cost savings incurred when consumers switch to lower priced substitutes, such as generics. Third, PPI-Drugs does not adequately separate pure price changes, which constitute inflation, from price changes that reflect different product characteristics, such as fewer side effects. Some progress has been made in addressing the causes of the overstatement.

Medicaid Managed Care: More Competition and Oversight Would Improve California's Expansion Plan (Report, 4/28/95, GAO/HEHS-95-87).

California plans a major expansion of its Medi-Cal managed care program in selected counties. Problems identified to date in a primarily voluntary enrollment program could be significantly magnified in a much larger

program with mandatory enrollment. GAO is concerned about whether the state will monitor managed care plans effectively enough to minimize any adverse effects on the availability and quality of health care provided to Medicaid enrollees placed in mandatory managed care. A vital factor in the success of the program will be the capabilities of the state's contract management staff. GAO is also concerned that the state does not give enough attention to the magnitude of financial incentives for providers to limit needed care and that the state has difficulty verifying whether services it pays for are actually provided, including preventive care for children. GAO believes that any benefits of competitive managed care will be lessened by the state's decision to limit beneficiaries in selected areas to choosing between two health plans.

Indian Health Service: Improvements Needed in Credentialing Temporary Physicians (Report, 4/21/95, GAO/HEHS-95-46).

The Indian Health Service (IHS) has unknowingly allowed temporary physicians with disciplinary actions taken against their licenses to treat patients. As a result, these patients may have been placed at risk of receiving substandard care. IHS' credentials and privileges policy does not explicitly require verifying all active and inactive state medical licenses that a physician may have. Rather, the policy requires that a physician have a current medical license with no restrictions against it to practice medicine. Furthermore, most IHS facilities that have contracts with private companies that supply temporary physicians do not require the companies to inform IHS of the status of all medical licenses a physician may hold. IHS facilities do not have a formal network to share information on the performance of temporary physicians who have worked with the IHS medical system. Therefore, IHS facilities are not always aware of temporary physicians who have had performance or disciplinary problems.

Long-Term Care: Current Issues and Future Directions (Report, 4/13/95, GAO/HEHS-95-109).

Long-term care consists of many different services aimed at helping people with chronic conditions compensate for limitations in their ability to function independently. More than 12 million Americans—young and old—report some long-term care need, and more than 5 million are estimated to be severely disabled. Expenditures for long-term care, particularly institutional care, are high. In 1993, of nearly $108 billion spent, about 70 percent paid for institutional care. Both federal and state governments provide most of the money for long-term care through

dozens of categorical funding streams. The financial burden on families, who pay over a third of the long-term care bill out of pocket, is also high. To guard against financial loss, a small but growing number of individuals are purchasing private long-term care insurance policies. Families also bear a considerable nonmonetary burden by caring for relatives. Recognizing this, some employers have begun to offer more flexible schedules and other assistance to help employees balance work and caregiving.

Ryan White Care Act of 1990: Opportunities Are Available to Improve Funding Equity (Testimony, 4/5/95, GAO/T-HEHS-95-126). Testimony on same topic (2/22/95, GAO/T-HEHS-95-91). Correspondence on same topic (2/14/95, GAO/HEHS-95-79R, and 3/31/95, GAO/HEHS-95-119R).

GAO found that the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990 funding formulas result in per case funding disparities that are, to a large extent, unrelated to service costs or to the ability of states and eligible metropolitan areas (EMA) to fund services from local sources. These funding disparities result from the fact that (1) EMA cases are inappropriately double counted in both the formula for EMAs and the title II formula for states, (2) the formulas contain no indicator that reflects differences in the cost of providing services in both states and EMAs, and (3) formula factors inappropriately measure caseloads and funding capacity. GAO believes that greater funding equity could be achieved by changing the structure of the two titles to correct the bias introduced by double counting EMA AIDS cases and by using more appropriate measures of EMA and state funding needs.

Medicaid: Spending Pressures Drive States Toward Program Reinvention (Report, 4/4/95, GAO/HEHS-95-122). Testimony on same topic (GAO/T-HEHS-95-129).

Medicaid costs are projected to increase from about $131 billion to $260 billion by the year 2000, according to the Congressional Budget Office. Between 1985 and 1993, federal Medicaid expenditures grew each year, on average, by 16 percent. In the mid-1980s, some states began using creative financing mechanisms to leverage additional federal dollars. More recently, states began seeking section 1115 waivers designed to contain the cost of their Medicaid programs through the use of capitated managed care delivery systems and expand coverage to uninsured individuals who would not normally qualify for Medicaid benefits. GAO's analysis of four states with approved waivers shows that Florida, Hawaii, and Oregon may

obtain more federal funding than they would have likely received under their original Medicaid programs. While these expansions will extend health care benefits to more low-income individuals, the result could also be a heavier burden on the federal budget.

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

Different advantages and disadvantages for each of the three basic approaches to restructuring Medicaid—federal block grants, federalizing the program, or splitting responsibility between federal and state governments—have been cited by observers and proponents. GAO found that all discussions identified to restructure Medicaid have focused on the altered financing arrangements and lacked information on how elements of program design would be structured. Further, little quantitative analysis has been done to determine any of the potential effects of restructuring. GAO's statistical analysis demonstrates the important influence of the business cycle on Medicaid spending. A rainy day fund could be one way to assist states during economic downturns if strong limits are placed on federal contributions. GAO found that in at least 22 states, including 8 of the 10 largest states, Medicaid spending is sensitive to state economic conditions. On average, Medicaid spending rises by 6 percent for every 1 percentage point increase in the unemployment rate.

Other Health Products

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

Vaccines for Children: Barriers to Immunization (Testimony, 5/4/95, GAO/T-PEMD-95-21).

Financial Audit: U.S. Senate Health Promotion Revolving Fund for the Periods Ended 9/30/93 and 12/31/92 (Report, 5/3/95, GAO/AIMD-95-105).

Maine Practice Guidelines (Letter, 4/4/95, GAO/HEHS-95-118R).

Education

Selected Summaries

School Safety: Promising Initiatives for Addressing School Violence (Report, 4/25/95, GAO/HEHS-95-106).

The four school-based violence-prevention programs—in Anaheim and Paramount, California; Dayton, Ohio; and New York City—that we visited all show initial signs of success. Violence-prevention literature and experts consistently associate at least seven characteristics with promising school-based violence-prevention programs. These characteristics are (1) a comprehensive approach, (2) an early start and long-term commitment, (3) strong leadership and disciplinary policies, (4) staff development, (5) parental involvement, (6) interagency partnerships and community linkages, and (7) a culturally sensitive and developmentally appropriate approach. Although few violence-prevention programs have been evaluated, efforts are under way to identify successful approaches for curbing school violence. For example, for fiscal years 1993 and 1994, GAO identified 26 federal grants (approximately $28 million) that help to evaluate the effectiveness of various school-based violence prevention programs.

School Facilities: America's Schools Not Designed or Equipped for 21st Century (Report, 4/4/95, GAO/HEHS-95-95). Testimony on same topic (4/4/95, GAO/T-HEHS-95-127).

School officials in a national sample of schools reported that although most schools meet many key facilities requirements and environmental conditions for education reform and improvement, most are unprepared for the 21st century in critical areas. Most schools do not fully use modern technology. Over 14 million students attend about 40 percent of schools that reported that their facilities cannot meet the functional requirements of laboratory science or large-group instruction even moderately well. Although education reform requires facilities to meet the functional requirements of key support services, about two-thirds of schools reported that they cannot meet the functional requirements of before- or after-school care or day care. Moreover, not all students have equal access to facilities that can support education into the 21st century, even those attending school in the same district.

Department of Education: Information on Consolidation Opportunities and Student Aid (Testimony, 4/6/95, GAO/T-HEHS-95-130).

The Department of Education's budget, in fiscal year 1995, accounts for about $33 billion of the estimated $70 billion in federal education assistance. The Department administers 244 education programs, and 30 other federal agencies administer another 308. The Department has already proposed several programs as candidates for consolidation. Some portion of an additional 151 programs administered by both the Department and other federal agencies may also present an opportunity to streamline federal education spending. Additional factors need to be considered in determining maximum efficiency from consolidation. For example, determining how to achieve a coordinated delivery of services at the local level needs to be considered. Concerning student aid, the Department's budget proposal may overstate the cost savings associated with fully implementing direct lending under credit reform rules, but substantial savings could still accrue. In addition, it is too early to evaluate the effectiveness of recent Department initiatives to improve its oversight of student aid programs.

Employment

Selected Summaries

EEOC: Burgeoning Workload Calls for New Approaches (Testimony, 5/23/95, GAO/T-HEHS-95-170).

The Equal Employment Opportunity Commission's (EEOC) world has changed drastically since EEOC was established by the Civil Rights Act of 1964. By law, EEOC must accept for possible investigation every charge of employment discrimination. It is burdened with a growing and aging inventory of pending charges. In addition, because of employees' increased awareness of their rights and the number of nondiscrimination laws, EEOC faces a large and growing inflow of new charges. To continue to approach its mission as it has in the past and reduce the current inventory of pending charges, EEOC would require large numbers of new staff. In the current economic climate, however, substantial increases in staff to handle EEOC's burgeoning workload are unlikely. EEOC recognizes its dilemma. It has discontinued its long-standing policy of fully investigating every charge in favor of a policy that targets investigative resources on the basis of the strength of a charge's evidence of discrimination. Beginning

October 1, 1995, EEOC will attempt to settle selected cases through mediation before using the traditional charge process.

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

GAO's work suggests that although the Department of Labor has accomplished much over its history, its current approaches to worker protection are dated and frustrate both workers and employers. What is needed, according to the employers and employees GAO spoke with, is a greater service orientation: improved communication, increased employers' and workers' accessibility to compliance information, and expanded meaningful input into the standard-setting and enforcement processes. By developing alternative regulatory strategies that supplement and in some instances might replace its current labor-intensive compliance and enforcement approach, Labor can carry out its statutory responsibilities in a less costly, more effective manner. Similarly, in the workforce development area, the nation's job training programs have become increasingly fragmented and unclear. What exists today, spread across many federal agencies, is a patchwork of federal programs with similar goals, conflicting requirements, overlapping populations, and questionable outcomes.

Other Employment Products

Personnel Practices: Selected Characteristics of Recent Ramspeck Act Appointments (Testimony, 5/24/95, GAO/T-GGD-95-173).

Title 6 T&A Data (NASA) (Letter, 5/23/95, GAO/AIMD-95-140R).

Title 6 T&A Data (NRC) (Letter, 5/23/95, GAO/AIMD-95-139R).

Sunday Premium Pay: Millions of Dollars in Sunday Premium Pay Are Paid to Employees on Leave (Report, 5/19/95, GAO/GGD-95-144).

Employees' Travel Claims (USIA) (Letter, 5/19/95. GAO/AIMD-95-138R).

Federal Affirmative Employment: Progress of Women and Minority Criminal Investigators at Selected Agencies (Report, 4/25/95, GAO/GGD-95-85).

Federal Quality Management: Strategies for Involving Employees (Report, 4/18/95, GAO/GGD-95-79).

Administratively Uncontrollable Overtime (Letter, 4/14/95, GAO/GGD-95-129R).

Equal Opportunity: DOD Studies on Discrimination in the Military (Report, 4/7/95, GAO/NSIAD-95-103).

Social Security, Disability, and Welfare

Selected Summaries

Welfare Programs: Opportunities to Consolidate and Increase Program Efficiencies (Report, 5/31/95, GAO/HEHS-95-139).

About 80 welfare programs provide assistance to low-income individuals and families; federal expenditures for these programs totaled $223 billion in 1993. These myriad welfare programs—each with its own rules and requirements—are difficult for families in need to access and cumbersome for program administrators to operate. GAO has identified several program areas—including employment training, food assistance, and early childhood programs—where numerous programs target the same clients, share the same goals, and provide similar services. Confronted with this complex system, state governments and local providers have sought to streamline program operations and service delivery. However, such efforts are hindered by the patchwork of federal programs and funding streams. To streamline this system, the Congress and the administration are considering consolidating specific federal programs, including employment training, child care subsidy, and housing programs.

Foster Care: Health Needs of Many Young Children Are Unknown and Unmet (Report, 5/26/95, GAO/HEHS-95-114).

GAO's work indicates that a significant proportion of young foster children did not receive critical health-related services in the three locations reviewed—Los Angeles County, New York City, and Philadelphia County. Despite state and county foster care agency regulations requiring comprehensive routine health care, an estimated 12 percent of young foster children received no routine health care, 34 percent received no immunizations, and 32 percent had at least some identified health needs that were not met. GAO also found that young foster children placed with relatives received fewer health-related services of all kinds than children placed with nonrelative foster parents. Local foster care agencies continue

to grapple with designing programs to meet the health-related service needs of children. In the locations reviewed, agencies have revised health-related foster care regulations and modified their programs in efforts to improve the delivery of health care to foster children.

Disability Insurance: Broader Management Focus Needed to Better Control Caseload (Testimony, 5/23/95, GAO/T-HEHS-95-164).

At nearly $40 billion annually in cash payments to disabled workers, plus $16 billion more for medical coverage, the Social Security Disability Insurance program represents a significant investment of public resources. A program of this magnitude and importance needs proper management and controls to ensure that funds are being spent as the Congress intended. GAO's work to date shows that the Social Security Administration (SSA) has not paid enough attention to controlling the program and managing caseload growth. SSA has devoted its management attention and resources to improving the disability determination process to reduce huge backlogs created by increases in applications and appeals. However, SSA needs to ensure that these efforts do not result in increased allowances and less accurate decisions. SSA also needs to focus more attention and resources on determining whether beneficiaries already on the rolls should still be there and whether more beneficiaries could be encouraged to return to work.

Welfare to Work: Most AFDC Training Programs Not Emphasizing Job Placement (Report, 5/19/95, GAO/HEHS-95-113).

Programs that stress the goal of employment for their participants and forge close links with employers show promise in promoting work among welfare recipients. The five programs that GAO visited all share that emphasis, although they differ in their approaches. A majority of county Job Opportunities and Basic Skills (JOBS) programs across the nation do not have a strong employment focus. About one-half of the county JOBS administrators nationwide stated that they do not work enough with employers to find jobs for participants. Program administrators reported that many obstacles stood in their way. Most local administrators cited insufficient staffing and resources as hindering their work with employers. Many also stated that more flexibility in federal rules governing employment subsidies and work-experience programs could facilitate their use. GAO also noted that states are currently not required to track the number of Aid to Families With Dependent Children (AFDC) recipients who

get jobs or earn their way off AFDC. As a result, programs need not make strong efforts to help them get jobs.

Welfare Dependency: Coordinated Community Efforts Can Better Serve Young At-Risk Teen Girls (Report, 5/10/95, GAO/HEHS/RCED-95-108).

The forces of poverty—eroding the foundations of individuals, families, and communities—can show some of their most debilitating effects on young at-risk teen girls. Generally, community service providers told GAO that services for at-risk girls aged 10 to 15 were limited and the services that were available were often provided after problems reached the crisis stage. To better serve and reach more area residents, including young girls, some neighborhoods are organizing coalitions led by local providers, often with assistance from private organizations and public agencies. In some cases, these efforts at integrating services have had a positive effect on neighborhood children. Some providers, often working in middle schools, have expanded their role in the community to better integrate services for at-risk teens and their families. Providers working in these coalitions told GAO they believed the emergence of neighborhood leadership is critical to the long-term success of the coalitions.

Welfare to Work: Participants' Characteristics and Services Provided in JOBS (Report, 5/2/95, GAO/HEHS-95-93).

In spite of the Family Support Act (FSA) aim of making AFDC a transitional program by providing the education, training, and supportive services that AFDC recipients need to move from welfare to work, most adult AFDC recipients do not participate in JOBS programs because of the act's allowable exemptions and minimum participation standards. JOBS programs offer participants a range of services that are drawn from existing community programs to avoid duplication of services. JOBS programs obtain many services at no cost to their programs, consistent with FSA's emphasis on using such services whenever possible. However, most programs also purchase at least some of the education and training services JOBS participants need. Despite the low percentage of adult AFDC recipients being served by JOBS, many JOBS programs lack the capacity to ensure that all participants receive the specific services they need when they need them.

Welfare to Work: Measuring Outcomes for JOBS Participants (Report, 4/17/95, GAO/HEHS-95-86).

HHS does not know whether the JOBS program is reducing welfare dependency because it does not gather enough information on critical program outcomes, such as the number of participants entering employment and leaving AFDC annually. While little progress has been made in monitoring JOBS outcomes at the federal level, the picture is better at the state level. Nearly all states use some information on participant outcomes to manage their individual programs, although the extent to which states monitor outcomes varies widely. The current national interest in making welfare more employment focused, as well as requirements in the Government Performance and Results Act (GPRA) that performance monitoring become more outcome oriented governmentwide, indicate a need for HHS to move decisively to ensure that it meets its current schedule for developing outcome measures and goals for JOBS.

Other Social Security, Disability, and Welfare Products

Combined Fund Update (Letter, 5/25/95, GAO/HEHS-95-166R).

Overview of Federal Retirement Programs (Testimony, 5/22/95, GAO/T-GGD-95-172).

Federal Retirement: Benefits for Members of Congress, Congressional Staff, and Other Employees (Report, 5/15/95, GAO/GGD-95-78). Testimony on same topic (5/15/95, GAO/T-GGD-95-165).

SSI Disability Issues (Letter, 5/11/95, GAO/HEHS-95-154R).

Veterans Affairs and Military Health

Selected Summaries

Operation Desert Storm: Health Concerns of Selected Indiana Persian Gulf War Veterans (Report, 5/16/95, GAO/HEHS-95-102).

Despite Department of Defense (DOD) and Department of Veterans Affairs (VA) efforts to address the concerns of Persian Gulf veterans, the Indiana veterans GAO surveyed still expressed concerns about their health and dissatisfaction with services from DOD and VA. Most respondents were still

in the reserves and almost all reported that they had health problems they believed were caused by their service in the Persian Gulf. Most also reported that these problems limited their physical and social activities to some extent. Over half of the respondents had taken advantage of medical services, either the special examinations or other health care, available to them through VA or DOD. Many, however, were dissatisfied with the medical care they received or were unaware of available services. DOD and VA have undertaken a variety of efforts to address the concerns raised by Persian Gulf veterans, including expanding the health examinations available to them. Also, in response to recent legislation, both agencies are expanding outreach efforts to better ensure that veterans are aware of available services.

VA Health Care: Challenges and Options for the Future (Testimony, 5/9/95, GAO/T-HEHS-95-147).

VA, with a $16 billion health care budget, faces increasing pressures to contain or reduce health care spending as part of governmentwide efforts to reduce the budget deficit. It also faces increasing challenges from a rapidly changing health care marketplace. GAO's work clearly demonstrates that VA lags far behind the private sector in improving the efficiency of its hospitals. VA is at a crossroad in the evolution of its health care system. The average daily workload in its hospitals dropped about 56 percent during the last 25 years, and further decreases are likely. At the same time, however, demand for outpatient care, nursing home care, and certain specialized services is expanding, taxing VA's ability to meet veterans' needs. Decisions made over the next few years about VA's role will have significant implications for veterans, taxpayers, and private health care providers. A complete reevaluation of the VA health care system appears to be needed. Absent such an effort, use of VA hospitals will likely continue to decline to a point where VA's ability to provide quality care and support its secondary missions will be jeopardized.

Veterans' Benefits: VA Can Prevent Millions in Compensation and Pension Overpayments (Report, 4/28/95, GAO/HEHS-95-88).

Despite its responsibility to ensure accurate benefits payments, VA continues to overpay veterans and their survivors hundreds of millions of dollars in compensation and pension benefits each year. For example, in 1994, VA detected about $372 million in overpayments to its beneficiaries. Based on our analysis of a survey of overpayments in May 1994, changes in income accounted for a large portion of overpayments, and receipt of

Social Security benefits accounted for a significant share of income-related overpayments. VA has the capability 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. VA does not systematically collect, analyze, and use information on the specific causes of overpayments that will help it target prevention efforts.

VA Health Care: Retargeting Needed to Better Meet Veterans' Changing Needs (Report, 4/21/95, GAO/HEHS-95-39).

Many veterans have health care needs that are not adequately addressed through current health care programs, including the VA health care system. VA cannot adequately address many of these health care needs because (1) it relies primarily on direct delivery of health care services in VA-owned and operated facilities, (2) its complex eligibility and entitlement provisions limit the services veterans can get from VA facilities, and (3) space and resource limitations prevent eligible veterans from obtaining covered services. In GAO's view, changes need to be made in the veterans' health care system to enable it to better meet veterans' needs. To make optimum use of limited health care resources, such changes would need to be designed to complement rather than duplicate coverage provided through other public and private health benefits programs. VA's plans for restructuring the VA health care system, however, focus primarily on preserving and expanding VA's acute care mission rather than retargeting VA programs and resources to enable VA to fill the gaps in veterans' coverage under other public and private health benefits programs.

Other Veterans Affairs and Military Health Products

Concurrent Receipt (Letter, 4/27/95, GAO/HEHS-95-136R).

Barriers to VA Managed Care (Letter, 4/20/95, GAO/HEHS-95-84R).

Veterans Compensation: Offset of DOD Separation Pay and VA Disability Compensation (Report, 4/3/95, GAO/NSIAD-95-123).

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