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AGING ISSUES

Related GAO Reports and Activities in Fiscal Year 1996

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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 1996 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. By the year 2020, the number of older Americans who are 65 years old and older, 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 1996 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 1996

Elderly issues	Reports and correspondence	Testimonies	Ongoing work
Education and employment	2	1	0
Health	37	15	18
Housing	1	3	0
Income security	21	8	6
Veterans/Department of Defense	15	7	8
Related issues	3	0	0
Total	**79**	**34**	**32**

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 Vernette G. Shaw, Evaluator-in-Charge, who may be reached at (202) 512-7234.

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Contents

Abbreviations

AARP	American Association of Retired Persons
AFIP	Armed Forces Institute of Pathology
CSRS	Civil Service Retirement System
DI	disability insurance
DOD	Department of Defense
DSH	disproportionate share hospital
FDA	Food and Drug Administration
FECA	Federal Employees' Compensation Act
FEHBP	Federal Employees Health Benefits Program
FERS	Federal Employees Retirement System
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HMO	health maintenance organization
HUD	Department of Housing and Urban Development
MAF	medical assistance facilities
MTS	Medicare transaction system
OIG	Office of Inspector General
PASS	plan for achieving self-support
PBGC	Pension Benefit Guaranty Corporation
PBM	pharmacy benefit manager
RIF	reduction in force
RSI	retirement and survivors insurance
SSA	Social Security Administration
SSI	supplemental security income
TRICARE	DOD's new nationwide managed health care program
TSP	Thrift Savings Plan
USTF	Uniformed Services Treatment Facility
VA	Department of Veterans Affairs
VBA	Veterans Benefits Administration

Fiscal Year 1996 Reports and Correspondence on Issues Affecting Older Americans

During fiscal year 1996, GAO issued 79 reports on issues affecting older Americans. Of these, 2 were on education/employment, 37 on health, 1 on housing, 21 on income security, 15 on veterans/Department of Defense (DOD), and 3 on other related issues.

Education Issues

Department of Labor: Senior Community Service Employment Program Delivery Could Be Improved Through Legislative and Administrative Actions (GAO/HEHS-96-4, Nov. 2, 1995)

The Department of Labor's Senior Community Service Employment Program finances part-time minimum-wage community service jobs for about 100,000 poor elderly Americans. GAO found that Labor distributes program funds through noncompetitive grants to 10 national organizations, called national sponsors, and to state agencies. These national sponsors and state agencies, in turn, use the grant funds to finance local employment projects run by community service host agencies, such as libraries, nutrition centers, and parks, that directly employ older Americans. GAO found that the relative distribution of funds to the national sponsors and state agencies along with Labor's method of implementing the hold-harmless provisions have resulted in the distribution of funds among and within states that bears little relationship to actual need. GAO also found that, under Labor's regulations, expenditures that GAO believes to be administrative in nature may be charged to another cost category, allowing grantees to exceed the statutory 15-percent limit on administrative costs. GAO summarized this report in testimony before Congress; see: Senior Community Service Employment: Program Delivery Could Be Improved Through Legislative and Administrative Actions, (GAO/T-HEHS-96-57, Nov. 2, 1995), by Cornelia M. Blanchette, Associate Director for Education and Employment Issues, before the Subcommittee on Early Childhood, Youth and Families, House Committee on Economic and Educational Opportunities.

People With Disabilities: Federal Programs Could Work Together More Efficiently to Promote Employment (GAO/HEHS-96-126, Sept. 3, 1996)

How efficient are federal efforts to help people with disabilities? In 1994, the government provided a range of services to people with disabilities through 130 different programs, 19 federal agencies, and a host of public and private agencies at the state and local levels. Although research groups and independent panels have stressed the need to simplify and streamline programs serving the disabled, creating a new service delivery system may prove difficult. GAO urged caution in 1992 when Congress was considering proposals that would have made fundamental changes in

human service delivery systems at the federal, state, and local levels. GAO also urges caution with regard to programs serving people with disabilities. Although the potential benefits of creating a new system to deliver services more comprehensively to people with disabilities may be great, so are the barriers and the risks of failure. Obstacles preventing officials from reorganizing service agencies, creating new funding and service agreements, and divesting authority from their own agencies are hard to overcome. Mandates alone are unlikely to secure the major time and resource commitments needed from officials—whether they are charged with directing reforms or have responsibility for administering services. In the current fiscal environment, a renewed focus by federal agencies on improving coordination would be a useful step toward improving services and enhancing the customer orientation of their programs.

Health Issues

AARP Medigap Premium Increases, 1996 (GAO/HEHS-96-119R, Apr. 19, 1996)

Pursuant to a congressional request, GAO examined why Medigap premiums offered through the American Association of Retired Persons (AARP) were increasing. GAO noted that: (1) premiums for more than 3 million AARP Medigap policyholders increased an average of 26 percent; (2) the increases varied by state and ranged between 0 to 40 percent for both standardized and prestandardized policies; (3) in 1994 and 1995, premiums increased in 8 and 10 states, respectively; (4) because benefit payments were less than expected, AARP standardized policyholders received an average credit of $75 and prestandardized policyholders received an average credit of $79 in 1994 and 1995; (5) in 1992, policyholders in 45 states received refunds averaging $47 because of lower-than-expected benefit payments; (6) AARP believes that the 1996 Medigap rate increases are justified because the number of services received and costs incurred by policyholders substantially increased; (7) although the average Medigap loss ratio decreased to 81 percent between 1991 and 1993, in 1994, the average loss ratio increased to 93 percent; (8) in 1994, the average loss ratio for prestandardized policies was 98 percent and 82 percent for standardized policies; and (9) the average loss ratio for 1995 policies was 100 percent and could increase to 112 percent without a rate increase.

Analysis of "Florida's Fair Share" (GAO/HEHS-96-168R, June 10, 1996)

Pursuant to a congressional request, GAO commented on the appropriateness of the Medicaid funding formula contained in H.R. 3507. GAO noted that: (1) over time, the proposed formula would cause Medicaid funding distribution to more closely reflect states' poverty and elderly populations; (2) there are more generous matching rates for low-income states that spend more on Medicaid services for eligible recipients; (3) because Florida spends less on benefits for eligible recipients than the other states reviewed, it receives less matching federal funds; (4) the new funding formula would establish targets for federal funding in proportion to the poor population in each state; (5) each state's federal allocation would increase depending on the differences between the level of federal funding and the target amount; and (6) by giving states like Florida higher growth rates, the new formula would enable states to receive federal funding in proportion to their poverty population.

Arizona Medicaid: Competition Among Managed Care Plans Lowers Program Costs (GAO/HEHS-96-2, Oct. 4, 1995)

Many states are converting their traditional fee-for-service Medicaid programs to managed care delivery systems. Arizona's Medicaid program offers valuable insights—especially in fostering competition and monitoring plan performance. Since 1982, Arizona has operated a statewide Medicaid program that mandates enrollment in managed care and pays health plans a capitated fee for each beneficiary served. Although the program had problems in its early years, such as the dismissal of the program administration and the state's takeover of the administration, it has successfully contained health care costs while maintaining beneficiaries access to mainstream medical care. Arizona's recent cost containment record is noteworthy. According to one estimate, Arizona's Medicaid program saved the federal government $37 million and the state $15 million in acute care costs during fiscal year 1991 alone. Arizona succeeded in containing costs by developing a competitive Medicaid health care market. Health plans that submit capitation rates higher than their competitors' bids risk not winning Medicaid contracts. Other states considering managed care programs can benefit from Arizona's experience. GAO concludes that the key conditions for holding down Medicaid costs without compromising beneficiaries' access to appropriate medical care include freedom from some federal managed care regulations, development and use of market forces, controls to protect beneficiaries from inadequate care, and investment in data collection and analysis capabilities.

Blue Cross FEHBP Pharmacy Benefits (GAO/HEHS-96-182R, July 19, 1996)

Pursuant to a congressional request, GAO provided information on the Blue Cross and Blue Shield Association's two pharmacy benefit managers (PBM) and the services they provide to the Federal Employees Health Benefits Program (FEHBP). GAO noted that: (1) to control drug costs, the Association is requiring Medicare part B participants to pay the standard copayment for drugs bought at participating retail pharmacies, but it is waiving copayments on drugs bought through its mail-order program for those participants; (2) the Association expects this change to achieve significant savings and prevent a premium increase in standard option coverage; (3) the Association's mail-order subcontractor has had significant difficulty meeting its customer-service performance measures because the increase in mail orders has been much larger and quicker than expected; (4) the subcontractor has increased its processing capacity to meet the unexpected demand; (5) retail pharmacies have experienced a 36-percent decrease in drug sales to part B participants and a 7-percent decrease in drug sales to all enrollees; and (6) the Association believes its pharmacy benefits managers provide valuable services to FEHBP, meet most of their contractual performance measures, and produce significant savings.

Consumer Health Informatics: Emerging Issues (GAO/AIMD-96-86, July 26, 1996)

Technology has increased the amount of health information available to the public, allowing consumers to become better educated and more involved in their own health care. Government and private health care organizations rely on a variety of technologies to disseminate health information on preventive care, illness and injury management, treatment options, post-treatment care, and other topics. This report discusses consumer health informatics—the use of computers and telecommunications to help consumers obtain information, analyze their health care needs, and make decisions about their own health. GAO provides information on (1) the demand for health information and the expanding capabilities of technology; (2) users' and developers' views on potential systems advantages and issues surrounding systems development and use; (3) government involvement—federal, state, and local—in developing these technologies; and (4) the status of related efforts by the Department of Health and Human Services (HHS). As part of this review, GAO surveyed consumer health informatics experts and presents their views on issues that need to be addressed when developing consumer health information systems. GAO summarized this report in testimony before Congress; see: Consumer Health Informatics: Emerging Issues (GAO/T-AIMD-96-134, July 26, 1996), by Patricia T. Taylor, Director of Information Resources Management Issues, before the Subcommittee on

	Human Services and Intergovernmental Relations, House Committee on Government Reform and Oversight.
Fraud and Abuse: Providers Target Medicare Patients in Nursing Facilities (GAO/HEHS-96-18, Jan. 24, 1996)	Nursing home patients are an attractive target for fraudulent and abusive health care providers that bill Medicare for undelivered or unnecessary services. A wide variety of providers, ranging from durable medical equipment suppliers to laboratories to optometrists and doctors, have been involved in fraudulent and abusive Medicare billing schemes. Several features make nursing home patients attractive targets. First, because a nursing facility houses many Medicare beneficiaries under one roof, unscrupulous billers of services can operate their schemes in volume. Second, nursing homes sometimes make patient records available to outsiders, contrary to federal regulations. Third, providers are permitted to bill Medicare directly, without certification from the nursing home or the attending physician that the items are necessary or have been provided as claimed. In addition, Medicare's automated systems do not collect data to flag improbably high charges or levels of services. Finally, even when Medicare spots abusive billings and seeks recovery of unwarranted payments, it often collects little money from wrongdoers, who either go out of business or deplete their resources so that they cannot repay the funds.
HCFA: Medicare Program—Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 1997 Rates (GAO/OGC-96-41, Sept. 13, 1996)	Pursuant to a legislative requirement, GAO reviewed the Health Care Financing Administration's (HCFA) new rule on changes to the Medicare program's hospital inpatient prospective payment systems and fiscal year 1997 rates. GAO found that: (1) the rule would adjust the classifications and weighting factors for diagnosis related groups, update the wage index associated with hospital operating costs, and make certain clarifications regarding the calculation of hospital payments excluded from the prospective payment systems; and (2) HCFA complied with applicable requirements in promulgating the rule.
Health Care Fraud: Information-Sharing Proposals to Improve Enforcement Efforts (GAO/GGD-96-101, May 1, 1996)	Estimates of health care fraud range from between 3 and 10 percent of all health care expenditures—as much as $100 billion based on estimated 1995 expenditures. In late 1993, the Attorney General designated health care fraud as an enforcement priority second only to violent crime initiatives. This report discusses (1) the extent of federal and state immunity laws protecting persons who report information on health care fraud and (2) the advantages and disadvantages of establishing a

centralized health care fraud database to strengthen information-sharing and support enforcement efforts.

Health Insurance: Coverage of Autologous Bone Marrow Transplantation for Breast Cancer (GAO/HEHS-96-83, Apr. 24, 1996)

Although many insurers now cover the cost of autologous bone marrow transplantation, a new and expensive treatment for breast cancer, issues surrounding the procedure have put several goals of the U.S. health care systems in conflict: access to the best, most advanced care; cost containment; and research adequate to assess the value of new treatments. Proponents of insurance coverage argue that autologous bone marrow transplantation provides breast cancer patients with a promising, potentially life-saving treatment. Critics say that the proliferation of such unproven treatments is costly and harmful, potentially hindering clinical research to determine whether the treatment is effective. This report discusses (1) the factors that have influenced insurers' decisions on whether to cover the treatment, (2) the status of research on autologous bone marrow transplantation for breast cancer and the consensus on what is known about its effectiveness, and (3) the consequences of increased use and insurance coverage of the treatment while it is still being evaluated in clinical trials.

Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance (GAO/HEHS-96-161, Aug. 19, 1996)

As concern about the affordability of health coverage has grown, the costs attributed to state regulation of health insurance have come under increasing scrutiny. State health insurance regulation is intended to protect consumers through oversight of health plans' financial solvency, monitoring of insurers' market conduct to prevent abuses, and mandated coverage for particular services. Although these measures do benefit consumers, they result in costs to insurers that are ultimately passed on to consumers in their premiums. These costs may influence an employer to self-fund its health plan—a move that avoids state insurance regulation. This report examines the costs associated with (1) premium taxes and other assessments, (2) mandated health benefits, (3) financial solvency standards, and (4) state health insurance reforms affecting small employers. GAO discusses the impact of these requirements on the costs of insured health plans compared with the cost of self-funded health plans.

Long-Term Care: Some States Apply Criminal Background Checks to Home Care Workers (GAO/PEMD-96-5, Sept. 27, 1996)

Pursuant to a congressional request, GAO examined federal and state requirements for criminal background checks of home health care workers. GAO found that: (1) there are few formal safeguards to protect elderly persons from unscrupulous home care workers; (2) the federal government indirectly regulates home care workers by requiring home care organizations or the individual provider to meet certain requirements for participation in Medicaid or Medicare; (3) states may be directed to disqualify home care providers convicted of fraudulent health care delivery, obstruction of justice, or the illegal manufacture, distribution, prescription, or dispensing of controlled substances; (4) state and local governments, as well as professional boards, impose certain restrictions on home care organizations and individual providers; (5) some states require all home care organizations to meet state imposed licensure or Medicare certification requirements; (6) some states incorporate home care workers into their state nursing home aide registry; (7) few states require criminal background checks of home care workers; and (8) most states do not use the Federal Bureau of Investigation's national criminal database system to check home care workers' backgrounds due to cost concerns.

Mammography Services: Initial Impact of New Federal Law Has Been Positive (GAO/HEHS-96-17, Oct. 27, 1995)

The Mammography Quality Standards Act of 1992 imposed uniform standards for mammography in all states, requiring certification and annual inspection of mammography facilities. GAO found that the act has had a positive impact, resulting in higher quality equipment, personnel, and practices. Mammography quality standards are now in place in all states, and these standards do not appear to have hampered access to services. To avoid large-scale closure of facilities, however, the Food and Drug Administration (FDA) settled on an approach that allowed some delay in meeting the certification requirements. For this and other reasons, such as the availability of outcome data, more time will be needed before the act's full impact can be determined. GAO is required to assess the effects of the act again in 2 years and to issue a report in 1997.

Medicaid Funding Formula Changes (GAO/HEHS-96-164R, June 10, 1996)

Pursuant to a congressional request, GAO provided information on the proposed changes to Medicaid funding formulas under H.R. 3507. GAO noted that: (1) states with large numbers of poor and disabled persons receive less federal assistance than states with larger numbers of poor and weaker tax bases; (2) states that offer extensive services and provide high provider reimbursement rates receive more federal funding; (3) the revised Medicaid formula would link the amount of federal aid a state receives to

the number of poor people in need of Medicaid services; (4) over 90 percent of the federal formula grant programs target funding on the basis of need; (5) H.R. 3507 would realign federal Medicaid funding over a number of years, so that funding is more related to state need rather than state spending patterns; (6) H.R. 3507 would place greater weight on the number of elderly and disabled people that require expensive services; and (7) the proposed formula change would enable states with low funding to acquire more federal funds.

Medicaid Long-Term Care: State Use of Assessment Instruments in Care Planning (GAO/PEMD-96-4, Apr. 2, 1996)

GAO examined how publicly funded programs assess the need for home and community-based long-term care for the elderly with disabilities. This care is provided to persons living at home who, because of a chronic condition or illness, cannot care for themselves. Services ranges from skilled nursing to assistance with day-to-day activities, such as bathing and housekeeping. Under the Medicaid program, 49 states have obtained waivers to provide home and community-based services to low-income elderly persons who would otherwise need institutional care paid for by Medicaid. These states are responsible for developing a care plan tailored to a client's specific needs. A well-designed assessment instrument helps identify all appropriate needs—increasing the likelihood that important aspects of the client's situation will not be overlooked in care planning. Standardized administration of the assessment instrument increases the likelihood that the needs of all clients will be determined in the same way. This report provides information on the (1) comprehensiveness of assessment instruments, (2) uniformity of their administration, and (3) training for staff who do the assessments.

Medicaid Managed Care: Serving the Disabled Challenges State Programs (GAO/HEHS-96-136, July 31, 1996)

With its emphasis on primary care, restricted access to specialists, and control of services, managed care is seen as a way to control spiraling Medicaid costs, which totaled $159 billion in fiscal year 1995. So far, states have extended prepaid care largely to low-income families—about 30 million persons—but to few of the additional 6 million Medicaid beneficiaries who are mentally or physically disabled. Managed care's emphasis on primary care and control of services is seemingly at odds with the care requirements of disabled beneficiaries, many of whom need extensive services and access to highly specialized providers. However, because more than one-third of all Medicaid payments go for the care of the disabled, policymakers have been exploring the possibility of enrolling disabled persons in managed care plans. These efforts affect three key groups: disabled beneficiaries, who include a small number of very

vulnerable persons who may be less able to effectively advocate on their own behalf for access to needed services; prepaid care plans, which are concerned about the degree of financial risk in treating persons with extensive medical needs; and the state and federal governments, which run Medicaid. This report examines the (1) extent to which states are implementing Medicaid prepaid managed care programs for disabled beneficiaries and (2) steps that have been taken to safeguard the interests of all three groups. GAO's review of safeguards focuses on two areas: efforts to ensure quality of care and strategies for setting rates and sharing financial risk.

Medicaid Section 1115 Waivers: Flexible Approach to Approving Demonstrations Could Increase Federal Costs (GAO/HEHS-96-44, Nov. 8, 1995)

Several states have been given waivers allowing them to use savings from managed care Medicaid programs to cover additional beneficiaries. GAO found that contrary to assertions that such waivers would be "budget neutral," most of them could increase federal Medicaid expenditures. Specifically, approved spending limits for demonstration waivers in Oregon, Hawaii, and Florida could boost federal Medicaid outlays. Only Tennessee's 1115 waiver agreement should cost no more than the continuation of its smaller, prewaiver program and, in fact, should yield savings. Federal Medicaid spending could rise significantly if the administration continues to show a similar flexibility in reviewing state 1115 financing strategies. Five waivers have been approved since Florida's in late 1994, and the large backlog of pending waivers includes three states with large Medicaid programs—New York, Illinois, and Texas. Additional federal dollars are available along with other funding sources identified in state waiver applications. GAO believes that the potential for additional federal funding serves as a hedge against the many uncertainties states face in implementing these ambitious demonstrations—including changing economic conditions, the accuracy of cost-containment assumptions, the availability of anticipated funding cited in waiver applications, and the lack of reliable cost data on the uninsured.

Medicaid: Waiver Program for Developmentally Disabled Is Promising but Poses Some Risks (GAO/HEHS-96-120, July 22, 1996)

More than 300,000 adults with developmental disabilities—typically mental retardation—receive long-term care paid for by Medicaid or, to a lesser extent, state and local programs. Such long-term care often involves supervision and assistance with everyday activities, such as dressing or managing money. Persons with developmental disabilities receive more than $13 billion annually in public funding for long-term care, second only to the elderly. Recently, states have begun to significantly expand the use of the Medicaid waiver program, which seeks to provide alternatives to

institutional care for persons with developmental disabilities. The waiver program has two advantages. First, it helps states to control costs by allowing them to limit the number of recipients being served. Without the waiver, states must serve all eligible persons in the regular Medicaid program. Second, it permits states to meet the needs of many persons with developmental disabilities by offering them a broader range of services in less restrictive settings, such as group or family homes, rather than in an institutional setting. This report examines (1) expanded state use of the waiver program, (2) the growth in long-term care costs for individuals with developmental disabilities, (3) how costs are controlled, and (4) strengths and limitations in states' approaches to ensuring quality in community settings.

Medical ADP Systems: Defense Achieves Worldwide Deployment of Composite Health Care System (GAO/AIMD-96-39, Apr. 5, 1996)

As the backbone of the military's medical operations, the Composite Health Care System—an automated medical system developed by DOD at a cost of $2.8 billion—will provide doctors and nurses with almost instant access to patient information, from medical history to current treatment and vital statistics. DOD should be able to significantly improve operations at its medical facilities while reducing costs. Improved appointment scheduling will increase patients' access to health care, while better access to patient information will save medical personnel time. If DOD is to realize the system's full potential, however, physicians and other health care providers must be able to access the system at all times. Although DOD's backup and recovery plan provides for recovery from disruptions in computer service because of power outages, it does not effectively address major disruptions requiring the repair or the replacement of equipment damaged by a natural disaster. Health care providers have become dependent on the patient data in the system, so any major disruption could result in injury or even death. DOD could greatly reduce this risk by developing a more effective backup and recovery plan for its equipment.

Medicare: Early Resolution of Overcharges for Therapy in Nursing Homes Is Unlikely (GAO/HEHS-96-145, Aug. 16, 1996)

Nursing homes and therapy companies continue to bill Medicare at very high rates for occupational and speech therapy. Moreover, the bills do not specify the amount of time spent with patients or the treatments provided. The weaknesses that GAO reported more than a year ago—the lack of salary guidelines setting limits on Medicare reimbursements for occupational and speech therapist's services and unclear billing for these services—persist. Although HCFA recognized as early as 1990 that inappropriate charges for occupational speech therapy were a problem, it

is still trying to establish salary equivalency guidelines for these services. HCFA proposed guidelines based on a Bureau of Labor Statistics survey of average salaries for hospital therapists, but the industry was not satisfied and did its own survey. HCFA is now analyzing those survey results. The prospect for a quick resolution to the billing problem with therapy services is unlikely. Historically, it has taken HCFA years to reduce high payment rates for supplies or services. Given the typical time involved in meeting federal notification and publication requirements for changing Medicare prices, salary equivalency guidelines may not be implemented until the summer of 1997 at the earliest. GAO urges Congress to consider granting HCFA legislative relief from these requirements.

Medicare: Federal Efforts to Enhance Patient Quality of Care (GAO/HEHS-96-20, Apr. 10, 1996)

In the past decade, Medicare costs have risen on average more than 10 percent per year. Expanding managed care options for Medicare patients has been proposed as a way to contain costs. Concerns have been raised, however, that such changes may undermine the quality of care provided to Medicare beneficiaries. Currently, Medicare reimburses only for care provided in health maintenance organizations (HMO) and by the fee-for-service sector. This report (1) discusses the present and future strategies of HCFA, which administers the Medicare program, to ensure that Medicare providers furnish quality health care in both fee-for-service and HMO arrangements and (2) provides the views of experts on attributes a quality assurance program should have if more managed care options are made available to Medicare beneficiaries.

Medicare HMOs: Rapid Enrollment Growth Concentrated in Selected States (GAO/HEHS-96-63, Jan. 18, 1996)

Private-sector insurers cite extensive use of HMO and other managed care approaches as a key factor in slowing the growth of their insurance premiums. As a result, part of the current interest in controlling Medicare costs has centered on ways to increase HMO use among Medicare beneficiaries. This report provides information on trends in the number of (1) Medicare beneficiaries enrolling in HMOs and (2) HMOs enrolling beneficiaries. GAO analyzes these data for factors that might be influencing decisions by HMOs to enroll Medicare beneficiaries and decisions by beneficiaries to enroll in HMOs. GAO found that about 2.8 million Medicare beneficiaries—about 7 percent of the total—were enrolled in risk-contract HMOs as of August 1995. This was double the percentage enrolled in 1987. The growth has been particularly rapid during the past 4 years and has centered on certain states. California and Florida, for example, have more than half of all enrollees.

Medicare: Home Health Utilization Expands While Program Controls Deteriorate (GAO/HEHS-96-16, Mar. 27, 1996)

Use of the Medicare home health benefit has increased dramatically, with spending rising from $2.7 billion in 1989 to $12.7 billion in 1994. Costs are projected to reach $21 billion by the year 2000. In earlier reports (GAO/HRD-81-155 and GAO/HRD-87-9), GAO cited lax controls over the use of the home health benefit and recommended measures to improve Medicare's ability to detect claims that were not medically necessary or did not meet the coverage criteria. Medicare's escalating home health outlays continue to raise concerns about the extent of benefit abuse. This report examines the factors underlying the growth in the use of the home health benefit. GAO discusses (1) changes in the composition of the home health industry, (2) changes in the composition of Medicare home health users, (3) differences in utilization patterns across geographic areas, (4) incentives to overuse services, and (5) the effectiveness of payment controls in preventing payments for services not covered by Medicare.

Medicare Insured Groups (GAO/HEHS-96-93R, May 1, 1996)

Pursuant to a legislative requirement, GAO examined Medicare insured groups, focusing on (1) the status of the demonstration program and individual projects; and (2) efforts to establish a reliable payment system. GAO found that: (1) with the passage of the Omnibus Reconciliation Act of 1987, five groups had entered into agreements with HCFA to operate Medicare insured groups; (2) HCFA expenditures for the agreements totalled $1.1 million over the last 8 years; (3) all the agreements have been terminated due to concerns over the projects' financial viability; (4) HCFA terminated one of the projects after experiencing prolonged delays and problems with contract negotiations; (5) another company encountered delays in obtaining employer commitments and data needed for rate-setting analysis; (6) the most recent group to terminate had developed an operating plan and proposed a payment rate-setting method before experiencing lengthy delays and problems with payment update methodology; (7) the proposed payment methodology would have established a base rate using 1986 to 1990 claims data and updated the rate on the basis of revised per capita costs; and (8) in using more recent claims data, groups would have faced financial risk, as well as additional time and expense.

Medicare Managed Care: Growing Enrollment Adds Urgency to Fixing HMO Payment Problem (GAO/HEHS-96-21, Nov. 8, 1995)

Enrollment of Medicare beneficiaries in HMOs has soared in recent years, concentrated in some states and locales. This rapid growth in enrollment highlights the urgency of correcting Medicare's excessive payment rates to HMOs—particularly in certain areas. Likewise, enrollment stagnation elsewhere underscores the need to examine the causes of payment rate disparities among states and counties. Medicare's HMO payment method is plagued by three flaws. First, the rigidity of the formula-based fixed payment rate does not allow Medicare to capitalize on the competition among HMOs that, in the private market, leads to lower rates. Second, rate adjustment for differences in beneficiaries' health status are so imprecise that Medicare overpays HMOs that enroll beneficiaries who are in good health. Third, the reliance on a country's fee-for-service health care costs to establish a payment rate produces rates that vary considerably within market areas. GAO concludes that a sensible approach would be to pursue three promising strategies concurrently—foster price competition among HMOs, improve risk adjusters' accuracy, and allow for adjustments in the current formula to reflect market competition and HMO's local health care costs. HCFA plans demonstration projects using competitive bidding and improved risk adjustment but results of a full-scale evaluation of these projects are years away. In the interim, HCFA should promptly gather and use valuable design and implementation data as they become available. HCFA's legislative authority to carry out these projects does not address managed care options explicitly, which raises questions about HCFA's authority to mandate HMO participation in the projects.

Medicare Managed Care Growth (GAO/HEHS-96-47R, Oct. 18, 1995)

Pursuant to a congressional request, GAO reviewed the growth of Medicare beneficiaries in managed health care plans. GAO noted that: (1) although more than 50 percent of employees covered by employer-provided insurance are enrolled in managed health care plans, fewer Medicare beneficiaries are enrolled in such plans; (2) the only managed care option Medicare offers is HMOs and they are not uniformly available; (3) the percentage of Medicare beneficiaries enrolled in an HMO has increased from about 3 percent in 1987 to about 7 percent in 1995; (4) although Medicare beneficiaries are increasingly choosing HMOs, about 87 percent of these beneficiaries live in 10 states, while about 55 percent live in just 2 states; and (5) only 3 states have Medicare HMO enrollment of 20 percent or more, while 7 states have non-Medicare HMO enrollments of 30 percent or more.

Medicare: Millions Can Be Saved by Screening Claims for Overused Services (GAO/HEHS-96-49, Jan. 30, 1996)

Medicare contractors routinely pay hundreds of millions of dollars in Medicare claims without first determining if the services provided are necessary. GAO reviewed payments to doctors for six groups of high-volume medical procedures—ranging from eye examinations to chest X rays—that accounted for nearly $3 billion in Medicare payments in 1994. GAO also surveyed 17 contractors to determine if they had used medical necessity criteria in their claims processing to screen for these six groups of procedures. For each of the six groups, more than half of the 17 contractors failed to use automated screens to flag claims for unnecessary, inappropriate, or overused treatments. These prepayment screens could have saved millions of taxpayer dollars now wasted on questionable services. Problems with controlling payments for widely overused procedures continue because HCFA lacks a national strategy to control these payments. HCFA now relies on contractors to focus on procedures where local use exceeds the national average. Although this approach helps reduce local overuse of some procedures, it is not designed to control overuse of a procedure nationwide. GAO summarized this report in testimony before Congress; see: Medicare: Millions Can Be Saved by Screening Claims for Overused Services (GAO/T-HEHS-96-86, Feb. 8, 1996), by Sarah F. Jaggar, Director of Health Financing and Public Health Issues, before the Subcommittee on Human Resources and Intergovernmental Relations, House Committee on Government Reform and Oversight.

Medigap Insurance: Alternatives for Medicare Beneficiaries to Avoid Medical Underwriting (GAO/HEHS-96-180, Sept. 10, 1996)

Although the Medicare program covers a substantial share of its beneficiaries' health expenses, it does require deductibles and coinsurance that can amount to thousands of dollars a year. Most beneficiaries obtain private insurance to supplement Medicare when they become eligible for the program at age 65. On occasion, beneficiaries decide to change Medigap policies and may then become subject to medical underwriting; that is, the insurer can take into account a person's health status or medical history in deciding whether to sell a policy. GAO found that few beneficiaries decide later to change their policies and those that do have at least one alternative for changing without being subject to medical underwriting. These alternatives, however, are not guaranteed by federal law, and it is possible that circumstances could change in the future. Federal Medigap law could be amended to furnish such a guarantee to beneficiaries who have been continuously covered by Medigap. Such a change should not have any major effect because it would not alter beneficiary incentives for Medigap coverage.

MediGrant: Florida (GAO/HEHS-96-11R, Oct. 2, 1995)

Pursuant to a congressional request, GAO provided information on how the proposed MediGrant Program will affect Florida's federal Medicaid funding between fiscal years 1996 to 2002. GAO noted that: (1) Florida state officials estimate that Florida would receive $7.6 billion less under the proposed MediGrant program; (2) Florida is expected to match $30.6 billion under Medicaid spending law and $15.8 billion under the MediGrant proposal; (3) the MediGrant program would guarantee minimum growth rates for some states and place limits on the maximum growth a state receives annually; and (4) the MediGrant program would increase Florida's share of federal Medicaid spending from 3.67 percent in fiscal year 1994 to 4.13 percent in fiscal year 2002.

Montana's Medical Assistance Facilities (GAO/HEHS-96-12R, Oct. 2, 1995)

Pursuant to a congressional request, GAO provided information on Montana's medical assistance facilities (MAF), focusing on the (1) services performed at MAF; (2) inpatient service costs to Medicare at MAF and acute-care hospitals; and (3) number of hospitals nationwide that qualify as MAF. GAO noted that: (1) MAF mainly serve patients with uncomplicated conditions or stabilize patients with more severe conditions before transferring them to full-service hospitals; (2) MAF serve as primary care providers for Medicare beneficiaries living in rural areas; (3) Medicare costs are generally less at MAF than at urban hospitals; (4) patients who are transferred from MAF to acute-care hospitals increase Medicare costs, because the two facilities receive payments for the same patient; and (5) although over 500 hospitals nationwide meet the qualifying criteria for MAF, no more than 150 hospitals would convert to MAF or rural primary care hospitals due to various circumstances.

Nonphysician Specialists (GAO/HEHS-96-135R, May 29, 1996)

Pursuant to a congressional request, GAO provided information on the policies and procedures governing the participation of certain nonphysician health specialists in several federal health care programs. GAO noted that: (1) although nonphysician specialists are authorized to participate and provide services in federal health care programs, participation requirements and allowable services vary among and within the programs; (2) participation requirements vary as to training, supervision, and specialty autonomy; and (3) some agencies that administer federal health programs are more involved in setting requirements and establishing service parameters for nonphysician specialists than other agencies.

Practice Guidelines: Managed Care Plans Customize Guidelines to Meet Local Interests (GAO/HEHS-96-95, May 30, 1996)

The inappropriate use of medical services can be costly and raises quality-of-care concerns. For example, a 1988 study found that 14 percent of bypass surgeries were performed inappropriately. To narrow the gap between current and optimal practice, some federal agencies and other groups develop clinical practice guidelines on the best practices for effective and appropriate care. Managed care plans, which employ various techniques intended to reduce inappropriate care, are likely sites of guideline use. This report discusses (1) the purposes clinical practice guidelines serve and (2) how health plans make use of already published guidelines developed by federal agencies and other groups.

Psychiatric Hospital Oversight (GAO/HEHS-96-132R, May 24, 1996)

Pursuant to a congressional request, GAO reviewed federal and state oversight of state-operated and private psychiatric hospitals. GAO noted that: (1) as of August 1995, 702 psychiatric hospitals were certified to participate in Medicare and Medicaid; (2) to become certified for participation in Medicare and Medicaid, psychiatric hospitals must satisfy general hospital requirements for health and safety, and special psychiatric hospital requirements for active treatment; (3) hospital medical records must reflect the degree of active treatment and hospitals must have qualified staff to evaluate and treat patients; (4) HCFA requires states to conduct surveys of psychiatric hospitals to determine whether they satisfy certification requirements; (5) surveys of psychiatric hospitals include examinations of hospital and patient records, direct observations of patients, and interviews with staffs and patients; (6) as of August 1995, most certified psychiatric hospitals satisfied HCFA requirements for medical records and staffing; and (7) the failure to evaluate a patient's strengths when developing a treatment plan, specify each patient's treatment goals, and indicate the methods of treatment were the most common deficiencies cited in surveys of psychiatric hospitals that failed to satisfy HCFA certification requirements.

State Medicaid Financing Practices (GAO/HEHS-96-76R, Jan. 23, 1996)

Pursuant to a congressional request, GAO provided information on state Medicaid financing arrangements in Michigan, Tennessee, and Texas. GAO noted that: (1) until HCFA ruled in 1985 that states could use Medicaid provider donations to reduce their share of Medicaid expenditures, states could only use provider donations for the cost of training administrative personnel; (2) Michigan raised $684 million for its Medicaid program through hospital donations and federal matching funds in fiscal years 1991 through 1993, allowing it to fund $566 million in additional Medicaid payments; (3) in 1993, Tennessee required certain medical providers to pay

a $2,600 tax on their nursing home beds and a 6.75-percent tax on services, but it discontinued the hospital services tax in 1994 when it implemented the TennCare program; (4) Tennessee earned $458 million from nursing home and hospital taxes in fiscal year 1993 and received $954 million in federal matching funds, which accounted for over half of its 1993 Medicaid spending; (5) Congress enacted legislation in 1993 that restricted state financing arrangements by limiting disproportionate share hospital (DSH) program payments, causing states to modify their DSH programs and overall DSH payments to decline; and (6) despite the 1993 legislation, states were able to use intergovernmental transfers and other creative funding arrangements to reduce their share of Medicaid costs.

Cholesterol Treatment: A Review of the Clinical Trials Evidence (GAO/PEMD-96-7, May 14, 1996)

Clinical trials and other scientific studies have consistently shown that cholesterol-lowering treatment benefits middle-aged white men with high cholesterol levels and a history of heart disease. Medical research also shows that men with moderate-to-high cholesterol levels and no history of heart disease have lower rates of nonfatal heart attacks but no statistically significant reductions in death rates as a result of cholesterol-lowering treatment. Clinical trials generally have not evaluated the value of cholesterol-lowering treatment for several important groups, including women, the elderly, and minorities. Thus, they provide little or no evidence of benefits or possible risks for these groups. Two recent trials using a new drug class—the statins—show greater reductions in heart problems with their greater reductions in cholesterol and no increase in fatalities from coronary heart disease. One trial studied men and women with coronary heart disease and found a significant reduction in total fatalities; the other, which studied only men who did not have coronary heart disease, showed encouraging but not statistically significant reductions in fatalities from coronary heart disease.

District of Columbia: Information on Health Care Costs (GAO/AIMD-96-42, Apr. 22, 1996)

Recent studies on the District of Columbia's health care system have concluded that the city's health care problems are aggravated by such social factors as high rates of poverty, crime, substance abuse, and unemployment. These factors account for the sizable numbers of persons who do not seek preventive health care and cannot pay for medical treatment, the inappropriate use of D.C. General Hospital for primary care, and the many trauma care patients at area hospitals. To help Congress evaluate various restructuring proposals being considered for the District, this report discusses the District's health care budget and the composition

of the District's health care system, including the number of Medicaid recipients and uninsured and the distribution of hospitals and clinics.

Medicare: Enrollment Growth and Payment Practices for Kidney Dialysis Services (GAO/HEHS-96-33, Nov. 22, 1995)

Medicare is the predominant health care payer for people with end-stage renal disease—the permanent and irreversible loss of kidney function. Medicare's cost for this program has increased, mainly because of the substantial increase in new program enrollees. The average annual rate of increase averaged 11.6 percent between 1978 and 1991. In addition to the rise in enrollment, the mortality rate for new patients decreased. For example, deaths among beneficiaries during the first year in the program fell from 28 percent to 24 percent between 1982 and 1991. Because the program began in 1973, technological advances and greater availability of kidney dialysis machines have meant that persons who were not considered good candidates for kidney dialysis in 1973—those 65 years old or older and those whose kidney failure was caused by diabetes and hypertension—are now routinely placed on dialysis. GAO's review of medical services and supplies provided to all Medicare end-stage renal disease patients in 1991 shows that no separately billable service or supply was provided often enough to make it a good candidate to be considered part of the standard dialysis treatment and thus included in a future composite rate.

Prescription Drugs and Medicaid: Automated Review Systems Can Help Promote Safety, Save Money (GAO/AIMD-96-72, June 11, 1996)

Inappropriate use of prescription drugs can lead to drug-induced illness, hospitalization, and even death. Inappropriate drug use can also prove expensive for the Medicaid program. As a result, Congress mandated that states establish utilization review programs—called prospective reviews—to review Medicaid prescriptions before drugs are dispensed. Automated prospective drug utilization review systems are proving a low-cost way for states to help both doctors and pharmacies safeguard Medicaid recipients from potentially harmful medical reactions. Although the main emphasis of these systems—appropriately—has been safety, both safety benefits and dollar savings accrue from their use. Because results vary on the basis of how such systems are administered, it is important that states share their experiences. Absent any analysis of data from the Iowa demonstration project or any concerted effort by HCFA to collect and share other states' experiences, states have had only limited access to both safety and cost data—information that is critical to informed decisionmaking and to maximizing the effectiveness and efficiency of automated prospective drug utilization review systems.

Housing Issues

Rural Housing Programs: Opportunities Exist for Cost Savings and Management Improvement (GAO/RCED-96-11, Nov. 16, 1995)

The Agriculture Department's Rural Housing and Community Development Service provides about $2.85 billion each year for rural housing loans. As of June 1995, the Service had an outstanding single-family and multifamily housing loan portfolio of about $30 billion, which represented a significant federal investment in affordable housing for the rural poor. The largest portion of the loan portfolio is for single-family direct and guaranteed mortgage loans that are made to families or individuals who are without adequate housing and who are unable to obtain loans from private lenders at reasonable costs. Rural multifamily rental housing loans, made to finance apartment-style housing or to buy and rehabilitate existing rental units, make up the rest of the portfolio. This report provides information on the Service's single- and multifamily housing loan programs and discusses suggestions made by GAO and others that could yield cost savings or improve management in these programs.

Income Security Issues

Social Security: Telephone Access Enhanced at Field Offices Under Demonstration Project (GAO/HEHS-96-70, Feb. 23, 1996)

The Social Security Administration (SSA) runs a nationwide toll-free telephone number and is testing enhanced local office telephone service at selected offices. In February 1995, SSA began installing new telephone equipment, called automated attendant and voice mail, at 30 of its 800 nationwide field offices that list their telephone numbers in local telephone directories. The equipment was installed in different configurations. Telephone access—calls reaching an SSA employee with the caller spending less than 2 minutes on hold—improved 23 percent under one of the configurations being tested by SSA. In addition, busy signals dropped by more than 55 percent. Staffing, however, did not increase, and many callers reaching SSA did spend some time on hold before reaching an SSA representative. SSA field office staff viewed the installation of voice mail equipment at their desks as having a very positive effect on office efficiency and public service. SSA has not yet completed its two internal evaluations of the demonstration project. GAO concludes that the technology tested in the demonstration projects has the potential to

further SSA's public service goals. Public reaction and the effect on operations, however, will need to be considered as SSA weighs the costs and the benefits of this technology.

Food Stamp Program: Achieving Cost Neutrality in Minnesota's Family Investment Program (GAO/RCED-96-54, Feb. 12, 1996)

In 1994, Minnesota began a 5-year federally authorized welfare reform project known as the Minnesota Family Investment Program. Aimed at simplifying the welfare system, the project consolidates the food assistance and the cash benefits provided by three programs—Aid to Families With Dependent Children, the Food Stamp Program, and Minnesota's Family General Assistance Program—into a single monthly payment. The Food Stamp Act of 1977 requires that the federal government spend no more for this project's food assistance component in any fiscal year than it would have spent for the Food Stamp Program. That is, the project must be cost neutral. To ensure cost neutrality, the act requires the Agriculture Department and the state of Minnesota to agree upon methodologies for estimating what the costs of the Food Stamp Program for both benefits and administration would have been had there been no project. This report (1) describes the methodologies that Minnesota agreed to use for estimating Food Stamp Program costs that would have been incurred if the project had not been implemented; (2) determines if Minnesota implemented these methodologies; (3) assesses the reasonableness of these methodologies, as implemented, for estimating the cost of the Food Stamp Program for fiscal year 1994; and (4) compares the payments that would have been paid to Minnesota using the agreed-upon methodologies with the actual payments in fiscal year 1994.

Congressional Retirement Costs (GAO/GGD-96-24R, Oct. 12, 1995)

Pursuant to a congressional request, GAO provided information on the proposal to change the congressional retirement system, focusing on (1) the cost of congressional retirement benefits; (2) the potential savings from the proposal; (3) how private sector retirement systems compare with the congressional retirement system; and (4) the extent to which private sector employers are replacing defined benefit pension plans with defined contribution plans. GAO noted that: (1) the estimated cost of providing future retirement benefits to 1994 congressional members would total $14,327,224; (2) over a 5-year period, the cost of providing retirement benefits would total $71.5 million; (3) if the proposal were enacted, it would significantly reduce the cost of member retirement programs; (4) the cost of providing retirement benefits to 1994 congressional staff members would total $116.5 million; (5) although federal employees

receive greater benefit amounts under the Civil Service Retirement System (CSRS) than nonfederal employees before age 62, they receive smaller amounts after age 62 and older when social security benefits are available to nonfederal employees; and (6) the private sector does not appear to be moving toward replacing defined benefit plans with defined contribution plans.

District's Workforce: Annual Report Required by the District of Columbia Retirement Reform Act (GAO/GGD-96-95, Mar. 29, 1996)

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 disability retirement rates exceed a certain limit. GAO concludes that no reduction is required in the fiscal year 1997 payment to the fund.

Federal Employees' Compensation Act: Issues Associated With Changing Benefits for Older Beneficiaries (GAO/GGD-96-138BR, Aug. 14, 1996)

The Federal Employees' Compensation Act (FECA) now allows beneficiaries who are at or beyond retirement age to receive worker's compensation benefits. Possible changes to the legislation would reduce these benefits. This briefing report provides (1) a profile of beneficiaries on the long-term FECA rolls, (2) views of proponents and opponents of changing FECA benefits for older beneficiaries, and (3) questions and issues that Congress might consider if crafting benefit changes.

Federal Pensions: Thrift Savings Plan Has Key Role in Retirement Benefits (GAO/HEHS-96-1, Oct. 19, 1995)

As of September 1994, about 940,000 federal workers covered by the Federal Employees Retirement System (FERS) were voluntarily contributing an average of 5.7 percent of their salaries to the Thrift Savings Plan (TSP). Most of the remaining 300,000 workers covered by FERS who were not contributing were in the lower pay ranges. Lower-paid workers who were contributing were doing so at lower rates than higher-paid workers—an average of 4.4 percent of their salaries. However, lower-paid workers may achieve satisfactory retirement income levels even with low contribution rates because Social Security benefits are proportionately greater for them than for higher-paid workers. Higher-paid workers need to defer at least 5 percent of their salaries throughout their careers—if not more—to achieve retirement income of 60 to 80 percent of their preretirement salaries. Educating FERS workers can play a key role in their making wise preretirement investment choices. Although TSP materials discuss the plan's financial aspects, they do not explicitly discuss how TSP can help workers covered by FERS achieve their retirement income goals. The TSP Board is seeking legislation that would enable employees to invest

in a domestic small capitalization fund and an international stock fund. GAO found that these two additions would make TSP's investment options more closely resemble those in similar private sector plans.

Older Americans Act Funding Formula (GAO/HEHS-96-137R, Apr. 24, 1996)

Pursuant to a congressional request, GAO provided information on how proposed changes to the funding formula for title III of the Older Americans Act would affect equity in state funding and per-person-in-need income. GAO found that: (1) the proposed formula changes would improve funding equity and target more aid to the elderly in the oldest age groups and low-income states; (2) the formula changes would not affect small states that are guaranteed at least 0.5 percent of the funds made available for state distribution; (3) the changes would reduce cross-state disparities, increase funding for states whose funding is below the national average, and decrease funding for those states whose funding is above the average; and (4) funding disparities could be further reduced if minority status and poverty were included in the formula changes.

PASS Program: SSA Work Incentive for Disabled Beneficiaries Poorly Managed (GAO/HEHS-96-51, Feb. 28, 1996)

SSA is poorly managing a small but growing program to encourage disability beneficiaries to seek employment. The plan for achieving self-support (PASS) program, established in 1972, is currently small—only about 10,300 persons participated in December 1994—but the number of participants has swelled more than fivefold during the past 5 years as awareness of the program has increased and millions more disabled beneficiaries have become eligible to participate. The PASS program is vulnerable to abuse because of vague guidelines, and its impact on employment is unknown because SSA does not collect basic data on participants and their employment. In addition, SSA top management has not adequately considered the potential problems posed by professional PASS preparers, whose fees—as much as $800—are often included as PASS expenses. SSA is trying to address some of these internal control weaknesses, but it cannot guarantee today that taxpayer dollars are being well spent.

Proposed Pension Reversion (GAO/HEHS-96-54R, Oct. 24, 1995)

Pursuant to a congressional request, GAO provided information on pension plan underfunding, focusing on a proposed legislative provision that would allow companies to transfer excess assets out of their defined benefit pension plans for any purpose. GAO noted that: (1) current and termination liabilities are measures of liabilities that a plan has accrued as of its valuation date and each relies on different assumptions and yields very

different estimates; (2) plans that are significantly funded over their current liability can lose plan funding rapidly due to bankruptcy, early retirements, or a decline in interest rates; (3) participants can lose benefits when a plan is terminated because the Pension Benefit Guaranty Corporation (PBGC) generally does not insure all benefit amounts; (4) companies may not transfer or obtain excess assets from a defined benefit plan under current law, but some transfers may be permissible if the plans merge and participants' benefits are not reduced; (5) it is unclear whether the transfer of excess plan assets would release capital for investment; and (6) although the proposed provision would allow withdrawal of overfunded assets, plan sponsors may be required to make longer cash contributions in the future.

Public Pensions: Section 457 Plans Pose Greater Risk Than Other Supplemental Plans (GAO/HEHS-96-38, Apr. 30, 1996)

Millions of state and local government employees are trying to increase their future retirement benefits by deferring some of their wages to supplement pension plans, known as salary reduction arrangements or plans. The amount deferred or contributed to these plans, however, may be at risk. Recent media stories have recounted instances of imprudent investment, improper use of plan funds by sponsors, and possible seizure of plan funds by sponsoring governments' creditors. This report examines the risks of financial loss inherent in such plans and discusses whether the provisions of such plans treat participants comparably. See also Public Pensions: Summary of Federal Pension Plan Data (GAO/AIMD-96-6, Feb. 16, 1996) and Public Pensions: State and Local Government Contributions to Underfunded Plans (GAO/HEHS-96-56, Mar. 14, 1996).

Public Pensions: State and Local Government Contributions to Underfunded Plans (GAO/HEHS-96-56, Mar. 14, 1996)

State and local governments with underfunded pension plans risk tough budget choices in the future if they do not make progress toward full funding. Their taxpayers will face a liability for benefits earned by current and former government workers, forcing these governments to choose between reducing future pension benefits or raising taxes. Funding of state and local pension plans has improved significantly since the 1970s. After adjusting for inflation, the amount of the unfunded liability has been cut in half. Still, in 1992, 75 percent of state and local government pension plans in the Public Pension Coordinating Council survey were underfunded; 38 percent were less than 80 percent funded. Sponsors of slightly more than half of the plans in the survey made contributions on schedule to pay off any unfunded liability. One-third of the pension plans, however, were underfunded in 1992 and were not receiving the actuarially required sponsor contributions. Of all plans with complete data, one-fifth

were underfunded and were not receiving full contributions in both 1990 and 1992. See also Public Pensions: Summary of Federal Pension Plan Data (GAO/AIMD-96-6, Feb. 16, 1996) and Public Pensions: Section 457 Plans Pose Greater Risk Than Other Supplemental Plans (GAO/HEHS-96-38, Apr. 30, 1996).

Public Pensions: Summary of Federal Pension Plan Data (GAO/AIMD-96-6, Feb. 16, 1996)

This report—one in a series of three reports on the status of public pension plan funding—provides summary data on federal government pension plans. The other two reports in the series address state and local government pension plans. GAO focuses on federally sponsored defined benefit and defined contribution plans. See also Public Pensions: State and Local Government Contributions to Underfunded Plans (GAO/HEHS-96-56, Mar. 14, 1996) and Public Pensions: Section 457 Plans Pose Greater Risk Than Other Supplemental Plans (GAO/HEHS-96-38, Apr. 30, 1996).

Social Security Administration: Effective Leadership Needed to Meet Daunting Challenges (GAO/HEHS-96-196, Sept. 12, 1996)

With a staff of 64,000, SSA runs the nation's largest federal program—social security—as well as the largest cash welfare program—the supplemental security income (SSI) program. SSA's expenditures totaled $363 billion in fiscal year 1995, nearly one-fourth of the $1.5 trillion federal budget. SSA programs touch the lives of nearly every American, providing benefits to the retired, the disabled, and their dependents and survivors. This report, which is based on July 1995 testimony before Congress (GAO/T-OCG-96-7), discusses SSA's progress in meeting the challenges of managing for results and accountability; funding future retirement benefits; rethinking SSI fraud, waste, and abuse; handling increasing workloads with fewer resources; and establishing effective leadership.

Social Security Disability: Backlog Reduction Efforts Under Way: Significant Challenges Remain (GAO/HEHS-96-87, July 11, 1996)

SSA runs the nation's largest programs providing cash benefits to people with severe long-term disabilities. The number of persons receiving either disability insurance (DI) or SSI benefits has soared during the past decade. At the same time, SSA has struggled to deal with unprecedented growth in appeals of its disability decisions and the resulting backlog of cases awaiting hearing decisions. Processing delays stemming from a backlog of more than half a million appealed cases have created hardships for disability claimants, who often wait more than a year for final disability decisions. This report discusses (1) factors contributing to the growth in appealed cases, (2) SSA initiatives to reduce the backlog, and (3) long-term steps that need to be taken to make the disability appeals process more timely and efficient.

Social Security: Issues Involving Benefit Equity for Working Women (GAO/HEHS-96-55, Apr. 10, 1996)

When the social security program was established in the 1930s, less than 15 percent of married women held paying jobs outside the home; today, about 60 percent of married women are paid workers. Despite the movement of women into the labor market, the social security benefit structure has remained essentially unchanged over the years. The fairness of the benefit structure has come under increasing scrutiny, especially as it affects women who have earned benefits in their own right. For example, a two-earner couple will receive lower combined benefits in retirement than an identical one-earner couple. Also, a married woman who works and pays social security taxes might not, because of the dual entitlement limitation, receive higher benefits than if she had never worked and received only a spousal benefit. Several proposals seek to remedy these inequities. These include two broad proposals—"earnings sharing" and a "double-decker" plan—and several narrower proposals, such as reducing spousal benefits. None of the measures has been adopted, however, partly because they would either boost program costs or reduce benefits for some beneficiaries. Their enactment could also impose a large administrative burden on SSA.

Social Security Trust Funds (GAO/AIMD-96-30R, Dec. 12, 1995)

Pursuant to a congressional request, GAO reviewed the Secretary of the Treasury's actions during the 1995 debt ceiling crisis, focusing on whether the Department of the Treasury followed normal investment and redemption policies regarding the Social Security trust funds. GAO noted that Treasury records show that the Secretary followed normal investment and redemption policies for all transactions affecting the trust funds between November 1, 1995, and December 8, 1995.

SSA Disability: Program Redesign Necessary to Encourage Return to Work (GAO/HEHS-96-62, Apr. 24, 1996)

During the past decade, the number of persons receiving benefits from Social Security's DI and SSI programs increased 70 percent because of program changes and economic and demographic factors. These programs, which provide assistance to persons with disabilities until they return to work, if that is possible, provided $53 billion in cash benefits to 7.2 million people in 1994. Advances in technology, such as standing wheelchairs and synthetic voice systems, and the medical management of some physical and mental disabilities have allowed some persons to work. Moreover, there has been a greater trend toward inclusion of and participation by people with disabilities in the mainstream of society. Yet both programs have done little to identify recipients who might benefit from rehabilitation and employment assistance and ultimately return to work.

SSA Overpayment Recovery (GAO/HEHS-96-104R, Apr. 30, 1996)

Pursuant to a congressional request, GAO reviewed how SSA recovers overpayments of benefits. GAO found that: (1) the amount of SSI, RSI, and DI payments that SSA withholds to recoup overpayments is not upwardly adjusted with cost-of-living increases in the many cases in which the withholding is based on a fixed dollar amount negotiated with the beneficiary, as opposed to a fixed percentage of the recipient's monthly income or monthly benefit amount; (2) basing the withholding on a percentage instead of a dollar amount would accelerate the recovery of overpayments without imposing an undue burden on recipients or causing excessive administrative costs; (3) accelerating recoveries while recipients are still receiving benefits improves the chance of collecting overpayments; (4) SSA administrative costs would likely increase only in the first year of implementation; and (5) the cost of notifying recipients of the new withholding procedures would be negligible, because SSA already notifies recipients when overpayments occur.

Supplemental Security Income: Some Recipients Transfer Valuable Resources to Qualify for Benefits (GAO/HEHS-96-79, Apr. 30, 1996)

Existing law does not prohibit people from transferring resources to qualify for benefits under the SSI program—the largest cash assistance program for the poor and one of the fastest growing entitlement programs. Between 1990 and 1994, 3,500 SSI recipients transferred assets, including cash, houses, land, and other items, valued at $74 million. Transfer values ranged as high as $800,000; most transfers fell between $10,000 and $25,000. The total amount of resources transferred, however, is likely to be larger than GAO's estimate because SSA is not required to verify the accuracy of resource transfer information, which is self-reported by individuals. Moreover, because the information is self-reported, SSA is unlikely to detect unreported transfers. Without a transfer-of-resource restriction, SSI recipients who transferred assets to qualify for benefits would receive nearly $8 million in benefits in the 24 months after they transferred resources. Many of these recipients also could have received Medicaid acute-care benefits at an annual value of between $2,800 and $5,300 per recipient. GAO estimates that from 1990 through 1995, SSA could have saved $14.6 million with a transfer-of-income restriction similar to that used for Medicaid. Such a restriction could also boost the public's confidence in the program's integrity.

Thrift Savings Plan (GAO/HEHS-96-66R, Nov. 14, 1995)

Pursuant to a congressional request, GAO reviewed (1) why Congress replaced CSRS with FERS; and (2) the Federal Retirement Thrift Investment Board's response to the GAO recommendation concerning the inclusion of participant information on contributions to TSP retirement accounts. GAO

noted that: (1) Congress replaced CSRS with FERS to provide federal employees with a retirement benefit that included a Social Security payment, a basic FERS annuity, and payments from amounts accumulated in a TSP account; and (2) the Board did not implement the recommendation because it believed that it would be violating its fiduciary duty to TSP participants and misusing its funds.

401(k) Pension Plans: Many Take Advantage of Opportunity to Ensure Adequate Retirement Income (GAO/HEHS-96-176, Aug. 2, 1996)

Many workers fill the gap between social security and an adequate retirement income with pension benefits, and one in four workers with pension coverage participates in a 401(k) program. GAO found, among other survey results, that workers with higher incomes and college educations tended to contribute more to 401(k) plans than others and women tend to invest more conservatively than do men. Also, higher-income workers and better-educated workers with 401(k) pension plans tend to contribute a larger percentage of their salaries to their pension accounts and to invest their pension funds in higher-yielding assets than do other 401(k) plan participants. Consequently, although many workers will have enough retirement income, some workers, especially those with less education and lower incomes, risk inadequate retirement incomes.

Veterans/DOD Issues

Neoplasms in Persian Gulf Veterans (GAO/PEMD-96-15R, June 21, 1996)

Pursuant to a congressional request, GAO reviewed Department of Veterans Affairs' (VA) data on the frequency of abnormal tissue growths among Persian Gulf War veterans and other military personnel. GAO noted that: (1) VA data show that Persian Gulf War veterans have a neoplasm-diagnosis rate that is more than three times higher than that of nonwar veterans; (2) the higher neoplasm rate for war veterans may be due to causes other than service in the Persian Gulf, such as war veterans seeking VA hospital treatment more often than nonwar veterans; (3) the rate of surgical procedures for the two groups is not significantly different, which could mean that war veterans' neoplasms are not as serious as those diagnosed among nonwar veterans; and (4) analyzing alternative explanations for war veterans' neoplasm rates would require extensive statistical analysis and professional judgment.

Defense Health Care: Effects of Mandated Cost Sharing on Uniformed Services Treatment Facilities Likely to Be Minor (GAO/HEHS-96-141, May 13, 1996)

The establishment of uniform benefits and cost sharing for DOD beneficiaries is a key component of the TRICARE program—DOD's new nationwide managed health care program—and is something that GAO and others have long advocated. Such uniformity would, in GAO's view, eliminate inequities and confusion that now exist among beneficiaries of military health plans. Although adopting TRICARE cost shares may cause some minor adverse selection for the Uniformed Services Treatment Facilities (USTF), there should be no lasting negative financial impact on its operations. Moreover, the new cost shares, which are similar to HMOs, are appropriate for the risks to be borne by the USTFs and will likely make the USTF population more similar to DOD's general beneficiary population. More importantly, there should be a financial impact. DOD's current USTF capitation methodology takes into account and allows for adjusted reimbursement levels for such higher costs that result from changes in the enrollee cost shares and population characteristics.

Defense Health Care: Medicare Costs and Other Issues May Affect Uniformed Services Treatment Facilities' Future (GAO/HEHS-96-124, May 17, 1996)

Since fiscal year 1994, Congress has appropriated nearly $1 billion for USTF to deliver health care to what now totals 124,000 beneficiaries. In recent years, Congress has grown concerned about the rising cost to treat USTF members, in part because some members retain dual eligibility and unrestricted access to other government health care services, such as Medicare and DOD hospitals. Congress directed DOD in 1991 to reform the USTF program by introducing a managed care program. As DOD begins to implement its new nationwide managed care program—TRICARE—questions about the program's future persist. This report discusses (1) whether unnecessary costs result from USTF members' use of other federally funded health care sources and (2) other issues that need to be considered as Congress deliberates reauthorization of the USTF program.

Defense Health Care: New Managed Care Plan Progressing, but Cost and Performance Issues Remain (GAO/HEHS-96-128, June 14, 1996)

The DOD health care system, which costs $15 billion annually, is undergoing sweeping reform. Through TRICARE, DOD is trying to improve access to care among its 8.3 million beneficiaries while containing costs. How well DOD implements and operates TRICARE may define and shape military medicine for years to come. Because of TRICARE's complexity, scale, and impact on beneficiaries, GAO reviewed the program, focusing on (1) whether DOD's experiences with early implementation yielded the expected results, (2) how early outcomes may affect costs, and (3) whether DOD has defined and is capturing data needed to manage and assess TRICARE's performance. GAO concludes that despite initial confusion among beneficiaries arising from marketing and education problems, as

well as problems with the compatibility of computer systems, early implementation of TRICARE is progressing consistent with congressional and DOD goals. However, the success of DOD's efforts to implement resource-sharing agreements and utilization management is critical to containing health care costs. DOD also needs to gather enrollment and performance data so that it and Congress can assess TRICARE's success in the future.

Readjustment Counseling Service: Vet Centers Address Multiple Client Problems, but Improvement Is Needed (GAO/HEHS-96-113, July 17, 1996)

VA operates 205 community-based facilities known as Vet Centers to help veterans make a successful transition from military to civilian life. Vet Center counselors reported visiting with about 138,000 veterans during fiscal year 1995, 84,000 of whom were new to Vet Centers. Most veterans do not establish long-term relationships with Vet Center counselors; however, those who do represent a core group who use services over extended periods for serious psychological problems, such as post-traumatic stress disorder. Other veterans usually visit Vet Center counselors only once or twice for social concerns, such as employment or benefit needs.

VA Health Care: Effects of Facility Realignment on Construction Needs Are Unknown (GAO/HEHS-96-19, Nov. 17, 1995)

As part of the fiscal year 1996 budget, the President requested $524 million for major VA construction projects. These projects include the construction of two new VA medical facilities and major renovations at seven existing facilities. This report discusses how the projects are expected to benefit veterans and the relationships between the proposed projects and VA's recent efforts to realign all of its facilities into a new service network. GAO also discusses the potential effects of funding delays on VA's construction award dates and costs.

VA Health Care: Exploring Options to Improve Veterans' Access to VA Facilities (GAO/HEHS-96-52, Feb. 6, 1996)

Since its creation in 1930, VA's health care system has become one of the nation's largest networks of direct delivery health care providers, with 173 hospitals and 376 outpatient clinics nationwide. But because public and private health insurance programs have also grown, most veterans now have alternatives to VA health care. Many veterans indicate that they use private providers because they live too far from VA hospitals or outpatient clinics. VA has recently encouraged its facilities to improve veterans' access to VA health care. This report discusses (1) characteristics of recent users of VA medical facilities; (2) the geographic accessibility of VA and private medical facilities that provide standard benefits; and (3) options that VA facilities might want to consider to improve the accessibility of VA

health care, such as locating new medical facilities closer to where veterans live and contracting with private providers.

VA Health Care: How Distance From VA Facilities Affects Veterans' Use of VA Services (GAO/HEHS-96-31, Dec. 20, 1995)

Living within 5 miles of a VA Hospital or outpatient clinic significant increases the likelihood that a veterans will use VA health care services. Although most veterans live within 25 miles of a VA hospital or outpatient clinic, use of VA facility declines significantly among veterans living more than 5 miles from a VA facility. Only about 11 percent of veterans live within 5 miles of a VA hospital providing acute medical and surgical care and 17 percent within 5 miles of a VA outpatient clinic. Use of VA health care services does not decline with distance as rapidly among veterans receiving VA compensation or pension payments. Even those veterans with a service-connected disability who live more than 100 miles from a VA outpatient clinic are more likely to avail themselves of VA outpatient services than are higher-income veterans with nonservice-connected disabilities who live within 5 miles of a VA outpatient clinic. Other factors that may contribute to differences in the use of VA services include broader eligibility and entitlement to outpatient care for service-connected and low-income veterans, veterans' ages, and differences in available resources.

VA Health Care: Issues Affecting Eligibility Reform Efforts (GAO/HEHS-96-160, Sept. 11, 1996)

Pursuant to a congressional request, GAO reviewed various proposals that would simplify and expand eligibility for veterans' health care benefits.

GAO found that: (1) eligibility requirements for veterans health care benefits have become increasingly complex and a source of frustration to veterans, VA physicians, and administrators; (2) VA does not have a defined or uniform benefits package and cannot ensure the availability of covered services; (3) VA has forced physicians to either deny needy veterans ineligible services or provide these services illegally free of charge; (4) VA health care eligibility reform could expand the types of services provided and allow veterans lacking supplemental insurance access to needed services; (5) the four legislative proposals reviewed could more than double the demand for VA outpatient services, cause VA to ration care, and force VA to seek larger appropriations to preserve its safety-net mission; (6) alternative approaches including limiting the number of eligible veterans and range of benefits added or increasing cost sharing could preserve VA ability to provide specialized services; (7) although the American Legion proposal incorporates all three of these approaches and is a basis for future reform proposals, changes need to be made to reduce

the number of veterans covered, exempt VA from most federal contracting laws, and designate VA as a Medicare provider; and (8) one option to reduce the number of veterans who would be eligible under the proposal and target those veterans who have low incomes and lack supplemental insurance, would be to limit VA benefits for veterans with no service-related disabilities.

VA Health Care: Opportunities for Service Delivery Efficiencies Within Existing Resources (GAO/HEHS-96-121, July 25, 1996)

VA, which operates one of the nation's largest health care systems, faces increasing pressure to contain or reduce spending as part of governmentwide efforts to balance the budget. This report discusses ways VA could operate more efficiently and reduce the resources needed to meet the needs of veterans in what is commonly referred to as the mandatory care category. GAO addresses (1) VA's forecasts of future resource needs, (2) opportunities to run VA's system more efficiently, (3) differences between VA and the private sector in efficiency incentives, and (4) recent VA efforts to reorganize its health care system and create efficiency incentives. GAO concludes that successful implementation of a range of reforms, coupled with reduced demand for services, could save the VA health care system billions of dollars during the next 7 years. The success of these efforts, however, depends on introducing efficiency incentives at VA that have long existed in the private sector.

VA Health Care: Travis Hospital Construction Project Is Not Justified (GAO/HEHS-96-198, Sept. 3, 1996)

Pursuant to a congressional request, GAO provided information on VA's planned construction of an outpatient clinic and additional bed space at the David Grant Medical Center, focusing on (1) whether the project could be adequately justified and (2) if there are cost-effective alternatives to planned hospital construction.

GAO found that: (1) VA planned construction of additional bed space and an outpatient clinic at Travis Air Base appears to be unjustified; (2) VA has not revised its construction plans to reflect the changes that have occurred in the health care marketplace and advances in medical practices and technology that have reduced the demand for hospital beds in Northern California; (3) VA has not considered whether its construction plans will negatively affect surrounding community hospitals; (4) the veteran population in Northern California is expected to decline by 25 percent between 1995 and 2010 and may not be large enough to support a new outpatient clinic; (5) VA is adequately meeting the health care needs of Northern California Health Care System veterans; (6) although VA clinics have experienced some space constraints, they have had no problem in

placing veterans needing hospital care and using community hospitals for medical emergencies; (7) alternatives to VA construction plans include modifying VA hospital referral patterns, expanding use of other military and VA hospitals, granting VA more authority to contract for lower cost community hospital services, or allowing it to purchase a local Air Force hospital for use as a hospital or outpatient clinic; (8) VA Sierra Pacific Network officials are evaluating the best way to meet veterans' future health care needs, make better use of VA facilities, and increase the use of private and other public facilities; and (9) Congress' decision on whether to fund the construction plan will significantly affect the alternatives and options that can be implemented.

VA Health Care: Trends in Malpractice Claims Can Aid in Addressing Quality of Care Problems (GAO/HEHS-96-24, Dec. 21, 1995.)

From fiscal year 1990 to fiscal year 1994, malpractice claims against VA medical centers have steadily increased, from 678 to 978, with payments made to claimants totaling more than $200 million. In 1992, VA entered into an agreement with the Armed Forces Institute of Pathology (AFIP) to analyze trends in VA malpractice claims. VA's quality assurance staff, however, are making only limited use of the information being developed by AFIP. Although malpractice claim information is available from DOD, it is not comparable to the malpractice data that VA collects. The main reason for the lack of comparability is the absence of a standard data collection format. Nonetheless, GAO found that DOD information may be useful to VA to draw comparisons in areas in which malpractice claims are being generated, such as incidents related to surgery, diagnosis, and medication.

Veterans' Health Care: Facilities' Resource Allocations Could Be More Equitable (GAO/HEHS-96-48, Feb. 7, 1996)

VA confronts the challenge of equitably allocating more than $16 billion in health care appropriations across a nationwide network of hospitals, clinics, and nursing homes. The challenge is made greater by the changing demographics of veterans. Although nationally the veteran population is declining, some veterans have relocated from the Northeast and the Midwest to southern and southwestern states in the past decade, offsetting veteran deaths in these states. VA has tried for years to implement an equitable resource allocation method—one that would link resources to facility workloads and foster efficiency. The need for such a system has become more urgent in recent years because of the demographic shift in veterans and the dramatic changes in health care resulting from increasingly limited resources. The resource allocation system can help VA achieve this goal by forecasting workload changes and providing comparative data on facilities' costs. Nonetheless, VA has not taken steps to overcome several barriers that can prevent it from acting on the data

the system produces. If the system is to live up to its potential, several changes must be made, including linking resource allocation to VA's strategic plan, conducting a formal review and evaluation of facility cost variations, evaluating the basis for not allocating funds through resource planning and management, and using resource planning and management to overcome differences in veterans' access to care.

Veterans' Health Care: VA's Approaches to Meeting Veterans' Home Health Care Needs (GAO/HEHS-96-68, Mar. 15, 1996)

In fiscal year 1994, VA provided home health care to more than 40,000 veterans at a cost of $64 million to VA and millions more to Medicare. By providing them with home health care, VA allows these veterans to continue living at home and in their communities, rather than receive care in institutions. Veterans may need home health care for various reasons. Some veterans may have chronic health problems, such as heart disease, and require periodic visits, while others may be discharged from VA medical centers following surgery and need dressings changed or medications administered. The number of veterans needing home health care is expected to grow as the veteran population ages and as VA discharges patients from its hospitals to reduce the costs of hospitalization. This report provides information on (1) the characteristics and the services of the home health care programs that VA uses, (2) the available data on program costs, and (3) the way in which VA ensures that veterans receive quality service.

Vocational Rehabilitation: VA Continues to Place Few Disabled Veterans in Jobs (GAO/HEHS-96-155, Sept. 3, 1996)

Pursuant to a congressional request, GAO reviewed VA's vocational rehabilitation program, focusing on (1) the percentage of rehabilitated veterans, (2) the services provided, (3) the characteristics of clients served, (4) the cost of rehabilitation, and (5) VA's efforts to improve program effectiveness.

GAO found that: (1) the VA vocational rehabilitation program continues to focus on training and higher education, but it places few veterans in jobs; (2) from 1991 to 1995, VA rehabilitated only about 8 percent of eligible veterans, while 51 percent continued to receive program services; (3) those program participants with a serious employment handicap declined from 40 percent to 29 percent over the last 5 years and those with a 10-to-20 percent disability increased from 34 percent to 42 percent; (4) over 90 percent of program applicants were male and had completed high school and almost 25 percent had some college courses; (5) VA spent on average about $20,000 on each employed veteran and $10,000 on each program dropout; (6) over one-half of VA rehabilitation costs were for

veterans' subsistence allowances; (7) state vocational rehabilitation agencies rehabilitated 37 percent of eligible individuals, while the remaining individuals continued to receive state program services; (8) the state vocational rehabilitation programs provided a wide range of rehabilitation services and had a majority of severely disabled clients; (9) almost 60 percent of the state program applicants were male and had completed high school and 17 percent had completed some college courses; (10) the state programs spent on average about $3,000 on each rehabilitated client and about $2,000 on each dropout, none of which covered clients' living expenses; (11) VA established a design team in 1995 to improve program effectiveness, primarily by increasing the percentage of suitably employed veterans, improving staff job finding and placement skills, and developing a data management system; and (12) VA plans to implement these program changes in fiscal year 1997.

Other Related Issues

Aging Issues: Related GAO Reports and Activities in Fiscal Year 1995 (GAO/HEHS-96-82, Mar. 6, 1996)

This report provides a compilation of GAO's fiscal year 1995 products and ongoing work on older Americans. Because the elderly are one of the fastest-growing segments of American society, Congress faces a host of issues—from health care to social security to pensions—in which the federal government will play an important role. This booklet is divided into three sections, which summarize different types of GAO products relating to older Americans: reports and correspondence, testimony before Congress, and ongoing work. Overall, health, income security, and veterans issues were the areas most frequently addressed by GAO work on older Americans.

Health, Education, Employment, Social Security, Welfare, and Veterans Reports: Five-Year Report 1991-96 (GAO/HEHS-96-98W, Mar. 1, 1996)

GAO published a listing of reports and testimonies issued from March 1991 through February 1996, regarding such issues as: (1) health care services and access; (2) health insurance and financing; (3) health care reform; (4) long-term care; (5) Medicare and Medicaid; (6) public health and education; (7) early childhood, elementary, secondary, and higher education; (8) school-to-work transition; (9) equal employment opportunities; (10) labor-management relations; (11) workplace quality; (12) children; (13) social security, disability, and welfare benefits; (14) pensions; (15) military health care; and (16) veterans' benefits.

Health, Education, Employment, Social Security, Welfare, and Veterans Reports (GAO/HEHS-96-15W, Oct. 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 month and summarizes key products. Another section lists all documents published during the past year, organized chronologically by subject. Order forms are included.

Fiscal Year 1996 Testimonies on Issues Affecting Older Americans

GAO testified 34 times before congressional committees during fiscal year 1996 on issues relating to older Americans. Of these testimonies, 1 was on education/employment, 15 on health, 3 on housing, 8 on income security, and 7 on veterans/DOD issues.

Education and Employment Issues

Senior Community Service Employment: Program Delivery Could Be Improved Through Legislative and Administrative Actions (GAO/T-HEHS-96-57, Nov. 2, 1995)

The Labor Department's Senior Community Service Employment Program finances part-time minimum-wage community service jobs for about 100,000 poor elderly Americans. GAO found that Labor distributes program funds through noncompetitive grants to 10 national organizations, called national sponsors, and to state agencies. These national sponsors and state agencies, in turn, use the grant funds to finance local employment projects run by community service host agencies, such as libraries, nutrition centers, and parks, that directly employ older Americans. GAO found that the relative distribution of funds to the national sponsors and state agencies along with Labor's method of implementing the hold-harmless provisions have resulted in the distribution of funds among and within states that bear little relationship to actual need. GAO also found that, under Labor's regulations, expenditures that GAO believes to be administrative in nature may be charged to another cost category, allowing grantees to exceed the statutory 15-percent limit on administrative costs.

Health Issues

Blue Cross and Blue Shield: Change in Pharmacy Benefits Affects Federal Enrollees (GAO/T-HEHS-96-206, Sept. 5, 1996)

Of the 400 health plans available to federal workers, the Blue Cross and Blue Shield plan is the largest, covering nearly 42 percent of the 4 million federal enrollees. To control drug costs, Blue Cross and Blue Shield recently began requiring federal enrollees to pay 20 percent of the price of prescriptions purchased at participating retail pharmacies. Previously, federal enrollees did not have to pay anything for prescription drugs. Enrollees may continue to receive drugs free of charge, however, if they buy them through the plan's mail order program. Members of Congress and retail pharmacies have raised concerns about the quality of mail order services and the effect of the change on the business of retail pharmacies

that serve plan enrollees. To provide pharmacy services to its federal employee health plan, Blue Cross and Blue Shield contracts with two PBMs: PCS Health Systems, Inc., which provides retail prescription drug services, and Merck-Medco Managed Care, Inc., which provides mail order drug services. This testimony discusses (1) Blue Cross and Blue Shield's reasons for the benefit change, (2) how it was implemented, (3) the change's effect on retail pharmacies, and (4) the extent to which PCS and Merck-Medco have met their contract requirements for services provided to the federal health plan.

Consumer Health Informatics: Emerging Issues (GAO/T-AIMD-96-134, July 26, 1996)

Technology has increased the amount of health information available to the public, allowing consumers to become better educated and more involved in their own health care. Government and private health care organizations rely on a variety of technologies to disseminate health information on preventive care, illness and injury management, treatment options, post-treatment care, and other topics. This report discusses consumer health informatics—the use of computers and telecommunications to help consumers obtain information, analyze their health care needs, and make decisions about their own health. GAO provides information on (1) the demand for health information and the expanding capabilities of technology; (2) users' and developers' views on potential systems advantages and issues surrounding systems development and use; (3) government involvement—federal, state, and local—in developing these technologies; and (4) the status of related efforts by HHS. As part of this review, GAO surveyed consumer health informatics experts and presents their views on issues that need to be addressed when developing consumer health information systems.

Fraud and Abuse: Medicare Continues to Be Vulnerable to Exploitation by Unscrupulous Providers (GAO/T-HEHS-96-7, Nov. 2, 1995)

Most Medicare providers try to abide by program rules and strive to meet beneficiaries' needs. Nevertheless, Medicare is overwhelmed in its attempts to keep pace with, much less stay ahead of, those bent on cheating the system. GAO's recent investigations of Medicare fraud and abuse have implicated home health agencies, medical suppliers, pharmacists, rehabilitation therapy companies, and clinical laboratories. They are attracted by the high reimbursement levels for some supplies and services, and the few barriers to entry into this lucrative marketplace. Once engaged in these profitable activities, exploitative providers too often escape detection because of inadequate claims scrutiny, elude pursuit by law enforcement authorities because of the authorities' limited

resources and fragmented responsibilities, and face little risk of speedy or appropriate punishment.

Fraud and Abuse: Providers Excluded From Medicaid Continue to Participate in Federal Health Programs (GAO/T-HEHS-96-205, Sept. 5, 1996)

Although HHS' Office of Inspector General (OIG) has excluded thousands of health care providers from state Medicaid programs because they committed fraud or delivered poor care to beneficiaries, weaknesses in the OIG's process could leave such providers on the rolls of federal health programs for unacceptable periods of time. This puts at risk the health and safety of beneficiaries and compromises the financial integrity of Medicaid, Medicare, and other federal health programs. The weaknesses include (1) lengthy delays in the OIG's decision process, even in cases where a provider has been convicted of fraud or patient abuse and neglect; (2) inconsistencies among OIG field offices regarding which providers will be considered for nationwide exclusion; (3) states not informing the OIG about providers who agree to stop participating in their Medicaid programs even though the provider withdrew because of egregious patient care or abusive billing practices; and (4) how states use information from the OIG to remove excluded providers from state programs. Because of incomplete records in the OIG field offices, GAO could not reach a conclusion as to the magnitude of these problems.

Medicaid: Spending Pressures Spur States Toward Program Restructuring (GAO/T-HEHS-96-75, Jan. 18, 1996)

Several factors, including federal mandates that expand eligibility, medical price inflation, and creative financing schemes, have boosted Medicaid costs. To contain these expenses, 22 states have recently sought waivers from federal regulations that limit their ability to run extensive managed care programs. Some of these states have required the enrollment of their acute care patients—primarily low-income women and children—into managed care programs and have expanded coverage to previously ineligible persons. Arizona, which runs a Medicaid managed care program under a federal waiver obtained more than 10 years ago, has lowered Medicaid spending by millions of dollars. It also leads the states in its development of information systems for collecting medical encounter data essential for assessing quality of care.

Medicare: Excessive Payments for Medical Supplies Continue Despite Improvements (GAO/T-HEHS-96-5, Oct. 2, 1995)

Despite improvements by HCFA in claims monitoring, problems in payments for medical supplies persist. The inflexibility of Medicare's fee schedule results in payment rates that are higher than wholesale and many retail prices. In addition, in the case of many part A claims, claims processing contractors do not know what they are paying for and in the case of part B claims, have not had a basis for questioning unreasonably high charges. Neither type of contractor has been able to test claims for possible duplicate payments. For these reasons, Medicare has lost hundreds of millions of dollars in unnecessary payments. By obtaining the legislative authority to modify payment rates in accordance with market condition, requiring providers to itemize claims, and introducing the relevant medical policies before paying for new benefits, HCFA could reduce its dollar losses arising from medical supply payments. Contractors could avoid paying unreasonable charges and making duplicate payments.

Medicare: Millions Can Be Saved by Screening Claims for Overused Services (GAO/T-HEHS-96-86, Feb. 8, 1996)

Medicare contractors routinely pay hundreds of millions of dollars in Medicare claims without first determining if the services provided are necessary. GAO reviewed payments to doctors for six groups of high-volume medical procedures—ranging from eye examinations to chest X rays—that accounted for nearly $3 billion in Medicare payments in 1994. GAO also surveyed 17 contractors to determine if they had used medical necessity criteria in their claims processing to screen for these six groups of procedures. For each of the six groups, more than half of the 17 contractors failed to use automated screens to flag claims for unnecessary, inappropriate, or overused treatments. These prepayment screens could have saved millions of taxpayer dollars now wasted on questionable services. Problems with controlling payments for widely overused procedures continue because HCFA lacks a national strategy to control these payments. HCFA now relies on contractors to focus on procedures where local use exceeds the national average. Although this approach helps reduce local overuse of some procedures, it is not designed to control overuse of a procedure nationwide.

Medicare: Private Payer Strategies Suggest Options to Reduce Rapid Spending Growth (GAO/T-HEHS-96-138, Apr. 30, 1996)

Improvements to Medicare's traditional fee-for-service program could yield much-needed savings. With better management, this program, which now serves about 90 percent of beneficiaries, could run more efficiently while continuing to provide good service to the nation's elderly. This means allowing Medicare to use tools similar to those used by private payers to manage health care costs. Negotiated discounts, competitive bidding, preferred providers, case management utilization reviews—these

and other tools allow private payers to use market forces to control health care costs. Most, however, are not authorized for general use by HCFA, which runs Medicare. This results in a publicly financed program that pays higher-than-market rates for some goods and services and sometimes pays without question for improbably high bills. Recent HCFA efforts and pending legislation to address these problems appear promising. In addition, HCFA should test the feasibility of applying management strategies in high-cost high-utilization areas. Finally, Congress needs to give HHS the flexibility to make prompt price adjustments.

Medicare: Private-Sector and Federal Efforts to Assess Health Care Quality (GAO/T-HEHS-96-215, Sept. 19, 1996)

HCFA now estimates that 4.3 million Medicare beneficiaries are enrolled in HMOs. Enrollment is believed to be growing at a rate of 100,000 new members per month. This testimony discusses ways to ensure that quality care is provided to the Medicare beneficiaries joining these HMOs. HCFA, which runs Medicare, finds the potential cost savings associated with managed care attractive. Concerns have been raised, however, that the cost control strategies employed by HMOs could undermine the quality of care. This testimony discusses (1) quality assessment methods used by large corporate purchasers of health insurance from HMOs, (2) quality assessment methods used by HCFA in administering the Medicare HMO program, (3) quality assessment methods HCFA plans for the future, and (4) what both corporate purchasers and HCFA are doing to share information about quality with employees and Medicare beneficiaries.

Medicare Transaction System: Strengthened Management and Sound Development Approach Critical to Success (GAO/T-AIMD-96-12, Nov. 16, 1995)

HCFA is developing a critical new claims-processing system, the Medicare transaction system (MTS), to replace the nine systems now used by Medicare. MTS' goal is to better protect program funds from waste, fraud, and abuse; allow better oversight of Medicare contractor operations; improve service to beneficiaries and providers; and cut administrative expenses. The weaknesses in HCFA's development of MTS stem from a lack of a disciplined management process that has as its hallmark managing information systems and technology as investments. Not managing MTS in this way has led to system design and development proceeding despite (1) difficulties in defining requirements, (2) a compressed scheduled containing significant overlap of system-development phases, and (3) a lack of reliable information on costs and benefits. These risks in the development of MTS can be substantially reduced if HCFA adopts some of the best practices that have proven effective in other organizations: managing systems as investment, changing information management

practices, creating line manager ownership, better managing resources, and measuring performance.

Pharmacy Benefit Managers: Early Results on Ventures With Drug Manufacturers (GAO/T-HEHS-96-85, Feb. 7, 1996)

Recently, some of the largest drug companies have merged or formed alliances with some of the largest PBMs. PBMs manage the prescription drug part of health insurance plans covering millions of Americans. These ventures gained attention not only because of their size but because of concerns that the PBMs would automatically give preference to their manufacturer partners' drugs over those made by competitors. The results of GAO's analysis of PBM formularies—a list of preferred prescription drugs by therapeutic class, often with cost designations—indicate that continued oversight of mergers and alliances between pharmaceutical manufacturers and PBMs is warranted to ensure competition in the marketplace. For example, the changes in Medco's formulary that appear to favor Merck drugs do not necessarily show that Medco automatically gave preference to Merck drugs over those of competitors. However, the formulary changes support the Federal Trade Commission's decision to continue monitoring the Merck/Medco merger and other such ventures.

Prescription Drug Pricing: Implications for Retail Pharmacies (GAO/T-HEHS-96-216, Sept. 19, 1996.)

Congressional hearings during the late 1980s highlighted the fact that the prices that consumers paid for prescription drugs were increasing more rapidly than the rate of inflation. In 1990, Congress tried to control prescription drug expenditures by significantly changing the way that Medicaid pays for outpatient drugs. Vertical integration in the pharmaceutical market later became a concern, particularly mergers between large drug companies and PBMs. This testimony responds to the following three questions: How and why has the process by which drugs get from manufacturers to patients changed? What have been the consequences for retail pharmacies of changes in this process? What general strategies are retail pharmacies undertaking or proposing to respond to an increasingly competitive environment?

Prescription Drugs and the Elderly: Many Still Receive Potentially Harmful Drugs Despite Recent Improvements (GAO/T-HEHS-96-114, Mar. 28, 1996)

GAO's analysis of 1992 data found that 17.5 percent of nearly 30 million Medicare recipients were still being prescribed drugs that were generally unsuitable for their age group. Although this is an improvement over the almost 25 percent reported for 1987 data, the inappropriate use of prescription drugs remains a major health problem for the elderly. Insufficient coordination of patient drug therapies and weaknesses in communication between providers, pharmacists, and patients have compounded the problem. Inappropriate prescribing practices and the

ensuing drug use have caused many elderly persons to suffer harmful effects that, according to FDA, have resulted in hospitalizations costing $20 billion annually. The costs are partly covered by Medicare and Medicaid. States, advocacy groups, and physician and pharmacy organizations have, however, taken steps to reduce inappropriate drug use. In addition, managed care, pharmacy benefit management, and other coordinated health care systems have features designed to reduce inappropriate prescription drug use among the elderly.

Prescription Drugs: Implications of Drug Labeling and Off-Label Use (GAO/T-HEHS-96-212, Sept. 12, 1996)

Physicians use a drug off-label when they prescribe an FDA-approved drug for treatments other than those specified on the label. GAO testified that off-label prescribing is prevalent and presents various problems for policymakers at different times. As it stands now, the problem is that the drug industry believes that labels overly constrain its ability to promote its products. This problem can be solved either by relying on sources in addition to the label to define appropriate promotion or by improving the process for updating the label. These two options are not necessarily mutually exclusive and both have benefits and drawbacks.

Status of Medicare's Federal Hospital Insurance Trust Fund (GAO/T-HEHS-96-94, Feb. 29, 1996)

This testimony focuses on GAO's ongoing review of the status of Medicare's Federal Hospital Insurance (part A) Trust Fund. GAO discusses (1) when the administration became aware that the trust fund had an operating deficit—that is, cash outlays exceeded cash receipts—of $36 million for fiscal year 1995 and how the information was disseminated and (2) what the status is of current projections regarding the trust fund.

Housing Issues

Housing and Urban Development: Limited Progress Made on HUD Reforms (GAO/T-RCED-96-112, Mar. 27, 1996)

Despite the promise of reform, reinvention, and transformation initiatives aimed at solving problems at the Department of Housing and Urban Development (HUD), much more remains to be done. HUD is very much an agency in limbo, and few of the proposals in its reinvention blueprint have been adopted. This testimony addresses HUD's difficulties in addressing (1) its long-standing management shortcomings, (2) its portfolio of multi-and single-family housing insured by the Federal Housing Administration, (3) budget and management problems plaguing the public

	housing program, (4) the spiraling cost of assisted housing programs, and (5) the need for consensus on HUD reforms.
Housing and Urban Development: Public and Assisted Housing Reform (GAO/T-RCED-96-22, Oct. 13, 1995)	Current federal housing programs are seen as overly regulated and leading to warehousing of the poor, and Congress is asking state and local governments to assume a larger role in defining how the programs work. Congress is now reconsidering the most basic aspects of public housing policy—whom it will house, the resources devoted to it, the amount of existing housing stock that will be retained, and the rules under which it will operate. These statements provide GAO's views on legislation then pending before Congress—S. 1260 and H.R. 2406—that would overhaul federal housing policy. GAO testified that the two bills contain provisions that will likely improve the long-term viability of public housing, such as allowing mixed incomes in public housing and conversion of some public housing to housing vouchers or tenant-based assistance when that makes the most sense. GAO also supports provisions to significantly beef up HUD's authority to intervene in the management of troubled housing authorities, but GAO cautions that questions remain about the reliability of the oversight system that HUD uses to designate these agencies as troubled.
Multifamily Housing: Issues and Options to Consider in Revising HUD's Low-Income Housing Preservation Program (GAO/T-RCED-96-29, Oct. 17, 1995)	HUD's program for preserving low-income housing seeks to maintain the affordable low-income housing that was created mainly under two federal housing programs during the 1960s and 1970s. Under these programs, when owners received HUD-insured mortgages with 40-year repayment periods, they entered into agreements with HUD that imposed affordability restrictions, such as limits on the income level of tenants and on the rents that could be charged at the properties. After 20 years, however, owners had the right to pay off their mortgages in full without prior HUD approval and terminate the affordability restrictions. The preservation program has proven to be complex and costly, prompting recommendations from HUD and others to change or repeal the program. This testimony focuses on (1) how the current preservation program works, (2) the status of preservation eligible projects, (3) concerns that have been raised about the program, and (4) options for revising the program.

Income Security Issues

Financial Management: Interior's Efforts to Reconcile Indian Trust Fund Accounts and Implement Management Improvements (GAO/T-AIMD-96-104, June 11, 1996)

Although the Department of the Interior has brought to a close its project to reconcile the Indian trust funds, tribal accounts were never fully reconciled because of missing records and the lack of an audit trail in Interior's automated accounting systems. In addition, the 1996 report package that Interior provided to each tribe on the reconciliation results did not explain or describe the many changes in reconciliation scope and methodologies or the procedures that had been planned but were not implemented. As a result, the limitations of the reconciliation were not evident. Also, because of cost considerations and the potential for missing records, individual Indian trust fund accounts were not included in the reconciliation project. Indian tribes have raised concerns about the scope and the results of the reconciliation process. The vast majority of tribes have yet to decide whether to accept or dispute their account balances. If Interior cannot resolve the tribes' concerns, a legislated settlement process could be used to settle disputes over account balances. Interior has taken steps during the past 3 years to correct these long-standing problems with the accuracy of the Indian trust fund accounts, but these efforts will take years to complete. Moreover, the existing trust fund management and accounting systems cannot ensure accurate trust fund accounting and asset management. The appointment of a Special Trustee for American Indians was an important step in establishing high-level leadership at Interior for Indian trust fund management.

Supplemental Security Income: Noncitizen Caseload Continues to Grow (GAO/T-HEHS-96-149, May 23, 1996)

Noncitizens are one of the fastest growing groups of recipients of SSI benefits. They represent nearly one-third of aged SSI recipients and about 6 percent of disabled recipients. Although the growth rate for noncitizen caseloads has slowed, it is still higher than that for citizens, and the percentage of noncitizens relative to other SSI recipients continues to rise. About two-thirds of noncitizens recipients—roughly 520,000—live in three states: California, New York, and Florida. On the whole, noncitizens are more likely to receive SSI than are citizens, but this may be primarily true for refugees and asylees. Adult children of aged immigrants and others who say they are willing to financially support them sometimes do not. Eventually, some of these older immigrants receive SSI. Also, some translators have helped noncitizens to fraudulently obtain SSI disability benefits.

Social Security: Disability Programs Lag in Promoting Return to Work (GAO/T-HEHS-96-147, June 5, 1996)

Each week, the DI and SSI programs make more than $1 billion in cash payments to persons with disabilities. Although these payments provide a measure of income security, they do little to enhance the work capacities and promote the economic independence of recipients. Societal attitudes have shifted, and current law, such as the Americans With Disabilities Act, promotes economic self-sufficiency among the disabled. A growing number of private companies are exploring ways to return people with disabilities to the workforce. Moreover, medical advances and new technologies provide greater opportunities for people with disabilities to work. This testimony discusses how the structure of the DI and SSI programs impedes recipients return to work and how strategies used in other disability systems could help restructure the programs to encourage recipients to return to work.

Federal Downsizing: the Status of Agencies' Workforce Reduction Efforts (GAO/T-GGD-96-124, May 23, 1996)

The downsizing of the federal workforce is ahead of the schedule set by the Workforce Restructuring Act. At the same time, the administration has called on agencies to restructure their workforces by reducing management positions. These jobs have yet to be reduced to the extent called for by the National Performance Review. With regard to future workforce reductions, GAO found that in terms of absolute numbers—and given historical quit rates—the remaining employment ceilings called for by the act probably could be achieved governmentwide through attrition. Nevertheless, some agencies may be forced to downsize more than others. In such situations, buyouts or reductions in force (RIF) may be necessary. GAO found that buyouts offer greater savings than RIFs, except when employees affected by a RIF do not bump and retreat and are eligible to retire.

SSA Benefit Statements: Statements Are Well Received by the Public but Difficult to Comprehend (GAO/T-HEHS-96-210, Sept. 12, 1996)

The personal earnings and benefit estimate is a six-page statement produced by SSA that supplies information about a worker's yearly earnings on record at SSA; eligibility for social security retirement, survivor, and disability benefits; and estimates of these benefits. SSA has tried to improve the statement, and the public has found it to be helpful for retirement planning. However, the statement falls short in clearly communicating the complex information that readers need to understand concerning SSA's programs and benefits. For example, the document's design and organization make it difficult for readers to locate important information. Readers are also confused by several important explanations, such as who in their family is also eligible for benefits and how much these family members might receive. SSA is considering redesigning the

	statement, but only if this effort reduces printing costs. This approach overlooks hidden costs, such as (1) inquiries from people who do not understand the statement and (2) the possibility that a poorly designed statement can undermine public confidence.
Supplemental Security Income: Noncitizens Have Been a Major Source of Caseload Growth (GAO/T-HEHS-96-88, Feb. 6, 1996)	Noncitizens are among the fastest growing groups receiving benefits from the SSI program, which provides means-tested benefits to eligible blind, elderly, or disabled persons. Noncitizens represent nearly one-third of aged SSI recipients and 5.5 percent of disabled recipients. About two-thirds of noncitizen SSI recipients live in three states—California, New York, and Florida. On the whole, noncitizens are more likely to receive SSI than citizens, but this may be true primarily for refugees and asylum seekers. Adult children of aged immigrants and others who say they are willing to financially support them sometimes do not. Eventually, many of these aged immigrants receive SSI. Also, some translators help noncitizens to fraudulently obtain SSI disability benefits.
SSA Disability Reengineering: Project Magnitude and Complexity Impede Implementation (GAO/T-HEHS-96-211, Sept. 12, 1996)	Given the high cost and lengthy processing times of SSA's current disability claims process, the agency needs to continue its redesign efforts. SSA's redesign plan is proving to be overly ambitious, however. Some initiatives are also becoming more complex as SSA expands the work required to complete them. The agency's approach is likely to limit the chances for the project's success and has delayed implementation: testing milestones have slipped and support for the redesign effort has waned. In addition, the increasing length of the overall project and specific initiatives heighten the risk of disruption from turnover among key executives. GAO believes that as SSA proceeds with its redesign project it should focus on key initiatives, starting first with those that will quickly and significantly reduce claims processing time and administrative costs.
Social Security Administration: Effective Leadership Needed to Meet Daunting Challenges (GAO/T-OCG-96-7, July 25, 1996)	With a staff of 64,000, SSA runs the largest federal program—Social Security—as well as the largest cash welfare program—SSI. The agency's expenditures totaled $363 billion in fiscal year 1995, almost one-fourth of the $1.5 trillion federal budget. This testimony discussed the difficult challenges facing SSA in the coming decades: taking part in the debate over future financing of Social Security; encouraging disability recipients to return to work; reducing fraud and abuse; and managing workforce and technology investments so that SSA can meet the needs of America's retired, disabled, and poor.

Veterans/DOD Issues

Defense Health Care: TRICARE Progressing, but Some Cost and Performance Issues Remain (GAO/T-HEHS-96-100, Mar. 7, 1996)

DOD's nationwide managed health care program—TRICARE—represents a sweeping reform of the $15 billion per year military health care system. TRICARE seeks to improve access to care and ensure high-quality, consistent health care benefits for the 1.7 million active-duty service members and some 6.6 million nonactive-duty beneficiaries. It also seeks to preserve choice for nonactive-duty beneficiaries by allowing them to choose whether to enroll in TRICARE Prime, which resembles an HMO; use a preferred provider organization; or use civilian health care providers under a fee-for-service arrangement. Despite initial beneficiary confusion caused by education and marketing problems, early implementation of the program is progressing consistent with congressional and DOD goals. Measures may be necessary, however, such as gathering cost and access-to-care data, to help Congress and DOD better assess the program's future success. In addition, retirees, who make up half of those eligible for military health care, remain concerned about TRICARE's effect on their access to medical services.

VA Health Care: Approaches for Developing Budget-Neutral Eligibility Reform (GAO/T-HEHS-96-107, Mar. 20, 1996)

Reforming eligibility for health care benefits offered by VA would pose a major challenge even with unlimited resources. But with Congress and VA facing mounting pressure to limit VA health care spending as part of governmentwide efforts to reduce the deficit, this challenge has become even greater. This testimony discusses (1) the problems that VA's current eligibility and contracting provisions create for veterans and providers, (2) the relationship between inappropriate admissions to VA hospitals and VA eligibility provisions, (3) proposals to reform VA eligibility and contracting rules and their potential impact on the deficit, and (4) options to achieving budget-neutral eligibility reform.

VA Health Care: Efforts to Improve Veterans' Access to Primary Care Services (GAO/T-HEHS-96-134, Apr. 24, 1996)

VA runs one of the nation's largest health care systems, including 173 hospitals and 220 clinics. Last year, VA spent about $16 million serving 2.6 million veterans. This testimony focuses on VA's efforts to increase veterans' access to health care. GAO discusses legal, financial, and equity-of-access issues facing VA managers as they try to establish new access points—a VA clinic or a VA-funded or VA-reimbursed private clinic, group practice, or individual practitioner that is geographically separate from the parent facility. Access points are intended to provide primary

	care to all veterans and refer those needing specialized services or inpatient stays to VA hospitals.
VA Health Care: Opportunities to Increase Efficiency and Reduce Resource Needs (GAO/T-HEHS-96-99, Mar. 8, 1996)	With a fiscal year 1995 appropriation of $16.2 billion, the VA health care system faces mounting pressure to contain or reduce spending as part of governmentwide efforts to reach a balanced budget. This testimony addresses (1) VA's forecasts of future resource needs, (2) opportunities to run the VA system more efficiently, (3) differences between VA and the private sector in terms of initiatives to become more efficient, and (4) recent VA efforts to reorganize its health care system and create incentives to operate more efficiently.
VA Health Care: Opportunities to Reduce Outpatient Pharmacy Costs (GAO/T-HEHS-96-162, June 11, 1996)	VA allows its doctors to prescribe over-the-counter products because concerns have been raised that some veterans may lack the money to buy needed items. VA requires prescriptions as a way to control veterans' access to over-the-counter products in VA pharmacies. In fiscal year 1995, for example, VA pharmacies dispensed analgesics, such as aspirin and acetaminophen, nearly 3 million times. The benefits package that most VA facilities offer for over-the-counter products is more generous than that available from other health plans. VA also provides other features, such as free over-the-counter product mail service and deferred credit for copayments owed, that are not common in other plans. GAO makes several suggestions for reducing the amount of money VA spends to dispense over-the-counter products. First, VA staff could more strictly adhere to statutory eligibility rules. Second, VA could more efficiently dispense over-the-counter products and collect copayments. Third, VA facilities could further reduce the number of over-the-counter products available to veterans on an outpatient basis. Finally, Congress could expand copayment requirements.
Veterans Benefits Modernization: Management and Technical Weaknesses Must Be Overcome If Modernization Is to Succeed (GAO/T-AIMD-96-103, June 19, 1996)	If the Veterans Benefits Administration (VBA) is to reduce operating costs and improve critical service to nearly 27 million veterans and their dependents, it needs to streamline its business processes and take more advantage of information technology. However, VBA is experiencing many of the classic management and technical problems that have prevented federal agencies from reaping the benefits of substantial investment in information technology. This testimony discusses the steps VBA needs to take in the following three areas to improve its chances for success: (1) creating a credible business strategy and supporting an information

resources management plan; (2) developing a better investment strategy for choosing and managing its portfolio of information technology projects in a more disciplined, businesslike way; and (3) strengthening its technical ability to develop software applications that are critical to its efforts to control costs and improve service to veterans.

Veterans' Health Care: Challenges for the Future (GAO/T-HEHS-96-172, June 27, 1996)

With a budget of $16.6 billion and a network of hundreds of hospitals, outpatient clinics, and nursing homes, VA's health care system provides medical services to more than 26 million veterans. VA was seeking to fundamentally change the way in which it runs its health care delivery and financing systems. It was also seeking authority to significantly expand eligibility for health care benefits and to both buy health care services from and sell them to the private sector. This testimony discusses (1) changes in the veterans population and the demand for VA health care services; (2) how well the existing VA system, and other public and private health benefits programs, meet the health care needs of veterans; (3) steps that could be taken using existing resources and legislative authority to address veterans' unmet health care needs and increase equity of access; (4) how other countries have addressed the needs of an aging and declining veteran population; and (5) approaches for preserving VA's direct delivery system, alternatives to preserving the direct delivery system, and combinations of both.

Ongoing Work as of September 30, 1996, on Issues Affecting Older Americans

At the end of fiscal year 1996, GAO had 32 ongoing assignments that affected older Americans. Of these, 18 were on health, 6 on income security, and 8 on veterans/DOD issues.

Health Issues

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

Review of Medicare Marketing Practices (code 101381)

Limiting the HMO Enrollment Period to Once a Year for Medicare Beneficiaries (code 101392)

Can Medicare Learn From Private Sector Market-Oriented Purchasing Strategies (code 101398)

Study of Key Factors Contributing to Enrollment in the Medicare Risk Contract Program (code 101400)

Medicare Certification of Home Health Agencies (code 101501)

Medicare Payments for Durable Medical Equipment (code 101502)

Medicare Spending Trends and the Impact of Managed Care (code 101507)

Care Management in Continuing Care Retirement Communities (code 101509)

Long-Term Care Use Spending by Medicare and Medicaid (code 101510)

Review of Lab Service Utilization Rates for Medicare End-Stage Renal Disease Patients (code 106433)

Review of Modern Management Practices That Can Be Implemented in Medicare to Achieve Savings and Improve Operations (code 106437)

Compliance With Federal Loss Ratio Standards in 1994 and 1995 (code 106438)

Review of Medicare Payments for Oxygen Equipment and Supplies (code 108281)

Skilled Nursing Facilities (code 106432)

Medicare Diabetes Care (code 108255)

HMO Enrollment of Chronically Ill (code 108269)

Epidemiology of Alzheimer's Disease (code 973430)

Income Security Issues

SSI Management Oversight (code 105153)

SSI/Medicaid Computer Matching (code 106809)

SSA's 800 Number Telephone Service (code 105936)

Update on SSA's Challenges (code 105938)

Report on Retirement Income Issues (code 207444)

Beneficiary Employability (code 106515)

Veterans/DOD Issues

Military Retirement Alternatives (code 703128)

Military Retiree Health Issues (code 101491)

VA Substance Abuse Programs (code 101482)

VA Hospital Issues (code 406117)

VA's Disability Rating Schedule (code 105746)

VA Nursing Home Issues (code 101471)

VA Health Care Access (code 406125)

Maximizing Use of VA's Excess Health Care Capacity (code 406126)

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