United States General Accounting Office

GAO

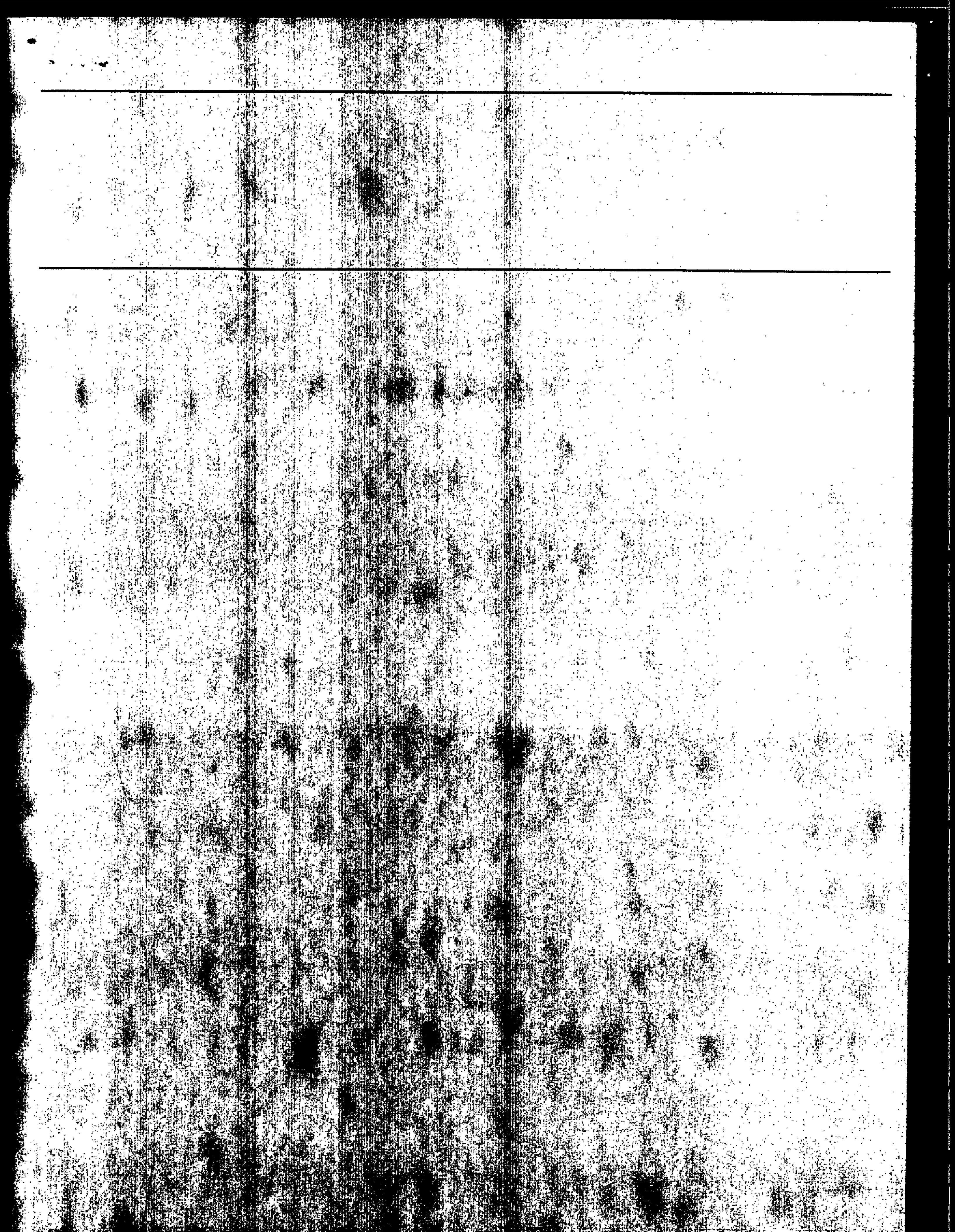
Report to the Honorable William S. Cohen, Special Committee on Aging, U.S. Senate

May 1991

SOCIAL SECURITY DISABILITY

Action Needed to Improve Use of Medical Experts at Hearings

GAO/HRD-91-68



GAO

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

143928

Human Resources Division

B-241432

May 20, 1991

The Honorable William S. Cohen
Special Committee on Aging
United States Senate

Dear Senator Cohen:

This report responds to the August 1, 1990, letter, in which the late Senator John Heinz asked for a study on the use of medical experts (MEs) by the Social Security Administration's (SSA's) Office of Hearings and Appeals (OHA).[1] He expressed concern that OHA's Cleveland, Ohio, hearing office used one ME excessively, almost to the exclusion of other physicians. He asked if this was a common practice at other hearing offices. He also asked several questions concerning OHA's policy and procedures for the use of MEs. Our detailed response to each question is in appendix I.

Claimants may appeal the denial of their applications for Social Security disability benefits to administrative law judges (ALJs) located at hearing offices throughout the nation. Before formal hearings, ALJs review claimants' medical evidence and decide on the need to use medical expert testimony. In seeking expert testimony, ALJs are instructed to select medical expert specialties that best match claimants' diagnosed impairments.

MEs are generally physicians recruited to testify as witnesses at hearings or through written responses to interrogatories. OHA makes agreements with physicians to perform ME services and places MEs on rosters according to their medical specialty. OHA uses a fee schedule to determine ME payments. The ME's role is to provide independent expert testimony that is impartial and unbiased.

OHA's policy requires that MEs be selected on a rotational basis by medical specialty to the extent possible.[2] OHA has a rotation policy to (1) ensure an independent relationship between ALJs and MEs and (2) avoid the appearance of favoring one ME over another.

[1]Although this report discusses OHA's use of medical experts, OHA has similar policy and procedures for the use of vocational experts. OHA's use of both types of experts is referred to as the expert witness program.

[2]For example, an ME with a particular medical specialty selected from the roster to provide expert testimony in a case is to be placed at the bottom of the roster and not used again until all other MEs in that specialty are used.

OHA uses blanket purchase agreements (BPAs) to purchase ME services. BPAs are a simplified method for making small, repetitive purchases. Federal procurement policy governing such purchases requires agencies to seek maximum, practicable competition and to distribute purchases equitably among those qualified. In seeking competition, every reasonable effort must be made to avoid purchases from only one source. If sufficient sources are not available to ensure competition, agencies must solicit new sources. Selections must be made impartially and without preferential treatment.

To perform our work, we reviewed OHA policy and procedures for the use of MEs and visited OHA's headquarters, Chicago Regional Office, and Cleveland Hearing Office. To determine compliance with OHA's ME rotation policy and federal procurement policy, we analyzed data on ME use by the Cleveland Hearing Office and each of the other 18 hearing offices in the Chicago Region. We also reviewed ME payment data nationwide for indications of frequent or repeated use of individual MEs.[3] We further reviewed the results of an OHA questionnaire on the expert witness program. Appendix II contains a detailed description of our scope and methodology.

We conducted our review primarily between October and December 1990 in accordance with generally accepted government auditing standards.

Results in Brief

When purchasing ME testimony, OHA has not ensured compliance with either its rotation policy or federal procurement policy. Many hearing offices in the Chicago Region used individual MEs repeatedly rather than distributing referrals proportionately among MEs in the same medical specialty on their rosters. In addition, some hearing offices may have relied unnecessarily on one ME for referrals in high-demand medical specialties. Frequent use of individual MEs occurred nationwide for this same reason.

The high use of individual MEs has resulted from (1) inadequate hearing office controls over the ME selection process, (2) inadequate regional office oversight of ME use by hearing offices, and (3) insufficient recruitment efforts.

[3] We judgmentally selected payments in excess of $50,000 to an individual ME as an indication of frequent or high use. Because MEs generally receive $160 per hearing, an ME would have to attend over 300 hearings a year to receive in excess of $50,000.

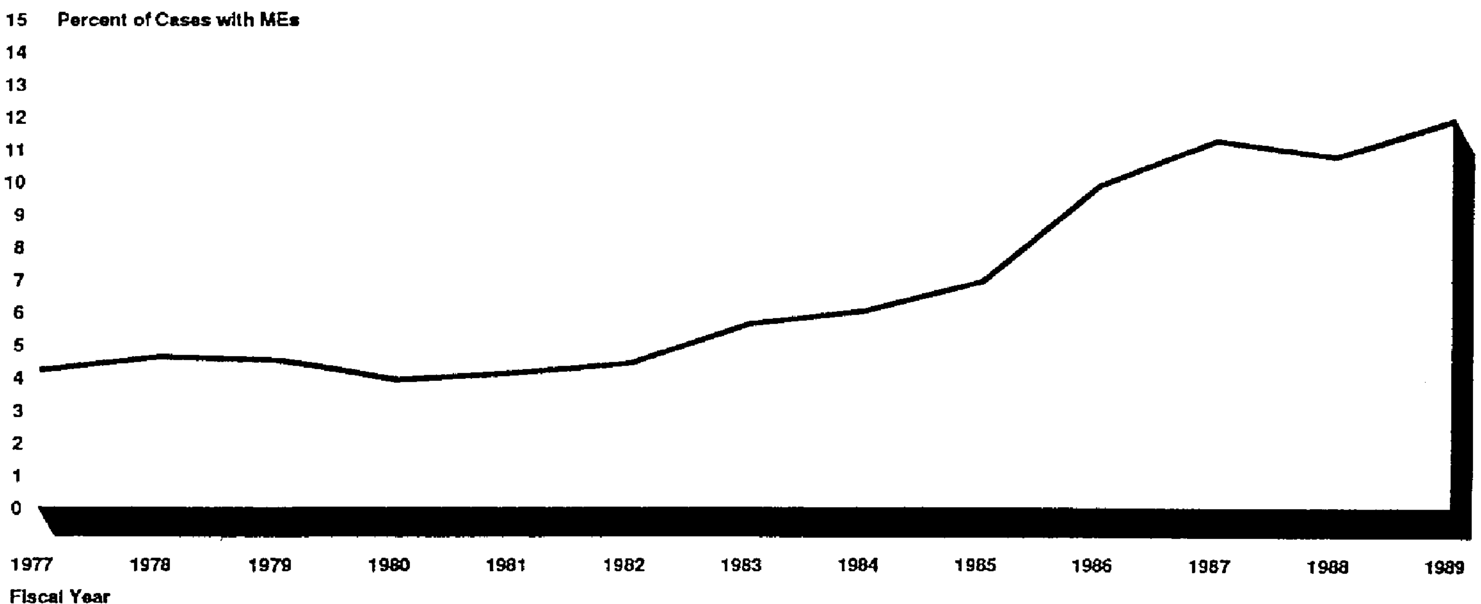
Repeated use has led some denied claimants to question the ME's impartiality and the independence between the ALJ and ME, which, in turn, has led to questions regarding the fairness of the hearings. In addition, MEs receiving a disproportionately smaller share of referrals have alleged favoritism. To ensure an independent relationship between ALJs and MEs and to protect the credibility of hearings, OHA needs to strengthen its oversight and procedures.

Background

Overall policy and procedures for the use of MEs are established by OHA's headquarters. OHA's 10 regional offices recruit and maintain rosters of MEs, prepare purchase documents, and perform program oversight. Staff in each of the 132 hearing offices select MEs for hearings, contact them to schedule their services, and prepare expense vouchers for payment.

Although the percentage of hearings with ME testimony remained relatively constant from 1977 to 1982, the use of MEs increased from 4 percent in 1982 to 12 percent in 1989 (see fig. 1). In fiscal year 1990, OHA spent about $6.6 million for MEs and had about 2,100 MEs under contract.

Figure 1: Growth in Use of Medical Experts



Source: OHA Case Control System.

To make appropriate hearing decisions, ALJs should have knowledge of the medical aspects of disability claims. When a case file contains conflicting or confusing medical evidence or there is a need to better understand and document the case, ALJs can seek the advice of MEs. The ALJ reviews ME opinion along with other medical evidence of record to make the final decision.

OHA has stated that its policy of selecting MEs for hearings on a rotational basis serves two important purposes. First, it helps ensure against the loss of MEs from the program. When MEs are used infrequently, they may lose interest in the program. Second, frequent or repeated use of the same ME by individual ALJs could raise questions about the credibility and fairness of hearings and may make OHA vulnerable to charges ranging from bias to collusion.

Hearing office noncompliance with OHA's rotation policy has been a longstanding problem. In a 1982 memorandum to ALJs, OHA's Associate Commissioner reiterated the importance of compliance with this policy. The memorandum cited a 1980 OHA study on the use of vocational experts (VEs) as an example of how the frequent use of individual VEs tended to compromise their independence. Because of their frequent contact with individual ALJs, the study showed that some of the VEs became less than objective in their testimony. The testimony of some frequently used VEs showed an almost automatic question-and-answer routine between ALJs and experts, rather than a careful, thorough probing by ALJs to fully benefit from the testimony.

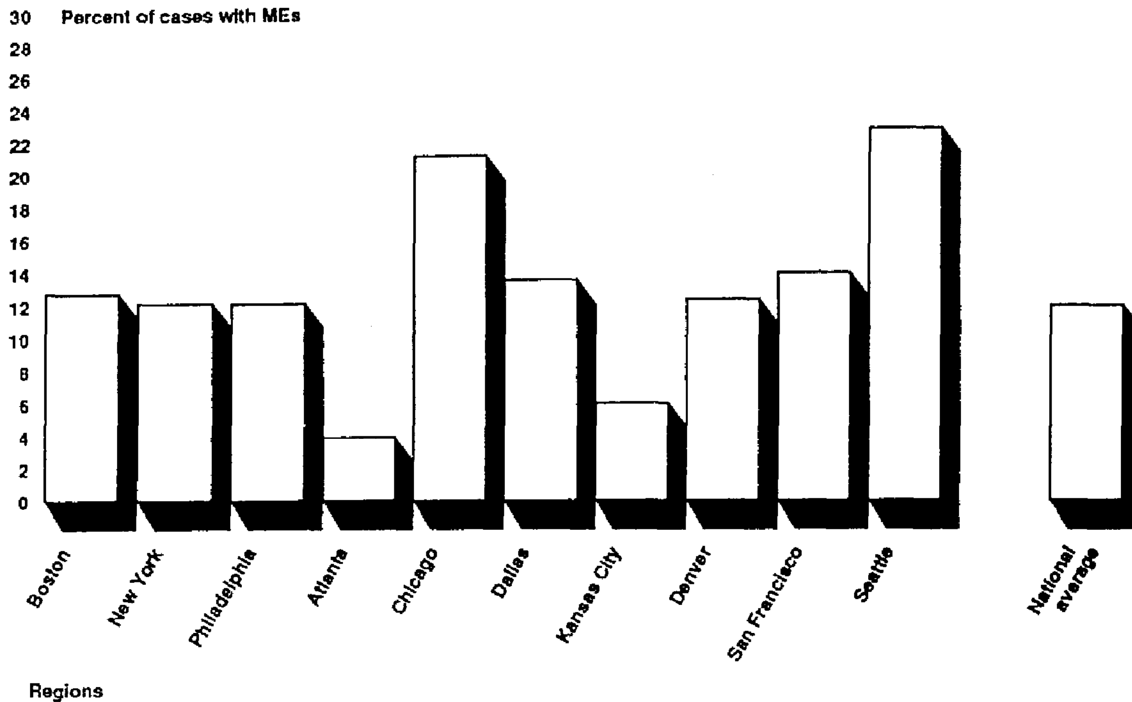
Variation in Use of Medical Experts

ALJ use of ME testimony varies widely. This is reflected by usage differences among regions, hearing offices within the same region, and ALJs within the same hearing office.

During the fourth quarter of fiscal year 1990, the percentage of hearings using MEs ranged from 4 percent in the Atlanta Region to 23 percent in the Seattle Region (see fig. 2). The national average was 12 percent. Within the Chicago Region, hearing office use of MEs ranged from a low of less than 1 percent in Detroit to a high of 53 percent in Cleveland. During the last quarter of calendar year 1988,[4] the use of MEs by 13 ALJs at the Cleveland Hearing Office varied considerably. One ALJ used MEs twice and another ALJ used MEs 94 times during the quarter.

[4]The last quarter of 1988 was the last time the hearing office prepared these data.

Figure 2: OHA Regional Variation in Use of Medical Experts in Hearings (Fourth Quarter of Fiscal Year 1990)



Source: OHA Case Control System.

Indications of Repeated Use of Individual Medical Experts

In the Chicago Region, hearing offices used some individual MEs repeatedly rather than selecting MEs proportionately from their rosters. In addition, the offices' recruitment efforts were insufficient to ensure the availability of more than one ME in high-demand medical specialties. One ME at the Cleveland Hearing Office was the most frequently used ME nationwide in calendar year 1989, receiving in excess of $150,000. We also found indications that such high use of one ME was not confined to the Chicago Region. In calendar year 1989, five other MEs in four OHA regions received payments in excess of $50,000.

Repeated Use of Individual Medical Experts in Chicago Region

The Chicago Region had approximately 420 MEs listed on its hearing office rosters during fiscal year 1990. However, 28 MEs (or about 7 percent) were used repeatedly and received almost half of the payments for ME services.

The most frequently used MEs at 6 of the region's 19 hearing offices were the only ones on the hearing offices' rosters in their medical specialty. Thus, because the hearing offices did not have other MEs on their rosters with the same medical specialty, these MEs received all referrals for their specialty.

The other 13 hearing offices in the Chicago Region had more than one ME on their rosters with the same specialty as the most frequently used ME. However, this ME received a disproportionately higher share of referrals than the other MEs with the same specialty. At the 13 offices, most of the repeatedly used MEs received 70 percent or more of the referrals. One ME received 100 percent of referrals, despite the hearing office's roster having two other MEs with the same medical specialty. Another ME received about 97 percent of the referrals, although five other MEs were on the roster.

Indications of High Use of Individual Medical Experts Nationwide

To provide an indication of the extent to which individual MEs nationwide received a frequent or high number of referrals, we identified six MEs who received in excess of $50,000 annually for their services. We chose this amount to provide an indication of the extent to which individual MEs nationwide received a high number of referrals. The six MEs that we identified as receiving such frequent referrals were at hearing offices in four different OHA regions.

One of the six MEs was at the Cleveland Hearing Office. This physician was the highest paid ME nationwide in both calendar years 1988 and 1989. In 1989, this ME received over $150,000, while the next most frequently used ME in the Cleveland office received about $27,000. Appendix III contains a discussion of the Cleveland office's high use of one ME. The most frequently used MEs that we identified generally received a high number of referrals because they were the only MEs on the hearing offices' rosters with a medical specialty in high demand.

Chicago Regional Office Survey of Medical Experts

During 1990, the Chicago Regional Office surveyed MEs within the region to solicit their views on program effectiveness. Responses were received from 246 MEs or 59 percent of the 415 MEs on the roster at that time. These responses indicate a dissatisfaction with how OHA's rotation policy is enforced. The Chicago office's assessment of the responses states that many of the MEs were dissatisfied with the scheduling procedures and complained of unfair rotation and favoritism. Also, many of the MEs said they preferred to be called for hearings more frequently.

Reasons for Repeated Use of Some Medical Experts

Reasons for the repeated use of the individual MEs that we identified include (1) inadequate hearing office controls over the ME selection process, (2) inadequate oversight of hearing office use and selection of MEs, and (3) insufficient ME recruitment.

Inadequate Hearing Office Controls Over the Selection of Medical Experts

OHA lacks adequate controls at the hearing office level to ensure compliance with its rotation policy for MEs and with federal procurement policy for ME purchases. At the hearing offices in the Chicago Region that we reviewed, some individual MEs received a disproportionately higher share of referrals than other MEs with the same medical specialty.

One reason for the disproportionate use of certain MEs is the use by some hearing offices of ALJ hearing assistants to schedule MEs rather than someone separate from ALJ influence to perform this function. In at least 8 of the 15 hearing offices we contacted, ALJ hearing assistants scheduled MEs for hearings.

OHA officials said that they were aware of problems with ME scheduling. For example, they said that a recent survey of ME use showed that some hearing assistants were scheduling their ALJs' preferred ME rather than complying with OHA's rotation policy.

In addition, OHA officials said that OHA procedures do not require hearing offices to document the reasons for ME selections out of rotation order. Without such documentation, OHA lacks a basis to question the appropriateness of disproportionate ME use to ensure compliance with its rotation policy.

To improve control over ME rotation, Chicago Region officials were considering requiring all hearing offices to use staff other than ALJ hearing assistants to select and schedule MEs. The officials said two hearing offices in the region already had separate staff for this purpose. The managers of these hearing offices told us that using separate staff provides better assurance of compliance with OHA's rotation policy.

Another reason contributing to noncompliance with OHA's rotation policy is the practice at some hearing offices of ALJs requesting MEs by name. Nine of the 15 hearing office managers we contacted indicated a problem with some ALJs requesting MEs by name. Managers believed they had little control or influence over ALJ actions because they lacked

support from their hearing offices' chief ALJs or from regional or headquarters management.

Inadequate Oversight of Medical Expert Use

OHA requirements for regional office oversight do not include the monitoring of hearing office use of MEs. Previously, OHA headquarters monitored ME use, but this practice ended when the regional offices assumed responsibility for managing the expert witness program in October 1988. The director of OHA's expert witness program said it was an oversight to discontinue such monitoring.

Monitoring of ME use would provide the regional offices a basis to question disproportionate use of and hearing office reliance on one ME in a high-demand medical specialty. Through monitoring, the regional offices would be able to identify inappropriate use as well as nonuse of MEs and take corrective action.

Because of complaints of unfair ME rotation, the Chicago Regional Office recently decided to monitor ME referrals and analyze data on ME use by its hearing offices. Improvement in ME use is expected to result from the region's improved oversight.

Insufficient Medical Expert Recruitment

Regional offices are not consistently conducting an ongoing or regular recruitment effort or identifying instances of disproportionate or sole source use of MEs. Rather, hearing offices are relied on to identify ME recruitment needs. In addition, OHA's recruitment guidelines specify only a limited methodology for soliciting physicians for the program.

Some OHA hearing offices have only one ME in a high-demand medical specialty. However, federal procurement policy requires that agencies solicit new sources of supply when an insufficient number of sources are available to ensure competition. The policy also requires agencies to make every reasonable effort to avoid sole-source purchases. OHA's recruitment guidelines, however, require regional offices to recruit MEs only in response to hearing office requests.[5] There is no requirement for regional offices to identify recruitment needs. In addition, OHA's guidelines instruct regional offices to rely mainly on the Directory of Medical

[5]In October 1988, OHA decentralized the management of ME recruitment to the regional offices. At that time, OHA developed step-by-step recruitment instructions. This was the first time the recruitment process and procedures had been issued in writing.

Specialists for ME recruitment.[6] Regional offices are not instructed to use other means of recruitment, such as contacting hospitals and medical schools or advertising.

In 1990, OHA headquarters sent a questionnaire to regional offices to gain insight into regional office management of the expert witness program. The responses show that 6 of OHA's 10 regional offices had not developed additional recruitment efforts to supplement OHA's guidelines and 3 were recruiting MEs only at the request of hearing offices.

The Chicago Regional Office recently enhanced its recruitment efforts beyond OHA's guidelines. Instead of recruiting only in response to hearing office requests, the office's chief ALJ informed hearing offices in January 1991 that additional MEs would be recruited only after regional staff had analyzed ME usage data and determined recruitment needs. Also, in an effort to reach additional sources of MEs, the office decided to write directly to hospitals and medical schools and ask current MEs for physician referrals. In addition, the office developed brochures and other materials to interest physicians at medical conventions and at other activities.

Conclusions

OHA's procedures do not ensure that hearing office use of MEs complies with its rotation policy and with federal procurement policy. Some hearing offices in the Chicago Region have not selected MEs proportionately from their rosters. Also, sufficient efforts have not been made to ensure the availability of more than one ME in a high-demand medical specialty. Procedural deficiencies and instances of frequent use of individual MEs in other regions indicate that inappropriate use may be occurring throughout other regions.

The repeated use of certain MEs has led some claimants to question MEs' impartiality and independence from ALJ influence as well as the fairness of hearings. In addition, MEs receiving a disproportionately smaller share of referrals have alleged favoritism. Proper implementation of OHA's rotation policy and federal procurement policy would help safeguard against these problems. Moreover, improved regional office oversight of ME use and recruitment needs would provide OHA greater assurance that MEs are used appropriately.

[6] The Directory of Medical Specialists, published by Marquis Who's Who, is a comprehensive listing of physicians certified by the 23 individual boards of the American Board of Medical Specialties. The Directory is arranged first by board, second by geographic location, and then alphabetically within each location.

Recommendations to the Commissioner of Social Security

To improve the use of MES, we recommend that the Commissioner of Social Security instruct OHA management to:

1. Issue necessary procedures to ensure compliance with OHA's rotation policy and federal procurement policy. Included in these procedures should be requirements to use staff who are separate from ALJ influence for selecting and scheduling MES and to document justification for ME selections out of rotation order.

2. Require regional offices to monitor and analyze ME use and identify ME recruitment needs.

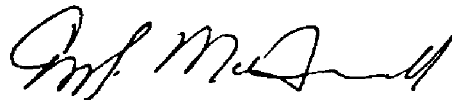
3. Review recruitment guidelines to identify additional means to reach potential MES.

Agency Comments

We requested that SSA provide written comments on a draft of this report. We did not receive SSA's written comments within the 30-day period specified by title 31 U.S.C., section 718(b). However, we did discuss this report's contents with SSA officials and incorporated their views where appropriate.

We are sending copies of this report to the Secretary of Health and Human Services and the Commissioner of Social Security. We will make copies available to other interested parties on request. If you have any questions concerning this report, please call me at (202) 275-6193. Other major contributors to this report are listed in appendix IV.

Sincerely yours,



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Abbreviations

ALJ	administrative law judge
BPA	blanket purchase agreement
OHA	Office of Hearings and Appeals
ME	medical expert
SSA	Social Security Administration
VE	vocational expert

Responses to Specific Questions

1. What type of purchase agreements does OHA use to contract with medical experts? Specifically, do these agreements allow for unlimited use of the same physician or is the system designed for periodic use of multiple physicians?

Response: OHA uses blanket purchase agreements (BPAS) to obtain the services of MES. Requirements for using BPAS are contained in the Federal Acquisition Regulation. They are generally used for making small, repetitive purchases. The maximum amount of an individual purchase is $25,000, although there is no annual limit on the total purchases from one source.

The Federal Acquisition Regulation requires that ME purchases be made with complete impartiality and with preferential treatment towards none. Purchases must be distributed equitably among qualified sources. When sufficient competition does not exist, additional sources should be recruited. Agencies should make every reasonable effort to avoid purchases from a single source.

2. What are the process and requirements for recruiting medical experts?

Response: OHA regional offices are responsible for the recruitment of MES. OHA procedures require regional offices to recruit MES when requested by hearing offices. Regional staff are to review the Directory of Medical Specialties. This directory, published by Marquis Who's Who, is a comprehensive listing of physicians certified by the 23 individual boards of the American Board of Medical Specialties. Physicians identified from this directory are sent form letters to determine their interest in the program.

3. How are the credentials of medical experts screened? Is there a formal process for checking credentials? If so, what data base is used? Does the screening occur at the regional level or at OHA headquarters?

Response: OHA requires that MES possess a current license to practice medicine. A medical license is required for private practice of medicine in each state. MES must generally be certified in a medical specialty by an appropriate medical specialty board. Regional office staff check physicians' board certification by using the Directory of Medical Specialties. This directory contains only board-certified physicians.

SSA has an agreement with the Federation of State Medical Boards to check on disciplinary actions taken against MEs. The disciplinary actions include license revocation and Medicare sanctions.

4. Once OHA establishes a list of medical experts, how do ALJs use this list to select physicians for individual cases? Is there a policy of rotation?

Response: When selecting an ME from a list of experts, OHA's policy states that an ALJ or designee must make selections in rotation order to the extent possible. This rotation should be made as equally as possible, according to ME specialty.

5. Are there requirements for the use of specialists? What guarantees are in place to ensure that the medical expert will have the expertise in the claimant's diagnosed impairments?

Response: OHA's policy states that MEs must generally be certified in a medical specialty by an appropriate medical specialty board. The ALJ or designee should select the ME whose expertise is most appropriate to the claimant's diagnosed impairment(s). However, there are no guarantees that an ME with the expertise needed will be available.

6. What procedures are in place for monitoring the use of medical experts by OHA's regional offices?

Response: OHA decentralized its management of MEs from its headquarters to its regional offices in October 1988. OHA requirements for regional office oversight do not include a requirement that ME usage data be monitored.

7. What is the difference between SSA's policies regarding the use of medical consultants by state disability determination services and the use of medical experts at the ALJ level?

Response: Initial disability determinations are made on behalf of SSA by state agencies called disability determination services. A state disability examiner together with a medical consultant determine disability. The medical consultant is part of the adjudicative team and participates in making disability determinations. The medical consultant's role also includes reviewing the need to obtain additional medical evidence as well as developing assessments of functional capability. Medical consultants are either hired as state employees or obtained under contract.

In contrast, ALJs decide on the need for ME testimony. MEs are used only in an advisory capacity to answer specific questions posed by an ALJ. MEs do not have a role either in assessing functional capability or in the disability decision. ME services are acquired under federal small purchase procedures.

Scope and Methodology

To determine requirements for the use of medical experts, we reviewed OHA's policy and procedures and the Federal Acquisition Regulation. We discussed policy and procedures for using MEs with OHA's headquarters officials and ME contracting with officials of SSA's Division of Acquisition and Policy.

We identified the extent of high use of MEs nationwide by analyzing data on ME annual income reported by SSA to the Internal Revenue Service for calendar years 1988 and 1989. We did not verify the accuracy of the data. We limited our analysis to MEs paid in excess of $50,000 annually.[1] We discussed the reasons for the high use with hearing office officials and reviewed ME rosters to determine the extent of available competition.

For the Chicago Region, we obtained and analyzed, but did not verify, fiscal year 1990 ME referral and expenditure data for its 19 hearing offices. We identified the most frequently used ME at each office and used the ME rosters to determine the medical specialties for these MEs and the extent of potential competition within their specialties. We also reviewed the 1991 rosters to determine the extent of changes in available competition.

We used a 1990 survey of MEs by the Chicago Regional Office to determine ME views on their satisfaction with the program. We also reviewed a 1990 OHA headquarters questionnaire on the expert witness program that had been sent to regional and hearing offices.

We contacted all 10 OHA regional offices to determine the extent to which they analyzed and monitored ME usage data.

At the Cleveland Hearing Office, we discussed the repeated use of one ME with the hearing office manager and staff involved in the rotation of MEs. We also discussed the repeated use of this ME with the chief ALJ and 5 of the 12 other ALJs. To obtain views on the use of this ME, and on MEs in general, we chose 3 ALJs who had used this ME frequently and 2 who had used MEs infrequently.

We contacted hearing office managers in 15 hearing offices in 6 OHA regions to obtain their views on ME selection and scheduling procedures

[1] We judgmentally selected payments in excess of $50,000 to an individual ME as an indication of frequent or high use. Because MEs generally receive $160 per hearing, an ME would have to attend over 300 hearings a year to receive in excess of $50,000.

and on any problems they had in carrying out OHA's rotation policy. We selected these hearing offices because we had identified them either as using an ME frequently or as having an ME with the same qualifications as the repeatedly used ME at the Cleveland Hearing Office.

We conducted our review primarily between October and December 1990 in accordance with generally accepted government auditing standards.

High Use of One Medical Expert by OHA's Cleveland Hearing Office

During the last quarter of calendar year 1988, the Cleveland Hearing Office made 193 referrals to one medical expert and 67 referrals to the next most frequently used ME, while 10 or fewer referrals were made to most of the MEs. The most frequently used ME accounted for over 50 percent of the ME needs for 3 of the hearing office's 13 ALJs.

ALJs justified the high use of one ME because he was qualified in both internal medicine and psychiatry and they believed they frequently needed an ME with both of these specialties. They also said that the ME was (1) very knowledgeable of SSA requirements for disability determinations, (2) superior at testifying, and (3) available and willing to travel. This physician was the only ME on the hearing office's roster qualified in both specialties.

Four other hearing offices nationwide had a similarly qualified ME, but none used the ME exclusively for both specialties. Instead, these MEs were used along with the hearing offices' other internists and psychiatrists. Furthermore, the hearing office managers we contacted indicated that it was not a common practice for ALJs to request two ME specialties for a hearing.

Allegations of excessive use of one ME in the Cleveland Office led the Chicago Regional Office to issue an instruction in June 1990 for the Cleveland Office to change the procedure for selecting the frequently used ME. The regional chief ALJ believed the change was needed to achieve a more balanced use of MEs. The change was to use separate internists and psychiatrists in rotation with the frequently used ME.

After the new rotation procedure was implemented, the frequently used ME received a reduced number of referrals as evidenced by the decline in this ME's share from 32 percent of referrals in fiscal year 1990 to 23 percent in December 1990. Nevertheless, this physician was still used five times as frequently as the other internists and psychiatrists in December 1990. Thus, he continued to receive a disproportionately higher share of referrals. A proportionate share for an ME with two specialties would generally be twice that for MEs in each of the two specialties.

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