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Health, Education and Human Services Division

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March 27, 1998

The Honorable Charles E. Grassley
Chairman, Special Committee on Aging
United States Senate

Subject: Aging Issues: Related GAO Reports and Activities in Calendar Years 1995 and 1996

Dear Mr. Chairman:

The elderly represent one of the fastest growing segments of the country's population, and the Congress faces many complex issues as a result of this growth. In the United States, the number of people aged 65 and older has grown from about 9 million in 1940 to about 34 million in 1995. Moreover, the number is expected to reach 80 million by 2050, according to Bureau of the Census projections. In 1940, people aged 65 and older made up 7 percent of the total population, and this proportion is expected to grow to 20 percent by as early as 2030. Although the aging of the baby-boom generation will contribute greatly to these trends, increased life expectancies and falling fertility rates are also important factors. Together, these demographic changes pose serious challenges for our Social Security system, Medicare, Medicaid, the federal budget, and our economy as a whole.

This report responds to your request for a compilation of our products from calendar years 1995 and 1996 that pertain to programs and issues affecting older Americans and their families.

In summary, our work on these programs and issues reflects the broad range and importance of federal programs for older Americans. Some federal programs, such as Social Security and Medicare, are directed primarily at older Americans. Other federal programs, such as Medicaid or federal housing programs, target older Americans as one of several groups served. Our work during calendar years 1995 and 1996 covered issues concerning education and employment, health care, housing and community development, income security, and veterans. In the enclosures, we describe three types of GAO products that relate to older Americans:

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- 166 reports and correspondence (see encl. I) and

- 69 congressional testimonies (see encl. II).

The summaries in these enclosures were prepared shortly after the products were issued and have not been updated to reflect subsequent developments.

Table 1 gives a breakdown of those products by category. The table shows that health, income security, and veterans' issues were the areas most frequently addressed among our products that focused on older Americans.

Table 1: GAO Products Relating to the Elderly in Calendar Years 1995 and 1996

Elderly issues	Reports and correspondence	Testimonies
Education and employment	4	2
Health	75	35
Housing and community development	8	3
Income security	45	20
Veterans and defense	34	9
Total	**166**	**69**

If you or your staff have any questions about the information in this letter please call me or Kay Brown, Assistant Director, at (202) 512-7215. Gerard V. Grant, Evaluator-in-Charge, also contributed to this document.

Sincerely yours,

Jane L. Ross
Director, Income Security Issues

Enclosures - 2

CALENDAR YEARS 1995 AND 1996 REPORTS AND CORRESPONDENCE ON ISSUES AFFECTING OLDER AMERICANS

During calendar years 1995 and 1996, GAO issued 166 reports on issues affecting older Americans. Of these, 4 were on education and employment, 75 on health, 8 on housing and community development, 45 on income security, and 34 on the Department of Defense (DOD) and veterans.

EDUCATION AND EMPLOYMENT ISSUES

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

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

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

GAO provided information on the Adult Education Act (AEA) that focused on the (1) funding history of AEA; (2) changes that have taken place in the amount of services that the State-Administered Basic Grant Program provides; and (3) goals, targeted populations, and service recipients of the State-Administered Basic Grant Program. GAO noted that (1) AEA funding under this program increased from $100 million in fiscal year 1984, to $255 million in fiscal year 1995, (2) enrollment in the State-Administered Basic Grant Program rose from approximately 377,000 participants in 1966 to almost 4 million participants in 1994, and (3) the purpose of the program is to provide educational opportunities for adults who lack the necessary literacy skills to become a citizen and to be productive in their employment.

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 the Congress; see Senior Community Service Employment: Program Delivery Could Be Improved Through Legislative and Administrative Actions, (GAO/T-HEHS-96-57, Nov. 2, 1995), statement 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 the 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) in January 1996 premiums for more than 3 million AARP Medigap policyholders increased an average of 26 percent; (2) the 1996 increases varied by state and ranged from 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' poor 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 current 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 poor 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 administrator 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 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.

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

Clinical trials showed men who took cholesterol-lowering treatments had fewer non-fatal heart attacks compared to those not treated. Reductions in coronary deaths in the same trials were restricted to high risk men, that is, those with a history of heart disease and high cholesterol. Surprisingly, the men that took the cholesterol lowering treatments suffered higher death rates from all non-coronary causes that canceled out the modest reduction in coronary deaths. The mixed benefit picture here may result from the generally modest cholesterol reductions achieved by the group of trials in our review. One of two recent trials that lowered cholesterol more found a significant reduction in total fatalities.

Trials are limited by the selected populations recruited and by limited duration. Since trials focused on middle-aged white men with higher than average cholesterol readings and a history of heart disease, useful trial data are lacking on benefits or risks for women, minorities, the elderly or people with the most common cholesterol readings. Trials proposed or underway may provide information on these groups. Trials usually follow people for 5 years or less, while drug treatment would be longer.

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

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

Consumer Health Information: 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 the Congress; see Consumer Health Informatics: Emerging Issues (GAO/T-AIMD-96-134, July 26, 1996), statement 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.

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 the 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.

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

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

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

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

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

GAO reviewed the Department of Agriculture's (USDA) domestic food and nutrition assistance programs, focusing on those programs that target benefits to women, children, infants, the elderly, and the needy. GAO noted that (1) USDA food assistance programs constitute about 60 percent of the USDA budget, and the Food Stamp Program accounts for more than one-half of those benefits; (2) 6 of the 14 USDA food programs target the groups reviewed; (3) participants' characteristics and the nature and level of benefits vary widely across the programs; (4) most of the programs have income eligibility criteria and some programs have additional criteria that individuals must meet to receive benefits; (5) benefit overlap is built into most of the programs, but it is not known how many persons participate in more than one program; (6) state and local governments and nonprofit organizations play a large role in distributing program benefits; (7) some USDA programs are similar to other agencies' assistance programs; (8) ineffective targeting of low-income people, burdensome administration, subsidizing providers rather than families, rising costs, duplication of services, inequitable funding allocations, and unfunded mandates affect the distribution of food benefits; and (9) alternatives to reduce costs and streamline program operations include improving low-income targeting, consolidating multiple programs, reducing some programs' funding levels, and eliminating some ineffective programs.

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.

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

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

Health Care Fraud: Information-Sharing Proposals to Improve Enforcement Efforts (GAO/GGD-96-101, May 1, 1996).

Estimates of health care fraud range from 3 to 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 Care Shortage Areas: Designations Not a Useful Tool for Directing Resources to the Underserved (GAO/HEHS-95-200, Sept. 8, 1995).

Many Americans live in places where barriers exist to obtaining basic health care. These areas range from isolated rural locations to inner-city neighborhoods. In fiscal

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

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

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

they feared losing their health care coverage would benefit from national portability standards. Such a change, however, could possibly boost premiums, according to insurers.

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.

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

GAO provided information on health maintenance organization (HMO) enrollment, focusing on the number of Medicare beneficiaries enrolled in risk-based HMOs. GAO noted that (1) between December 1993 and 1994, the percentage of Medicare beneficiaries enrolled in risk-based HMOs increased from 5.1 to 6.3 percent for a total of about 2.3 million beneficiaries; (2) although older beneficiaries had lower enrollment rates than the general Medicare population, they also increasingly joined risk-based HMOs; (3) between 1993 and 1994, the percentage of Medicare beneficiaries aged 75 and older enrolled in risk-based HMOs increased from 4.8 to 6.1 percent; and (4) the percentage of beneficiaries aged 85 and older enrolled in risk-based HMOs increased from 3.9 to 4.7 percent between 1993 and 1994.

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

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

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

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

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

Today, an increasing number of Americans need long-term care. Unprecedented growth in the elderly population is projected for the twenty-first century, and the population aged 85 and older--those most in need of long-term care--is expected to outpace the rate of growth for the entire elderly population. In addition to the dramatic rise in the elderly population, a large portion of the long-term care population consists of younger people with disabilities. The importance of long-term care was underscored by the 1994 congressional debate over health care reform and, more recently, by the "Contract with America," which proposed assistance such as tax deductions for long-term care insurance and tax credits for family caregiving. This report (1) defines what is meant by long-term care and discusses the conditions that give rise to long-term care need, how such need is measured, and which groups--young and old--require long-term care; (2) examines the long-term care costs that are borne by federal and state governments as well as by families; (3) addresses strategies that states and foreign countries are pursuing to contain public long-term care costs; and (4) discusses predictions by experts on the future demand for long-term care.

Long-Term Care: 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 related more to state need than to 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 range 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: More Competition and Oversight Would Improve California's Expansion Plan (GAO/HEHS-95-87, Apr. 28, 1995).

The Medicaid program was established to make health care more accessible to the poor. In many communities, however, beneficiaries' access to quality care is far from guaranteed. Too few doctors and other health care providers choose to participate in Medicaid because of low payment rates and administrative burdens. To address the access problem, as well as rising costs and enrollment in its $15 billion Medi-Cal program (which serves about 5.4 million beneficiaries), California intends to increase its reliance on managed care delivery systems. This report (1) describes California's current Medicaid managed care program, (2) reviews the state's oversight of managed care contractors with a focus on financial incentive arrangements and the provision of preventive care for children, (3) describes the state's plans for expansion, and (4) identifies key issues the state will face as it implements the expanded program.

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

Over the years, various proposals have been made to restructure the Medicaid program. One approach calls for providing federal block grants to the states and giving them increased responsibility for running the program. Under another proposal, Medicaid would be entirely funded and administered by the federal government. Yet another would split Medicaid into two programs, one encompassing acute and primary

care and the other long-term care. This report compares the different restructuring approaches and discusses their implications for federal-state financing and administration of the program. GAO also provides information on the need to establish a federal "rainy day" fund if restrictions, such as block grants, are placed on federal revenues paid to states. GAO also provides the most recent data on the amount of federal Medicaid funds provided to each state.

Medicaid 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: Oversight of Institutions for the Mentally Retarded Should Be Strengthened (GAO/HEHS-96-131, Sept. 6, 1996).

Medicaid provides more than $5 billion each year to support state institutions that house and care for the mentally retarded. Despite federal standards, serious quality-of-care problems exist at some institutions. Insufficient staffing, lack of treatments to enhance patients' independence and functional ability, and deficient medical and psychiatric care are some of the shortcomings that have been cited most frequently. In a few cases, these practices have led to injuries, illness, physical degeneration, and even death for some residents. States, which play a key role in ensuring that these institutions meet federal standards, do not always identify serious deficiencies and sometimes do not take adequate enforcement measures to prevent the

recurrence of poor care. Although the Health Care Financing Administration has tried to improve the process for spotting serious deficiencies in these institutions and has sought to make more efficient use of limited federal and state resources, oversight weaknesses persist. Moreover, state surveys may lack independence because states are responsible for surveying their own institutions. This potential conflict of interest raises concern, given the decline in direct federal oversight of both care in these facilities and the performance of state surveying agencies.

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

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

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

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

report discusses (1) TennCare's basic design and objectives, (2) the degree to which the program is meeting these objectives, and (3) the experiences of TennCare's insurers and medical providers and their implications for TennCare's future.

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

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

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: States' Efforts to Educate and Enroll Beneficiaries in Managed Care (GAO/HEHS-96-184, Sept. 17, 1996).

With managed care now being increasingly offered as an option for Medicaid recipients, reports of marketing abuses by managed care organizations have grown, prompting several states to restrict direct marketing efforts by managed care organizations. GAO found that some managed care organizations and their agents have engaged in unscrupulous practices to maximize beneficiary enrollment–and thereby boost plan revenues and commissions. These practices include bribing public officials to obtain confidential information on beneficiaries, paying beneficiaries cash and providing other incentives to sign up, deliberately misinforming beneficiaries about access to care, and enrolling ineligible beneficiaries–as many as 4,800 in one state. To avoid these problems, many states have banned or restricted direct-marketing activities by managed care organizations and have retained responsibility for enrolling or disenrolling Medicaid beneficiaries. This report provides detailed information on four states–Minnesota, Missouri, Ohio, and Washington–with innovative education and enrollment programs.

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

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

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

With an investment of only $20 million in off-the-shelf commercial software, Medicare could save nearly $4 billion over 5 years by detecting fraudulent claims by physicians–primarily manipulation of billing codes. On the basis of a test in which 4 commercial firms reprocessed samples of more than 20,000 paid Medicare claims,

GAO estimates that the software could have saved $603 million in 1993 and $640 million in 1994. GAO estimates that because beneficiaries are responsible for about 22 percent of the payment amounts–mainly in the form of deductibles and copayments–Medicare could have saved them $134 million in 1993 and $142 million in 1994. The test results indicate that only a small portion of providers are responsible for most of the abuses: fewer than 10 percent of providers in the sample had miscoded claims. GAO summarized this report in testimony before the Congress; see Medicare Claims Billing Abuse: Commercial Software Could Save Hundreds of Millions Annually (GAO/T-AIMD-95-133, May 5, 1995), by Frank W. Reilly, Director of Information Resources Management in the Health, Education, and Human Services Area, before the Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, Senate Committee on Appropriations.

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

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

Medicare Drug and Nutrient Prices (GAO/HEHS-97-22R, Oct. 11, 1996).

Medicare part B covers (1) drugs that are incident to physician services and are not self-administered and (2) tube-fed liquid nutrients for patients who cannot ingest food orally or whose digestive systems are impaired. Reports by the Department of Health and Human Services Office of Inspector General have indicated that the prices paid by Medicare for some medications and nutrients are higher than necessary and recommended reduced reimbursement for these items. Also, a home infusion and nutritional service provider GAO contacted had collected data indicating that Medicare payment levels for some drugs were much higher than the provider's cost to acquire them.

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 the Congress to consider granting HCFA legislative relief from these requirements.

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 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.

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

In fiscal year 1994 alone, Medicare was billed more than $6.8 billion for medical supplies. Congressional hearings and government studies have shown that Medicare has been extremely vulnerable to fraud and abuse in its payments for medical supplies, especially surgical dressings. In one case discussed in congressional

testimony in 1994, Medicare paid more than $15,000 in claims for a month's supply of surgical dressings for a single patient, apparently without reviewing the reasonableness of the claims before payments. Until recently, medical suppliers had considerable freedom in choosing the Medicare contractors that would process and pay their claims. Some exploited this freedom by "shopping" for contractors with the weakest controls and highest payment rates. This report discusses the (1) circumstances allowing payment for unusually high surgical dressing claims and (2) adequacy of Medicare's internal controls to prevent paying such claims.

Medicare: 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: HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance (GAO/HEHS-97-23, Oct. 22, 1996).

Until recent years, nearly all Medicare beneficiaries received care through a fee-for-service arrangement, with benefits and cost-sharing provisions standardized nationwide. Today, however, nearly 4 million beneficiaries have opted for health maintenance organizations (HMO), Medicare's leading managed care alternative. Although HMOs must cover the benefits available under traditional fee-for-service Medicare, they differ from one another in the provision of additional benefits, required premiums, provider networks, and ability to satisfy members. As a result, beneficiaries need reliable information to pick the plan that is right for them. Some beneficiaries do not understand even the basic difference between traditional Medicare and HMOs and may confuse HMOs with supplemental "Medigap" insurance. Moreover, some HMO sales agents have misled or used other questionable marketing practices to enroll poorly informed beneficiaries. This report reviews (1) the performance of HCFA, which administers Medicare, in providing beneficiaries with enough information on Medicare HMOs and (2) the usefulness of readily available HCFA data to caution beneficiaries about poorly performing HMOs.

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

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

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

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

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

Private-sector insurers cite extensive use of HMOs 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 analyzed 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 adjustments 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 county'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 the 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.

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

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

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

GAO provided information on and suggested language for proposed legislation regarding the recovery of health care costs from private insurers where Medicare is the secondary payer. GAO noted that (1) the proposed legislation would give a clearer statutory basis for existing Medicare regulations on cost recovery from private insurers, which were recently invalidated by a court ruling; (2) HHS is also preparing a legislative proposal to address this and other Medicare issues; (3) the government may have to refund millions of dollars in past recoveries and forego future recoveries because of the court ruling; and (4) the court ruling barred recoveries from third-party administrators and claims filed past the insurers' filing deadlines and before 1989.

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

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

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

Nursing homes and rehabilitation centers are taking advantage of ambiguous payment rules and the lack of guidelines to bill Medicare at inflated rates for therapy services. State averages for physical, occupational, and speech therapists' salaries range from about $12 to $25 per hour, but Medicare has been charged upwards of $600 per hour. The extent of overcharging and its precise impact on Medicare outlays are unclear; however, billing schemes uncovered in recent years suggest that the problem is nationwide and growing in magnitude. Extraordinary markups on therapy can result

from providers exploiting regulatory ambiguity and weaknesses in Medicare's payment rules. Payment rules and procedures developed when the therapy industry was much smaller and less sophisticated have proved no match for increasingly complex business practices designed to generate increased Medicare revenue and skirt program controls. Although the overbilling problem has been known since 1990, no action has been taken to close loopholes that allow payment for these overcharges.

Medigap Insurance: 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.

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

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

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 and 2002. GAO noted that (1) Florida state officials estimated that Florida would receive $7.6 billion less under the proposed MediGrant program than it does under current law; (2) between 1996 and 2002 Florida is expected to match $30.6 billion under the current Medicaid spending law and $15.8 billion under the MediGrant proposal; (3) the MediGrant program would phase in a new formula by guaranteeing minimum growth rates for some states and placing limits on the maximum growth a state could receive each year; and (4) the MediGrant program would increase Florida's share of federal Medicaid funding from 3.67 percent in fiscal year 1994 to 4.13 percent in fiscal year 2002.

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

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

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) cases treated and services performed at MAFs; (2) costs to Medicare for inpatient services provided at MAFs compared to the costs at acute-care hospitals; and (3) number of hospitals that might qualify as MAFs if the program was expanded nationwide. GAO noted that (1) MAFs mainly serve patients with uncomplicated conditions or stabilize patients with more severe conditions before transferring them to full-service hospitals; (2) MAFs serve as primary care providers for Medicare beneficiaries living in rural areas; (3) Medicare costs are generally less at MAFs than if the same patients had been treated at non-MAFs; (4) patients who are transferred from MAFs to acute-care hospitals increase Medicare costs, because the two facilities receive payments for the same patient; and (5) if the MAF or a similar program for rural hospitals in seven other states were

expanded nationwide academic researchers estimated that although over 500 hospitals meet the qualifying criteria for MAFs, no more than 150 hospitals would convert to such limited service centers.

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.

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

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

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.

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

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

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, the 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.

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

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

Private Health Insurance: Millions Relying on Individual Market Face Cost and Coverage Trade-Offs (GAO/HEHS-97-8, Nov. 25, 1996).

Most Americans obtain health insurance coverage through their jobs or through government programs like Medicare and Medicaid. About 10.5 million Americans, however, purchased private health insurance for themselves or their families in 1994. The family farmer, the recent college graduate, the early retiree, and the employee of a company that does not offer health insurance coverage are all examples of persons who are often not covered in a voluntary, employment-based insurance market. Integrating the individual market into health insurance reform proposals has been a thorny issue at both the federal and state level, in part because of the paucity of information on the nature of this market and the characteristics of its participants. This report discusses the (1) size of the individual market, recent trends in it, and the demographic characteristics of its participants; (2) market structure, including how persons access the market, the prices and other characteristics of health plans offered, and the number of individual carriers offering plans; and (3) insurance reforms and other measures states have taken to improve individuals' access to health insurance.

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.

Public Health: A Health Status Indicator for Targeting Federal Aid to States (GAO/HEHS-97-13, Nov. 13, 1996).

Premature mortality is the best single proxy for reflecting differences in the health status of states' populations as measured by both the Healthy People 2000 indicators and the ReliaStar index. GAO's analysis showed that using premature mortality to distribute federal funding for core public health functions would systematically target federal assistance to states on the basis of their populations' rates of mortality, disease incidence, and risk for mortality and morbidity. Several other variables, including the proportion of states' populations that are poor or minorities, were also found to be correlated with health status differences as measured by the Healthy People 2000 indicators and the ReliaStar index. However, including these variables along with premature mortality did not significantly enhance GAO's ability to differentiate the health status of state populations. Moreover, improving the targeting of funds beyond that obtained by using premature mortality alone would require using several additional variables, which would add to the complexity of the allocation formula.

Skilled Nursing Facilities: Approval Process for Certain Services May Result in Higher Medicare Costs (GAO/HEHS-97-18, Dec. 20, 1996).

Skilled nursing facilities provide posthospital care for people who need more care than is available in the home. Medicare payments to these facilities have grown rapidly, from $456 million in 1983 to nearly $11 billion in 1996. The number of facilities that have sought and been granted payments higher than those normally allowed by Medicare has also grown, from a total of 80 during fiscal years 1979-92 to 552 in fiscal year 1995. The skilled nursing facility industry contends that the higher payments are justified because these facilities care for more complex and costly patients than they

did in the past. However, GAO did not find that skilled nursing facilities that collected the higher fees had a larger proportion of patients requiring complex care than did other facilities. Moreover, in the area of therapy, which could be indicative of complex care needs, GAO found no major differences in the amount and types of therapy provided. Although the number of skilled nursing facilities granted exceptions to routine cost limits under Medicare soared from 62 in fiscal year 1992 to 552 in 1995, the Health Care Financing Administration's review process for exception requests does not ensure that facilities actually provide atypical services to their Medicare patients. In addition, the patient-specific data obtained from requesting skilled nursing facilities generally are not used to assess whether the Medicare beneficiaries need or receive atypical services.

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) the 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.

HOUSING AND COMMUNITY DEVELOPMENT ISSUES

Community Development: Status of Urban Empowerment Zones (GAO/RCED-97-21, Dec. 20, 1996).

The Empowerment Zone and Enterprise Community Program targets federal grants to distressed urban and rural communities for social services and community redevelopment and provides tax and regulatory relief to attract or retain businesses in distressed communities. This report focuses on six urban empowerment zones that

receive most of the program's funds--Atlanta, Baltimore, Chicago, Detroit, New York, and Philadelphia/Camden. GAO discusses the (1) status of the program's implementation in the urban empowerment zones, including the extent to which public housing officials and residents have been involved; (2) factors that participants believe have either helped or hindered efforts to carry out the program; and (3) plans for evaluating the program.

Housing Counseling Demonstration Program (GAO/RCED-96-238R, Sept. 16, 1996).

The National Affordable Housing Act of 1990 required GAO to report on the effectiveness of a U.S. Department of Housing and Urban Development prepurchase and foreclosure-prevention counseling demonstration program. This counseling was intended to (1) reduce defaults and foreclosures on single-family mortgages insured by the Federal Housing Administration (FHA), (2) encourage responsible and prudent use of such mortgages, (3) help homeowners with FHA mortgages keep their homes, and (4) encourage the availability and expansion of home ownership through the FHA mortgage insurance program. The act required that the demonstration program, which was funded from September 30, 1992, to September 30, 1994, include a comparison of three locations where the counseling was provided (target areas) and three similar locations where counseling was not provided (control areas).

Several implementation problems precluded GAO from assessing the impact of the program. Specifically, target and control areas were not comparable, the counseling intervention was not always implemented properly, and the program was geographically more limited than originally planned. Consequently, valid data does not exist upon which to base a study for determining whether a permanent program of mandatory counseling would be effective in reducing defaults and foreclosures.

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

GAO provided information on the Department of Housing and Urban Development's (HUD) rental assistance programs, focusing on the potential for assisted households to move toward or achieve economic self-sufficiency. GAO noted that based on samples of 1989 data (1) HUD-assisted renters' median age was 50 years, with 29 percent 34 years or younger, 36 percent between the ages of 35 and 64, and 35 percent 65 years or older; (2) the elderly and the disabled, who constituted about 49 percent of HUD-assisted households, had limited potential for achieving self-sufficiency; (3) 45 percent of assisted households had children, with 12 percent having three or more children; (4) about 55 percent of the households were headed by single parents; (5) single parents needed child care and other services to participate in training or employment programs; (6) about 36 percent of the heads of assisted households had graduated from high school, another 18 percent had 1 or more years of college, and 21

percent had fewer than 8 years of schooling; (7) at least 45 percent of HUD-assisted renters needed additional education or training to become self-sufficient; (8) the renters' median income was $7,320; (9) about 7 percent of the renters had incomes of $20,000 or more; (10) only 40 percent of the households reported income from wages or salaries; and (11) a 3-member family renting a 2-bedroom apartment would need an annual income ranging from $18,396 to $36,264 to become economically independent of the housing program.

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

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

Information Technology: Streamlining FHA's Single Family Housing Operations (GAO/AIMD-97-4, Oct. 17, 1996).

The Secretary of Housing and Urban Development has proposed a major overhaul of the agency's programs and operations during the next several years. One proposal is to cut staff at FHA by more than 50 percent by the year 2000. Information technology figures prominently in FHA's plans to streamline its single family operations, boost efficiency, and meet mandated staff reductions. Thus far, the planned actions are consistent with, but are not as extensive as, efficiency improvements taken by leading mortgage industry organizations. FHA's streamlining efforts, however, are in the early stages and, as other efforts continue, FHA will be deciding on specific operational changes, information technology applications, and management controls that will determine the efficiency and effectiveness of its operations and the achievement of staff reductions. In doing so, it can use the recently enacted Information Technology

Management Reform Act of 1996 to establish an effective framework for making these information technology decisions.

Multifamily Housing: Effects of HUD's Portfolio Reengineering Proposal (GAO/RCED-97-7, Nov. 1, 1996).

About 8,600 privately owned multifamily properties with federally insured mortgages totaling nearly $18 billion receive federal rental subsidies for all or some of their apartments under the Department of Housing and Urban Development's (HUD) Section 8 program. For subsidized apartments, HUD pays the difference between the rent and 30 percent of the household's income. The rents at many properties exceed market levels, resulting in high subsidies. To reduce costs and address other problems, HUD has proposed adjusting the rents to market levels and writing down mortgages as needed to allow the properties to operate at market rents. In essence, HUD's proposal recognizes a reality that has persisted for some time–namely, that many of the properties in the insured Section 8 portfolio are worth far less than their mortgages suggest. This report examines the (1) problems affecting the properties in HUD's insured Section 8 portfolio and HUD's plans for addressing them, (2) results and reasonableness of a study done by Ernst & Young assessing the effects of HUD's proposal on the properties in the portfolio, and (3) key issues facing the Congress as it assesses HUD's proposal.

Public Housing: Partnership Can Result in Cost Savings and Other Benefits (GAO/RCED-97-11, Oct. 17, 1996).

The Congress is considering giving the nation's 3,300 public housing authorities greater flexibility in managing their properties and in operating public and assisted housing for more than 4 million households. This greater discretion is expected to strengthen the long-term viability of public and assisted housing and allow the public housing authorities to better meet the needs of local communities. Public housing authorities have begun establishing partnerships with public and private sector groups to help stretch limited financial resources. Some partnerships have generated quantifiable cost savings, while others have produced nonmonetary benefits, such as improved social services, that would not have been possible without the partnership. This report describes four types of arrangements that public housing authorities have established and provides the views of public housing authority officials on the advantages of these arrangements.

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

Buyout Recipients' Compliance with Reemployment Provisions (GAO/GGD-97-7R, Oct. 3, 1996).

In Reemployment of Buyout Recipients (GAO/GGD-96-102R), GAO identified 68 persons who took a buyout to leave government, were reemployed as civil servants, and also were required to take certain steps to satisfy reemployment requirements. On the basis of information from Office of Personnel Management (OPM) data and interviews with personnel officials at the affected agencies, GAO concluded in this report that 11 of the 68 individuals were in apparent violation of the reemployment requirements, while 45 were not. GAO could not determine whether the remaining 12 were in violation because of inconsistencies between OPM and agency data. GAO will refer information about the 11 individuals in apparent violation of reemployment requirements and has already referred the 12 whose compliance was uncertain to the appropriate Office of Inspector General (OIG). GAO will report on the status of the OIG's investigations of the 23 cases and whether agencies had adequate internal controls to ensure compliance with buyout repayment requirements. [This was subsequently reported in GAO/GGD-98-12, Jan. 26, 1998.]

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

GAO reviewed the United Mine Workers of America (UMWA) Combined Benefit Fund, focusing on the fund's (1) beneficiaries, expenses, and revenues; and (2) Medicare reimbursement arrangements. GAO noted that (1) as of October 1, 1994, the fund had 96,700 beneficiaries, about three-quarters of whom were coal industry operators; (2) 29

firms terminated their contributions to the fund between October 1994 and March 1995, which necessitated the reassignment of 3,114 beneficiaries; (3) the fund had billed all operators about $162 million for fiscal year 1995 premiums; (4) the fund's Medicare per capita reimbursement rate was renegotiated and reduced for the year beginning July 1994, which makes it unlikely that future annual surpluses will occur; and (5) overall annual operating deficits are expected to begin in 1995, which would eliminate the current surplus by 2003.

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

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

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 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.

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

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

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

The federal government makes annual payments to the District of Columbia retirement fund for police officers and firefighters. To encourage the District government to control disability retirement costs, these payments must be reduced when the disability retirement rates exceed a certain limit. GAO concludes that no reduction is required in the fiscal year 1996 payment to the fund.

District's Workforce: Annual Report Required by District of Columbia Retirement 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 the Congress might consider if crafting benefit changes.

Federal Grants: Design Improvements Could Help Federal Resources Go Further (GAO/AIMD-97-7, Dec. 18, 1996).

Grants-in-aid are payments from the federal government to state and local governments to help them finance various activities, such as public assistance, highway construction, and education. In addition, lesser-known grant programs help finance public libraries, efforts to restore sport fish, programs to promote boating

safety, and other activities. In fiscal year 1995, the federal government earmarked $225 billion for more than 600 grant programs–about 15 percent of all federal spending. This report focuses on the extent to which the grant system meets two goals frequently cited by public finance experts: (1) encouraging the states to use federal dollars to supplement rather than replace their own spending on nationally important activities and (2) targeting grant funding to states with relatively greater programmatic needs and fewer fiscal resources.

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 FERS-covered workers 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.

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

The retirement benefits provided by the Civil Service Retirement System for Members of Congress are generally more generous than those provided for other federal employees. The major differences are found in the eligibility requirements for retirement and the formulas used to calculate benefits. The Member benefit formula applies to congressional staff, but they are covered by the general employee retirement eligibility requirements. Law enforcement officers and firefighters may retire earlier than general employees and are covered by a more generous benefit formula than are general employees. Under the Civil Service Retirement System, the provisions for air traffic controllers fall between those for law enforcement officers

and firefighters and those for general employees. Many of the advantages afforded to Members of Congress and congressional staff under the Civil Service Retirement System were continued under the Federal Employees Retirement System, which covers workers hired in 1984 and thereafter. But under the Federal Employee Retirement System, provisions for law enforcement officers, firefighters, and air traffic controllers are very similar to provisions for Members. GAO summarized this report in testimony before the Congress; see Congressional Retirement Issues (GAO/T-GGD-95-165, May 15, 1995), by Johnny C. Finch, Assistant Comptroller General for General Government Programs, before the Subcommittee on Post Office and Civil Service, Senate Committee on Governmental Affairs.

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.

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

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

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

Military Retirement: Possible Changes Merit Further Evaluation (GAO/NSIAD-97-17, Nov. 15, 1996).

Payments to military retirees and their survivors totaled $29 billion in fiscal year 1996. Various factors, including the end of the Cold War, defense downsizing, changes in civilian retirement systems, and increasing federal budgetary constraints, have raised questions about whether the military retirement system today best meets the needs of the Pentagon and members of the armed forces. A number of analysts, including several who participated in a roundtable discussion convened by GAO, believe that fundamental changes to the military retirement system could increase its effectiveness or reduce costs by yielding a force of different composition and size than exists today. The suggestions of the GAO panel, which included Defense Department experts and compensation analysts, ranged from earlier vesting of retirement benefits to more sweeping reforms, such as placing military personnel under a system similar to the Federal Employees Retirement System.

Older American 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).

The Social Security Administration (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 5-fold 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.

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

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

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

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

of pension plans in the retail sector to over 60 percent in the transportation industry; and (7) ad hoc adjustments to private sector pension benefits have declined in recent years from over 50 percent to under 10 percent of plans.

Private Pensions: Most Employers That Offer Pensions Use Defined Contribution Plans (GAO/GGD-97-1, Oct. 3, 1996).

In response to congressional interest in possibly changing the structure of federal employee retirement plans, this report provides information on the approaches that private sector employers are using to provide their employees with retirement benefits and the extent to which these approaches may be changing. GAO describes (1) the numbers and types of pension plans sponsored nationwide by private employers during 1984 to 1993, (2) the proportions of total contributions made to these plans by employers and employees, (3) the average administrative expense for the plans, and (4) the explanations provided in retirement literature on why employers might decide to sponsor a particular type of pension plan.

Proposed Pension Reversions (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 larger 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 supplemental 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).

Reemployment of Buyout Recipients (GAO/GGD-96-102R, June 14, 1996).

As part of its downsizing efforts, the federal government has offered employees of various federal agencies incentive payments, or buyouts, to leave federal employment through voluntary separations. Pursuant to a congressional request, GAO reviewed agencies' use of buyout authority and whether agencies subsequently reemployed buyout recipients as civil servants or government contractors. Using the Office of Personnel Management's (OPM) data, GAO determined that governmentwide agencies paid 87,743 buyouts from January 1993 through June 30, 1995. However, GAO could not determine the total number of employees who were eligible to receive buyouts. Of the 87,743 buyout recipients, agencies rehired 394 as civil servants. However, it is not clear how many were reemployed as federal contractors. The limited available data suggest the practice was not used extensively. Reemployment of buyout recipients as civil servants or contractors is not prohibited, but, under certain circumstances, buyout recipients are required to take steps to satisfy reemployment provisions. Of the 394 buyout recipients reemployed as civil servants, GAO identified 68 cases in which these reemployment provisions applied. Finally, through a survey of National Aeronautics and Space Administration and Department of Transportation units, respondents reported that they had management controls designed to prevent reemployment abuses.

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

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

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

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

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.

Social Security: Union Activity at the Social Security Administration (GAO/HEHS-97-3, Oct. 2, 1996).

The Social Security Administration (SSA), like other federal agencies and some private sector firms, pays for approved time spent by its employees on union activities. SSA has a special fiduciary responsibility to effectively manage and maintain the integrity of the social security trust funds from which most of these expenses are paid. In a time of shrinking budgets, it is crucial that SSA, as well as other agencies, evaluate how resources are being spent and have reliable monitoring systems to support this evaluation. To ensure accurate tracking of time spent on union activities and the staff conducting these activities, SSA has developed and is testing a new time-reporting system for its field offices and teleservice centers. GAO believes that the new system should be implemented agencywide. With an improved agencywide system, SSA management should have better information on where its money is being spent.

SSA Benefit Statements: Well Received by the Public But Difficult to Comprehend (GAO/HEHS-97-19, Dec. 5, 1996).

SSA in 1995 began sending statements–called Personal Earnings and Benefit Estimate Statements–automatically to workers who had reached age 60. By fiscal year 2000, these statements will reach an estimated 123 million people annually–almost every U.S. worker aged 25 and older. These six-page statements provide workers with information on their yearly earnings on record at SSA, information on their eligibility for social security retirement and other benefits, and estimates of these benefits. Experts agree that SSA's approach is generally reasonable, and feedback suggests that the public generally finds the statements to be helpful in retirement planning. However, GAO believes that the statements could benefit from extensive revisions. Specifically, the statements need a better layout and design and simpler explanations. SSA will need to start now to complete these changes by its 1999 redesign target date because the agency will require time to collect data and test alternatives.

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.

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 otherwise identical one-earner couple. And, 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 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 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.

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

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

Supplemental Security Income: Administrative and Program Savings Possible by Directly Accessing State Data (GAO/HEHS-96-163, Aug. 29, 1996).

The Supplemental Security Income program, which provides cash benefits to the aged, the blind, and the disabled, could be run more efficiently. More importantly, millions of dollars in overpayments could be prevented or detected quickly if information were available on-line during eligibility assessments. GAO estimates that direct on-line access to state computerized income information could have prevented or quickly detected more than $131 million in overpayments caused by unreported or underreported income nationwide in one 12-month period. However, in SSA field offices where direct access to computerized state information has been implemented, SSA claims representatives did not use it to detect overpayments. The claims representatives did use it to process claims more efficiently, and SSA's preliminary results have shown that its use has reduced administrative expenses. Establishing on-line access between SSA field offices and state agency databases would require only minimal computer programming in most states; some states would need additional hardware, such as computer lines.

Supplemental Security Income: Growth and Changes in Recipient Population Call for Reexamining Program (GAO/HEHS-95-137, July 7, 1995).

The SSI program is the largest cash assistance program for the poor and one of the fastest growing entitlement programs; program costs have risen 20 percent annually during the last 4 years. SSI provides means-tested income support payments to aged, blind, or disabled persons. Last year, more than 6 million people received about $25 billion in federal and state benefits. In response to SSI's rapid growth, the Congress passed legislation limiting drug addicts' benefits, and this year it is considering further restrictions for these recipients as well as for children and noncitizens. This report provides an overview of the SSI program and its recent history. Specifically, it examines factors contributing to caseload growth and changes in the characteristics of SSI recipients.

Supplemental Security Income: SSA Efforts Fall Short in Correcting Erroneous Payments to Prisoners (GAO/HEHS-96-152, Aug. 30, 1996).

Despite SSA procedures to detect supplemental security income recipients in county and local jails, GAO found that $5 million had been erroneously paid to prisoners in the jail systems it reviewed. SSA had been unaware of many of these payments and, therefore, had made no attempt to recover them. Various factors contributed to these payments. First, SSA field offices have not been obtaining information regularly on prisoners in county and local jails. Second, the supplemental security income recipient–or the person or organization designated to receive payments on the

recipient's behalf–has not been reporting the incarceration, as required. Third, SSA sometimes falls short in periodically reviewing–either by mail or interview–a recipient's continued financial eligibility for supplemental security income. Under a new SSA initiative, field offices will be required to obtain prisoner information from county and local jails, and SSA plans to monitor field office compliance with this requirement. It is too early to tell, however, whether this initiative will be successful.

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, 3,505 SSI recipients transferred resources, including cash, houses, land, and other items, valued at $74 million. Reported resource 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, GAO estimated the 3,505 SSI recipients who reported transferring resourses to qualify for benefits would receive nearly $8 million in SSI benefits during 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 estimated that from 1990 through 1995, SSA could have saved $14.6 million with a transfer-of-resource restriction similar to that used for Medicaid which delays individuals' date of eligibility for benefits. 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 the 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) the 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.

Welfare Benefits: Potential to Recover Hundreds of Millions More in Overpayments (GAO/HEHS-95-111, June 20, 1995).

Under welfare reform legislation being considered by the Congress, resources for helping poor families may become increasingly limited–making it critical that only those who are eligible for benefits receive them. In 1992, benefit overpayments in three welfare programs–Aid to Families With Dependent Children (AFDC), Food Stamps, and Medicaid–totaled $4.7 billion, or about 4 percent of the total benefits paid. Moreover, nationwide recovery of these benefits was relatively low. This report discusses (1) what states are doing to recover benefit overpayments, what the more effective practices are, and what states could do better and (2) what the federal government could do to help states recover more overpayments.

Welfare Programs: Opportunities to Consolidate and Increase Program Efficiencies (GAO/HEHS-95-139, May 31, 1995).

The federal government provides billions of dollars in public assistance each year through an inefficient welfare system that is increasingly cumbersome for program administrators to manage and difficult for eligible clients to access. Program consolidation may be one strategy to reduce the inefficiency of the current system of overlapping and fragmented programs. This report (1) describes low-income families' participation in multiple welfare programs, (2) examines program inefficiencies, such as program overlap and fragmentation, and (3) identifies issues to consider in deciding whether and to what extent to consolidate welfare issues. Regardless of how the welfare system is restructured, ensuring that federal funds are used efficiently and that programs focus on outcomes remains important. Without a focus on outcomes, concerns about the effectiveness of welfare programs will not be adequately addressed.

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

GAO found that the percentage of immigrants receiving public assistance–specifically SSI or AFDC–is higher than the percentage of citizens receiving these benefits. Six percent of all immigrants receive benefits compared with 3.4 percent of all citizens. Most immigrant recipients live in four states: California, New York, Florida, and Texas; more than one-half of all immigrant recipients live in California. Between 1983 and 1993, the number of immigrants receiving SSI more than quadrupled, increasing from 151,000 to 683,000. During this period, immigrants grew from about 4 percent of all SSI recipients to more than 11 percent. As a percentage of all adult AFDC recipients, immigrants grew from about 5 percent to 8 percent. In all, immigrants received an estimated $3.3 billion in SSI benefits and $1.2 billion in AFDC benefits in

1993. Most immigrant recipients are lawful permanent residents or refugees, but other characteristics of immigrants receiving SSI and AFDC vary. For example, the number of immigrants receiving SSI aged benefits–available to those 65 years and older–has increased dramatically. According to the Congressional Budget Office, a welfare reform proposal now before the Congress (H.R. 4) would save $9.2 billion from the SSI program and $1 billion from the AFDC program over 4 years. GAO estimates that 522,000 SSI recipients and 492,000 AFDC recipients would become ineligible for benefits under H.R. 4.

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' AND DOD ISSUES

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

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

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

Since fiscal year 1994, the Congress has appropriated nearly $1 billion for USTF to deliver health care to what now totals 124,000 beneficiaries. In recent years, the 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. The 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 the 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 the Congress can assess TRICARE's success in the future.

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

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

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.

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

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

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.

Substance Abuse Treatment: VA Programs Serve Psychologically and Economically Disadvantaged Veterans (GAO/HEHS-97-6, Nov. 5, 1996).

About 25 percent of all Department of Veterans Affairs (VA) patients discharged from inpatient settings in fiscal year 1995 were diagnosed with alcohol or drug abuse problems. VA estimates that it spent $2 billion–or about 12 percent of its total health care budget in fiscal year 1995–to treat veterans with substance abuse disorders. The VA health care system is now evaluating what services to offer and where to provide them. VA's new organizational structure, called the Veterans Integrated Service Network, replaces VA's central office and regional structure with 22 networks of hospitals and clinics. VA expects this consolidation and realignment to boost efficiency by trimming management layers, eliminating duplicative medical services, and making better use of available public and private resources. This report provides information on the (1) characteristics of veterans who receive substance abuse treatment, (2) services that VA offers to veterans with substance abuse problems, (3) methods that VA uses to monitor the effectiveness of its substance abuse treatment programs, (4) community services available to veterans who suffer from substance

abuse disorders, and (5) implications of changing VA's current methods for delivering substance abuse treatment.

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

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

VA Health Care: Better Data Needed to Effectively Use Limited Nursing Home Resources (GAO/HEHS-97-27, Dec. 20, 1996).

VA reported spending $1.6 billion in fiscal year 1995 on nursing home care for nearly 80,000 veterans–about 14 percent of the estimated demand by veterans for such care. VA provides nursing home care in its own facilities, contracts with community nursing homes, and pays state veterans' homes part of the cost to care for veterans. All veterans are eligible for nursing home care essentially on a first-come, first-served basis within VA's budget constraints. As the number of veterans aged 65 and older increases to 9.3 million by the year 2000, the demand for nursing home care will likely rise. The funds for VA nursing home care, however, are expected to be limited. This report provides information on the (1) distribution of veterans in VA, community, and state nursing homes; (2) costs to VA for these nursing homes; (3) factors affecting VA's use of community and state veterans' nursing homes; and (4) relative quality of the care provided by VA, community, and state veterans' homes.

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 significantly 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 facilities 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 physicians sometimes must decide to either deny needy veterans noncovered services or ignore the law and provide the noncovered services 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's 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: Improving Veterans' Access Poses Financial and Mission-Related Challenges (GAO/HEHS-97-7, Oct. 25, 1996).

VA runs one of the nation's largest health care delivery systems, including more than 170 hospitals and nearly 400 clinics, over one-half of which are free-standing clinics. Veterans must often travel long distances, however, to receive care at these facilities. VA has a policy encouraging its hospitals to improve access to care for eligible veterans. As a result, many hospitals have either planned or established new, free-standing outpatient clinics, known as "access points." Access points provide primary care to veterans and generally refer those needing specialized services or inpatient stays to VA hospitals. This report examines VA's policy for establishing access points. GAO discusses the legal, financial, and mission-related implications of VA's efforts to establish access points.

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

VA assumed control of the former Naval Hospital in Orlando, Florida, in June 1995. VA plans to convert the hospital into a nursing home while continuing to operate an existing outpatient clinic. VA also plans to build a new hospital and nursing home in Brevard County, 50 miles from Orlando. GAO concludes that VA's conversion of the former Orlando Naval Hospital into a nursing home and construction of a new hospital

and nursing home in Brevard County is not the most prudent and economical use of its resources. These construction projects are based on questionable planning assumptions that may result in the unneeded expenditure of federal dollars. Specifically, VA did not adequately consider the availability of hundreds of community nursing home beds and unused VA hospital beds as well as potential decreases in future demand for VA hospital beds. VA could achieve its goals in Central Florida by using existing capacity.

VA Health Care: 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: Opportunities to Significantly Reduce Outpatient Pharmacy Costs (GAO/HEHS-97-15, Oct. 11, 1996).

All pharmacies run by VA provide medications and medical supplies that are available over the counter through other local outlets. The most frequently dispensed over-the-counter products include (1) medications, such as aspirin and insulin; (2) dietary supplements, including Sustacal and Ensure; and (3) medical supplies, such as alcohol prep pads, lancets, and glucose test strips. Unlike VA, public and private health plans cover few, if any, over-the-counter products for their beneficiaries. VA pharmacies dispensed over-the-counter products more than 15 million times during fiscal year 1995 at an estimated cost of $165 million, including handling costs of $48 million. VA recovered about $7 million through veterans' copayments, or about four percent of its total over-the-counter costs. Although many veterans shared a modest portion of the costs and some paid the full amount, most veterans paid nothing. GAO suggests several ways that VA could cut costs associated with dispensing over-the-counter products or boost revenues from copayments. First, VA could more narrowly define when to provide over-the-counter products. 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, the Congress could expand copayment requirements.

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

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

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

Many veterans have health care needs that are not adequately met through current health care programs, including VA's health care system. About one-third of the nation's homeless are veterans, nearly one-half of whom have serious mental problems, suffer from substance abuse, or both. The homeless have limited access to health care services and may not seek medical treatment. About 38 percent of male and 25 percent of female Vietnam veterans with post-traumatic stress disorder have not sought treatment. About 91,000 low-income, uninsured veterans with no apparent health care options indicated in a 1987 VA survey that they had never used VA health facilities because they were unaware that they were eligible or they had concerns about the quality or accessibility of VA health care. VA cannot adequately address many of these health care needs because (1) it relies primarily on direct delivery of health care services in VA facilities, (2) its complex eligibility and entitlement provisions limit the services that veterans can obtain from VA facilities, and (3) space and resource limitations prevent eligible veterans from obtaining covered services. This report presents several options for restructuring VA's health care system to enable it to better meet the health care needs of veterans.

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

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

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

GAO addressed a series of questions related to VA's acquisition and intended use of the Naval Hospital in Orlando, Florida. GAO noted that (1) the VA Integrated Planning Model is based upon veterans' ages, average lengths of hospital stays, and number of patients treated in selected medical services; (2) VA used its model to project veterans' inpatient, outpatient, and nursing home needs for the year 2005; (3) VA did not consider the number of VA hospitals per square mile per capita in making its construction planning decisions for central Florida and significantly overestimated the number of hospital beds it would need in 1995; (4) it is unclear why Florida's hospital utilization rates are far below the national rates; (5) the veteran population is expected to decline in Florida and the nation over the next 15 years, while the total population in these areas is expected to increase; (6) there are waiting periods for certain elective medical treatments in central Florida VA hospitals due to staffing reductions; and (7) the VA Integrated Planning Model adequately accounts for the aging nature of the veteran population.

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

In 1993, VA's Dependency and Indemnity Compensation (DIC) program paid benefits totaling $2.7 billion to about 276,000 surviving spouses of service members who had died on active duty and surviving spouses of some disabled veterans. These benefits were paid under the Veterans' Benefits Act of 1992, which changed the basis for DIC

benefits from the military rank of the deceased service member or veteran to a flat rate for all surviving spouses. This report (1) estimates DIC recipients' total income and determines the kinds and the amounts of benefits received from other programs, (2) determines the financial impact on surviving spouses of the deaths of totally disabled veterans and of veterans who were receiving supplemental payments because they had multiple severe disabilities and could not care for themselves, and (3) assesses alternative ways to set DIC benefits.

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

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

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

Veterans often wait months for VA to decide their compensation and pension claims. In addition, the 40,000 veterans who appeal VA's decisions each year wait much longer--more than 2 years for a final decision, according to agency officials. GAO found that VA's appeals process is increasingly bogged down, and the outlook for the future is not bright. Legislation and court rulings have expanded veterans' rights but also expanded VA's adjudication responsibilities. VA is having difficulty integrating these responsibilities into its already complex and unwieldy adjudication process. Since 1991, the number of appeals awaiting board action has risen by 175 percent and the average processing time has increased by more than 50 percent. Studies by GAO, VA, and others have recommended the need for autonomous organizations in VA to work together to identify and resolve problems. Yet GAO found that problems continue to go unidentified and unresolved. Unless VA clearly defines its adjudication responsibilities, it will be unable to determine whether it has the resources to meet those responsibilities and whether new solutions may be needed, including laws amending VA's responsibilities or reconfiguring the department.

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

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

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

DOD uses separation pay to induce people to serve in the military despite the risk of involuntary separation. The Congress authorized special separation pay to minimize the use of involuntary separations in the ongoing force drawdown. Pay offsets prevent service members from receiving dual compensation for a single period of service. Repealing offsets for separation and disability pay would cost the federal government an estimated $435 million for those service members who separated during fiscal years 1995 to 1999. A repeal would cost about $799 million if it was made retroactive to fiscal year 1992, when the special separation pay program began. Separation and disability pay offsets have not significantly undermined the voluntary separation incentive. According to DOD, the bulk of the drawdown since fiscal year 1992 has been accomplished through voluntary separations. DOD requires the services to inform separating service members about the offset.

Veterans' Health Care: 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 need home health care for various reasons. Some veterans have chronic health problems, such as heart disease, and require periodic visits, while others have been 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 taken 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 a majority of their clients were severely disabled; (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.

VHA's Management Improvement Initiative (GAO/HEHS-96-191R, Aug. 30, 1996).

Pursuant to a congressional request, GAO examined VA's progress in implementing management improvement initiatives to its health care system, administered by the Veterans Health Administration (VHA). GAO noted that (1) VA has concentrated its efforts on implementing those initiatives aimed at reducing centrally funded activities while deferring most of the more significant recommendations and (2) VA addressed the 1995 and 1996 budget reductions mainly through across-the-board cuts. In an August 20, 1996, letter, VA commented to GAO that the agency is making considerable progress toward implementing those initiatives still appropriate.

CALENDAR YEAR 1995 AND 1996 TESTIMONIES ON ISSUES AFFECTING OLDER AMERICANS

GAO testified 69 times before congressional committees during calendar years 1995 and 1996 on issues relating to older Americans. Of these testimonies, 2 were on education and employment, 35 on health, 3 on housing, 20 on income security, and 9 on veterans and DOD issues.

EDUCATION AND EMPLOYMENT ISSUES

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

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

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 pharmacy benefit managers (PBM): 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.

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

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

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.

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

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

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.

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

Many Americans face discontinuity in their health care coverage when they change employers, and others do not change jobs because of concerns about losing health care coverage. GAO surveyed the status of federal and state insurance reforms and the number of individuals who would be affected by legislation to establish national portability standards. GAO found that federal and state laws reflect steps taken to

improve the portability of health insurance, but the possibility remains that an individual's coverage would be reduced when changing jobs because most private health plans still require waiting periods before making people with preexisting conditions fully eligible for coverage. On the basis of existing data on the number of people who change jobs and studies on the effect of health insurance on job mobility, GAO estimates that up to 21 million Americans would benefit from legislation waiving preexisting condition exclusions for individuals who have maintained continuous health care coverage.

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

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

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

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

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

The $131 billion Medicaid program is at a crossroads. Between 1985 and 1993, Medicaid costs tripled and the number of beneficiaries rose by more than 50 percent. Medicaid costs are projected to rise to $260 billion, according to the Congressional Budget Office. Despite federal and state budgetary constraints, several states are exerting pressure to expand the program and enroll hundreds of thousands of new beneficiaries. The cost of expanded coverage, they believe, will be offset by the reallocation of Medicaid funds and the wholesale movement of beneficiaries into some type of managed care arrangement. This testimony examines (1) federal and state Medicaid spending, (2) some states' efforts to contain Medicaid costs and expand coverage through waiver of federal requirements, and (3) the potential impact of these waivers on federal spending and on Medicaid's program structure overall.

Medicaid: 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.

Medicaid: State Flexibility in Implementing Managed Care Programs Requires Appropriate Oversight (GAO/T-HEHS-95-206, July 12, 1995).

Requiring states to obtain waivers to broaden use of managed care may hamper their efforts to aggressively pursue cost-containment strategies. At the same time, because current program restrictions on managed care were designed to reinforce quality assurance, their absence requires the substitution of appropriate and adequate mechanisms to protect both Medicaid beneficiaries and federal dollars. Finally, the reinvestment of managed care savings to expand Medicaid coverage to several million additional persons suggests the need for up-front consultation with the Congress because of (1) the heavier financial burden such 1115 waivers may place on the federal government and (2) the issue of whether the U.S. Treasury should benefit from those savings.

Medicaid: Statewide Section 1115 Demonstrations' Impact on Eligibility Service Delivery and Program Cost (GAO/T-HEHS-95-182, June 21, 1995).

The growth of Medicaid, which accounted for $142 billion in federal and state outlays in 1994, is outpacing even the growth of Medicare. This is happening at a time when states are feeling pressured financially and are seeking ways to care for their uninsured populations. In response, states are, one by one, reinventing their Medicaid programs, using the authority of section 1115 waivers. Named for section 1115(a) of the Social Security Act, these waivers free states from some Medicaid restrictions on the use of managed care delivery systems. They also allow states to expand Medicaid-financed coverage to persons not normally eligible for Medicaid. This testimony presents a detailed look at Medicaid's growing expenditures, describes states' efforts to obtain section 1115 waivers, and summarizes the expenditures forecast of programs operating with waivers.

Medicare: Adapting Private Sector Techniques Could Curb Losses to Fraud and Abuse (GAO/T-HEHS-95-211, July 19, 1995).

Medicare's loss of billions of dollars to fraud and abuse could be curbed by adopting such private sector techniques as competitive bidding, use of advanced software to detect gross overpayments, and preferred networks to better control costs. Medicare's losses stem from inappropriate pricing and inadequate scrutiny of claims for payments. Further, abusive and poorly qualified providers of medical services and supplies continue to participate in the program. These problems are not unique to Medicare. However, private payers are often able to react quickly, through a variety of management approaches, whereas Medicare's pricing methods and controls over utilization, which were consistent with health care financing and delivery when the program started, have not been adapted to today's environment.

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

In response to a congressional request, GAO investigated allegations against ABC Home Health Care, a home health agency (HHA), and its participation in the Medicare home health care program. In the Medicare program, providers may receive reimbursement for only those expenses that are reasonable in amount and related to patient care for eligible patients. Current and former employees told GAO that local ABC officer managers directed them to alter records to make it appear that patients continued to need home health visits. Additionally, managers directed employees to continue visiting patients who, in the employees' opinion, did not qualify for home health care because they no longer met Medicare rules defining homebound status. ABC also reportedly charged Medicare for the cost of acquiring other HHAs by paying

owners a small sum up front and the balance in the form of salary under employment agreements, a practice that is inconsistent with Medicare regulations for reimbursement. Finally, according to former employees, some managers directed employees to market ABC and its services with the intent of charging Medicare for costs that were not reimbursable. GAO has shared information concerning possible illegal activities with appropriate law enforcement authorities.

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

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

Medicare: 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 conditions, 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: High Spending Growth Calls for Aggressive Action (GAO/T-HEHS-95-75, Feb. 6, 1995).

The government faces strong obstacles to bringing Medicare expenditures under control. Broad-based payment system reforms have slowed overall spending, but Medicare growth rates remain higher than overall inflation. And although more reforms may be needed, their nature is the subject of much debate. There is less dispute, however, that Medicare pays too much for some services and supplies. Fiscal pressures have increasingly led private and state-government payers to negotiate discounts with providers and to manage the form and the volume of care. Medicare has not exercised its potential market power in similar fashion when buying some services, such as rehabilitation therapy. GAO suggests that the government change the reimbursement policies for these excessively costly services to ensure that it is acting as a prudent buyer. Also, greater vigilance over wasteful or inappropriate payments could better protect Medicare against fraudulent and abusive billings from providers.

Medicare: Increased Federal Oversight of HMOs Could Improve Quality of and Access to Care (GAO/T-HEHS-95-229, Aug. 3, 1995).

This testimony discusses problems that HCFA has had monitoring HMOs it contracts with to provide services to Medicare beneficiaries and ensuring that they comply with Medicare's performance standards. GAO found weaknesses in HCFA's quality assurance monitoring, enforcement measures, and appeal processes. Although HCFA routinely reviews HMO operations for quality, these reviews are generally perfunctory and do not consider the financial risks that HMOs transfer to providers. Moreover, HCFA collects virtually no data on services received through HMOs to enable HCFA to identify providers who may be underserving beneficiaries. In addition, HCFA's HMO oversight has two other major limitations: enforcement actions are weak and the beneficiary appeal process is slow. HCFA's current regulatory approach to ensuring good HMO performance appears to GAO to lag behind the private sector.

Medicare Managed Care: Enrollment Growth Underscores Need to Revamp HMO Payment Methods (GAO/T-HEHS-95-207, July 12, 1995).

Rapid growth in the number of Medicare beneficiaries in HMOs increases the urgency of correcting rate-setting flaws that result in unnecessary Medicare spending. By not tailoring its HMO capitation payment to how healthy or sick HMO enrollees are, HCFA cannot realize the savings that private-sector payers capture from HMOs. Two lessons can be learned from GAO's review of ways to fix Medicare's HMO capitation payments. First, a multipronged approach to rate setting makes sense. The large disparities in market conditions between states call for solutions keyed to market conditions. Second, with respect to achieving the promise of such initiatives, details

matter. How these strategies are designed and implemented could mean the difference between success and failure. GAO believes that in the short term, HCFA can overcome its capitation problem by introducing a better health status risk adjustor. HCFA should also promptly test competitive bidding and other promising approaches to setting HMO rates that reduce Medicare costs.

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

(This testimony is similar to our July 12, 1995, testimony summarized above.)

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

Medicare's vulnerability to provider exploitation of its billing system stems from a combination of factors: (1) higher than market rates for some services, (2) inadequate checks for detecting fraud and abuse, (3) superficial criteria for confirming the authenticity of providers billing the program, and (4) weak enforcement efforts. Various health care management techniques help private payers avoid these problems, but Medicare generally does not use these techniques. The program's pricing methods and controls over utilization have not kept pace with changes in health care financing and delivery. To some extent, the predicament inherent in public programs–the uncertain line between adequate managerial control and excessive government intervention–helps explain the dissimilarity in the ways in which Medicare and private

health insurers run their respective "plans." GAO believes that a viable strategy for remedying the program's weaknesses consists of adapting the health care management approach of private payers to Medicare's public payer role. This would entail (1) more competitively developed payment rates, (2) beefed-up fraud and abuse detection that uses modern information systems, and (3) more rigorous criteria for granting authorization to bill the program.

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

(This testimony is similar to our July 31, 1995, testimony described above.)

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

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

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

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

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

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

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; a process in which information systems and technology should be managed 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 Manufacturing (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, the 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 the Congress is asking state and local governments to assume a larger role in defining how the programs work. The 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 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

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

The retirement benefits provided by the Civil Service Retirement System for Members of Congress are generally more generous than those provided for other federal employees. The major differences are found in the eligibility requirements for retirement and the formulas used to calculate benefits. The Member benefit formula applies to congressional staff, but they are covered by the general employee retirement eligibility requirements. Law enforcement officers and firefighters may retire earlier than general employees and are covered by a more generous benefit formula than are general employees. Under the Civil Service Retirement System, the provisions for air traffic controllers fall between those for law enforcement officers and firefighters and those for general employees. Many of the advantages afforded to Members of Congress and congressional staff under the Civil Service Retirement System were continued under the Federal Employees Retirement System, which covers workers hired in 1984 and thereafter. But under the Federal Employee Retirement System, provisions for law enforcement officers, firefighters, and air traffic controllers are very similar to provisions for Members.

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

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

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

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

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

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

Federal 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.

Federal Retirement Issues (GAO/T-GGD-95-111, Mar. 10, 1995).

This testimony focuses on ongoing GAO work on two issues involving federal employee retirement programs. First, GAO compares the retirement provisions for Members of Congress and congressional staff in the Civil Service Retirement System and the Federal Employees Retirement System with the provisions applicable to other employees covered by these systems. Second, GAO analyzes retirement programs in the private sector and state government.

Federal Retirement System Financing (GAO/T-GGD-95-197, June 28, 1995).

Federal retirement system financing is a complex issue. This testimony seeks to bring some perspective to the subject by describing how the government finances its retirement system and by describing the budget implications of the financing methods being used and possible changes to these methods. GAO concentrates on the Civil Service Retirement System and the Federal Employees Retirement System because they are the largest retirement programs for federal workers.

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.

Means-Tested Programs: An Overview, Problems, and Issues (GAO/T-HEHS-95-76, Feb. 7, 1995).

Nearly 80 means-tested programs have been created over the years for low-income people. In fiscal year 1992, the federal government spent about $208 billion on these programs to meet the needs of poor Americans of all ages. The many means-tested programs are costly and difficult to administer. On the one hand, the programs sometimes overlap one another; on the other hand, they are often so narrowly focused that service gaps hinder clients. GAO notes that although advanced computer technology is essential to the programs operating efficiently, it is not being effectively developed or used. Due to their size and complexity, many of these programs are vulnerable to waste, fraud, and abuse. Moreover, the welfare system is often difficult for clients to use effectively. Finally, administrators have not articulated clear goals and objectives for some programs and have not collected data on how well the programs are working.

Overview of Federal Retirement Programs (GAO/T-GGD-95-172, May 22, 1995).

This testimony describes how the federal retirement systems work, the benefits they provide, and how they compare with private sector programs. GAO concentrates on the Civil Service Retirement System and the Federal Employees Retirement System because they are the largest retirement systems for federal civilian personnel. GAO describes the history of the two retirement systems and discusses four issues that are often raised in connection with federal retirement: (1) retirement eligibility provisions, (2) benefit formulas, (3) COLAs, and (4) system financing.

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

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

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

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

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

On average, SSA pays over $1 billion in cash payments to DI and SSI beneficiaries each week. 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.

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.

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.

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.

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.

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

(This testimony is similar to our February 6, 1996, testimony summarized above. Since the data used was updated from that used in the February testimony, the May testimony is summarized below.)

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 noncitizen 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 asylum seekers. 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

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

This testimony discusses the growth of SSI rolls and changes in the characteristics of SSI recipients. Last year, SSA paid nearly $22 billion in federal benefit payments to about 6.3 million aged, blind, and disabled SSI recipients. Since 1986, payments have

risen by $13.5 billion, more than doubling. Benefits for the disabled accounted for nearly 100 percent of this increase. Since 1986, the number of disabled SSI recipients under age 65 has increased an average of more than 8 percent annually, adding nearly 2 million younger recipients to the rolls, while the number of aged and blind recipients has remained level. The trend toward younger beneficiaries, coupled with low exit rates from the program, means that costs will continue to burgeon in the near term. Without a slowing in the growth of this younger population, SSI will become even more costly. Since 1991, three groups--disabled children, legal immigrants, and adults with mental problems--have accounted for nearly 90 percent of the SSI caseload growth. Of the 2 million mentally disabled adults, roughly 100,000 are disabled mainly by drug addiction or alcoholism. The dramatic increases pose fundamental questions about eligibility standards, accountability, and program effectiveness.

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

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

VETERANS' AND 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 the 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 the 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 for achieving budget-neutral eligibility reform.

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

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

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

In this testimony GAO summarizes the results of a number of reviews that have detailed problems in administering VA's outpatient eligibility provisions; compared VA benefits and eligibility to those of other public and private health benefits programs; and assessed VA's role in a changing health care marketplace. In summary, veterans' eligibility for VA health care has evolved over time in terms of both the types of veterans eligible for care and the services they are eligible to receive. VA has gone from a system primarily covering hospital care for veterans with war-related injuries to a system covering a wide array of hospital and other medical services for both wartime and peacetime veterans and veterans both with and without service-connected disabilities. VA now has multiple categories of veterans eligibility based on a number of factors.

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, the 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 has sought to fundamentally change the way in which it runs its health care delivery and financing systems. It has also sought 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.

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