

**GAO**

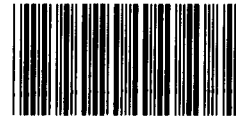
United States General Accounting Office

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

December 1991

# AGING ISSUES

## Related GAO Reports and Activities in Fiscal Year 1991



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**Human Resources Division**

B-246844

December 17, 1991

The Honorable David H. Pryor  
Chairman, Special Committee on Aging  
United States Senate

Dear Mr. Chairman:

This report is in response to the Committee's October 2, 1991, request for a compilation of our fiscal year 1991 products and ongoing work regarding older Americans.

GAO's work in aging reflects the continuing importance of an aging population for federal government programs. Today about 32 million Americans are age 65 or older. By the year 2020, that number will exceed 52 million, of which almost 7 million will be age 85 or older. Although most of the nation's elderly citizens are healthy and independent members of society, a growing number need assistance to maintain their independence and avoid institutionalization. This changing demography will continue to challenge both government and the private sector in the 1990s and beyond.

Our work in fiscal year 1991 covered a broad range of issues, including federal government activities in health care, housing, income security, and social and community services. Some federal programs, such as Social Security and Medicare, are directed primarily at the elderly. Other federal programs target the elderly as one of several groups served, such as in the Low-Income Home Energy Assistance Block Grant or Medicaid programs. We have organized the summaries of our fiscal year 1991 reports accordingly.

In the appendixes, we describe four types of GAO activities that relate to older Americans:

- Reports on policies and programs directed primarily at older Americans (see app. I).
- Reports on policies and programs that include the elderly as one of several target groups (see app. II).
- Congressional testimonies on issues related to older Americans (see app. III).
- Ongoing work on issues related to older Americans (see app. IV).

These products, ongoing work, and the issues addressed are presented in table 1. The table shows that health and income security were the

leading issues addressed among reports directed primarily at the elderly. Health was the leading issue across all types of reports and activities that either primarily affected the elderly or affected both the elderly and other groups.

**Table 1: GAO Activities Relating to the Elderly in Fiscal Year 1991**

Issue	Type of activity			
	Reports focused on the elderly	Reports with elderly as one of several target groups	Testimony	Ongoing activities as of 9/30/91
Health	16	21	16	55
Housing	1	8	1	2
Income security	16	11	6	20
Social services	4	0	4	8
Veterans	1	7	2	29
Other	1	10	6	5
<b>Total</b>	<b>39</b>	<b>57</b>	<b>35</b>	<b>119</b>

Appendix I provides summaries of 39 issued reports on policies and programs directed primarily at the elderly. We include in this section reviews of health, income security, social services, and veterans' issues.

Appendix II provides summaries of 57 reports in which the elderly were one of several target groups for specific federal policies. Many of these activities are generally financed in conjunction with services to other populations. For example, block grants fund community services or energy assistance for the elderly, as well as for other age groups; Medicaid finances nursing home care, as well as medical care for poor people of all ages.

Appendix III describes 35 testimonies given during fiscal year 1991 on subjects focused on older Americans. We testified most often on health issues. In appendix IV we have listed 119 studies related to older Americans that were ongoing as of September 30, 1991.

We are also providing information on GAO's employment of older Americans. As you are aware, our policies prohibit age discrimination (see app. V). On September 30, 1991, about 57 percent of our work force was 40 years of age or older. We continue to provide individual retirement counseling and group preretirement seminars.

As arranged with your office, we are sending copies of this report to interested congressional committees and subcommittees. Copies will also be made available to others on request.

This report was prepared under the direction of Joseph F. Delfico, Director, Income Security Issues, who may be reached at (202) 275-6193 if you have any questions. Other major contributors are listed in appendix VI.

Sincerely yours,

*for* *Edward A. Bensmore*

Lawrence H. Thompson  
Assistant Comptroller General

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**Abbreviations**

ADP	automated data processing
AFDC	Aid to Families With Dependent Children
ALJ	administrative law judge
CDC	Centers for Disease Control
COBRA	Consolidated Omnibus Budget Reconciliation Act of 1985
DDS	Disability Determination Service
DOD	Department of Defense
DOL	Department of Labor
EEOC	Equal Employment Opportunity Commission
ERISA	Employee Retirement Income Security Act of 1974
FmHA	Farmers Home Administration
FNS	Food and Nutrition Service
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HMO	health maintenance organization
HUD	Department of Housing and Urban Development
IRS	Internal Revenue Service
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
LIHEAP	Low-Income Home Energy Assistance Program
MIG	Medicare Insured Group
OEA	Office of Energy Assistance
OHA	Office of Hearings and Appeals
OPM	Office of Personnel Management
PBGC	Pension Benefit Guaranty Corporation
PES	Post Enumeration Survey
PRO	peer review organization
SBA	Small Business Administration
SCORE	Service Corps of Retired Executives
SSA	Social Security Administration
VA	Department of Veterans Affairs



# Fiscal Year 1991 GAO Reports on Issues Primarily Affecting Older Americans

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During fiscal year 1991, we issued 39 reports on issues primarily affecting the elderly. Of these, 16 were on health, 1 on housing, 16 on income security, 4 on social services, 1 on veterans' issues, and 1 on other issues.

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## Health

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**Employee Benefits: Effect of Bankruptcy on Retiree Health Benefits (GAO/HRD-91-115, Aug. 30, 1991)**

Almost half of the 40 bankrupt companies GAO surveyed terminated retiree health benefits, leaving 91,000 retirees responsible for obtaining their own health coverage. In some cases, the loss of benefits lasted for between 1 and 16 months; in others, termination was permanent. The laws intended to protect retiree health benefits in bankruptcies failed to stop companies from ending benefits because the firms either were not subject to the U.S. bankruptcy code, were legally permitted to sever benefits because they had terminated active workers' benefits as well, or had the approval of the bankruptcy court to do so. Once a company enters bankruptcy, there is little chance of securing retirees' health benefits. Therefore, GAO concludes that future efforts to increase the security of these benefits must address such issues as advance funding of benefits. Retirees from companies that self-insured were more likely to have unpaid claims for covered health services received before the plan terminated than were retirees from firms offering coverage through insurance companies or health maintenance organizations.

**Health Care: Actions to Terminate Problem Hospitals From Medicare Are Inadequate (GAO/HRD-91-54, Sept. 5, 1991)**

State survey agencies often spot acute care hospitals that do not comply with one or more Medicare conditions of participation. Most hospitals correct the problems identified to the satisfaction of state surveyors within the required 90 days. Yet many do not, and the Health Care Financing Administration (HCFA) rarely terminates them from Medicare. GAO believes that the penalty for noncompliance must be credible enough to make a hospital take prompt action. HCFA's termination record casts doubt on its willingness to remove any but the worst hospitals from the Medicare program. Termination for failure to correct deficiencies within 90 days may be too harsh a penalty to impose on some hospitals, however. In GAO's view, HCFA needs a variety of options in dealing with such situations, including imposing monetary penalties and closing beds. Termination should be used as a last resort against those few hospitals that either cannot or will not comply with Medicare requirements. Several states—in enforcing their own licensing requirements—have



recognized this and supplement their termination authority with enforcement options that can be tailored to the severity of the deficiency identified.

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**Health Care: Hospitals With Quality-Of-Care Problems Need Closer Monitoring (GAO/HRD-91-40, May 9, 1991)**

The Health Care Financing Administration (HCFA) considers hospitals that are out of compliance with Medicare conditions of participation to be susceptible to providing poor quality care. These hospitals can be terminated from the Medicare program if they do not comply within a specified period. HCFA has been unable, however, to accurately determine whether hospitals accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) are complying with Medicare conditions of participation. Further, in nonaccredited hospitals, HCFA has discovered that state agency surveys are not always identifying Medicare conditions that are not being complied with. As a result, HCFA cannot be sure that quality health care is being provided to Medicare beneficiaries. Until HCFA completes development of a crosswalk that will define the relationship between Medicare conditions of participation and JCAHO standards, full access to JCAHO survey data will not greatly enhance HCFA's overall ability to evaluate the JCAHO's effectiveness in ensuring that hospitals meet Medicare requirements.

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**Long-Term Care: Projected Needs of the Aging Baby Boom Generation (GAO/HRD-91-86, June 14, 1991)**

By virtue of its numbers, the baby boom generation—about 76 million people born between 1946 and 1964—has already had a profound impact on the American education system and, in more recent years, the work force. As the baby boom generation ages, rapid growth in the numbers of elderly people who need nursing home care or care at home will increase long-term care resource requirements. This report provides information on projections of (1) the disabled elderly population and its use of long-term care services, (2) the number of home health aides required, (3) the costs of future long-term care services, and (4) the base of taxpayers or employed work force available to pay for the elderly needing care.

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**Medicare: Flawed Data Add Millions to Teaching Hospital Payments (GAO/IMTEC-91-31; June 4, 1991)**

Medicare reimburses teaching hospitals over \$2 billion annually for indirect medical education costs that are thought to stem from factors like more diagnostic testing, procedures, and recordkeeping, as well as high staffing ratios associated with graduate medical education programs. The amount of the payment is determined by multiplying the amount a hospital receives for its operating costs by the number of residents per available bed and a statistically estimated factor thought to represent

the incremental patient care costs due to providing graduate medical education. Supplemental Medicare payments to teaching hospitals are based on inaccurate and unverifiable data, however, and are causing Medicare to pay millions more in indirect medical education costs than it should. Moreover, allowing teaching hospitals to exclude some beds used to treat sick newborns from their bed counts is inconsistent with a federal court decision and costs the Medicare program millions each year. These weaknesses show that strong internal controls are needed. The Health Care Financing Administration (HCFA) needs a valid and reliable way of determining supplemental payments so that their reasonableness can be ensured and HCFA can better control Medicare costs. Until this occurs, HCFA and the intermediaries cannot meet their responsibilities to reduce waste and abuse in the Medicare program.

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**Medicare: Further Changes Needed to Reduce Program and Beneficiary Costs (GAO/HRD-91-67, May 15, 1991)**

Medicare pays about one-quarter of all hospital and physician services in this country and has become the fourth-largest category of federal expenditures, surpassed only by defense, Social Security, and interest payments on the national debt. As such, the Medicare program bears a responsibility to be a leader in health care reform, and, to a large extent, Medicare has met its responsibility in this area. Despite efforts to constrain costs, however, Medicare spending and beneficiary out-of-pocket expenses have risen at troubling rates. Medicare expenditures rose from about \$70 billion in 1985 to \$106 billion in 1990, while average beneficiary out-of-pocket costs rose from about \$630 to over \$1,000 for Medicare-covered services. Medicare's high cost and continued rapid growth are evidence of inadequate economic incentives for patients and providers to contain costs. Consequently, much remains to be done to translate recent payment reforms into fully functioning systems. This report identifies issues that Congress may want to examine to (1) help ensure that current Medicare reforms achieve their objectives and (2) identify additional opportunities to reduce Medicare beneficiary and program costs.

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**Medicare: HCFA Should Improve Internal Controls Over Part B Advance Payments (GAO/HRD-91-81, Apr. 17, 1991)**

During a recent review of Medicare claims-processing contractor changes, GAO discovered that the controls for advance payments that are sometimes made for physician services, medical equipment, and suppliers under part B do not ensure that the people approving these payments have clear, specific authority to do so. This report brings this weakness to the attention of the Administrator of the Health Care Financing Administration (HCFA). HCFA has not issued guidance to its regional offices or contractors on part B advances, and GAO recommends

that HCFA determine whether advance payments under part B are appropriate and, if so, develop regulations and instructions on such payments.

**Medicare: Information Needed to Assess Payments to Providers (GAO/HRD-91-113, Aug. 8, 1991)**

Because of excessive tentative settlements made by Medicare contractors, Medicare providers may be receiving hundreds of millions of dollars each year above the amounts due them. These amounts can remain outstanding for up to 2 years before being recovered, and the Medicare trust fund could be losing about \$40 million annually in interest. Knowledge of the full extent of excessive tentative settlements and associated interest costs is limited by the incompleteness and inaccuracy of data in the Health Care Financing Administration's (HCFA) information systems. GAO believes that the completeness and accuracy of information entered into these systems needs to be improved. HCFA could then analyze these data to identify problems that consistently result in excessive tentative settlements. Also, HCFA could make more informed decisions on what type of corrective action is needed and use the Hospital Cost Report Information System data to monitor tentative settlements on a broad basis. If such monitoring spotted problems, HCFA could use the detailed System Tracking for Audit and Reimbursement data for an in-depth analysis.

**Medicare: Millions in Disabled Beneficiary Expenditures Shifted to Employers (GAO/HRD-91-24, Apr. 10, 1991)**

The Omnibus Budget Reconciliation Act of 1986 made Medicare the secondary payer for medical expenses incurred by disabled beneficiaries covered by large group health plans. This report addressed cost savings associated with this legislation and effects on employment and health insurance coverage. GAO concludes that the secondary payer provision has succeeded in shifting considerable Medicare expenditures to large group health plans without adversely affecting disabled beneficiaries or their families. In addition to suffering little adverse effect from the provision, the disabled are safeguarded by rules proposed by the Health Care Financing Administration (HCFA) in March 1990 that discourage employers from discriminating against the disabled and their families in regard to health insurance. However, future changes to employer health plans could harm disabled individuals with employee status. In proposed regulations, HCFA has identified a broad category of individuals subject to the secondary payer provision because of an active employee status. GAO is concerned that HCFA's proposed factors indicative of employee status stretch the ordinary understanding of the term "employee" and will prompt employer efforts to avoid meeting them. As a result, the number of individuals with employee status could decline by an estimated 25 percent annually.

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**Medicare: Millions in Potential Recoveries Not Being Sought by Maryland Contractor (GAO/HRD-91-32, Jan. 25, 1991)**

As part of a broader GAO effort to evaluate the adequacy of the Medicare contractor budget for claims processing and program safeguard activities, GAO discovered a situation that it believes warrants congressional attention. GAO found that Blue Cross and Blue Shield of Maryland, a Medicare claims-processing contractor, has paid at least \$8.8 million in claims for which it has identified other health insurers that may have primary payment responsibility under the Medicare secondary payer provisions. In this case, the contractor through its investigative efforts has identified other parties that may owe Medicare sizeable sums. However, the contractor lacks the resources to recover these amounts. GAO concludes that any additional funding of the contractor's activities to recover these payments may yield considerably more than each dollar spent for this purpose.

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**Medicare: Need for Consistent National Payment Policy for Special Anesthesia Services (GAO/HRD-91-23, Mar. 13, 1991)**

GAO looked at the extent to which "modifier units" have been used to allow extra anesthesia payments for factors like a patient's age, physical status, or unusual risk circumstances, and at the appropriateness of such payments. Before 1989, because payments for anesthesia modifiers and special monitoring procedures differed considerably among carriers, Medicare paid some anesthesiologists more than others for identical services delivered under similar circumstances. In fiscal year 1988, of the 52 Medicare carriers, 33 paid an estimated \$43 to \$72 million for anesthesia modifiers. The other carriers did not reimburse for these factors. The Health Care Financing Administration (HCFA) recently discontinued separate modifier payments but required carriers to adjust conversion factors to compensate providers for the value of the discontinued modifiers. GAO's analysis of Medicare payments made by nine carriers for eight common procedures indicated that this action did not eliminate the payment inconsistencies and inequities caused by the modifier payments. Rather, HCFA's action actually perpetuated them. Also, HCFA allowed problems with special monitoring procedure payments to continue by requiring carriers to maintain prior practices. To remedy this, GAO recommends that HCFA assess the appropriateness of additional Medicare payments for anesthesia services and establish a consistent national payment policy for such services.

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**Medicare: Payments for Clinical Laboratory Test Services Are Too High (GAO/HRD-91-59, June 10, 1991)**

GAO reviewed the appropriateness of Medicare's fee schedule payments for clinical laboratory test services, considering both laboratory costs and revenues. To measure appropriateness, GAO compared laboratories' profit rates from Medicare with their overall profit rates. GAO found that profits from Medicare business substantially exceeded laboratories' overall profit rates, and GAO concludes that Medicare's fee schedules are too high. GAO recommends that the Congress cap Medicare payments for clinical laboratory test services so that Medicare's contribution to laboratories' profits does not exceed their overall profit. GAO believes that capping fees at 76 percent of the median of all fee schedules would accomplish this goal.

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**Medicare: PRO Review Does Not Assure Quality of Care Provided by Risk HMOs (GAO/HRD-91-48, Mar. 13, 1991)**

Under risk contracts, health maintenance organizations (HMOs) agree to provide all covered health care services to Medicare beneficiaries in return for a fixed payment per enrollee. While this payment system encourages HMOs to be cost efficient and to avoid unnecessary care, it may also promote inappropriate cuts in services. Peer review organizations (PROs) now assess the quality of care at HMOs. However, GAO concludes that after almost 4 years of operation, the PRO program has failed to ensure that Medicare beneficiaries enrolled in risk HMOs are receiving quality health care. GAO believes that the program's effectiveness has been impeded by a lack of strong central management from the Health Care Financing Administration (HCFA). First, HCFA has no assurance that internal quality assurance programs at most HMOs are effectively identifying and correcting quality-of-care problems. Second, the PRO external medical records review has not provided a valid assessment of the quality of care at risk HMOs, because the PROs have not had access to comprehensive HMO data from which to select their review samples. Third, HCFA has not used the PRO review results in its own HMO compliance monitoring process. While HCFA recently proposed a new PRO review methodology that it believes will correct some of these problems, GAO is concerned that it does not address the underlying data problems that have beset the PRO/HMO review program from the outset.

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**Medicare: Variations in Payments to Anesthesiologists Linked to Anesthesia Time (GAO/HRD-91-43, Apr. 30, 1991)**

Medicare costs for physician anesthesia services grew from \$757 million in fiscal year 1985 to \$1.2 billion in fiscal year 1988. In response to congressional concerns about these increased costs and the appropriateness of anesthesia times billed, GAO (1) reviewed the average anesthesia times claimed for payment for these services and compared them with average surgical times, (2) verified reported anesthesia times from patient medical records, and (3) examined the appropriateness of the

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anesthesia times Medicare recognizes for payment purposes. Unexplained variations in anesthesia time, the resulting differences in anesthesia payments, and the inability to validate anesthesia time lead GAO to conclude that the Department of Health and Human Services (HHS) should adopt an alternative to basing Medicare payment on an anesthesiologist's reported anesthesia time. GAO also believes that payment for anesthesia services should be consistent with payment for other physician services.

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**Medicare Claims Processing: HCFA Can Reduce the Disruptions Caused by Replacing Contractors (GAO/HRD-91-44, Apr. 4, 1991)**

Beginning in December 1988, Medicare beneficiaries and health care providers in Georgia and Florida encountered serious payment delays and errors after the program changed its claims-processing contractor in Georgia and its data-processing subcontractor in Florida. This report (1) looks at the impact of these changes on beneficiaries and providers and (2) identifies actions the Health Care Financing Administration should take to reduce the impact of any future changes.

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**Medigap Insurance: Better Consumer Protection Should Result From 1990 Changes to Baucus Amendment (GAO/HRD-91-49, Mar. 5, 1991)**

GAO found that Medigap sales abuses have continued. Officials in many of the 12 states GAO visited have said that abuses have declined since the implementation of the Baucus amendment, which established federal standards for Medigap policies. When the revised standards required by the Omnibus Budget Reconciliation Act of 1990 and consumer protection provisions of the National Association of Insurance Commissioners' 1989 model regulation are fully implemented, GAO believes that they should help curb abusive marketing and sales practices. GAO found that state regulatory reviews of Medigap advertising materials vary considerably, as do state consumer education efforts related to Medigap. GAO notes that the 1988 loss ratios of about 38 percent of the companies were below the minimum standards; however, about 88 percent of premium dollars were with companies with loss ratios that met the standard.

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## Housing

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### Tax-Exempt Bonds: Retirement Center Bonds Were Risky and Benefited Moderate-Income Elderly (GAO/GGD-91-50, Mar. 29, 1991)

GAO surveyed 271 tax-exempt bonds totaling \$2.8 billion that were issued from 1980 through July 1990 on behalf of charitable organizations to finance housing for the elderly. The facilities offered a variety of living arrangements, health care, and amenities for their residents. Entrance and monthly fees supported both the specialized services and the relatively high debt payments that these highly debt-financed projects must pay. Accordingly, GAO found that 75 percent of the facilities housed residents with average incomes higher than \$15,000—making the facilities affordable only for about one-quarter of the nation's elderly. At the end of 1989, GAO estimated that the overall default rate for these retirement center bonds was about 20 percent. In comparison, GAO estimated an overall default rate of about 1 percent for selected revenue bonds like those for industrial development projects and hospitals. GAO found that many of the defaulted projects were highly debt-financed and that the bonds' interest rates were higher than average rates paid on revenue bonds issued during the same period. This weak financial structure, combined with the inexperience of some developers and their overestimated occupancy projections, made the facilities vulnerable to default.

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## Income Security

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### District's Workforce: Annual Report Required by the District of Columbia Retirement Reform Act (GAO/GGD-91-71, Mar. 29, 1991)

The District of Columbia Retirement Reform Act provides for annual federal payments to the District of Columbia Police Officers and Fire Fighters' Retirement Fund. These payments, however, are to be reduced when the disability retirement rate exceeds an established limit, a measure that was meant to encourage control of disability retirement costs by the District government. Since the disability retirement rate reported by GAO—0.754 percent—is less than eight-tenths of one percentage point, no reduction is required in the fiscal year 1992 payment to the Fund.

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**Employee Stock  
Ownership Plans:  
Participants' Benefits  
Generally Increased, but  
Many Plans Terminated  
(GAO/HRD-91-28, Dec. 10,  
1990)**

This report examines (1) the value of Employee Stock Ownership Plan accounts, (2) how much company stock participants are receiving, and (3) how benefits are allocated among participants. GAO found that between 1981 and 1987, participants in Employee Stock Ownership Plans fared well, with account balances generally tripling. However, because the plans are not required to diversify investments, participants relying on them for retirement benefits face increased risks. The risk involved in linking employee retirement funds to the stock performance of a single sponsoring company is highlighted by the wide range of account balances GAO discovered; some accounts were nearly worthless. Further, the higher than expected termination rates of Employee Stock Ownership Plans call into question whether current plan participants will ultimately receive a significant retirement benefit from their plan. These risks are especially significant at the many companies where the Employee Stock Ownership Plan is the only company retirement plan available to employees.

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**Federal Benefit Payments:  
Agencies Need Death  
Information From Social  
Security to Avoid  
Erroneous Payments  
(GAO/HRD-91-3, Feb. 6,  
1991)**

As a result of its contacts with family members, funeral homes, and other federal and state agencies, the Social Security Administration (SSA) maintains the most comprehensive death information in the federal government—if not the nation. GAO found that federal and state agencies, which are erroneously paying out millions of dollars each month to dead beneficiaries, rarely avail themselves of SSA's comprehensive death information. Instead agencies continue to rely on voluntary reporting of deaths in order to stop payments or to adjust survivor benefits. GAO notes the existence of barriers to governmentwide use of SSA's purchased death information, including (1) state-negotiated restrictions on the use of data by other federal agencies and (2) states' desire to be compensated by each federal agency's use of the death information they provide. However, this state death information is a critical internal control for reducing erroneous payments in both federal and state benefit programs, and GAO believes that it should be provided to SSA without restrictions for use by federal and state benefit programs. GAO concludes that legislation is needed to enable SSA to more easily disclose the purchased data to other agencies. In addition, the Office of Management and Budget should require governmentwide use of SSA's comprehensive file of death information.



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**Mail Management:  
Improved Social Security  
Mail Management Could  
Reduce Postage Costs  
(GAO/GGD-91-34, Feb. 13,  
1991)**

This report—one in a series on how federal agencies can improve management of their mail operations—looks at how the Social Security Administration (SSA), one of the largest civilian agency mailers, could reduce postal costs through improved mail management. GAO found that while SSA's mail managers have begun some mail cost reduction measures, more needs to be done. SSA's mailing initiatives cut fiscal year 1989 postage costs by about \$16 million. However, SSA could have further reduced mail costs by (1) using a nine-digit ZIP Code on first-class, computer-generated mail; (2) presorting first-class, computer-generated mail from large volume mailing locations; and (3) printing a barcode on outgoing mail where applicable. In addition, SSA could have reduced overpayments to the U.S. Postal Service resulting from overstating anticipated postage costs. Further, SSA lacks a multi-year mail management plan with goals and timetables for making mail management improvements.

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**Pension Plans: Fiduciary  
Violations in Terminated  
Underfunded Plans (GAO/  
HRD-91-87, May 13, 1991)**

GAO reviewed fund abuses in pension plans for which the Pension Benefit Guaranty Corporation (PBGC) assumed responsibility. Fiduciaries' fund abuses totaling about \$9.2 million had occurred in over 25 percent, or 11, of the 40 plans GAO reviewed. One individual who owned businesses that sponsored three of the plans was responsible for \$7.5 million of the misused funds. The abuses mostly involved prohibited loans of plan funds to the sponsoring business or the owners using such funds for personal expenses. For some plans, PBGC was alerted to the possible misuse of funds by plan participants. In most of the other cases, PBGC staff identified the abuses when inquiring into the status of plans or reviewing the financial data. In GAO's view, PBGC's actions to recover the misused funds were reasonable, given its untimely involvement with most of the plans. PBGC is developing procedures for legislation that would allow it to fine plan administrators up to \$1,000 per day for not complying with the notification requirement. PBGC officials believe that the penalty provision will result in better compliance.

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**Pension Plans: IRS Needs  
to Strengthen Its  
Enforcement Program  
(GAO/HRD-91-10, July 2,  
1991)**

Currently, about 76 million Americans count on private pension plans for retirement income. The Employee Retirement Income Security Act of 1974 (ERISA) established comprehensive standards to rid these employee benefit plans of mismanagement, fraud, and abuse, which can place plan assets at risk and threaten benefits. The Internal Revenue Service (IRS) has increased the resources it devotes to examining pension plan operations, a key element in its enforcement strategy, but IRS has been less effective than expected in identifying plans in violation of the act. IRS's

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criteria for targeting plans with a high potential for violations are outdated, and most plans examined during the past 3 years were selected to train inexperienced staff, rather than because the plan was likely to have a violation. In addition, IRS has not maintained an adequate oversight program to ensure that examinations were thorough enough to detect violations. IRS intends to focus on small, underfunded plans whose sponsoring employers may have received excessive tax deductions for plan contributions. While this initiative may raise significant revenues, it shifts IRS's limited enforcement resources away from examining plans in which participants' benefits and the government's insurance program may be at risk. Further, IRS may approve design changes to many plans without a detailed review to handle an anticipated large increase in approval requests resulting from the Tax Reform Act of 1986. This could diminish IRS's ability to ensure that plan designs comply with ERISA.

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**Pension Plans:  
Terminations, Asset  
Reversions, and  
Replacements Following  
Leveraged Buyouts (GAO/  
HRD-91-21, Mar. 4, 1991)**

A leveraged buyout involves the purchase of a company with mostly borrowed funds, using the company's assets as collateral. As a result of leveraged buyouts, 345 publicly traded companies went private—at a cost of \$150 billion—between January 1982 and March 1990. Twenty percent of the defined benefit plans that GAO reviewed were terminated after the leveraged buyout. Most of these plans were overfunded, and the terminations resulted in a reversion of assets to the company. Most terminated plans were replaced, with most active participants given another defined benefit plan. GAO could not determine whether the replacement plan offered participants the same benefits as did the terminated plan. Information about the financial condition of plans that continued was limited, but when available showed that the financial condition of most plans did not deteriorate after the leveraged buyout.

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**Private Pensions: Millions  
of Workers Lose Federal  
Benefit Protection at  
Retirement (GAO/HRD-91-  
79, Apr. 25, 1991)**

Insurance industry and government data suggest that 3 to 4 million retirees and their surviving dependents receive annuities that their pension plans bought for them from life insurance companies. Even though pension plan benefits are guaranteed by federal law, these pensioners lost this protection when they became dependent on an insurance company for retirement income. Furthermore, retirees holding these annuities may be unaware that federal guarantees do not extend to them. Without federal guarantees, pensioners holding insurance annuities must rely on state guarantees, which provide incomplete coverage. As a result, some pensioners could lose all or part of their pension benefits in the wake of insurance company failures. Due to limited data, GAO was

unable to determine the likelihood or value of losses by annuitants. However, 170 life insurance companies have failed since 1975—40 percent of them in the last 2 years.

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**Private Pensions: 1986  
Law Will Improve Benefit  
Equity in Many Small  
Employers' Plans (GAO/  
HRD-91-58, Mar. 29, 1991)**

In response to concerns that women may not be receiving fair treatment under the pension system even though pension rules are gender neutral, the Congress passed the Retirement Reform Act of 1984. Before this bill became law, many participants in small employers' pension plans were treated inequitably, in GAO's view. GAO assumes that a plan is equitable if every participant earns a benefit that is the same percentage of pay per year of service; conversely, a plan is deemed inequitable if men earn more than \$1.10 in benefits as a percentage of pay per year of service for every \$1.00 women earn. GAO found that most defined benefit plans sponsored by small employees favored the higher-paid, who were mostly men. The Retirement Reform Act's integration changes and proposed Internal Revenue Service (IRS) nondiscrimination rules will, GAO believes, substantially limit the extent to which a plan may favor the higher-paid in the allocation of benefits. Consequently, the extent of benefit inequity should decrease in many small employers' defined benefit plans. GAO supports IRS's new rules and believes that they will result in substantial gains in benefit equity.

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**Social Security: Analysis  
of a Proposal to Privatize  
Trust Fund Reserves  
(GAO/HRD-91-22, Dec. 12,  
1990)**

This report analyzes a proposal by a Member of Congress to create a new system of Individual Social Security Retirement Accounts. Under this proposal, part of the accumulating reserves of the Social Security Trust Fund would be returned to workers and invested in individual accounts in the private sector, where they would be held until the workers' retirement. In effect, the proposal would partially and temporarily privatize Social Security. GAO found that the proposal could be integrated with the existing progressive benefit structure and, given favorable financial market conditions, could improve retirement incomes. If implemented, the individual accounts may change the mix of public and private saving but not necessarily the magnitude of national saving. The proposal also raises many administrative difficulties and policy issues that need to be addressed before individual accounts could be considered a fully working alternative to the use of trust fund reserves.

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**Social Security:  
Information About the  
Accuracy of Earnings  
Records (GAO/HRD-91-  
89FS, Apr. 19, 1991)**

In an effort to determine the accuracy of the earnings records maintained by the Social Security Administration (SSA), GAO reviewed available studies and found that if SSA receives and processes a wage report, the chances of it recording the report to the wrong account, or in a different amount than reported, are very small. Certain studies, however, are limited in their ability to spot errors in the earnings records. In a nationwide sample of over 1,700 people who received their first retirement check in June 1985, a 1987 study found that about 6.5 percent had errors in their earnings records, although not all of these errors affected their earnings records. While GAO found no studies directly relating to the types of workers most prone to earnings record problems, an unpublished internal study of SSA's 1978 suspense file showed that in 1978, almost 20 percent of the wage reports filed by businesses involved in agricultural production and services were not credited to valid workers' Social Security accounts.

**Social Security: Measure of  
Telephone Service  
Accuracy Can Be  
Improved (GAO/HRD-91-  
69, Aug. 30, 1991)**

This report assesses the Social Security Administration's (SSA) method for measuring the accuracy of the information it provides to the public over its toll-free 800 telephone service. GAO found that SSA's method of assessing accuracy did not produce consistent evaluation of the responses it provided to callers. Hence, SSA's study results were unreliable. GAO disagreed with SSA's rating of response accuracy and completeness on 35 percent of the 260 issues evaluated during 188 jointly monitored phone calls. Further, SSA reviewers inconsistently rated the responses of their teleservice representatives. The inconsistent ratings were caused by two fundamental shortcomings in SSA's "live-call" study methodology. First, SSA guidance for evaluating telephone responses was inadequate. Second, SSA did not record the telephone calls it sampled, making it hard for reviewers to make consistent and well-reasoned evaluations of conversations. In a related matter, recent legislation requires SSA to restore the public's phone access to more than 800 local SSA field offices in addition to its ongoing toll-free 800 number services. To have a comprehensive monitoring system, SSA needs to develop a methodology for measuring the accuracy of phone service to be provided by these offices.

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**Social Security: Production Initiatives in OHA's Region V Comply With Law and Guidelines (GAO/HRD-91-36BR, Dec. 21, 1990)**

Persons denied Medicare and Social Security benefits may appeal such decisions to administrative law judges (ALJ) in 132 hearing offices around the country. The Social Security Administration's Office of Hearings and Appeals (OHA) is responsible for managing these judges. GAO reviewed productivity initiatives underway in OHA's Chicago Regional Office and found that they complied with the Administrative Procedures Act and OHA guidelines. GAO also found that by including dispositions of regional chiefs and retired judges in hearing office statistics, average production figures for the Chicago region and some hearing offices were slightly overstated. However, in terms of distribution of monetary awards, the only apparent gain from the overstatement was that one hearing office received an additional \$3,529 for awards and bonuses to support staff for which it would not have been otherwise eligible. As OHA studies and redesigns its system of productivity measures for its ALJs, it should ensure that whatever measurement system it designs fairly recognizes the work done by individuals and by offices. In the interim, GAO believes that when calculating the productivity of its hearing offices, OHA should count regional chiefs and any retired judges as resources for those hearing offices that received credit for their dispositions.

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**Social Security: Restoration of Telephone Access to Local SSA Offices (GAO/HRD-91-76FS, Mar. 5, 1991)**

In an effort to give local field offices more time for complex work and walk-in clients, the Social Security Administration (SSA) began a toll-free 800 number telephone service nationwide in October 1988 that restricted the public's access to local office phone numbers. Legislation passed in 1990, however, requires SSA to publish phone numbers and addresses for affected offices and to restore the public's phone access to local offices by May 1991. This fact sheet provides information on (1) SSA's policy for directing the public to either the nationwide 800 telephone service or local field offices, (2) SSA's plans for publishing local office numbers and addresses, (3) changes in available telephone lines and equipment in affected offices since September 1989, and (4) staffing levels for these offices since September 1989.

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**Social Security: Telephone Access to Local Field Offices (GAO/HRD-91-112, Sept. 13, 1991)**

Legislation passed in 1990 requires the Social Security Administration (SSA) to maintain the public's telephone access to local offices. It also requires SSA to ask phone companies to publish telephone numbers and addresses for local offices. GAO found that local SSA field offices have requested that their numbers and addresses be printed in local phone books. While SSA has maintained local office general inquiry telephone service, some offices have fewer lines and less staff available to handle

telephone inquiries. SSA's local field offices have experienced reductions in both staffing and telephone equipment since September 1989, the date that the law uses as a benchmark for telephone service levels. This happened in conjunction with the agency's overall downsizing program and because it planned to convert its telephone service entirely to a national 800 telephone service. SSA interprets the law as allowing some discretion in deciding how local telephone access will be achieved. Therefore, SSA has no plans to reverse the decreases.

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**Social Security  
Downsizing: Significant  
Savings but Some Service  
Quality and Operational  
Problems (GAO/HRD-91-  
63, Mar. 19, 1991)**

In response to an Office of Management and Budget directive, the Social Security Administration (SSA) cut 17,000 staff positions. SSA completed the staff reduction on schedule and achieved cost savings for fiscal years 1985-90 of \$1.9 billion with recurring savings of \$600 million expected annually. Despite the staff cuts, SSA was able to maintain overall service at past levels, payment accuracy remained stable, and client satisfaction with the quality of SSA service remained high. These accomplishments came at a price, however. During the downsizing, employee morale plummeted, implementation of a new 800 telephone service had problems, and some processing times and pending work loads increased. In addition, staffing imbalances in certain areas caused some service deterioration. While questions have been raised about the adequacy of SSA's current staffing level, SSA lacks work-load time standards on which to base its total staffing needs. As a result, SSA's credibility was harmed in its 1992 budget request for more staff.

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**Social Services**

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**Administration on Aging:  
More Federal Action  
Needed to Promote Service  
Coordination for the  
Elderly (GAO/HRD-91-45,  
Apr. 23, 1991)**

Elderly Americans fear institutionalization in nursing homes, and in national polls they have expressed a desire to live in their own homes as long as possible. To maintain their independence, the elderly need an array of home and community-based services, including meal preparation, home health care, and assistance with bathing and other personal needs. About 6 million elderly need such services today, and this population is expected to grow to about 10 million by 2020. Despite its mandate to promote better coordination of services for the elderly, the Administration on Aging's efforts in the 1980s did not keep pace with growing coordination needs. Management decisions and cuts in federal resources reduced technical assistance and information dissemination necessary to

foster coordination at the state and local levels. In effect, the Administration on Aging withdrew from the "aging network" it had helped to create. As a result, its knowledge base, largely acquired from direct contact with state and local agencies, eroded and its capacity to provide assistance weakened. Improving the efficiency and quality of services provided through stronger coordination will continue to be important in the 1990s as an aging population increases the demand for home and community-based services. The federal government has a direct stake in strengthening coordination because it shares in the cost of financing these services. GAO believes that the Administration on Aging, through more efficient use of its resources, is in a unique position to promote coordination in the 1990s through the aging network.

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**Elder Abuse: Effectiveness of Reporting Laws and Other Factors (GAO/HRD-91-74, Apr. 24, 1991)**

The term "elder abuse" refers to the abuse, the neglect, or the exploitation of people aged 60 or older. It may include physical, psychological, and sexual abuse; material or financial exploitation; and neglect or self-neglect. To help identify victims, nearly every state has passed laws on the reporting of elder abuse. Mandatory reporting laws require all people or groups of professionals, like doctors and social workers, to report cases to authorities. In contrast, people are not required to report incidences of elder abuse under voluntary reporting laws. GAO concludes that the debate over mandatory versus voluntary reporting laws will yield uncertain answers on the relative effectiveness of these laws in identifying, preventing, and treating elder abuse. State officials agree that other factors, including public awareness campaigns, interagency coordination, and in-home services and respite care, are more important than reporting laws. This suggests that improvement in elder abuse programs is more likely to result from attention to these other factors, rather than from requiring a particular kind of reporting law.

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**Older Americans Act: Promising Practice in Information and Referral Services (GAO/PEMD-91-31, Aug. 8, 1991)**

The Older Americans Act of 1965 sought to improve the lives of older Americans through income, health, nutrition, employment, and long-term care programs. Promising practices in information and referral services provided under the act include (1) providing information and referral where elderly persons live or frequently visit, (2) using automated information resources and telephone technology, (3) hiring minorities to serve diverse cultural populations, and (4) publicizing services through active outreach by mass media and presentations. All the programs GAO reviewed used multiple outreach methods, conducted some follow-up with clients or service providers, and provided training to program staff or volunteers. However, GAO's ability to evaluate success

was hampered by data problems. The Administration on Aging's data collection instrument and methodology contained several flaws that raise questions about the accuracy and reliability of the national data; local data were also problematic. No formal mechanisms exist for the Administration on Aging to disseminate information about exemplary programs to other providers. Staff of these programs do sometimes exchange information through local workshops and conferences, but these methods are neither systematic nor viewed as effective by program officials.

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**Services for the Elderly:  
Longstanding  
Transportation Problems  
Need More Federal  
Attention (GAO/HRD-91-  
117, Aug. 29, 1991)**

Three longstanding barriers—fragmentation of service delivery among multiple providers, confusion about program requirements, and inadequacies in data needed to manage and evaluate programs—impede effective delivery of special transportation services for the elderly in many communities. These barriers result in duplication of service in some localities at the expense of little or no service in others and higher unit costs per trip than necessary. Lower service quality could also occur for some clients. Some communities have been able to overcome special transportation barriers, but many have not. Much is known about how to reduce barriers, yet many communities are poorly informed. Without improvements in the dissemination of information on how to successfully run programs and more technical help in applying this information to local circumstances, special transportation barriers will likely remain.

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**Veterans**

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**Veterans' Benefits: VA  
Needs to Verify Medical  
Expenses Claimed by  
Pension Beneficiaries  
(GAO/HRD-91-94, July 29,  
1991)**

In the eligibility verification report they file annually with the Department of Veterans Affairs (VA), veterans and their survivors who receive pension benefits are allowed to claim certain out-of-pocket medical expenses to offset countable income that would otherwise reduce their pension benefits. For the year ended January 26, 1990, these beneficiaries claimed over \$1.6 billion in medical expenses, resulting in income offsets of \$762 million. This meant that VA paid out an equal amount in increased pension benefits. Most of these expenses were claimed by beneficiaries in nursing homes. VA does not know whether these claimed expenses are valid, however, because it does not systematically verify or request "proof of payment" for these expenses. Because of the significant dollars involved, VA should establish procedures to validate these



expenses. The need for such procedures is underscored by IRS's discovery that similar medical deductions were overstated by about 23 percent on individual tax returns.

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## Other

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### **Aging Issues: Related GAO Reports and Activities in Fiscal Year 1990 (GAO/HRD-91-47, Dec. 14, 1990)**

This report is a compendium of GAO's fiscal year 1990 products (reports and congressional testimony), ongoing work, and activities like speaking engagements or publications by GAO staff relating to older Americans. Income security, health care, housing, social and community services, employment and age discrimination are some of the issues addressed. This report also provides information on GAO employment of older Americans.

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# Fiscal Year 1991 GAO Reports on Issues Affecting the Elderly and Others

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GAO issued 57 reports in fiscal year 1991 on policies and programs in which the elderly were one of several target groups. Of these, 21 were on health, 8 on housing, 11 on income security, 7 on veterans' issues, and 10 on other issues.

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## Health

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### Canadian Health Insurance: Lessons for the United States (GAO/HRD-91-90, June 4, 1991)

Some elements of the Canadian health care system are worthy of consideration in a reformed U.S. system because they might solve recognized problems. Canada has been more successful than the United States in controlling the growth in health care spending, even while providing health insurance to all its residents. If the universal coverage and single-payer features of the Canadian system were applied in the United States, the savings in administrative costs alone would be more than enough to finance insurance coverage for the millions of Americans who are now uninsured. Enough would be left over to reduce, or possibly even eliminate, copayments and deductibles, if that were deemed appropriate. The Canadian system is not without flaws, however. The Canadian method of controlling hospital costs has limited the use of expensive, high-technology diagnostic and surgical procedures. As a result, waiting lists or queues—sometimes months long—have developed for some specialty surgical care services, like cardiac bypass surgery, lens implants, and magnetic resonance imaging. While the United States can learn from the Canadian model, a reformed U.S. system should also build upon the unique strengths of the existing U.S. health care structure. The continuing development of advanced medical technology; detailed management information systems; and the flexibility to incorporate alternative service delivery mechanisms, like health maintenance organizations (HMOs), are characteristics of the U.S. system that should be preserved.

### Community Health Centers: Hospitals Can Become Centers Under Certain Conditions (GAO/HRD-91-77FS, Mar. 22, 1991)

This fact sheet provides information on whether hospitals that have closed or are at risk of closing can be converted to community health centers. The Department of Health and Human Services (HHS) provides grants to nonprofit private organizations to plan, develop, and operate these centers in urban and rural areas for medically underserved people. GAO concludes that converting a hospital to a community health center is not prohibited by law or regulation. While GAO did not identify any instances in which HHS had approved grant funds to convert a hospital

to a community health center, at least two centers had acquired and renovated closed hospitals in order to expand their services to needy individuals. Although HHS approved the conversions, the costs were underwritten by state and local governments and/or a loan obtained by the county.

**Defense Health Care:  
Health Promotion in DOD  
and the Challenges Ahead  
(GAO/HRD-91-75, June 4,  
1991)**

The Department of Defense's (DOD) health promotion program focuses on the military's major health concerns, including heart disease, cancer, and alcohol abuse. Program activities fall under six categories: (1) early identification of hypertension, (2) physical fitness, (3) alcohol and drug abuse prevention, (4) smoking cessation and prevention, (5) nutrition, and (6) stress management. The health promotion programs GAO reviewed at three military installations appeared comparable to those of the four private sector firms GAO contacted. Although studies of private sector health promotion programs have been done, the costs and benefits are hard to assess because certain common design problems limit the representativeness of the studies and the extent to which they are able to quantify and link benefits to health promotion interventions. Cost-benefit studies have not been done on DOD programs, in part because DOD has not collected cost information on its health promotion activities. DOD's health promotion program will be an important part of its efforts to reach its health goals for the year 2000, but the program needs certain enhancements, such as the development of baseline program data on the health status and behavior of its target groups, including active duty members and retirees.

**Employee Benefits:  
Improvements Needed in  
Enforcing Health  
Insurance Continuation  
Requirements (GAO/HRD-  
91-37, Dec. 18, 1990)**

GAO reviewed the Department of Labor's (DOL) and the Internal Revenue Service's (IRS) enforcement of the health insurance continuation requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). This legislation requires firms employing 20 or more employees and offering a group health insurance plan to provide employees and their families the option of continued coverage in cases of job loss, death, or divorce. This report discusses (1) DOL and IRS efforts to help private individuals who bring cases of alleged noncompliance by employers to their attention, (2) procedures for investigating these allegations, and (3) enforcement history. Both IRS and DOL provide information about COBRA to those who inquire, and DOL will contact employers to help employees obtain benefits. However, if employers refuse to provide benefits, IRS cannot and DOL generally does not try to force employers to provide benefits. Further, the extent of COBRA violations is unknown. IRS's method of dealing with potential COBRA beneficiaries, in GAO's view,

discourages the reporting of violations. GAO believes that DOL and IRS should do more to ensure that IRS is made aware of potential COBRA violations. The knowledge that excise taxes may be assessed for these violations could deter such violations. Also, people referred by IRS to DOL could get help more quickly if they were given DOL's phone number along with its address.

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**Fraud and Abuse: Stronger Controls Needed in Federal Employees Health Benefits Program (GAO/GGD-91-95, July 16, 1991)**

The Congress passed the Financial Integrity Act of 1982 to reduce waste, fraud, abuse, and misappropriation of federal program funds. Although the Office of Personnel Management (OPM) has made some improvements in the health insurance program's internal controls, it cannot reasonably ensure that program funds are adequately protected from fraud and abuse. The act requires federal agencies to evaluate internal controls in the programs for which they are responsible; however, the carriers themselves are exempt from the requirements of the act. GAO believes that OPM's Retirement and Insurance Group needs to evaluate the controls used by the carriers as part of the group's Financial Integrity Act responsibilities. OPM has found that the plans are highly vulnerable to fraud and abuse, with misappropriation of carrier funds occurring in 7 of the 25 fee-for-service plans. These cases involved embezzlement, use of plan funds to finance union or employee organization activities, improperly charging the plan for over \$1 million in expenses not incurred, and improperly charging the program \$7.2 million for federal income taxes paid on its service charges (profit) over a 5-year period. Although the Retirement and Insurance Group has found that oversight of the carriers is too limited, the group continues to rely almost entirely on the Inspector General to perform the oversight role. In addition to the limited oversight, other control weaknesses need to be improved. OPM needs (1) to ensure that Inspector General recommendations for correcting deficiencies are implemented by the carriers and (2) to develop an aggressive programwide antifraud policy for pursuing enrollee and provider fraud. OPM also needs to use its statutory authority to penalize providers who commit fraud or program-related offenses.

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**Health Care: Antitrust Issues Relating to Physicians and Third-Party Payers (GAO/HRD-91-120, July 10, 1991)**

This report examines (1) the effect of antitrust laws on the ability of physicians to collectively educate and discipline peers to reduce and eliminate ineffective practice patterns and inappropriate utilization and (2) antitrust issues as they relate to the adoption of practice guidelines by third-party payers. GAO concludes that U.S. antitrust laws need not unduly interfere with the responsible actions of physicians to reduce

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ineffective practice patterns and inappropriate utilizations or with those of payers to adopt practice guidelines. There appears to be no need at present for legislation providing antitrust immunity to physicians or payers to facilitate these activities.

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**Health Insurance Coverage: A Profile of the Uninsured in Selected States (GAO/HRD-91-31FS, Feb. 8, 1991)**

This fact sheet profiles individuals in the United States without health insurance. GAO found that in 1988 about 32 million Americans under age 65—about 15 percent of the population—lacked some form of health insurance coverage. The uninsured were concentrated most heavily among poor, young, unmarried, less educated, and minority groups. Particularly striking was the large number of working people who lacked insurance. Uninsured rates for employees in service industries—like wholesale and retail trade, real estate, and entertainment—tended to be higher than for persons in manufacturing fields—like the auto, textile, and chemical industries.

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**Indian Health Service: Funding Based on Historical Patterns, Not Need (GAO/HRD-91-5, Feb. 21, 1991)**

The Indian Health Service now distributes funds among its 12 service delivery areas primarily on the basis of how much money each area received in past years, an approach that takes little account of the number of Indians eligible for or using services in an area, their health status, or the area's specific service needs. At a minimum, this method gives the perception of funding inequities. However, given less than full funding for the overall Indian Health Service system, GAO believes that any change in the allocation system will mean that some areas will get more funds and others less. Because the Service has met strong opposition in the past from Indian tribes facing cuts, it has had limited success in redistributing funds. In GAO's view, the Congress may wish to consider requiring the Service to distribute its funds on the basis of other methods, such as those that give greater weight to need. In addition to discussing overall Indian Health Service funding and distribution methods, this report looks at (1) per capita funding for Indians in the Oklahoma area and (2) the effect of Service funding constraints on health services delivery in Oklahoma, with special attention to the Contract Health Services program.

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**Medicaid: Alternatives for Improving the Distribution of Funds (GAO/HRD-91-66FS, May 20, 1991)**

GAO reported on the fairness of the formula used to distribute Medicaid funds to the states. GAO suggested replacing the existing per capita income factor with two other factors: (1) total taxable resources and (2) people in poverty. To illustrate their effect, GAO offered one alternative, designed to be budget neutral, that lowered the minimum federal

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reimbursement rate from its current value of 50 to 40 percent. This would reduce reimbursements to those states with high incomes and low poverty rates. In this fact sheet, GAO describes this alternative and several others meant to improve the distribution of Medicaid funds. Each alternative uses the two factors replacing per capita income, but differs in the size of the minimum federal reimbursement rate and the level of federal funding.

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**Medicaid: HCFA Needs Authority to Enforce Third-Party Requirements on States (GAO/HRD-91-60, Apr. 11, 1991)**

States are supposed to resort to Medicaid payment for health care only after a recipient's other health care resources have been exhausted. The Health Care Financing Administration (HCFA), however, has identified significant state noncompliance with federal third-party requirements. Although HCFA has not estimated Medicaid program losses resulting from this noncompliance, GAO found more than \$175 million in backlogged claims in two states for which third parties may have some liability. The Omnibus Budget Reconciliation Act of 1985, while imposing additional third-party requirements on states, has severely limited HCFA's enforcement authority. As a practical matter, HCFA's authority to enforce third-party requirements with financial penalties is almost nonexistent. To encourage states to comply with these requirements and, when they do not, ensure that the federal government does not contribute to Medicaid payments, the Congress should broaden HCFA's authority to impose financial penalties.

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**Medicaid: Legislation Needed to Improve Collections From Private Insurers (GAO/HRD-91-25, Nov. 30, 1990)**

As a public assistance program, Medicaid was expected to pay for health care only after Medicaid recipients had used all their other health care resources. GAO found that two major problems hinder states from collecting from private insurers for recipients' covered health care costs. First, states cannot prohibit some out-of-state insurers from trying to avoid paying state Medicaid agencies for such costs. States now lack jurisdiction over insurers that operate only incidentally in the state. Second, states' limited authority over plans covered under the Employee Retirement Income Security Act of 1974 (ERISA) does not allow them to prohibit these plans from trying to avoid payments for recipients' covered costs. Further, many states have not exercised the authority they do have to mandate that no ERISA plan include any contract provision that might limit or exclude payments for Medicaid recipients' health care costs. While state officials found it hard to pinpoint losses resulting from their payment systems, examples of state Medicaid losses obtained by GAO suggest that the problem may be substantial—perhaps millions of dollars in losses each year—and growing. To minimize future losses,

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federal legislation is needed to clarify Medicaid's role as a payer of last resort and to enhance the ability of states to collect from out-of-state insurers and ERISA plans.

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**Medicaid: Millions of Dollars Not Recovered From Michigan Blue Cross/Blue Shield (GAO/HRD-91-12, Nov. 30, 1990)**

Over the past 18 years, the Michigan Medicaid agency has had serious difficulties in recovering payments made for Medicaid recipients insured by Blue Cross/Blue Shield. GAO found that Michigan has not fully used its authority or taken all available action to enforce Blue Cross/Blue Shield compliance with Medicaid's third-party recovery provisions. Ineffective state management, coupled with lack of leadership by the Health Care Financing Administration (HCFA), has allowed millions of dollars to go unrecovered from Blue Cross/Blue Shield. A big part of the problem has been that insurers can profit financially by setting up legal or administrative barriers to delay or postpone payments to the state. As a result, GAO recommends that the Medicaid statute be changed to allow assessment of double damages on insurers that do not pay when they should. GAO is also evaluating more broadly the options available to the federal government when a state like Michigan has not met its responsibilities to recover Medicaid costs. Until changes are made in the Medicaid recovery system, Michigan and the federal government will continue to pay the bill for claims for which Blue Cross/Blue Shield is liable.

**Medicaid Expansions: Coverage Improves but State Fiscal Problems Jeopardize Continued Progress (GAO/HRD-91-78, June 25, 1991)**

Since 1984, the Congress has made several modifications to the Medicaid program aimed at expanding eligibility and improving services. These measures helped reverse the effects of earlier cutbacks, which had severely reduced the access of low-income families to medical services. Gains are most evident in states whose coverage in 1984 was relatively limited. The changes have reduced disparities among states in access to Medicaid services for pregnant women and children. While states' costs for these gains were relatively modest—\$900 per capita for low-income women and children annually versus an average of \$2,400 for recipients overall—the Medicaid program as a whole contributed to state fiscal stress during this period. It is the second largest program in most states and is generally the fastest growing. Judging by the last 6 years, it appears that future expansion of Medicaid access could be jeopardized by the combined effects of budget shortfalls, recession-related increases in levels of need, and more costly Medicaid mandates.

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**Medical ADP Systems:  
Automated Medical  
Records Hold Promise to  
Improve Patient Care  
(GAO/IMTEC-91-5,  
Jan. 22, 1991)**

The United States spends more than half a trillion dollars each year on health care, yet the use of automation in the health care industry lags behind that of other industries. GAO found that automated medical records may greatly improve the management of patient care. Such records are far more accessible, complete, and accurate than paper records and could potentially increase staff productivity and decrease operating costs. Several factors have, however, impeded progress in health care automation, including costliness, lack of fully developed technology, potential misuse of automated information, and user resistance to automated systems. Further, the lack of standardization in data collection and processing limits the usefulness of this information for research. Automated records also raise security, privacy, and legal questions. GAO believes that the health care community needs to find solutions to the problems associated with automating medical records. In GAO's view, the issue is less whether computers can support medical practice than how to bring about the development and use of the technology to do so.

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**Medical Malpractice: Data  
on Claims Needed to  
Evaluate Health Centers'  
Insurance Alternatives  
(GAO/HRD-91-98, May 2,  
1991)**

To help provide health care to vulnerable populations—including poor pregnant women, the homeless, migrant workers, and HIV-infected people—the Bureau of Health Care Delivery and Assistance awards grants to public or nonprofit facilities. About 10 percent of the federal funds is spent on malpractice insurance. If recipient facilities could reduce their malpractice insurance costs, they could provide health care to more people without increasing federal grant expenditures. To help the Congress consider alternative ways of providing insurance for these facilities, GAO identified elements needed to assess alternatives, which may include (1) the federal government assuming liability under the Federal Tort Claims Act, (2) establishing a risk-retention group to self-insure the centers, and (3) purchasing commercial insurance through a nationally formed risk-purchasing group. Historical claims experience is critical to assessing the alternatives, but claims data are too limited or dated to form an adequate basis for assessment.



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**Medical Malpractice: Few Claims Resolved Through Michigan's Voluntary Arbitration Program (GAO/HRD-91-38, Dec. 27, 1990)**

The current ways of resolving medical malpractice claims in this country are neither efficient nor equitable. Claims take a long time to be resolved, awards and settlements are unpredictable, and legal costs are steep. Concern about the existing system has inspired alternative proposals for claims resolution, including fault-based and no-fault-based approaches. This report looks at one of the fault-based alternatives—the Michigan Medical Malpractice Arbitration Program. GAO assessed (1) the extent of hospital, health care provider, and patient participation under the Michigan plan; (2) the arbitration alternative's effect on medical malpractice claims resolution; and (3) whether arbitration contributed to reducing medical malpractice insurance costs. GAO's conclusions about the program are limited because program participation has been low. GAO does not foresee significant increases in program participation because of the voluntary nature of the program and because of the lack of incentives for patient participation.

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**Off-Label Drugs: Reimbursement Policies Constrain Physicians in Their Choice of Cancer Therapies (GAO/PEMD-91-14, Sept. 27, 1991)**

Physicians argue that the treatment of cancer patients is being compromised by restrictions on health care. Specifically, oncologists report that health insurers are denying reimbursements for some drugs used "off label" (that is, using drugs approved for one type of cancer to treat other types). GAO found that off-label use of anticancer drugs is widespread; one-third of all drugs given to cancer patients were off-label, and more than half of the patients received at least one off-label drug. More than half of the oncologists GAO surveyed reported reimbursement problems for the use of drugs off-label, with most indicating that problems were getting worse. Respondents also reported that reimbursement policies and the costs of certain drugs have made them alter their preferred treatments. Most important—because of the high prevalence of the diseases—is GAO's finding that the treatments for lung and colon cancers were among those most influenced by reimbursement policies. Some 62 percent of GAO's respondents reported admitting patients to the hospital solely to circumvent restrictions imposed by reimbursement policies. They are doing so because drug reimbursement policies are generally less restrictive for inpatient care.

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**Private Health Insurance: Problems Caused by a Segmented Market (GAO/HRD-91-114, July 2, 1991)**

GAO discusses the problems of availability and affordability of private health insurance, particularly for small businesses. GAO also looks at some reform attempts proposed by interested organizations and discusses some of their limitations.

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**Rural Hospitals: Federal Effort Should Target Areas Where Closures Would Threaten Access to Care (GAO/HRD-91-41, Feb. 15, 1991)**

Between 1980 and 1988, 200 rural hospitals closed—about one-half of the total number of hospitals that closed over that period. GAO examined the factors that contribute to the risk of closure and assessed the impact rural hospital closures have on access to medical care, health care costs, and local economies. GAO found that the factors associated with a high risk of closure did not include rural location. Factors did include small size, low occupancy rate, weak local economy, and competition from other hospitals; a higher percentage of rural hospitals suffer from some combination of these contributing factors. Most rural hospital closures did not significantly reduce access to care, but in some areas closures did appear to worsen access, especially for Medicaid recipients and the uninsured. GAO recommends that federal and state programs designed to provide relief for hospitals undertake to identify those hospitals at risk of closure and assess the impact of such closure on access to care. Programs could then target funding to communities that would be most adversely affected.

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**Substance Abuse Treatment: Medicaid Allows Some Services but Generally Limits Coverage (GAO/HRD-91-92, June 13, 1991)**

States are shouldering most of the funding burden for substance abuse treatment services, with the federal government assisting through block grants. The federal government also reimburses states for treatment of some substance abusers through the federal-state Medicaid program. The Congress has been concerned about the Health Care Financing Administration's (HCFA) lack of a national policy on the use of Medicaid funds for substance abuse and about HCFA, in the absence of specific guidance in law or regulation, giving states differing interpretations on what substance abuse treatment services Medicaid would reimburse. This report examines federal guidance to the states on Medicaid coverage of substance abuse treatment services, the types of Medicaid services available in states, the level of federal and state spending, and barriers that may exist to obtaining treatment reimbursement by Medicaid.

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**U.S. Health Care Spending: Trends, Contributing Factors, and Proposals for Reform (GAO/HRD-91-102, June 10, 1991)**

GAO discusses U.S. health spending trends; their effects on business, government, and individuals; factors contributing to rising expenditures; and a comprehensive approach to reform.

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## Housing

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### Assisted Housing: Utility Allowances Often Fall Short of Actual Utility Expenses (GAO/RCED-91-40a and GAO/RCED-91-40b, Mar. 26, 1991)

While over 3 million lower income households now receive rental housing assistance through the Department of Housing and Urban Development's (HUD) public housing and section 8 certificate programs, concerns have arisen that many of these households are not receiving adequate allowances to pay their utility bills. The first volume of this report examines how utility allowances are provided to households and the extent to which the allowances cover utility costs. It also discusses benefits and drawbacks of two alternatives for ensuring that a greater proportion of assisted households pay 30 percent of their adjusted income for rent and utilities. The second volume presents detailed results on utility allowance practices from a nationwide survey of public housing agencies. It also contains the results of GAO's review of household rent payments, utility allowances, and utility costs for an estimated 9,500 households at six housing agencies.

### Community Development: Oversight of Block Grant Monitoring Needs Improvement (GAO/RCED-91-23, Jan. 30, 1991)

Local governments rely on the Community Development Block Grant program to help meet locally defined community development needs, including the creation of decent housing and the expansion of economic opportunities. However, the Office of Inspector General found that many problems plagued the administration of grantees' programs. GAO reviewed three Department of Housing and Urban Development (HUD) field offices (Baltimore, Maryland; Columbus, Ohio; and Detroit, Michigan) to determine how they monitored entitlement grantees of Community Development Block Grants. GAO found that weaknesses in HUD's guidance for monitoring entitlement grantees may have contributed to inadequate supervisory and evidentiary control practices. Without adequate supervisory and evidentiary controls over its monitoring program, HUD cannot ensure that management problems are detected or that staff do not duplicate previous work. In addition, without using information found in Office of Inspector General reports when planning their monitoring, field offices may not be using their limited resources most effectively.

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D.C. Government:  
Information on the  
Homeless Family Program  
(GAO/GGD-91-108,  
Aug. 22, 1991)

While the District of Columbia has been providing housing to homeless families since the mid-1960s, enactment of the D.C. Right to Overnight Shelter Initiative of 1984 gave every homeless person in the District the right to overnight shelter. As a result, the number of homeless families assisted has increased more than 300 percent from fiscal years 1984 through 1990. This report addresses five issues concerning the operation of the District's homeless family program: (1) What approaches has the District used to acquire its apartment-style shelter housing? (2) What is the District paying for contract shelter and support services? (3) How does the District monitor contractor performance? (4) How many once-homeless families have located permanent housing? (5) How many families who left a shelter have returned to the program?

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Homelessness: Access to  
McKinney Act Programs  
Improved but Better  
Oversight Needed (GAO/  
RCED-91-29, Dec. 28,  
1990)

GAO found that the Departments of Housing and Urban Development (HUD), Health and Human Services (HHS), Education, and Labor (DOL) have eased barriers that assistance providers and others claimed hindered their efforts to help the homeless through McKinney Act program funds. These barriers included requirements for matching funds, environmental reviews, and time limits for program expenditures. While all federal agencies have made it easier to obtain McKinney Act funds, monitoring efforts vary. GAO believes that without adequate monitoring, there is a greater likelihood of misused funds and inefficient programs. Further, the lack of (1) federal guidance to assistance providers on the type of data they should be collecting for evaluation and (2) program effectiveness evaluations have hindered the government's knowledge of whether McKinney Act programs are working. Although agency officials believe that the reduction in barriers will make it easier for grantees to obtain McKinney Act funds, they are concerned about how slowly some grantees are spending the funds. As a result, federal agency officials have changed their program regulations, issued guidance, and proposed legislative changes to ensure that program funds are spent in a more timely manner.

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Homelessness: Action  
Needed to Make Federal  
Surplus Property Program  
More Effective (GAO/  
RCED-91-33, Oct. 9, 1990)

GAO found that although there has been progress in making surplus federal property available for use by the homeless under title V of the McKinney Act, problems remain that hinder the effective implementation of title V. Specifically, properties are being listed in the Federal Register as suitable for homeless use before screening for federal need is completed. As a result, assistance providers are misled and may be applying for properties that are unavailable. In addition, many assistance providers are dissatisfied because they lack easy access to the

Federal Register. In response, the General Services Administration and the Department of Housing and Urban Development (HUD) have developed additional ways of publicizing federal properties, including sending notices directly to interested assistance providers. The McKinney Act authorizes only the leasing of federal properties and not transfers of property titles and donations. As a result, some assistance providers say that they cannot afford to renovate these properties or obtain loans to do so because leased property cannot be used as loan collateral. GAO believes that federal leases for facilities for the homeless may expose the government to liability. Also, local jurisdictions may seek compensation for additional costs associated with nongovernment use, such as emergency services for shelter residents. Changes in the leases could minimize these potential costs.

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**Homelessness: Federal  
Personal Property  
Donations Provide Limited  
Benefit to the Homeless  
(GAO/HRD-91-108,  
July 15, 1991)**

The Federal Surplus Property Donation Program disposes of property no longer needed by federal agencies; items range from heavy equipment, like planes, ships, cars, and construction equipment, to more common domestic items, like clothing, kitchen equipment, hardware, furniture, and office equipment. Property not claimed by groups, such as the Boy Scouts or the Red Cross, is then made available to state agencies, which can distribute it to public and nonprofit private organizations, including homelessness assistance providers. Overall, GAO found that the program is not a significant source of aid to the homeless. In fiscal year 1990, according to General Services Administration estimates, only about one-twentieth as many providers obtained property directly from state agencies for surplus property as received assistance through the single largest McKinney Act program. The dollar value of the donations these providers have received since 1987 has also been limited. The donation program is limited in its potential to help the homeless because of the types of items available for donation, the resources required for providers to obtain donated items, the priority assigned to providers in the distribution process, and an impractical reporting requirement. Neither the types of property available for donation nor the resources required for homelessness assistance providers to participate could be altered without changing the overall purpose and focus of the donation program. Providers could, however, be allowed to select surplus items earlier in the disposal process, and restrictions on the use of donated property could be modified to simplify providers' administrative tasks.

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**Homelessness: McKinney  
Act Programs and Funding  
Through Fiscal Year 1990  
(GAO/RCED-91-126,  
May 1, 1991)**

The McKinney Act's homeless assistance programs provide the homeless with emergency food and shelter, transitional and permanent housing, primary health care services, mental health care, alcohol and drug abuse treatment, education, and job training. This report provides a legislative history of the act, describes each program established pursuant to the act, and lists the amount of money provided under each program by state for fiscal year 1990. The Congress appropriated about \$600 million for 18 direct assistance programs for the homeless and the Interagency Council on the Homeless. Of the 18 programs, 6 provided funds through a formula, or block-grant-type process, and 12 used a competitive process. The single largest funded program for 1990 was the Federal Emergency Management Agency's Emergency Food and Shelter Program, which received around \$496 million. The Congress appropriated about \$655 million for 15 existing programs and 5 new ones for fiscal year 1991 and the Interagency Council on the Homeless.

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**Housing for the Elderly:  
HUD Policy Decisions  
Delay Section 202  
Construction Costs (GAO/  
RCED-91-4, Jan. 14, 1991)**

Under the section 202 program, nonprofit organizations receive direct loans for building or rehabilitating rental housing for the elderly and handicapped, primarily those of lower income. Over the past 9 years the time required to process a section 202 project has increased. In 1988, the Department of Housing and Urban Development (HUD) had a 3-year backlog of projects for which construction had not yet begun. As a result, housing assistance to many low-income elderly and handicapped people has been delayed. GAO identified three main reasons for processing delays: (1) HUD has indirectly restricted funds available to finance 202 projects by establishing fair market rents that are too low in some cases and do not reflect the cost of construction; (2) HUD offices are inconsistent in their cost containment reviews and often change project plans in an effort to lower costs to limits supportable by fair market rents; and (3) HUD's field offices vary in their administration of the program, with some offices having developed effective processing procedures while others have not. This report contains recommendations to the Secretary of HUD for ensuring the timely completion of section 202 projects.

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## Income Security

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### Computer Matching Act: Many States Did Not Comply With 30-Day Notice or Data-Verification Provisions (GAO/HRD-91- 39, Feb. 8, 1991)

To improve payment integrity and to reduce erroneous payments in the face of mounting budget deficits, the Congress passed legislation in 1984 requiring each state to determine recipients' eligibility for Aid to Families With Dependent Children (AFDC), Food Stamps, Medicaid, and other programs by computer-matching federal income tax data as well as other federal and state source data. States were required to give recipients at least 10 days notice before reducing or cutting off benefits. The Computer Matching and Privacy Protection Act of 1988 expanded the data-verification and advance notice provisions by directing states to (1) independently verify all federally furnished data, including that provided by the Social Security Administration (SSA), used in a state computer matching program and (2) give people at least 30 days' notice before cutting any benefits. A majority of the states told GAO that they had implemented the 30-day notice and data-verification provisions, although some states said that these provisions would be costly and expressed hope that the Congress would amend the provisions. As of June 1990, over half the states had implemented the 30-day provision; the rest said that they were planning to do so in the near future. GAO found that while most states used SSA benefit data in their computer matching programs, nearly half did not verify this information. About 22 percent of the states said that the act's provisions conflicted with state laws or regulations, which often required a 10-day notice period. Although 26 states provided cost estimates for implementing the 30-day notice provision, GAO found these estimates to be unreliable.

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### Debt Management: More Aggressive Actions Needed to Reduce Billions in Overpayments (GAO/HRD- 91-46, July 9, 1991)

This report assesses the effectiveness of SSA's efforts to improve its collections of overpayments and provides information on the debt management practices of several other agencies. From 1986 to 1989, SSA's overpayments collections remained a constant 28 percent of outstanding debt. GAO concluded that SSA made little progress in increasing the percentage of debt collected because it lacked an organizational focus and emphasis on debt management, had insufficient information to control and account for the more than \$2 billion in overpayments, did not adhere to debt collection policies, and had been legally restricted from using certain collection methods that have been successfully used by other agencies. GAO made a number of recommendations to correct these problems.

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**Financial Audit: Food and Nutrition Service's Financial Statements for Fiscal Years 1988 and 1987 (GAO/AFMD-91-3, Dec. 21, 1990)**

This report presents the results of GAO's financial audit of the Agriculture Department's Food and Nutrition Service (FNS) for fiscal years 1988 and 1987. GAO found that, due to weak internal controls, FNS is not adequately monitoring states' control over food coupons, which increases the chance of theft or abuse of coupons. Also, FNS does not produce reliable financial statements; its financial staff did not apply generally accepted accounting principles for the years examined, leading to significant errors in the agency's financial statements. GAO makes several recommendations aimed at correcting these weaknesses.

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**Low-Income Home Energy Assistance: A Program Overview (GAO/HRD-91-1BR, Oct. 23, 1990)**

The Low-Income Home Energy Assistance Program (LIHEAP) provides eligible households with assistance for home energy costs. Assistance is available to (1) help families pay heating and cooling costs, (2) prevent energy cutoff in crisis situations, and (3) help families make their homes more energy efficient. This report provides background information on the program in preparation for hearings on the program's reauthorization in 1990.

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**Low-Income Home Energy Assistance: HHS Has Not Assured State Compliance With Administrative Cost Restrictions (GAO/HRD-91-15, Nov. 13, 1990)**

The Low-Income Home Energy Assistance Program (LIHEAP) provides eligible households with assistance for home heating and cooling, home weatherization, and home energy crises. The Department of Health and Human Services (HHS) distributes funds to states, which are responsible for administering the program. The legislation authorizing the program requested that states not use more than 10 percent of LIHEAP funds for administrative and planning costs. GAO reviewed the program in Georgia, and found that two local agencies administering LIHEAP on behalf of the states were planning to use other federal funds to supplement the available LIHEAP funds to meet administrative and planning costs. This practice could have resulted in more than 10 percent of administrative costs being paid with federal funds, which the law prohibits. Georgia state officials were advised of this possibility and said that the state would take steps to prevent this from happening in 1990 and future years. GAO also found that HHS does not now monitor for possible noncompliance, and recommended actions the HHS Secretary could take to ensure that administrative costs in excess of 10 percent are paid with nonfederal funds, which the law allows.



**Low-Income Home Energy Assistance: Observations on HHS's Administration of the Program (GAO/HRD-91-119FS, Sept. 30, 1991)**

The most prominent of several federal programs that provide energy assistance for the poor, the Low-Income Home Energy Assistance Program (LIHEAP) was created in 1981. In effect, a series of one-time federal categorical crisis assistance programs aimed at supplementing the incomes of recipients to meet their energy expenses was converted into a state-run federal block grant program. The Office of Energy Assistance (OEA) within the Department of Health and Human Services (HHS) manages LIHEAP. To ensure that federal legal and regulatory requirements are met, OEA reviews the annual requests that states, territories, and Indian tribes submit for LIHEAP funds and conducts compliance reviews. Most grantees are reviewed for compliance about once every 5 years. While about half of the reviews are conducted on-site, the others are done in Washington, D.C., and are based on information supplied to OEA by the grantees. Noncompliance cases often take years to fully resolve, although OEA has made some headway recently in reducing the backlog.

**Low-Income Home Energy Assistance: States Cushioned Funding Cuts but Also Scaled Back Program Benefits (GAO/HRD-91-13, Jan. 24, 1991)**

The Low-Income Home Energy Assistance Program (LIHEAP) provides eligible households with assistance for home energy costs. Assistance is available to (1) help families with cooling costs, (2) prevent energy cut-offs in crisis situations, and (3) help families make their homes more energy efficient. GAO found that between fiscal years 1986 and 1989, the states—while offsetting about one-fourth of the cuts in federal funding for the program, mainly with oil overcharge funds resulting from legal settlements with major oil producers—scaled back energy assistance benefits. In addition, most states served fewer households, although 43 percent attributed the decrease to factors other than federal funding cuts, such as improved economic conditions that reduced the need for assistance. States generally complied with key program requirements by assuring the Department of Health and Human Services (HHS) that they were (1) doing outreach activities, especially for the elderly and handicapped, and (2) targeting benefits to households most in need. Also, the four states GAO visited had incorporated fiscal controls to prevent erroneous payments. GAO found that in nearly all states, other government and private sector programs provide home energy assistance to low-income households. In fiscal year 1989, this assistance amounted to about \$200 million.

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**Social Security: District Managers' Views on Outreach for Supplemental Security Income Program (GAO/HRD-91-19FS, Oct. 30, 1990)**

This fact sheet presents the results of GAO's telephone survey on the outreach activities for the Supplemental Security Income program carried out by field offices of the Social Security Administration. Outreach is done because many nonparticipants who may be eligible for Supplemental Security Income may be unaware of the program or of their eligibility for benefits.

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**Social Security Disability: Action Needed to Improve Use of Medical Experts at Hearings (GAO/HRD-91-68, May 20, 1991)**

When individuals are denied Social Security disability benefits, they may appeal to administrative law judges (ALJ), who may seek out medical expert testimony in deciding on the validity of a claim. The Social Security Administration's Office of Hearings and Appeals (OHA) relies on a fee schedule to determine payments for these medical experts, who are to be selected to testify on a rotational basis. GAO found that when purchasing medical expert testimony, OHA has not ensured compliance with either its rotation policy or federal procurement policy. Many hearing offices in the Chicago Region use specific medical experts repeatedly rather than rotating among a number of individuals with the same medical specialty. In addition, some hearing offices may have relied unnecessarily on one medical expert for referrals in high-demand medical specialties. Frequent use of individual medical experts occurred nationwide for this same reason. The high use of specific medical experts has resulted from (1) inadequate hearing office controls over the selection process, (2) inadequate regional office oversight of medical expert use by hearing offices, and (3) insufficient recruitment efforts. Repeated use of medical experts has led to questions about the impartiality and independence of the system, and GAO believes that OHA needs to strengthen its oversight and procedures.

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**Welfare Benefits: States Need Social Security's Death Data to Avoid Payment Error or Fraud (GAO/HRD-91-73, Apr. 2, 1991)**

Each year, the federal government spends billions of dollars on state-administered welfare programs like Aid to Families With Dependent Children, Food Stamps, and Medicaid; states spend billions more in welfare benefits through their state-funded general assistance programs. While payments should promptly cease once a beneficiary dies, a GAO review in the mid-Atlantic region—Maryland, Pennsylvania, and the District of Columbia—discovered nearly 3,000 cases during a 2-year period in which benefit payments continued for up to 2 years or more after the beneficiaries had died. GAO believes that erroneous welfare payments and welfare fraud could be reduced or avoided by having the Social Security Administration (SSA) routinely provide states with death

information contained in its files. With minimal investment, SSA could modify its Social Security number verification system to provide states with available death information.

**Workers at Risk: Increased Numbers in Contingent Employment Lack Insurance, Other Benefits (GAO/HRD-91-56, Mar. 8, 1991)**

This report examines the “contingent” work force—nontraditional work arrangements like part-time, temporary, and contract employment. GAO found that a large segment of the work force—estimated at about 32 million—have jobs that no longer fit the description of traditional, full-time permanent employment; this segment of the work force is expected to grow in coming years. Many of these workers, particularly those who head families, lack the economic protections enjoyed by their full-time counterparts. Part-time workers generally receive lower pay and fewer benefits than do workers in comparable full-time jobs. For example, one in five part-time workers lacks health insurance, and only 10 percent of part-time workers are included in their employers’ pension plans. Non-traditional workers often do not qualify for federal/state worker and income security protection programs. Accordingly, many of these individuals, especially those supporting families, may slip more easily into poverty. The absence of data on contingent workers has sharply limited the analysis that can be done of the problems these workers may face and the related policy consequences.

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## Veterans

**Financial Audit: Department of Veterans Affairs Financial Statements for Fiscal Years 1989 and 1988 (GAO/AFMD-91-6, Nov. 14, 1990)**

This report presents the results of GAO’s financial audit of the Department of Veterans Affairs (VA) for fiscal years 1989 and 1988. In GAO’s opinion, except for property and equipment, VA’s financial statements are fairly stated in accordance with generally accepted accounting principles. The property and equipment accounts shown in the financial statements are inaccurate primarily because of missing or undocumented values of the assets and the inconsistent adherence to capitalization and depreciation policies by VA’s field personnel. In addition to the audit reports, GAO discusses and analyzes VA’s financial position and operations, including VA health care costs and veterans’ benefits costs. GAO also includes a statement analyzing VA’s appropriation activity and a summary of VA’s self-assessment of internal controls under the Federal Managers’ Financial Integrity Act. VA’s self-assessment identifies eight areas where its major accounting systems fail to conform with accounting principles and standards for government agencies. These

areas include weaknesses in controls over property and equipment accounts, security controls at automated data processing centers, and the inability to adequately control funds and effectively detect duplicate payments for the loan guaranty program. GAO believes that a financial statement that analyzes appropriation activity is a desirable addition to the standard set of financial statements, providing fuller reporting of the relationship between accrual-based statements and the status of appropriations used. GAO also believes that a summary of an agency's Financial Integrity Act report should be part of an agency's annual report and should be eventually included within the scope of the independent auditor's work and report.

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**Medicaid: Changes in Drug Prices Paid by VA and DOD Since Enactment of Rebate Provisions (GAO/HRD-91-139, Sept. 18, 1991)**

In 1990, rapid increases in Medicaid prescription drug costs led the Congress to significantly change how Medicaid programs pay for outpatient prescription drugs. Drug manufacturers are now required to give rebates to state Medicaid programs on the basis of the discounts offered to large purchasers. Reports that drug manufacturers were raising prices charged to the Departments of Veterans Affairs and Defense raised congressional concerns about the impact of the legislation on federal agencies' costs. This report focuses on how the prescription drug prices paid by the two departments have changed and what effect the changes have had on costs.

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**VA Health Care: Actions in Response to VA's 1989 Mortality Study (GAO/HRD-91-26, Nov. 27, 1990)**

GAO reviewed follow-up actions taken by the Department of Veterans Affairs (VA) to address quality-of-care problems documented in a June 1989 report about VA medical centers. In that report, VA said that 44 of its 172 medical centers had higher-than-normal mortality rates in 1986, and that "likely" quality of care problems were found in 90 cases in which deaths occurred. GAO found that most of the actions VA planned to take to assess the significance of the mortality study findings had been completed. VA is still analyzing deaths that occurred in psychiatric centers to determine quality of care in those centers compared with that provided in other VA facilities. Preliminary data on 1989 deaths in psychiatric centers suggest that quality-of-care problems may still exist. GAO notes that the VA has not used information obtained from individual medical centers to make systemwide improvements and concludes that doing so could help ensure more uniform care for all VA patients.

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**VA Health Care:  
Alcoholism Screening  
Procedures Should Be  
Improved (GAO/HRD-91-  
71, Mar. 27, 1991)**

Alcoholism is a frequently overlooked health problem despite its significant medical, economic, social, and legal consequences. GAO looked at how physicians detect alcohol problems among veterans who have applied for treatment at Department of Veterans Affairs (VA) medical centers. During a 10-day period in late 1990, GAO surveyed over 2,000 veterans who had sought health care at five VA medical centers. The information from the survey strongly suggests that 29 percent of the veterans have alcohol problems, and suspicions were raised about an additional 14 percent of the veterans surveyed. Yet the five centers provided alcohol treatment to fewer than 3 percent of the veterans who had sought care during fiscal year 1990. Because GAO found that the screening practices for alcoholism varied widely at the five centers, it recommended that each medical center systematically screen veterans for alcohol problems when they first apply for health care.

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**VA Health Care: Delays in  
Awarding Major  
Construction Contracts  
(GAO/HRD-91-84, May 30,  
1991)**

The Department of Veterans Affairs' (VA) appropriation for fiscal year 1990 includes funding for 18 major construction projects, each estimated to cost \$2 million or more. VA's March 1991 letter to the Congress and to GAO correctly identified the 17 projects that were required but did not have working drawings on construction contracts awarded by September 30, 1990. In GAO's view, the contracting delays for 15 of the 17 projects do not constitute an impoundment of budget authority under the Impoundment Control Act. GAO is continuing to review the impoundment implications of VA's actions on the projects at the Dallas and Gainesville medical centers, however, and will report its conclusions later. VA's actions for the other 15 projects show no intent to avoid using the funds for the purpose for which they were intended. VA has awarded or expects to award contracts for 13 of the 17 projects by September 1991.

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**VA Health Care:  
Inadequate Controls Over  
Addictive Drugs (GAO/  
HRD-91-101, June 6, 1991)**

Drug abuse in the United States is not limited to illegal drugs like heroin and "crack" cocaine; about 8.6 million Americans misused prescription drugs last year, and health care workers are particularly susceptible to such abuse because of their access to prescription drugs. The Department of Veterans Affairs (VA) has inadequate internal controls over many addictive prescription drugs used in its health care system. Too many employees have access to pharmacy stocks of these drugs, and stocks are rarely inspected. Because of these weaknesses, pharmacy employees have been able to steal a wide range of prescription drugs for years. VA managers often became aware of these thefts, which sometimes totaled thousands of doses, only after law enforcement agencies

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notified them of criminal activities involving VA drugs. In addition, large amounts of addictive prescription drugs may have been stolen without VA managers ever detecting the thefts.

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**VA Health Care: Telephone Service Should Be More Accessible to Patients (GAO/HRD-91-110, July 31, 1991)**

With few exceptions, the Department of Veterans Affairs (VA) medical centers do not provide telephones in patients' rooms. If patients are ambulatory, they must use pay phones; otherwise, they have to rely on nurses to bring them phones. This is an inconvenience for the patient and means that nurses have to spend more time on nonclinical duties. VA can procure telephone and equipment with appropriated funds but has not done so because of the substantial cost involved. However, VA has options available under which it can provide telephone services to its patients and recoup at least part of the costs for providing such services.

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**Other**

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**Accessibility for the Disabled: Standards for Access to State Department-Designed Buildings Overseas (GAO/NSIAD-91-170, Apr. 3, 1991)**

When building or renovating facilities in other countries, the State Department is subject to building guidelines issued in 1984 designed to provide disabled people with full access. However, the State Department did not adopt these standards until March 1990. Of 23 building designs completed between 1984 and 1990, only 3 were produced after the standards had been adopted. However, State Department officials said that accessibility features, like ramps and appropriately designed rest rooms, were incorporated in designs before 1990.

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**Federal Aid: Programs Available to State and Local Governments (GAO/HRD-91-93FS, May 22, 1991)**

This fact sheet provides information on federal financial assistance programs (grants and direct payments) for which state and local governments are eligible applicants. It discusses 606 federal programs, with estimated obligations of \$155.3 billion, available to such governments in fiscal year 1990. In addition, it includes the Catalog of Federal Domestic Assistance number identifying the federal funding agency, program name, types of financial assistance, eligibility, budget function, and estimated funds obligated.

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**Financial Audit: Farmers Home Administration's Financial Statements for 1989 and 1988 (GAO/AFMD-91-36, May 6, 1991)**

GAO's opinion on the Farmers Home Administration's (FmHA) consolidated financial statements is qualified for both fiscal years 1989 and 1988 because GAO was unable to satisfy itself that the acquired farm and rural housing property accounts were presented fairly. Specifically, GAO's opinion discloses that (1) accounting records used to support the reported amount of FmHA's acquired property were inaccurate and (2) reports produced by the Acquired Property Tracking System were not properly reconciled with the detailed acquired property files at FmHA field offices. GAO's report on FmHA's internal control structure discusses the problem with the Acquired Property Tracking System and an additional internal control weakness related to the new farm loan classification system's inability to project loan losses on FmHA's \$22 billion direct farm loan portfolio. GAO has identified FmHA as a high-risk area within the federal government, and this report discusses the nature and extent of problems associated with FmHA systems and programs.

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**Nutrition Monitoring: Mismanagement of Nutrition Survey Has Resulted in Questionable Data (GAO/RCED-91-117, July 26, 1991)**

Concerns about food safety and Americans' nutritional status point to the need for reliable, timely information on food use and U.S. dietary habits. The Department of Agriculture's Nationwide Foods Consumption Survey, completed most recently in 1987-88, is the government's major survey on food and nutrition consumption. However, methodological problems, deviations from the survey's original design, and lax controls over the collection and processing of the results all raise doubts about the quality and usefulness of the most recent survey. Most importantly, results from the survey may not be representative of the U.S. population because of low response rates. Agriculture's Human Nutrition Information Service and Food and Nutrition Service (FNS) poorly managed the contract for the 1987-88 survey, at times violating key internal controls meant to safeguard the government's best interests. The contracting officer's representative improperly approved changes without consulting the contracting officer. The contracting officer exercised no oversight during much of this time. As a result, the contractor did not complete key procedures required by the contract. These actions increased the contract's costs and delayed its completion by 2 years.

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Pay and Benefits: Data on Energy Employees Who Retired or Resigned in Fiscal Year 1989 (GAO/ GGD-91-14BR, Oct. 25, 1990)

Questions continue to be raised about the federal government's ability to hire and retain high-quality workers. Many studies by GAO and others have concluded that noncompetitive federal salaries contribute to federal recruitment and retention problems. This briefing report contains information on former Department of Energy employees at grade 13 and above who retired or resigned during fiscal year 1989. GAO found that 43 of 78 employees who left Energy that year took private sector jobs that paid more than the government did—up to \$15,000 more in some cases.

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Small Business: Efforts to Improve Activities of the Service Corps of Retired Executives (GAO/RCED-91-5, Nov. 20, 1990)

The Service Corps of Retired Executives (SCORE) is a voluntary nonprofit organization whose primary purpose is to apply the experience of its counselors in solving the problems of small businesses. This report discusses (1) how SCORE operates and what services it provides and (2) several managerial and administrative issues, including SCORE's management information system, the Small Business Administration's (SBA) oversight of SCORE chapters, the chapters' interaction with the Small Business Development Center Program, evaluations of counselors' performances, and funding for clerical support and travel. GAO believes that SCORE chapters can provide counseling workshops with modest financial and administrative support from SCORE headquarters or SBA. Some chapters, however, may not need large amounts of funds because facilities and/or services are provided without charge by SBA or business associations, like the local chambers of commerce. GAO concludes that SCORE's recent efforts to improve chapter operations by issuing reporting guidelines and revoking charters of chapters that do not improve their performance are a step in the right direction. GAO realizes that SCORE's members are volunteers who provide valuable assistance to SBA and the small business community; nevertheless, accurate reporting of chapters' counseling sessions and workshops are important for improving management.

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Transportation: Status of GAO's Open Recommendations on Transportation Policies and Programs (GAO/RCED-91-112, Apr. 10, 1991)

In January 1991, GAO issued its annual report summarizing findings and open recommendations resulting from GAO work at federal agencies for which satisfactory legislative or administrative actions had not been completed. That report discussed over 2,200 GAO recommendations that remained open as of September 30, 1990. This report on 142 open recommendations—138 in the transportation area and four in related areas—is being issued as a separate document to focus attention on matters of primary interest to congressional committees with transportation-related responsibilities.



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**Workforce Issues:  
Employment Practices in  
Selected Large Private  
Companies (GAO/GGD-91-  
47, Mar. 13, 1991)**

As part of an effort to assess the government's ability to attract and retain employees, GAO examined employment practices in the nonfederal sector that may have applications in the government. GAO surveyed large companies with many employment locations around the country. This report presents the results of that survey concerning recruiting and hiring practices; benefit programs; pay practices; and other programs—planned or in place—dealing with family concerns, alternatives to traditional work arrangements, older workers, and managing an increasingly diverse workforce.

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**1990 Census: Reported Net  
Undercount Obscured  
Magnitude of Error (GAO/  
GGD-91-113, Aug. 22,  
1991)**

GAO estimates that the 1990 census contained a minimum of 14.1 million gross errors and perhaps as many as 25.7 million errors, depending on how broadly census error is defined. In either case, these are substantially more errors than indicated by the Census Bureau's widely reported 1990 census undercount of about 5.3 million persons. A focus on the net undercount obscures the true magnitude of the error in the census because, while millions of people were missed by the census, millions of other people were improperly counted. Examining the amount of gross error, therefore, provides a more complete picture of the quality of the census. In addition, the 1990 census contained proportionately more errors than the 1980 census. The estimated minimum number of errors in the 1980 census (7.8 million) represented about 3.4 percent of the 1980 count in contrast to 1990, when the minimum (14.1 million errors) represented about 5.7 percent of the count.

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**1990 Census Adjustment:  
Estimating Census  
Accuracy—A Complex  
Task (GAO/GGD-91-42,  
Mar. 11, 1991)**

Decennial census counts play an important role in reapportioning the House of Representatives and in redrawing congressional, state, and municipal legislative district lines. However, the census has historically undercounted the population, especially black persons; undercounting can create inequities in political representation and the distribution of federal funds. GAO reviewed the Census Bureau's procedures for estimating the accuracy of the census counts in the 1988 dress rehearsal—the final precensus test. This report focuses on the post-enumeration survey, which is the key census activity for a possible adjustment. GAO discusses a number of major hurdles to completing a high-quality post-enumeration survey in 1990.

# Fiscal Year 1991 Testimony Relating to Issues Affecting the Elderly

GAO testified 35 times before congressional committees during fiscal year 1991 on issues relating to older Americans. Of the testimonies, 16 were on health issues, 1 on a housing issue, 6 on income security issues, 4 on social services issues, 2 on veterans' issues, and 6 on other issues.

## Health

Access to and Utilization of the Ombudsmen Program Under the Older Americans Act, by Eleanor Chelimsky, Assistant Comptroller General for Program Evaluation and Methodology, before the Subcommittee on Aging, Senate Committee on Labor and Human Resources (GAO/T-PEMD-91-11, June 13, 1991)

The national ombudsmen program was created in 1975 in response to incidents of grossly inadequate care and abuse of residents in nursing homes. Ombudsmen investigate and resolve complaints made by or on behalf of residents, monitor laws governing elderly persons living in facilities, and provide information on long-term care options. The Administration on Aging, through its 10 regional offices, oversees and distributes funds earmarked for state ombudsmen programs. The Administration also provides technical support and guidance to state and local ombudsmen, collects data on their activities from each state, and presents a yearly summary report to the Congress. GAO testified on (1) use of the ombudsmen program by nursing home or board and care residents and how that use varies across states, (2) barriers preventing access by ombudsmen to residents, and (3) the likely impact of the program, as well as what impact data are being collected by the Administration on Aging and the states.

Canadian Health Insurance: Lessons for the United States, by Charles A. Bowsher, Comptroller General of the United States, before the House Committee on Government Operations (GAO/T-HRD-91-35, June 4, 1991)

Canada has been more successful than the United States in controlling the growth in health care spending, even while providing health insurance to all its residents. Canada's success is based on the following three principles: universal health coverage, uniform reimbursement rules, and systemwide spending controls. If the universal coverage and single-payer features of the Canadian system were applied in the United States, the savings in administrative costs alone would be more than enough to finance insurance coverage for the millions of Americans who are now uninsured. Enough would be left over to reduce, or possibly

even eliminate, copayments and deductibles, if that were deemed appropriate. The Canadian system is not without flaws, however. The Canadian method of controlling hospital costs has limited the use of expensive, high-technology diagnostic and surgical procedures. As a result, waiting lines, or queues—sometimes months long—have developed for some specialty surgical care services, like cardiac bypass surgery, lens implants, and magnetic resonance imaging. While the United States can learn from the Canadian model, a reformed U.S. system should also build upon the unique strengths of the existing U.S. health care structure. The continuing development of advanced medical technology; detailed management information systems; and the flexibility to incorporate alternative service delivery mechanisms, like health maintenance organizations, are characteristics of the U.S. system that should be preserved.

Health Care: Limited State Efforts to Assure Quality of Care Outside Hospitals, by Lawrence H. Thompson, Assistant Comptroller General for Human Resources Programs, before the Subcommittee on Regulation, Business Opportunities, and Energy, House Committee on Small Business (GAO/T-HRD-91-20, Apr. 29, 1991)

Over the past 20 years, medical and diagnostic procedures that were traditionally done in hospitals have increasingly been done in “freestanding” facilities, like ambulatory care centers and emergency centers. Relocating complex and risky medical procedures, like surgeries and radiology services, to these freestanding facilities has prompted concerns about the quality of care provided. GAO testified that states that license freestanding providers generally establish minimum quality assurance requirements, conduct on-site inspections to determine compliance with requirements, and have the authority to impose sanctions against providers when necessary. States have been slow, however, to license freestanding providers. Further, they have limited plans to expand licensing requirements. Unless the Department of Health and Human Services or a reputable private accrediting organization is monitoring an unlicensed freestanding facility, consumers have little assurance about the quality of care being offered.

Long-Term Care Insurance: Risks to Consumers Should Be Reduced, by Janet L. Shikles, Director of Health Financing and Policy Issues, before the Subcommittee on Health, House Committee on Ways and Means (GAO/T-HRD-91-14, Apr. 11, 1991)

By June 1990, about 1.6 million Americans had bought long-term care insurance as a protection against the devastating costs of nursing home care. Although state standards and long-term care insurance policies have improved over the past 5 years, consumers still face considerable risks in purchasing policies. Due to the absence of uniform terms and definitions, it is hard or even impossible for a consumer to understand when benefits will be paid or to compare the benefits and value of policies. Consumers also risk unpredictable premium hikes that can make it difficult for them to keep their policies. Yet if the policies are allowed to lapse, consumers lose the money they invested in premiums. GAO believes that the Congress should consider passing legislation—as was done in the case of Medigap insurance—that would set minimum standards for long-term care insurance.

Managed Care: Oregon Program Appears Successful but Expansions Should Be Implemented Cautiously, by Janet L. Shikles, Director of Health Financing and Policy Issues, before the Subcommittee on Health and the Environment, House Committee on Energy and Commerce (GAO/T-HRD-91-48, Sept. 16, 1991)

Under its demonstration proposal, Oregon plans to expand its prepaid managed care activities as part of a larger proposal to restructure its Medicaid program. Oregon plans to institute a more cost-effective Medicaid program while substantially expanding eligibility by (1) establishing a priority list of covered services and (2) instituting a statewide managed care program. While financial oversight activities and reporting requirements could be strengthened, GAO concludes that Oregon has designed, implemented, and operated a Medicaid managed care program that provides access to quality care for most of its recipients of Aid to Families With Dependent Children. GAO is uncertain, however, whether Oregon can implement the statewide managed care system as rapidly as proposed, and whether financial oversight and monitoring activities will be adequate. In GAO's view, the apparent success of the Oregon program to date may be credited in large part to the deliberate pace with which it was implemented with proper state oversight. Moving to a statewide system in only one year seems very difficult. It is unclear that Oregon can establish the provider network to support the large enrollment that quickly. The state assumes that health maintenance organizations not now participating in the Medicaid program will become interested and that physician care organizations now participating will convert to full capitation or consolidate with other plans. GAO believes that the Health Care Financing Administration should require Oregon to demonstrate that there is adequate provider

capacity and enough oversight in place before it is allowed to implement the demonstration project.

Medicaid Formula: Fairness Could Be Improved, by Janet L. Shikles, Director of Health Financing and Policy Issues, before the Subcommittee on Human Resources and Intergovernmental Relations, House Committee on Government Operations (GAO/T-HRD-91-5, Dec. 7, 1990)

The current Medicaid formula, which was adopted in 1965, has two main objectives: (1) reducing differences among states in medical care coverage of the poor and (2) distributing fairly the burden of financing program benefits among the states. GAO testified that these objectives have not been met. Nationwide, 75 percent of those below the poverty line are covered; however, this coverage varies from 37 percent in Idaho to 111 percent in Michigan. Also, states face varying burdens in financing the cost of providing for those in need. This happens, in part, because the formula does not target most federal funds to states with the greatest needs; that is, those with weak tax bases and high concentrations of poor people. In GAO's view, the Congress may wish to consider revising the formula to accommodate these concerns.

Medicare: Further Changes Needed to Reduce Program Costs, by Charles A. Bowsher, Comptroller General of the United States, before the Subcommittee on Health, House Committee on Ways and Means (GAO/T-HRD-91-34, June 13, 1991)

Medicare pays for about one-quarter of all hospital and physician services in this country and has become the fourth largest category of federal expenditures, surpassed only by defense, Social Security, and interest payments on the national debt. As such, the Medicare program bears a responsibility to be a leader in health care reform, and, to a large extent, Medicare has met its responsibility in this area. Despite efforts to constrain costs, however, Medicare spending and beneficiary out-of-pocket expenses have risen at troubling rates. Medicare expenditures rose from about \$70 billion in 1985 to \$106 billion in 1990, while average beneficiary out-of-pocket costs rose from about \$630 to over \$1,000 for Medicare-covered services. Medicare's high cost and continued rapid growth are evidence of inadequate economic incentives for patients and providers to contain costs. Consequently, much remains to be done to translate recent payment reforms into fully functioning systems. This report identifies issues that the Congress may want to examine to (1) help ensure that current Medicare reforms achieve their

objectives and (2) identify additional opportunities to reduce Medicare beneficiary and program costs.

Medicare: Millions in Potential Recoveries Not Being Sought by Contractors, by Janet L. Shikles, Director of Health Financing and Policy Issues, before the Subcommittee on Oversight, House Committee on Ways and Means (GAO/T-HRD-91-8, Feb. 26, 1991)

At a time when Medicare costs are soaring, GAO believes that Medicare carriers should be trying to recover the hundreds of millions of dollars potentially owed to the Medicare program by other insurers. A recently initiated Internal Revenue Service/Social Security Administration data match and a Department of Health and Human Services (HHS) regulation make it imperative that this problem be addressed immediately. The data match could add several million more claims to the existing backlog of mistaken Medicare payments. Further, the HHS regulation limits the time that contractors have to initiate recovery action after they identify another insurer. Thus, unless contractors are given enough resources to begin recovering the mistaken payments, hundreds of millions of dollars owed to Medicare will never be recovered. GAO believes that the additional funding for contractor recovery of mistaken payments should return considerably more than the dollars spent.

Medicare: PRO Review Does Not Assure Quality of Care Provided by Risk HMOs, by Janet L. Shikles, Director of Health Financing and Policy Issues, before the Senate Special Committee on Aging (GAO/T-HRD-91-12, Mar. 13, 1991)

After almost 4 years of operation, the peer review organization program has not provided the intended assurance that Medicare beneficiaries enrolled in risk health maintenance organizations are receiving quality health care. The program's effectiveness has been impeded by a lack of strong central management from the Health Care Financing Administration.

Mental Health Grants: Funding Not Distributed in Accordance With State Needs, by Linda G. Morra, Director of Human Services Policy and Management Issues, before the Subcommittee on Health and the Environment, House Committee on Energy and Commerce (GAO/T-HRD-91-32, May 16, 1991)

GAO discussed how \$1.3 billion in federal funds are being distributed under the Alcohol, Drug Abuse, and Mental Health block grant programs. Recent formula changes have improved the targeting of the block grant to states in relation to their population at risk of drug abuse. Populations at risk of mental health and alcohol problems, however, will have little influence on the distribution of block grant funding when hold-harmless funding is eliminated. Within states, the current formula's allocation of funding between mental health and substance abuse is unrelated to state differences in mental health needs. Allocating mental health funds through a separate apportionment formula, as proposed in pending legislation, would significantly improve the targeting of mental health funds in accordance with state needs. It would, however, redistribute mental health funds across states; some would gain funds and others would lose them.

Nonprofit Hospitals: Better Standards Needed for Tax Exemption, by Mark V. Nadel, Associate Director for National and Public Health Issues, before the House Committee on Ways and Means (GAO/T-HRD-91-43, July 3, 1991)

GAO found that the link between tax-exempt status and the provision of charitable activities for the poor or underserved is weak for many nonprofit hospitals. Typically, in the states GAO reviewed, large urban teaching and public hospitals provided a disproportionate share of charity and other unreimbursed care.

Private Health Insurance: Problems Caused by a Segmented Market, by Mark V. Nadel, Associate Director for National and Public Health Issues, before the Subcommittee on Health, House Committee on Ways and Means (GAO/T-HRD-91-21, May 2, 1991)

GAO testified that small businesses face particular difficulties in obtaining affordable private health insurance for their employees. Small businesses, generally those with fewer than 25 employees, bear higher costs than do larger companies, and their costs are rising more rapidly. A growing percentage of small firms do not offer their employees insurance benefits; about one-third of all the uninsured—about 10 million people—work for or are dependents of people who work for small businesses. GAO discusses efforts aimed at reforms targeted toward the small group health insurance market, but says that it will be difficult to move from the current segmented system into one that spreads risks more broadly. Also, reform initiatives do not address the problems of ever increasing health care costs, nor can they directly address the different

regulatory treatment of health benefit plans resulting from the Employee Retirement Income Security Act of 1974.

Retiree Health: Company-Sponsored Plans Facing Increasing Costs and Liabilities, by Gregory J. McDonald, Associate Director for Income Security Issues, before the Subcommittee on Health, House Committee on Ways and Means (GAO/T-HRD-91-25, May 6, 1991)

Company group health plans have played a major role in providing active and retired workers and their dependents with access to needed medical services. Confronted by cost, accounting, and funding constraints, companies are rethinking their commitment to providing retiree health benefits. Some companies have changed their health plan provisions to shift some costs to retirees and/or cut benefits, and retirees have limited protection under current law against such actions. This testimony describes (1) the extent of plan coverage and the cost of benefits, (2) the level of companies' retiree health liabilities, (3) advance funding options, (4) the extent to which companies are modifying their plans, (5) workers' protection under current law, and (6) congressional options.

Rural Hospitals: Closures and Issues of Access, by Mark V. Nadel, Associate Director for National and Public Health Issues, before the Task Force on Rural Elderly, House Select Committee on Aging (GAO/T-HRD-91-46, Sept. 4, 1991)

Between 1980 and 1988, 200 rural hospitals closed. GAO testified that the Department of Health and Human Services (HHS) needs to actively work on a coordinated approach to identifying and helping communities where essential hospitals are at risk. In GAO's view, the issue is not one of authority or available resources but rather how HHS uses its authority to deliver the right kinds of assistance to the right hospitals. Further, if the Congress decides to take additional action to help rural hospitals, funding should (1) target at-risk, essential, and potentially viable hospitals; (2) be enough to make a difference in financial status for these hospitals; and (3) help a community strengthen access to alternative sources of care if a hospital providing essential services is not likely to remain viable.

Substance Abuse Funding: High Urban Weight Not Justified by Urban-Rural Differences in Need, by Lawrence H. Thompson, Assistant Comptroller General for Human Resources Programs, before the Senate Committee on Labor and Human Resources (GAO/T-HRD-91-38, June 25, 1991)



Under the apportionment formula used to distribute \$1.3 billion in federal funds provided by the Alcohol, Drug Abuse, and Mental Health block grant program, urban states receive higher per capita funding than can be justified by studies of urban-rural differences in drug abuse or the cost of providing services. Funding was not systematically targeted to low-income states, as was intended by 1988 legislation. Although a high weight on urban population may serve as a proxy for the cost of providing services, GAO believes that it would be preferable to introduce a cost factor directly into the formula. Legislation pending before the Congress would distribute block grant funds so that they more closely reflect high concentrations of high-risk people, the cost of providing services, and state taxpayers' ability to fund service needs.

U.S. Health Care Spending: Trends, Contributing Factors, and Proposals for Reform, by Charles A. Bowsher, Comptroller General of the United States, before the House Committee on Ways and Means (GAO/T-HRD-91-16, Apr. 17, 1991)

Today, over 12 percent of U.S. national income goes for health care services, and by the year 2000, this amount is projected to grow to nearly 15 percent of the gross national product. At that point, \$300 billion will have been added to national health spending—an amount equivalent to the current defense budget. The Comptroller General concludes that piecemeal reforms, whether undertaken by business or the government, are unlikely to rein in the growth of national health spending substantially. If the spiral in health care is to be slowed, reform must be comprehensive. GAO believes that any reform should include three elements found in approaches used by other countries to successfully restrain health care spending: (1) insuring each individual; (2) instituting uniform payment rules for health care services; and (3) setting caps on total expenditures for major provider categories, like hospitals, physicians, and technology.

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## Housing

Counting the Homeless: Limitations of 1990 Census Results and Methodology, by L. Nye Stevens, Director of Government Business Operations Issues, before the Subcommittee on Government Information and Regulation, Senate Committee on Governmental Affairs, and the Subcommittee on Census and Population, House Committee on Post Office and Civil Service (GAO/T-GGD-91-29, May 9, 1991)

GAO testified on the Census Bureau's 1990 Shelter and Street Night (S-Night) Enumeration, which was designed to count people who might

otherwise have been missed by the census. The census and S-Night were not designed to, and did not, provide a complete count of the nation's homeless. The Bureau consistently has warned data users that the decennial census is not the appropriate vehicle for determining the extent of homelessness. In past reports, GAO has discussed efforts that extend well beyond the census that need to be done to estimate the number of homeless. As a result of methodological and operational weaknesses, however, the Bureau added fewer people to the census count through S-Night than it probably could have if it had aggressively pursued the daytime method early in the decade. S-Night is an example of what has been one of GAO's major concerns for several years—that the late census planning and the failure to fully consider and evaluate alternatives that characterized the 1990 census must be avoided for the 2000 census.

## Income Security

Federal Agencies Need SSA's Death Information to Avoid Erroneous Payments, by Lawrence H. Thompson, Assistant Comptroller General for Human Resources Programs, before the Subcommittee on Oversight, House Committee on Ways and Means (GAO/T-HRD-91-6, Feb. 6, 1991)

As a result of its contacts with family members, funeral homes, and other federal and state agencies, the Social Security Administration (SSA) maintains the most comprehensive death information in the federal government—if not the nation. GAO found that federal and state agencies, which are erroneously paying out millions of dollars each month to dead beneficiaries, rarely avail themselves of SSA's comprehensive death information. Instead, agencies continue to rely on voluntary reporting of deaths in order to stop paying or to adjust survivor benefits. GAO notes the existence of barriers to governmentwide use of SSA's purchased death information, including (1) state-negotiated restrictions on the use of data by other federal agencies and (2) states' desire to be compensated by each federal agency's use of the death information they provide. However, this state death information is a critical internal control for reducing erroneous payments in both federal and state benefit programs, and GAO believes that it should be provided to SSA without restrictions for use by federal and state benefit programs. GAO concludes that legislation is needed to enable SSA to more easily disclose the purchased data to other agencies. In addition, the Office of Management and Budget should require governmentwide use of SSA's comprehensive file of death information.

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GAO Views on H.R. 2898, the "Social Security Protection Act of 1991," by Harry S. Havens, Assistant Comptroller General, before the Subcommittee on the Legislative Process, House Committee on Rules (GAO/T-AFMD-91-11, Sept. 26, 1991)

GAO testified on H.R. 2898's proposed treatment of the administrative expenses of the Social Security Old-Age, Survivors, and Disability Insurance programs. From fiscal year 1986 to the enactment of the Budget Enforcement Act of 1990, the receipts and disbursements of the programs were off-budget but were included in the deficit calculations of the Gramm-Rudman-Hollings legislation. H.R. 2898 would provide explicitly that program administrative expenses not be counted for purposes of the budget submitted by the President, the congressional budget, or Gramm-Rudman-Hollings; not be considered to be in any discretionary spending category; and be exempt from any sequestration order. GAO does not favor excluding program administrative expenses from the discretionary spending category. If, however, the Congress does enact such a change, GAO also favors prohibiting an appropriate adjustment in the discretionary spending limits.

Insurance Company Failures Threaten Retirement Income, by Joseph F. Delfico, Director of Income Security Issues, before the Subcommittee on Select Revenue Measures, House Committee on Ways and Means (GAO/T-HRD-91-41, June 27, 1991)

Recent developments in the insurance industry have raised concern about the security of private pensions. Between 1975 and 1990, 170 life insurance companies failed—40 percent of these during the last 2 years. While most of these failures have been small, the Executive Life Insurance Company was placed into conservatorship in April 1991; if this firm fails, it would be the largest U.S. insurance company ever to do so. The basic problem is that despite a federal pension guaranty agency and a network of state insurance guaranty associations, some pensioners risk losing a portion of retirement income due to insurance company insolvency. In some cases, pensions have no guaranty coverage, and in others, they receive incomplete protection. Furthermore, pensioners are not routinely informed when they lose federal protection. This testimony addresses the guaranty system now protecting pension plan annuitants and how the system applies to pension plan investments.

Private Pensions: Risks to Retirees Posed by Insurance Company Failures, by Joseph F. Delfico, Director of Income Security Issues, before the

Subcommittee on Retirement Income and Employment, House Select  
Committee on Aging (GAO/T-HRD-91-23, Apr. 30, 1991)

Insurance industry and government data suggest that 3 to 4 million retirees and their surviving dependents receive annuities that their pension plans bought for them from life insurance companies. Even though pension plan benefits are guaranteed by federal law, these pensioners lost their protection when they became dependent on an insurance company for retirement income. Furthermore, retirees holding these annuities may be unaware that federal guarantees do not extend to them. Without federal guarantees, pensioners holding insurance annuities must rely on state guarantees, which provide incomplete coverage. As a result, some pensioners could lose all or part of their pension benefits in the wake of insurance company failures. Due to limited data, GAO was unable to determine the likelihood or value of losses by annuitants. However, 170 life insurance companies have failed since 1975—40 percent of them in the last 2 years.

Service to the Public: How Effective and Responsive Is the Government?, by Lawrence H. Thompson, Assistant Comptroller General for Human Resources Programs, before the House Committee on Ways and Means (GAO/T-HRD-91-26, May 8, 1991)

Are the American people getting their money's worth from the federal government? A lot will be required of the government and its managers to operate more efficiently and effectively in the years ahead, GAO testified, but positive signs are on the horizon. In general, the problems of the government are its management, not its people. To improve management, agencies need to develop strategies to overcome disruptive effects of leadership changes, such as long-range plans and sound financial management systems. They also must become accustomed to operating with the customer's needs in mind and to measure performance accordingly. The Congress can play an important role in this type of reform by supporting agency efforts in the following three areas: quality management, stewardship of public funds, and more systematic program evaluation.

Social Security: Reforms in the Disability Determination and Appeals Process, by Joseph F. Delfico, Director of Income Security Issues, before the Subcommittee on Social Security, House Committee on Ways and Means (GAO/T-HRD-91-24, May 2, 1991)

Evidence suggests that the quality of state disability decisions has declined over the last few years, while the workload for the state Disability Determination Services (DDS) has significantly increased. The success rate for claimants who appeal to administrative law judges (ALJ) has risen in the last several years to about 63 percent, calling into question the worth of the denial decisions made by state DDSS. One difference between the two decision processes is the face-to-face appearances of the claimant: ALJs ask claimants direct questions, while DDSS review case files only. GAO believes that face-to-face meetings, on a limited basis, at the initial decision level could improve DDS determinations. GAO also testified on proposed legislation to eliminate the reconsideration level of appeal.

## Social Services

Adequacy of the Administration on Aging's Provision of Technical Assistance for Targeting Services Under the Older Americans Act, by Robert York, Acting Director for Program Evaluation in Human Services Areas, before the Subcommittee on Human Resources, House Committee on Education and Labor, and the House Select Committee on Aging (GAO/T-PEMD-91-3, Apr. 25, 1991)

Several studies suggest that, in addition to having a higher poverty rate, elderly minorities have greater needs in areas like health services and supportive social services. Despite these needs, many minority elderly do not receive adequate services because of access problems, cultural barriers, and lack of awareness about the availability of these services. This testimony addresses the targeting of minorities in programs and services administered by the Administration on Aging. GAO discusses (1) the data that are available to assess the effectiveness of targeting, (2) how the Administration provides technical assistance on targeting to state units on aging, (3) the unmet technical assistance needs of state units with regard to targeting, and (4) the ability of the Administration to administer Older Americans Act programs given its current location within the Office of Human Development Services of the Department of Health and Human Services.

Effectiveness of Reporting Laws and Other Factors in Identifying, Preventing, and Treating Elder Abuse, by Gregory J. McDonald, Associate Director for Income Security Issues, before the Subcommittee on Human Services, House Select Committee on Aging (GAO/T-HRD-91-27, May 15, 1991)

The term "elder abuse" refers to the abuse, the neglect, or the exploitation of people aged 60 or older. To help identify victims of elder abuse, nearly every state has passed laws on the reporting of elder abuse. Certain persons in states with mandatory reporting laws are required to report incidences of elder abuse, but such reporting is not required in states with voluntary reporting laws. GAO concludes that this debate over mandatory versus voluntary reporting laws will yield uncertain answers on the relative effectiveness of these laws and that other factors are more important in identifying, preventing, and treating cases of elder abuse.

The Administration on Aging: Harmonizing Growing Demands and Shrinking Resources, by Eleanor Chelimsky, Assistant Comptroller General for Program Evaluation and Methodology, before the Subcommittee on Human Services, House Select Committee on Aging (GAO/T-PEMD-91-9, June 12, 1991)

GAO testified on (1) the match between the Administration on Aging's resources, on the one hand, and its mandated mission and services, on the other; (2) how the Administration provides technical assistance and oversight to state units on aging; and (3) whether the technical assistance provided by the Administration meets the needs of state units. GAO believes that more consideration needs to be given to the impact of declining staff and travel funds on the ability of the Administration to perform its oversight functions and to deliver the required technical assistance to state units and area agencies on aging. GAO also believes that the technical assistance needs of the state units need to be better identified, prioritized, and resolved. Finally, it seems likely that some overall conciliation process will be needed to harmonize the Administration's increasing responsibilities, the elderly population's growing demands for services, and shrinking funds.

Vocational Rehabilitation: Improved Federal Leadership Could Help States Focus Services on Those With Severe Handicaps, by Franklin Frazier, Director of Education and Employment Issues, before the Subcommittee on Select Education, House Committee on Education and Labor (GAO/T-HRD-91-10, Sept. 26, 1991)

Due to limited program funding, vocational rehabilitation now serves only a fraction of those potentially eligible. Program officials expect the number of handicapped Americans to grow as the population ages and medical technology prolongs the lives of the seriously injured. Under the

Rehabilitation Act of 1973, states that cannot provide services to all eligible applicants must give individuals with the most severe handicaps first priority for rehabilitation services. GAO testified that most states have not implemented this order-of-selection provision, although the states that have find it to be a fair and manageable way to set priorities for limited resources. Overall, these states have a higher percentage of clients with severe handicaps in their caseload. GAO believes that guidance and monitoring regarding how states implement this procedure should be improved.

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## Veterans

Alcoholism Screening Procedures at VA Medical Centers, by David P. Baine, Director of Federal Health Care Delivery Issues, before the Senate Committee on Governmental Affairs (GAO/T-HRD-91-15, Apr. 18, 1991)

Alcoholism is a frequently overlooked health problem despite its significant medical, economic, social, and legal consequences. GAO looked at how physicians detect alcohol problems among veterans who have applied for treatment at Department of Veterans Affairs (VA) medical centers. During a 10-day period in late 1990, GAO surveyed over 2,000 veterans who had sought health care at five VA medical centers. The information from the survey strongly suggests that 29 percent of the veterans have alcohol problems, and suspicions were raised about an additional 14 percent of the veterans surveyed. Yet the five centers provided alcohol treatment to fewer than 3 percent of the veterans who had sought care during fiscal year 1990. Because GAO found that the screening practices for alcoholism varied widely at the five centers, it recommends that each medical center systematically screen veterans for alcohol problems when they first apply for health care.

Controls Over Addictive Drugs in VA Pharmacies, by David P. Baine, Director of Federal Health Care Delivery Issues, before the Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs (GAO/T-HRD-91-36, June 19, 1991)

Drug abuse in the United States is not limited to illegal drugs like heroin and "crack" cocaine; about 8.6 million Americans misused prescription drugs last year, and health care workers are particularly susceptible to such abuse because of their access to prescription drugs. The Department of Veterans Affairs (VA) has inadequate internal controls over many addictive prescription drugs used in its health care system. Too many employees have access to pharmacy stocks of these drugs, and

stocks are rarely inspected. Because of these weaknesses, pharmacy employees have been able to steal a wide range of prescription drugs for years. VA managers often became aware of these thefts, which sometimes totaled thousands of doses, only after law enforcement agencies notified them of criminal activities involving VA drugs. In addition, large amounts of addictive prescription drugs may have been stolen without VA managers ever detecting the thefts.

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## Other

Bureau of Indian Affairs' Efforts to Reconcile and Audit the Indian Trust Funds, by Jeffrey C. Steinhoff, Director of Civil Audits, before the Subcommittee on Interior and Related Agencies, House Committee on Appropriations (GAO/T-AFMD-91-2, Apr. 11, 1991)

The Department of the Interior manages the Indian trust funds, which at the end of fiscal year 1990 included about 2,000 tribal and 300,000 individual Indian money accounts with balances totaling over \$2 billion. Money in the trust funds is derived from a variety of sources: payments of claims; oil, gas, and mineral royalties; land use agreements; and investment income. Over the years, audit reports have cited many weaknesses in the control and oversight of these accounts by the Bureau of Indian Affairs. As a result, the Bureau has lost credibility with the account holders. GAO testified on Bureau efforts to reconcile and audit the Indian trust funds, a major undertaking scheduled to begin in the summer of 1991. The Bureau will try to identify and correct balances in the accounts, many of which are 50 to 100 years old—a task GAO compares with determining the correct balance of a personal checking account that was active for over 50 years but not reconciled periodically.

Components of the 1990 Census Count, by L. Nye Stevens, Director of Government Business Operations Issues, before the Subcommittee on Census and Population, House Committee on Post Office and Civil Service (GAO/T-GGD-91-8, Feb. 21, 1991)

The 1990 census population count came from three broad sources: (1) data that individuals and households provided on themselves; (2) data gathered from nonhousehold sources, such as administrative records or neighbors; and (3) data generated through statistical methods, such as imputation. GAO testified that data are not available that show clearly how much each source contributed to the count, although it is clear that most of the data were supplied directly by households. An evaluation of the comparative quality of the three



sources of data should provide insight into the best mix of methodologies to improve the cost effectiveness of future censuses.

Expanding the Role of Local Governments: An Important Element of Census Reform, by L. Nye Stevens, Director of Government Business Operations Issues, before the Subcommittee on Census and Population, House Committee on Post Office and Civil Service (GAO/T-GGD-91-46, June 15, 1991)

The success of the decennial census requires a strong partnership between the Census Bureau and local governments—one probably much stronger than commonly realized. During the 1990 census, local governments helped to determine what data would be collected on the census questionnaire, encouraged public participation through publicity and outreach efforts, and helped improve the completeness of the Bureau's address list and the accuracy of the population counts through the census local review program. A successful 2000 census demands that the Bureau and local governments work even more closely together throughout the coming decade. GAO believes that it is in the best interests of both the Bureau and the governments to make sure that their important partnership yields the most complete count possible.

Major Issues Facing the 102nd Congress, by Charles A. Bowsher, Comptroller General of the United States, before the Senate Committee on Governmental Affairs (GAO/T-OCG-91-1, Jan. 23, 1991)

GAO's 1988 transition series sought to alert the President-elect and the new Congress to the many challenges facing the nation. This testimony updates the status of the issues GAO cited in 1988. The Comptroller General first reviews the overall state of the economy and the budget, cautioning that a protracted war in the Middle East, the recession at home, and further increases in the cost of deposit insurance could trigger another explosive rise in the deficit over the next several years; the general fund deficit—excluding the surpluses in the Social Security and other trust funds—already appears likely to top \$400 billion in 1991. He then discusses critical policy problems in the following program areas: defense, the financial sector, health, transportation, agriculture, energy, the environment, financial management, and public service. In some cases GAO reports significant progress, but that is the exception. Many of the problems, including some of the most important ones like the thrift crisis, have become more severe. Given the rapid developments in international affairs—as evidenced by changes in the Warsaw Pact countries and by the economic and political integration of Western Europe—the

Comptroller General believes that it is time to revisit the question: What is required of our government? If the United States is to succeed in this new world order, the Comptroller General believes that several prerequisites must be satisfied. First, we must have a government that works, one that operates efficiently and effectively, both in its internal functions and in its delivery of services to the American people. To reach that goal, investment in government, its people, its facilities, and its technology is needed. Second, we must have a government whose financial performance relates properly to the national and world economy. For that to be achieved, the United States must move toward a long-term fiscal policy that recognizes the need for a much higher level of national savings. Third, we must have a financial system in whose safety and soundness the American people can have complete confidence, so that our market economy can effectively allocate capital to the most productive uses. To accomplish that, we must resolve the thrift crisis, restore the soundness of the banking industry, and ensure an efficient and effectively regulated structure of capital markets.

1990 Census: Applying PES Results and Evaluations to the Adjustment Decision, by L. Nye Stevens, Director of Government Business Operations Issues, before the Subcommittee on Census and Population, House Committee on Post Office and Civil Service (GAO/T-GGD-91-49, June 27, 1991)

In this testimony, a supplement to GAO's June 19 statement (see GAO/T-GGD-91-26), GAO discusses the results of the 1990 census Post Enumeration Survey (PES)—a central methodology that the Commerce Department is using to decide whether or not to adjust the 1990 census counts. While all measures of coverage error indicate that the 1990 census missed a greater percentage of the U.S. population than did the 1980 census, GAO believes that the dependability of the PES as a tool for adjusting census counts remains questionable. In the three weeks remaining before the deadline for an adjustment decision, the Commerce Department will have to grapple with some hard technical questions in deciding if adjustment would improve the accuracy of the counts, particularly at lower geographic levels.

1990 Census: Financial Preparations for a Possible Adjustment, by L. Nye Stevens, Director of Government Business Operations Issues, before the Subcommittee on Government Information and Regulation, Senate Committee on Governmental Affairs (GAO/T-GGD-91-26, June 19, 1991)

All measures of coverage error indicate that the 1990 census missed a greater percentage of the U.S. population than did the 1980 census, the first time in modern census history that the coverage rate did not improve over that of the previous census. Furthermore, the differential undercount between the undercount of blacks and the undercount of nonblacks was greater than at any time since the Bureau began measuring the differential in 1940. At this point, however, GAO is unable to assess the quality of the 1990 Post Enumeration Survey (PES)—a central methodology the Department of Commerce will use to decide whether or not to adjust census counts—because it has not had time to assess the results of the Census Bureau's evaluations of the survey. The quality of the survey data will influence Commerce's confidence in the PES when deciding on adjustment. In the final analysis, GAO testified, the Census Bureau and the Commerce Department will need to use available data and their informed judgment when deciding upon the technical quality of the PES.

# Ongoing GAO Work as of September 30, 1991, Relating to Issues Affecting the Elderly

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At the end of fiscal year 1991, GAO had 119 ongoing jobs that were directed primarily at the elderly, or had older Americans as one of several target groups. Of these, 55 were on health issues, 2 on housing issues, 20 on income security issues, 8 on social services issues, 29 on veterans' issues, and 5 on other issues.

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## Health

Accuracy of Medicare Facility Cost Report Data Bases

Administration of Drugs in Board and Care Homes for the Elderly

Alternative Resolution Procedures for Medical Malpractice Claims Involving Services Provided through Medicare

Automated Medical Records

Case Management of Long-Term Care for the Elderly

Changes in Hospital/HMO Prescription Drug Prices

Comparison of Administrative Costs of International Health Care Systems

Comparison of United States and Canadian Prescription Drug Prices

Comparison of 1988 and 1989 Medigap Insurance Loss Ratio Experience

Compatibility of State Agency Surveyors to Identify Hospitals That Are Not Complying With Medicare Requirements

Conditions Affecting Utilization of Emergency Departments

Costs and Services of End Stage Renal Disease Facilities

Costs of Health Insurance to Business in the U.S. and Canada

Department of Health and Human Services Health Information for Mid-life and Elderly Women

Diabetes in the Minority Population

Do Interstate Differences in Health Care Spending Suggest Improvements in Federal Cost Containment Policy?

Drug Utilization Reviews Under the State Medicaid Program

Effect of External Utilization Management Firms' Decisions on the Quality of Health Care

Effect of Medicare's Durable Medical Equipment Fee Schedule on Program Payments and Alternative Payment Approaches

Efforts to Improve Small Business Employee Access to Health Care

Equity of and Access to Indian Health Service

Feasibility of Establishing a Separate Fee Schedule for Professional Services Provided by the Supplier Personnel

Federal and State Efforts to Increase Organ Donation and Provisions for Equitable, Efficient, and Effective Procurement and Allocation of Organs

Health Care Financing Administration's Oversight of Medicare's Risk HMO Program and the Humana Risk in Florida

Health Care Financing Administration's Recoveries of Medicare Carrier Payments

Health Insurance Waste and Abuse

Hospital-Based and Freestanding Skilled Nursing Facilities' Costs

Impact of Extending Medicare Secondary Payer Period for End Stage Renal Disease Beneficiaries

Implementation of Medicare Insured Group Demonstration Project—Year Three

International Comparison of Medical Malpractice and Quality Assurance Systems

International Health Care Systems

Long-Term Care Insurance Policyholder Protections

Managed Care in the Medicaid Program

**Marketing of Long-Term Care Insurance**

**Medical Malpractice Insurance Alternatives for Community and Migrant Health Centers**

**Medicare's Effectiveness in Handling Beneficiary Complaints of Fraud and Abuse**

**Medicare Payment Levels for CAT Scans and MRIs in Light of Increased Utilization of Such Specialized Technologies**

**Medicare Payments for Durable Medical Equipment**

**Medicare Payments to Home Health Agencies**

**Medicare Payments to Physicians for Medically Directing Nurse Anesthetists**

**Medicare System Sharing**

**Medicare Technical Component Payments for MRI**

**Methods to Prevent False Medicare Claims**

**Methods Used to Fund Community Health Centers**

**Multiple Copy Prescription Programs**

**Oregon's Proposal to Contain Medicaid Costs by Rationing Health Care Services**

**Peer Review Organization's Review of Ambulatory Surgery**

**Recovery of Medicare Part B Overpayments**

**Social Security and Family Support Administration's Medical Responsibilities for Identifying Liable Third Parties**

**Sources of Rising Hospital Costs**

**State Initiatives to Achieve Universal Access to Health Care**

State Policy on Reimbursement for Disproportionate Share Hospitals in the Medicaid Program

The Appropriateness of Medicare Payments for Durable Medical Equipment

The District of Columbia's Medicaid Eligibility System and Its Input on Hospital Reimbursement

The Magnitude of Medicare Credit Balances and the Impact on the Medicare Program

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## Housing

Elderly Use of Housing Vouchers

Problems with Housing the Mentally Disabled With the Elderly

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## Income Security

Annuitants From Pension Plan Terminations

Benefits and Problems in Allowing Organizations Serving as Representative Payees to Charge Fees

Department of Labor and Internal Revenue Service Actions on ERISA Violations Reported by Pension Plan

Department of Labor and Pension Benefit Guaranty Corporation Roles When Pension Plans Purchase Annuities

Effectiveness of the Social Security Administration's Effort to Assist Supplemental Security Income Applicants' Application for Food Stamps

Examine the Results of Internal Revenue Service/Social Security Administration Efforts to Reconcile Differences in Wage Reports Filed for Fiscal Year 1978-87

Financial Assumptions Used in Estimating Defined-Benefit Pension Plans' Liabilities

Internal Revenue Service Refund Information Could Permit the Social Security Administration to Credit Some Currently Uncredited Earnings to the Correct Accounts

Monitoring the Bureau of Indian Affairs' Efforts to Reconcile Indian Trust Funds

Pension Benefit Guaranty Corporation Fiscal Year 1991 Financial Audit

Pension Benefit Guaranty Corporation's Collection of Premiums Under the Employee Retirement Income Security Act of 1974

Pension Fund Investments in Low- and Moderate-Income Housing Projects

Pension Survivor Benefits After Implementation of the 1984 Retirement Equity Act

Quality of Financial Statement Audits of Private Sector Employee Benefit Plans

Selected Employee Benefit Taxation Issues

Social Security Administration's Acquisition and Processing of Death Information

Spousal Consent Forms Mandated Under the 1984 Retirement Equity Act

Tax Treatment of Long-Term Care Insurance

The Primary Cause of Overpayments at the Social Security Administration

Utilization of Simplified Employee Pensions

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## Social Services

Adequacy of Services Provided to Disabled Persons

An Analysis of State Eldercare Policies Submitted to the Administration on Aging

Cost Sharing Under the Older Americans Act Program

Poverty Among the Elderly

Public/Private Partnerships Under the Older Americans Act



Reorganization of the Administration on Aging

Social Indicators: Comparing Rural Areas and Inner Cities

Vocational Rehabilitation Services Authorized Under the Rehabilitation Act of 1973

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## Veterans

Allegations of Poor Quality Care in Selected Department of Veterans Affairs Medical Centers

Comparison of Benefits Provided to Disabled Veterans in U.S. and Foreign Countries

Department of Veterans Affairs Copayment Exemption Practices

Department of Veterans Affairs Efforts to Assure That Psychiatric Patients Receive Quality Care

Department of Veterans Affairs Health Care Services for Women Veterans

Department of Veterans Affairs Life Insurance Administration Costs

Department of Veterans Affairs Life Insurance Program Management

Department of Veterans Affairs Medical Centers' Management of Scarce Medical Specialist Contracts

Department of Veterans Affairs Patient Treatment File Data

Department of Veterans Affairs Payments to Private Physicians for Veterans' Outpatient Care

Department of Veterans Affairs Pension Beneficiaries Receiving Medicaid-Covered Nursing Home Care

Department of Veterans Affairs Prescription Drug Refill Policies, Procedures, and Practices

Department of Veterans Affairs (VA) Quality Assurance and Joint Commission on Accreditation of Healthcare Organizations' Standards: Non-compliance at VA and Non-VA Hospitals

Department of Veterans Affairs Rehabilitation Program

Department of Veterans Affairs Rehabilitation Service for the Severely Disabled

Department of Veterans Affairs Use of Part-Time Physicians in Its Health Care System

Effect of State-Mandated Health Insurance Programs on the Demand for Department of Veterans Affairs Services

Health Care Services Available to Veterans at Department of Veterans Affairs Medical Centers

Impact of GAO Recommendations on Department of Veterans Affairs Quality Assurance Program

Management of the Department of Veterans Affairs: Human Resource Management Vital to Success of the Secretary's Strategic Management Process

Medical Equipment Failures at Department of Veterans Affairs Medical Centers

Need for a Department of Veterans Affairs Hospital in Hawaii

Potential Copayments for Department of Veterans Affairs Long-Term Care

Secretarial-Level Oversight of the Department of Veterans Affairs Programs and Administrative Activities

The Effect of the Availability of Support on the Quality of Care Furnished by Department of Veterans Affairs Nurses Working in Acute Care Settings

The Effectiveness of the Department of Veterans Affairs Implementation of Section 8051 of the Omnibus Budget Reconciliation Act of 1990

Veterans' Federal Health Care Benefits

Veterans Receiving Either Department of Veterans Affairs Compensation or Military Retirement Disability Benefits

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Waiting Times for Veterans Using Department of Veterans Affairs Medical Centers

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**Other**

Assessment of Whether Statutory Amendments to Block Grants Have Constrained States' Flexibility

Comparability of the Department of Defense's Mental Health Benefits With Other Health Programs

Comparison of the Operations and Results of the Trade Adjustment Assistance and Economic Dislocation and Worker Adjustment Assistance Programs

Equal Employment Opportunity Commission Administration of the Age Discrimination in Employment Act

Opportunities to Increase the Department of Defense's Early Retirement

# GAO Activities Regarding Older Workers

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GAO appointed 940 persons to permanent and temporary positions during fiscal year 1991, of whom 222 (24 percent) were age 40 and older. Of GAO's total work force of 5,619 on September 30, 1991, 3,176 (57 percent) were age 40 and older.

GAO employment policies prohibit discrimination based on age. GAO's Civil Rights Office continues to (1) provide information and advice and (2) process complaints involving allegations of age discrimination.

GAO continues to provide individual counseling and preretirement seminars for employees nearing retirement. The counseling and seminars are intended to assist employees in

- calculating retirement income available through the Civil Service and Social Security systems and understanding options involving age, grade, and years of service;
- understanding health insurance and survivor benefit plans;
- acquiring information helpful in planning a realistic budget based on income, tax obligations, and benefits, and making decisions concerning legal matters;
- gaining insights and perspectives concerning adjustments to retirement;
- increasing awareness of community resources that deal with preretirement planning, second career opportunities, and financial planning; and
- increasing awareness of lifestyle options available during the transition from work to retirement.

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# Major Contributors to This Report

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