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GAO

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

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AGING ISSUES

Related GAO Reports and Activities in Fiscal Year 1992

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Human Resources Division

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

Dear Mr. Chairman:

This report was prepared in response to the Committee's October 7, 1992, request for a compilation of our fiscal year 1992 products and ongoing work regarding older Americans and their families.

GAO's work in aging reflects the continuing importance of federal programs for an increasing aged population. The 1990 Census counted over 31 million older Americans, comprising 12 percent of the nation's population. By the year 2020, that number will exceed 53 million, or 17 percent of the population, of which 7 million will be 85 or older. Although most of the nation's elderly citizens are healthy and independent members of society, a growing number of them continue to 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 1992 covered a range of issues, including federal government activities in employment, health care, housing, income security, social services, and veterans issues. Some federal programs, such as Social Security and Medicare, are directed primarily at older Americans. Other federal programs target older Americans as one of several groups served, such as Medicaid or federal housing programs. We have organized the summaries of our fiscal year 1992 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 older Americans 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).

The issues addressed by these products and ongoing work are presented in table 1. The table shows that health and income security were the leading issues addressed among reports focused primarily on older Americans. Health was the leading issue that either primarily affected older Americans or affected both older Americans and other groups. To make information in this report easier to use, we have included an index of terms and subjects cross referenced to the GAO reports and testimonies listed in this report.

Table 1: GAO Activities Relating to the Elderly in Fiscal Year 1992

Issue	Reports focused on the elderly	Reports with elderly as one of several target groups	Testimonies	Ongoing work as of 9/30/92
Employment	2	4	2	0
Health	18	22	26	60
Housing	1	4	3	7
Income Security	12	2	7	20
Social Services	3	0	3	6
Veterans-DOD	3	20	7	35
Other	0	4	1	0
Total	**39**	**56**	**49**	**128**

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

Appendix II provides summaries of 56 reports in which older Americans 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, Medicaid finances nursing home care, as well as medical care for poor people of all ages.

Appendix III describes 49 testimonies given during fiscal year 1992 on subjects focused on older Americans. We testified most often on health issues. In appendix IV, we have listed 128 studies related to older Americans that were ongoing as of September 30, 1992.

In addition, appendix V lists four GAO publications that are related to our work involving older Americans. These publications summarize GAO

reports and testimonies on aging, health, income security, and housing and community development issues.

We have also provided information on GAO's employment of older Americans. As you are aware, our policies prohibit age discrimination (see app. VI). On September 30, 1992, about 56 percent of our work force was 40 years of age and 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) 512-7215 if you have any questions. Other major contributors are listed in appendix VII.

Sincerely yours,

Lawrence H. Thompson

Lawrence H. Thompson
Assistant Comptroller General

Contents

Abbreviations

AIDS	acquired immunodeficiency syndrome
ADP	automatic data processing
AOA	Administration on Aging
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
DOD	Department of Defense
EEOC	Equal Employment Opportunity Commission
FDA	Food and Drug Administration
FHA	Federal Housing Administration
GAO	General Accounting Office
GMP	Good Manufacturing Practices
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
MEWA	multiple employer welfare arrangements
MRI	magnetic resonance imaging
NAIC	National Association of Insurance Commission
NIH	National Institutes of Health
OPM	Office of Personnel Management
PBGC	Pension Benefit Guaranty Corporation
PHA	public housing agencies
SGLI	Servicemen's Group Life Insurance Program
SSA	Social Security Administration
SSI	Supplemental Security Income
USDA	United States Department of Agriculture
VA	Department of Veteran's Affairs
VHA	Veterans Health Administration

Fiscal Year 1992 GAO Reports on Issues Primarily Affecting Older Americans

During fiscal year 1992, we issued 39 reports on issues primarily affecting older Americans. Of these, 2 were on employment, 18 on health, 1 on housing, 12 on income security, 3 on social services, and 3 on veterans issues.

Employment

Age Employment Discrimination: EEOC's Investigation of Charges Under 1967 Law (GAO/HRD-92-82, Sept. 4, 1992)

People who believe that they are victims of age discrimination can file charges with the Equal Employment Opportunity Commission (EEOC). The Age Discrimination in Employment Act of 1967 required that lawsuits in federal court be filed within 2 years of the alleged violations. During the 1980s, however, sizable numbers of suits filed in federal court lapsed. The government had not finished investigating these charges even though 2 years had passed since the alleged violations took place. The the Congress, concerned about the lapse problem, deleted the 2-year limitation in 1991. Charging parties' rights to file private lawsuits now expire 90 days after receiving notice that EEOC has completed action on the charge. This report responds to several questions from Members of the Congress about how EEOC investigates employment discrimination charges.

Employee Benefits: Improved Plan Reporting and CPA Audits Can Increase Protection Under ERISA, (GAO/AFMD-92-14, Apr. 9, 1992)

The Department of Labor's Office of Inspector General revealed in November 1989 that it had uncovered major deficiencies in audits of private employee benefit plans, raising concerns about how well American workers are being protected. More than one-third of the 25 plan audits GAO reviewed had weaknesses so serious that their reliability and usefulness were questionable. In some cases, the auditors failed to adequately test investments amounting to millions of dollars or to test the appropriateness of millions of dollars in payments to insurance companies. To protect the interests of plan participants, legislation is needed to (1) eliminate limited scope audits; (2) require reports by plan administrators and auditors on internal controls; (3) require reporting by auditors of fraud and serious Employee Retirement Income Security Act violations; and (4) require peer review of auditors conducting plan audits.

Health

Durable Medical Equipment: Specific HCFA Criteria and Standard Forms Could Reduce Medicare Payments (GAO/HRD-92-64, June 12, 1992)

The Health Care Financing Administration (HCFA) could cut Medicare spending on durable medical equipment subject to unnecessary payments by developing more detailed coverage criteria that give carriers a clear, well-defined, objective basis for paying or denying claims. Medicare paid about $1.7 billion in 1990 for durable medical equipment purchases and rentals, such as hospital beds and wheelchairs. To save even more money, HCFA could also develop medical necessity certification forms for equipment subject to unnecessary payments. These forms should require doctors to explain patients' needs for the prescribed equipment. Among carriers that use this kind of form, Medicare payments for three types of equipment have fallen significantly because the forms gave detailed information that led to denial of claims.

Elderly Americans: Health, Housing, and Nutrition Gaps Between the Poor and Nonpoor (GAO/PEMD-92-29, June 24, 1992)

The elderly poor, many of whom are burdened by medical and housing costs, also tend to suffer from more health and nutritional problems than do higher income elderly. Although many federal programs are tailored to the needs of the poor, participation by the elderly is rather low. Possible reasons include (1) the inability of federal programs with limited money to serve all needy elderly; (2) the lack of effective federal outreach efforts to enroll eligible individuals; and (3) differing state eligibility criteria for some programs, such as Medicaid. Absent definitive information on this gap between needs and services, the Congress may want to focus on this issue to see what can be done to close the gap.

GAO summarized this report in testimony before the Congress; see Elderly Americans: Health, Housing, and Nutrition Gaps Between the Poor and Nonpoor (GAO/T-PEMD-92-10, June 24, 1992), by Robert L. York, Director of Program Evaluation in Human Services Areas, before the House Select Committee on Aging.

Home Health Care: HCFA Evaluation of Community Health Accreditation Program Inadequate (GAO/HRD-92-93, Apr. 20, 1992)

How well does the Community Health Accreditation Program ensure that home health agencies adhere to Medicare conditions of participation? GAO found that the Health Care Financing Administration's evaluation of the program's effectiveness is inadequate. HCFA determined that the program's standards were similar to Medicare conditions of participation and, where differences existed, the agreed-upon modifications to the program's

standards were documented. But other areas cited in the proposed regulation, such as examining the accrediting organization's staff and other resources, received little or no evaluation. While HCFA has tried to address these issues, it plans no further program evaluation because it believes that its earlier work, together with GAO's, adequately evaluates the program's ability to ensure that Medicare conditions of participation are met. GAO disagrees because its work was not intended to be a detailed evaluation of the program, and believes that HCFA should do a comprehensive evaluation before granting the program deemed status.

Long-Term Care Insurance: Better Controls Needed in Sales to People With Limited Financial Resources (GAO/HRD-92-66, Mar. 27, 1992)

Among the eight insurance companies it reviewed, GAO found that except for Medicaid recipients, companies are doing little to prevent the sale of long-term care insurance to low-income people. While company officials said that their policy is to avoid selling such insurance to low-income individuals, this policy is not always in writing, and companies' actual practices are hard to determine. Despite their stated intentions, the companies have few controls over such sales. Most of the companies' training materials are vague or silent about whether an insurance agent should consider a consumer's income and assets when selling long-term care insurance. In addition, companies do not monitor whether agents sell this insurance to low-income people. Substantial agent commissions could spur policy sales to people who do not need such insurance. Marketing materials from half of the companies do not caution consumers to consider whether long-term care insurance is appropriate, given their particular income and assets.

Long-Term Care Insurance: Risks to Consumers Should Be Reduced (GAO/HRD-92-14, Dec. 26, 1991)

The National Association of Insurance Commission's (NAIC) long-term care insurance standards, which provide a national model for the states, have improved significantly in the past 5 years. Although state standards have also improved, many states have not adopted key NAIC standards, and insurers have not incorporated more recent NAIC standards into their policies. In addition, NAIC standards do not adequately address several significant issues. For example, the absence of uniform terms, definitions, and eligibility criteria makes it hard for consumers to understand what benefits will be provided under what circumstances and how certain provisions can limit eligibility. Consumers also face considerable pricing risks, such as unpredictable pricing increases, that may force many policyholders to lapse policies and lose their investment in premiums. Finally, in the absence of standards, consumers are limited in their options to upgrade policies and are vulnerable to sales abuses created by high

first-year commissions for insurance agents. GAO believes that additional standards are needed to address these issues. While these standards would likely increase premiums, GAO believes that they would significantly improve consumer protection in a rapidly evolving, complex market. Many states still have not adopted NAIC standards, however, and the Congress may want to pass legislation setting minimum federal standards for long-term care insurance.

Medicare: Effect of Durable Medical Equipment Fee Schedules on Six Suppliers' Profits (GAO/HRD-92-22, Nov. 6, 1991)

Medicare maintains a fee schedule payment system for durable medical equipment, such as wheelchairs and oxygen systems, used in patients' homes. In reviewing the appropriateness of the payment amounts in the fee schedules, GAO found that equipment suppliers have not been maintaining records in a manner that permits direct computation of costs and profits by item. As a result, GAO had to individually develop these data for each supplier. GAO selected six suppliers representative of various sized firms in different parts of the country. The aggregate profit margin for these suppliers in 1988 was 19 percent on Medicare business versus a 24-percent loss on other business. The overall loss was 2 percent. GAO estimates, using the same volume of services and constant 1989 dollars, that the six suppliers' aggregate profit margin on their Medicare business would be higher under both the original fee schedules and those revised by the Omnibus Budget Reconciliation Act of 1990 than under the reasonable charge payment method the fee schedules replaced.

Medicare: Excessive Payments Support the Proliferation of Costly Technology (GAO/HRD-92-59, May 27, 1992)

Have Medicare payments for sophisticated radiology services like magnetic resonance imaging (MRI) been adjusted to reflect declining costs for such technology? In some localities, GAO has found that Medicare payments for MRI do not take into account lower costs arising from faster scanning and broader diagnostic uses for the machines. Medicare payments generally do not take into account providers' costs and do not promote efficient use of expensive new technology. Even with legislatively imposed payment reductions in recent years, MRI payments in some areas are still too high relative to the costs incurred by high-volume providers. High Medicare payment rates encourage needless MRI proliferation by reimbursing providers for excess capacity. GAO believes that payment levels should be based primarily on the costs incurred by high-volume, efficient providers and should be updated periodically to reflect the economies achieved as the technologies evolve.

Medicare: HCFA Needs to Take Stronger Actions Against HMOs Violating Federal Standards (GAO/HRD-92-11, Nov. 12, 1991)

During the past decade, the Health Care Financing Administration has encouraged Medicare beneficiaries to enroll in health maintenance organizations (HMO). HMOs are attractive because they have financial incentives to control costs and utilization and offer beneficiaries more services than are normally covered under Medicare. Yet HCFA has been ineffective in getting certain HMOs to promptly correct violations of Medicare requirements. Continued violations by Humana Medical Plan in Florida demonstrate HCFA's unwillingness and inability to enforce Medicare requirements on HMOs serving Medicare beneficiaries. Press articles alleged widespread problems with Humana—Medicare's largest HMO contractor—including marketing and claims payment abuses and quality-of-care issues. HCFA found Humana in violation of federal standards in four areas: marketing, claims payment, processing of beneficiary appeals, and implementation of an internal quality assurance system. Deficiencies in these areas can mean that beneficiaries incur high out-of-pocket expenses or are denied appropriate care. As a result, GAO believes that allowing Humana to enroll more than 125,000 new beneficiaries during its protracted period of noncompliance was unreasonable. GAO concluded that HCFA can and should have done more to require Humana to resolve its deficiencies. To help prevent the recurrence of sustained difficulties, HCFA needs to unequivocally establish both its authority and intention to take timely and decisive action against HMOs that violate Medicare's minimum beneficiary safeguard standards.

GAO summarized this report in testimony before the Congress; see Medicare: HCFA Needs to Take Stronger Actions Against HMOs Violating Federal Standards (GAO/T-HRD-92-11, Nov. 15, 1991), 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.

Medicare: Improper Handling of Beneficiary Complaints of Provider Fraud and Abuse (GAO/HRD-92-1, Oct. 2, 1991)

The fastest growing portion of Medicare is part B, which covers physician services, outpatient hospital services, durable medical equipment, and other services. Part B will account for an estimated half a billion claims and $445 billion in benefit payments in fiscal year 1991. The growth of these payments increases Medicare's vulnerability to erroneously paid claims that may result from provider fraud and abuse. A key line of defense in identifying and correcting fraud and abuse are the Medicare contractors (carriers) who process and pay part B claims. The carriers' primary source of information on possible fraud and abuse is part B beneficiaries. GAO found that carriers are missing opportunities to detect

fraud and abuse because telephone personnel who first receive beneficiary complaints often do not refer them to the carriers' investigative units. Instead, beneficiaries are often told to submit their complaints in writing or to resolve them with providers—even though the caller has described the complaint in detail over the phone. Further, when complaints are referred, investigative units often do not examine those that contain substantial indications of potential fraud and abuse. Almost three-fourths of such complaints in GAO's sample were not fully investigated. Although the mishandling of complaints results partly from inadequate government guidance and oversight, the administration's initial fiscal year 1992 budget request significantly reduced funding for carrier personnel who answer beneficiary complaints, including those involving fraud and abuse. However, it appears that funds will be reallocated to minimize this reduction.

GAO summarized this report in testimony before the Congress; see Medicare: Improper Handling of Beneficiary Complaints of Provider Fraud and Abuse (GAO/T-HRD-92-2, Oct. 2, 1991), by Janet L. Shikles, Director of Health Financing and Policy Issues, before the Senate Special Committee on Aging.

Medicare: Millions of Dollars in Mistaken Payments Not Recovered (GAO/HRD-92-26, Oct. 21, 1991)

Although Medicare provides health care coverage for most citizens over 65, it is not always the primary insurer. Medicare is the secondary payer when beneficiaries are covered by both Medicare and workers' compensation, certain employer-sponsored group health insurance plans, and automobile and other liability insurance plans. Hospitals are responsible for obtaining data on beneficiaries' health insurance coverage to identify other insurers who should pay before Medicare. Hospitals receiving payments from both Medicare and a primary insurer must refund any amount due Medicare. Intermediaries (insurance companies under contract with Medicare) process Medicare claims for the hospitals, and they are responsible for ensuring that any mistaken payments are identified and returned to the program. GAO reviewed 196 patient accounts at 17 hospitals; each hospital owed Medicare refunds ranging from $1,300 to $327,400, which collectively amounted to more than $900,000. The credit balances resulted primarily from Medicare and another insurer mistakenly paying for the same inpatient service or Medicare paying twice for the same service. The five intermediaries that service these hospitals lacked the necessary internal controls to ensure that credit balances were identified and promptly recovered, and they gave recovery activities low priority. During GAO's review, Medicare officials initiated actions to help

resolve many of the credit balance problems brought to its attention, but additional efforts are needed.

Medicare: Over $1 Billion Should Be Recovered From Primary Health Insurers (GAO/HRD-92-52, Feb. 21, 1992)

Medicare has already paid more than $1 billion in claims that should have been billed to private health insurers and another $1 billion in mistaken payments may be in the offing, but efforts to recoup the funds are hampered by deep budget cuts in Medicare safeguard efforts and time limits on recovery periods. During the last decade, the Congress sought to reduce Medicare costs by making certain insurers the primary payers for beneficiary services. Amounts owed by other health insurers, however, are unrecovered or, in many cases, unidentified even after Medicare contractors have confirmed that beneficiaries have other health insurance that provides primary coverage. Nationwide, large backlogs of mistaken payments remain unrecovered. Significant programs savings have gone unrealized because contractors do not have the money to recover mistaken payments under the Medicare secondary payer program. The fiscal year 1992 funding levels for the program were below the amounts provided in fiscal year 1989, yet the number of beneficiary claims is significantly higher, and large backlogs remain. Increased funding of program activities is essential if over $1 billion in mistaken payments are to be recovered.

Medicare: Payments for Medically Directed Anesthesia Services Should Be Reduced (GAO/HRD-92-25, Mar. 3, 1992)

The Omnibus Budget Reconciliation Act of 1987 reduced Medicare payments to anesthesiologists when one anesthesiologist is involved in two or more overlapping surgeries. For each surgery, the anesthesiologist must meet several conditions, including being present when the patient enters and leaves anesthesia and providing directions to the nurse anesthetists, who actually do much of the work.

GAO found that Medicare still pays substantially more for directed cases than for services provided personally by an anesthesiologist. Because physicians' hourly revenue for concurrently directed services is much higher than for personally provided services, Medicare payments can influence the way in which anesthesia is delivered. GAO concludes that Medicare should set a fair price for anesthesia services and pay that amount regardless of how the service is delivered. GAO believes that the reduced payment was not large enough to cause anesthesiologists to alter their relationship with nurse anesthetists. other factors that may contribute to maintaining the anesthesiologist-nurse status quo are the (1)

shortage of nurse anesthetists and (2) ratio of anesthesiologists to nurse anesthetists in an area.

Medicare: Program and Beneficiary Costs Under Durable Medical Equipment Fee Schedules (GAO/HRD-92-78, July 7, 1992)

The fee schedule payment system for durable medical equipment sold or rented to Medicare patients—everything from wheelchairs to oxygen tents—has resulted in both Medicare and its beneficiaries paying more than they would have under the former reasonable charge system. For the high-volume items GAO reviewed, Medicare costs increased 17 percent in 1989. The recent legislative changes to the fee schedule payment system will return Medicare payments, in 1989 dollars, to the level that would have been incurred under the former reasonable charge system. The wide payment variations across geographic areas that existed under both the reasonable charge method and the fee schedules will be substantially reduced under the recent legislative changes.

Medicare: Rationale for Higher Payment for Hospital-Based Home Health Agencies (GAO/HRD-92-24, Jan. 31, 1992)

GAO concludes that allowing hospitals additional reimbursement for home health services is consistent with Medicare payment principles and federal legislation. The add-on is designed to pay a hospital for legitimate costs allocated to its home health agency if those costs cause its total home health agency costs to exceed predetermined Medicare cost limits. Nonetheless, the effect of this policy is to pay some hospitals more than freestanding home health agencies for the same services. GAO discusses several factors that suggest that the add-on may be unnecessary to ensure beneficiary access to home health care.

Medicare: Reimbursement Policies Can Influence the Setting and Cost of Chemotherapy (GAO/PEMD-92-28, July 17, 1992)

GAO has previously reported that oncologists have admitted sending patients to hospitals to avoid reimbursement problems associated with treating patients in their offices. In this report, GAO discusses the factors that influence where oncologists treat Medicare patients and the potential cost to the government of treatment in different settings. Some oncologists have treated cancer patients in hospital inpatient and outpatient settings when, by clinical standards, they could have received treatment at lower cost in the office. Financial factors influenced the oncologist's choice of setting, suggesting that the Health Care Financing Administration's reimbursement policies can have consequences beyond their intent. That is, whether and how much doctors are reimbursed by Medicare can influence the oncologist's choice of treatment setting and, as a result, can escalate Medicare expenditures.

Medicare: Shared Systems Policy Inadequately Planned and Implemented (GAO/IMTEC-92-41, Mar. 18, 1992)

To save administrative costs and promote uniformity, the Health Care Financing Administration has been encouraging its Medicare claims-processing contractors to share automated data processing systems. In fiscal year 1991, HCFA paid 85 contractors $1.4 billion to process more than half a billion Medicare claims. This report presents GAO's evaluation of (1) HCFA's implementation of this policy and (2) the policy's impact on Medicare claims processing.

GAO summarized this report in testimony before the Congress; see Medicare: Shared Systems Policy Inadequately Planned and Implemented (GAO/T-IMTEC-92-11, Mar. 18, 1992), by Frank Reilly, Director of Human Resources Information Systems Issues, before the Subcommittee on Oversight and Investigations, House Committee on Energy and Commerce.

Medicare: Third Status Report on Medicare Insured Group Demonstration Projects (GAO/HRD-92-53, Jan. 29, 1992)

Under an ongoing demonstration project authorized by 1987 legislation, a maximum of three employment-related groups, such as employers or unions, can agree to pay for Medicare beneficiaries' covered health care services in exchange for a fixed-per-capita payment from Medicare. The idea was that such projects, which are known as Medicare Insured Groups, could combine Medicare benefits with supplemental ones offered by an employer or union and reduce costs for both by managing the combined benefits better than could be done separately.

In this third status report on the projects, GAO reported that three companies had completed studies about the feasibility of establishing Medicare Insured Groups for their retirees. Two of the companies decided not to develop such group projects because of concerns that the operations might not be financially viable. The other company has submitted a proposal to develop a group project, which was being evaluated by Medicare administrators. Two additional Medicare Insured Group projects are active. In December 1990, a health care provider began trying to pool a group of employers to form a group project, and a year later was continuing this effort. A union-related Medicare Insured Group project continues to develop the health network necessary for the group project to become operational.

Medigap Insurance: Insurers Whose Loss Ratios Did Not Meet Federal Minimum Standards in 1988-89 (GAO/HRD-92-54, Feb. 28, 1992)

The percentage of premiums returned to Medigap insurance policyholders as benefits (called the loss ratio) for both 1988 and 1989 were 75 percent for policies sold to groups and 60 percent for policies sold to individuals. In 1988, 335 companies collected $7.3 billion in premiums for Medigap policies. By 1989, these numbers had increased to 348 companies and $8.1 billion. GAO found that 10 percent of premiums in 1988 (or $388 million) were for policies from companies that did not meet the loss ratio standards. By 1989, this had risen to 17 percent (or $805 million). As of November 1991, insurers must grant refunds or credits to policyholders in amounts sufficient to raise loss ratios to the standards. If this federal requirement had been in effect in 1988-89, policyholders would have been entitled to about $75 million in refunds or credits.

Housing

Public Housing: Housing Persons With Mental Disabilities With the Elderly (GAO/RCED-92-81, Aug. 12, 1992)

The mentally disabled occupy about 9 percent of the public housing units for the elderly that GAO studied, and the number of such individuals housed among the elderly appears to be on the rise. Public housing authorities report that people in almost one-third of those households cause serious problems like threatening other tenants and having disruptive visitors. Although about 78 percent of public housing authorities say that mental health services are provided in their communities, the extent to which public housing residents avail themselves of such services is unclear. Agreements between public housing authorities and local mental health services, however, have helped to deliver needed mental health care to public housing residents with disabilities. The rights of the mentally disabled to live in federally subsidized housing primarily serving the elderly vary by federal program. Excluding the nonelderly mentally ill from public housing for the elderly or from section 8 rental housing would violate the antidiscrimination requirements of the Fair Housing Act and the Rehabilitation Act of 1973.

Income Security

District's Workforce: Annual Report Required by the District of Columbia Retirement Reform Act (GAO/GGD-92-78, Mar. 31, 1992)	The District of Columbia Retirement Reform Act provides for annual federal payments to a retirement fund for D.C. police officers and firefighters. To encourage the District Government to control disability retirement costs, these payments are to be reduced when the disability retirement rate exceeds an established limit. GAO reviewed a report prepared by an enrolled actuary on the District's disability retirement rate and concludes that no reduction is required in the fiscal year 1993 federal payment to the District's police and firefighters' retirement fund.
Employee Benefits: Financing Health Benefits of Retired Coal Miners (GAO/HRD-92-13OFS, July 22, 1992) and Employee Benefits: Financing Health Benefits of Coal Industry Retirees (GAO/HRD-92-137FS, July 22, 1992)	These two fact sheets provided information on proposed legislation in the 102nd Congress concerning financing health benefits for retirees in the coal industry, an issue that has sparked considerable interest because of shortfalls in the two trusts that are providing benefits. GAO responded to questions about the characteristics of the trusts' beneficiaries, the benefits provided, and the present and projected financial condition of the trusts. The first fact sheet focus solely on benefits accruing to retired coal miners, while the second examines benefits accruing for coal industry retirees in general, including miners and white-collar workers.
Financial Audit: Pension Benefit Guaranty Corporation's 1991 and 1990 Financial Statements (GAO/AFMD-92-35, Mar. 2, 1992)	This report presents the results of GAO's attempt to audit the Pension Benefit Guaranty Corporation's (PBGC) financial statements for 1991 and 1990. Included is GAO's disclaimer of opinion on PBGC's 1991 financial statements and a description of weaknesses in internal controls and financial systems that continue to limit PBGC's ability to prepare reliable financial statements. PBGC has made a commitment to correct the weaknesses, and this report describes PBGC's efforts. It also discusses PBGC's reported financial condition and operations, which continued to deteriorate during the fiscal year. Reflecting a $600 million loss, the guaranty fund's deficit grew to more than $2.5 billion. In addition, the fund is increasingly exposed to underfunded plans sponsored by companies facing severe financial difficulty. While PBGC reports more than $5 billion in cash and invested assets on hand to pay future benefits and other operating needs, the continuing growth in the unfunded deficit raises concern about PBGC's ability to meet its long-term benefit obligations.

Financial Audit: System and Control Problems Further Weaken the Pension Benefit Guaranty Fund (GAO/AFMD-92-1, Nov. 13, 1991)

Serious financial system deficiencies and internal control weaknesses prevent the Pension Benefit Guaranty Corporation from preparing reliable financial statements. These conditions seriously affect the Congress' ability to assess whether PBGC's premium levels are adequate to meet its long-term obligation to pay timely and uninterrupted benefits on terminated plans. PBGC's reported financial condition as of September 30, 1990, while unaudited, indicates that it faces an uncertain financial future. While PBGC still has enough assets to meet its near-term benefit payment obligations, it reported an operating loss of $780 million for fiscal year 1990, increasing its accumulated deficit to $1.8 million. This deficit has arisen because PBGC's premiums and invested assets have not covered its losses and other operating expenses. In keeping with the self-financing nature of the guarantee program, sponsors of ongoing pension plans will be expected to fund the accumulated deficit in addition to financing the future cost of the guarantee program. During economic downturns like the current recession, the combination of falling investment values and an increased potential for losses from termination of underfunded pension plans places PBGC's financial condition at increased risk. Economic downturns tend to increase the risk posed by underfunded plans in distressed industries, such as steel, automobiles, and airlines, and PBGC's financial future will largely depend on the economic health of these industries. GAO is concerned that the ongoing weaknesses at PBGC reveal an ineffective management commitment to establishing and maintaining internal controls and financial systems.

These weaknesses, along with PBGC's accumulated deficit and possible future losses for underfunded ongoing pension plans, have led GAO and the office of Management and Budget to include PBGC on their respective lists of "high-risk" agencies and programs.

Pension Plans: Survivor Benefit Coverage for Wives Increased After 1984 Pension Law (GAO/HRD-92-49, Feb. 28, 1992)

In 1989, about 3 million widowed Americans aged 65 and over received survivor benefits on the basis of the pension of a deceased spouse. Women comprised virtually all benefit recipients and received on average about twice the benefits of men with survivor benefits. Although most of these women also received social security, they were far less likely to have a pension based on their own employment. For many widows, survivor benefits from their husbands' pension plan constituted a significant part of the retirement income received from employment-based sources. Millions of spouses will receive survivor benefits if they outlive married retired workers. As of 1989, about 3 of 5 million pensioners had retained the joint and survivor annuity. Moreover, because more men than women earn

pensions and keep the joint and survivor annuity, wives have a greater chance of receiving survivor benefits than do husbands. Survivor benefit coverage for wives of private-pension retirees has increased since the 1984 Retirement Equity Act, as evidenced by a 15-percent rise in the rate at which married men retained the joint and survivor annuity after the legislation's spousal consent requirement took effect.

Premium Accounting System: Pension Benefit Guaranty Corporation System Must Be an Ongoing Priority (GAO/IMTEC-92-74, Aug. 11, 1992)

The Pension Benefit Guaranty Corporation insures the pension benefits of more than 40 million Americans participating in about 85,000 private-sector plans. Although PBGC has an automated premium accounting system to process and account for the insurance premiums received from plan sponsors, this system has not been fully operational since 1988, when PBGC unsuccessfully tried to modify it in response to new legislative requirements. This failure is due mainly to insufficient management attention to efforts to modify the current system and procure a replacement system. PBGC, acknowledging this weakness, instituted an interim solution in July 1992 to beef up senior management oversight of the premium accounting system initiative. This is a step in the right direction, but PBGC must continue to make management of the system an ongoing priority, even after the replacement system is in place.

Private Pensions: IRS Efforts Underway to Improve Spousal Consent Forms (GAO/HRD-92-31, Dec. 20, 1991)

In 1989, GAO reported on the need for informative and understandable spousal consent forms for private pension plans. Since then, IRS has published two pamphlets to inform spouses about survivor benefits but has neither required employers to include the information GAO recommended on spousal consent forms nor developed nontechnical language examples. In December 1991, however, the Internal Revenue Service began work on regulations that would require forms to contain the needed information—including the survivor benefit's estimated dollar amount and the consequences of waiving the benefit. IRS has also started to develop language examples. In GAO's view, consent forms should also state (1) that the spouse's decision to waive survivor benefits is voluntary and (2) whether a spouse has the right to revoke an earlier decision. This information would further help spouses make well-informed decisions about survivor benefits. IRS has agreed to consider requiring this information on consent forms in its regulations.

Social Security: Causes of Increased Overpayments, 1986 to 1989 (GAO/HRD-92-107, Sept. 28, 1992)

GAO reported in July 1991 (GAO/HRD-91-46) that the amount of newly detected benefit overpayments by the Social Security Administration (SSA) had increased from $1 billion in 1986 to nearly $1.5 billion in 1989. Several factors account for the $500 million increase. First, a one-time accounting adjustment to SSA overpayment records cut the amount of overpayment detections in 1986 from about $1.3 billion to $1 billion. This $340 million adjustment accounts for 68 percent of the increase. Second, SSA estimates that an operational improvement enhanced overpayment detection by about $100 million, or 20 percent of the increase. Growth in the number of people receiving benefits along with increases in benefit levels accounts for the small remaining increase in overpayment detections. Although staff reductions could have led to increases in overpayments, GAO found no evidence to support this.

Social Security: Need for Better Coordination of Food Stamp Services for Social Security Clients (GAO/HRD-92-92, Sept. 25, 1992)

When seeking government services, the poor often confront fragmented delivery systems. Too often, those most in need have no idea what services are available to them or how to obtain them; many take advantage of only those services offered by the first agency they contact. To boost the use of food stamps by eligible Social Security clients, the Congress passed the Food Stamp Act of 1977. This legislation requires government agencies to work together to make food stamp services readily available at Social Security Administration offices. SSA has not, however, adequately carried out its responsibilities. It has taken relatively few food stamp applications from the Social Security clients that the Congress sought to help. Currently, SSA uses posters and brochures in its offices to inform the public of food stamp availability. Yet many offices do not have such displays. Moreover, this approach will not reach the millions of people who apply for benefits by telephone. In addition, the use of unnecessarily complex food stamp application forms impedes the delivery of services. In GAO's view, the Department of Health and Human Services and the Department of Agriculture need to develop jointly a plan for dealing with the shortcomings in how food stamps are offered to Social Security clients. Further, the two agencies need to update the Congress on their progress and any need for legislation to remove obstacles to providing quality service.

Social Security: Reconciliation Improved SSA Earnings Records, but Efforts Were Incomplete (GAO/HRD-92-81, Sept. 1, 1992)

A 1987 GAO report noted that employers had reported $58 billion more in social security wages to the Internal Revenue Service than to the Social Security Administration. As a result, millions of workers may be shortchanged when their social security benefits are calculated because they were never credited for wages they had earned and paid social security taxes on. In addition, billions of dollars provisionally credited by the Department of the Treasury to the social security trust fund were not supported by SSA's records. Considerable progress has been made in addressing the differences between wages reported to SSA and IRS, although the reconciliation process would have been more successful had IRS met all of its commitments to share wage data. Its delays in setting up a penalty program caused IRS to overrun a statute of limitations on applying such penalties. IRS did not effectively institute provisions to help prevent known causes of reporting differences and arbitrarily limited the number of referred SSA cases that it worked on. In addition, SSA needs to do more to prevent employer reporting problems. Also unresolved is the trust fund problem arising from differences in SSA and IRS records. After reconciliation, more than $65 billion in wage differences remain for 1978-86 cases. Thus, about $9 billion credited to the trust funds—social security taxes on the unreconciled wages—are not supported by SSA's earnings records. GAO concludes that funding of the trust funds should be based on the amount of social security taxes collected.

Social Security: Reporting and Processing of Death Information Should Be Improved (GAO/HRD-92-88, Sept. 4, 1992)

Prompt receipt and processing of information about dead beneficiaries by the Social Security Administration (SSA) is crucial to preventing SSA overpayments. SSA's death information is also valuable to other federal agencies in preventing millions of dollars in overpayments to deceased beneficiaries. This report discusses (1) how long it takes family members, states, and others to report deaths to SSA; (2) how long it takes SSA to stop payments once a death is reported; and (3) whether delays in reporting and processing death notices prevent SSA from recovering erroneous payments from the Department of the Treasury in a timely manner. GAO also discusses ways to improve the timeliness of death information reported to SSA.

Social Services

Administration on Aging: Operations Have Been Strengthened but Weaknesses Remain (GAO/PEMD-92-27, June 11, 1992)

Department of Health and Human Services (HHS) officials announced in April 1991 that the status of the Administration on Aging (AOA) had been elevated within the Department's organizational structure. As a result, AOA is now responsible for many administrative duties in addition to its existing programmatic functions. AOA's enhanced status means that the Commissioner on Aging is theoretically on an equal footing with other HHS division heads and that AOA's role as an advocate for the elderly should be strengthened. To assist with its new responsibilities, AOA received additional full-time staff for fiscal year 1992. AOA has also received substantial travel funds, has filled many key positions long vacant, and plans to beef up its program expertise. At the same time, however, AOA's oversight abilities remain questionable, its expertise in the regions has not been enhanced, and its plans to address program responsibilities may be inadequate. Further, the need persists to harmonize AOA's responsibilities, its program funds, and the demands of the elderly.

GAO summarized this report in testimony before the Congress; see Administration on Aging: Autonomy Has Increased but Harmonization of Mission and Resources Is Still Needed (GAO/T-PEMD-92-9, June 11, 1992), by Robert L. York, Director of Program Evaluation in Human Services Areas, before the Subcommittee on Human Resources, House Committee on Education and Labor.

Board and Care Homes: Elderly at Risk From Mishandled Medications (GAO/HRD-92-45, Feb. 7, 1992)

Board and care homes for the elderly are nonmedical, community-based facilities that provide room, meals, and some supervision of residents, including assistance with medications. In reviewing board and care homes in three states—California, Missouri, and Washington—GAO found that (1) staff receive little medication training and often violate medication-handling regulations, (2) state inspection procedures may not spot such violations, and (3) staff frequently did not keep required resident records. While resident records supported the appropriateness of medications for about half of the 35 residents GAO reviewed, they were insufficient for GAO to judge the others. GAO concludes that residents in these homes are at risk of medication errors and that the Department of Health and Human Services should help states address these medication handling issues and develop training programs.

GAO summarized this report in testimony before the Congress; see Board and Care Homes: Medication Mishandling Places Elderly at Risk (GAO/T-HRD-92-16, Mar. 13, 1992), by Joseph F. Delfico, Director of Income Security Issues, before the Subcommittee on Health and Long-Term Care, House Select Committee on Aging.

Older Americans Act: More Federal Action Needed on Public/Private Elder Care Partnerships (GAO/HRD-92-94, July 7, 1992)

A relatively new and unusual development—private corporations buying elder care services for their employees from public sector agencies—offers benefits but carries the risk of neglecting senior citizens with the greatest economic or social need. This report discusses (1) the status of state policies that permit elder care contracts between corporations and area agencies on aging and (2) whether such policies adequately ensure that their public missions will be preserved when area agencies on aging enter into corporate elder care contracts.

GAO summarized this report in testimony before the Congress; see Public/Private Elder Care Partnerships: Balancing Benefit and Risk (GAO/T-HRD-92-45, July 9, 1992), by Jane L. Ross, Associate Director for Income Security Issues, before the Subcommittee on Human Services, House Select Committee on Aging.

Veterans-DOD

Disability Benefits: Selected Data on Military and VA Recipients (GAO/HRD-92-106, Aug. 13, 1992)

This report provides information on the Defense Department's (DOD) military disability retirement and the Department of Veterans Affairs (VA) disability compensation programs. GAO discusses (1) military retirements over time, (2) the ratio of officers to enlistees receiving military retirements benefits, (3) the number of years of service military personnel have when they begin disability retirement, and (4) the number of military disability retirees also receiving VA disability compensation.

VA Health Care: Offsetting Long-Term Care Costs by Adopting State Copayment Practices (GAO/HRD-92-96, Aug. 12, 1992)

The Department of Veterans Affairs (VA) could offset more of the costs of providing nursing home and domiciliary care in VA and community facilities if the Congress allowed it to increase charges to veterans. In fiscal year 1990, VA offset less than one-tenth of one percent of its costs to provide care. In comparison, the eight states GAO visited required copayments of between 4 and 43 percent of state home operating costs. If

VA had offset similar percentages, its yearly recoveries would have been between $43 million and $464 million. State homes offset a larger percentage of their operating costs through copayments than does VA because more veterans are required to make copayments and veterans who contribute toward the cost of their care typically must make larger copayments. State homes also provide safeguards to help prevent copayments from impoverishing a veteran's spouse or dependent children and to help ensure that veterans capable of returning home retain enough financial resources to return to the community.

Veterans' Benefits: Savings From Reducing VA Pensions to Medicaid-Supported Nursing Home Residents (GAO/HRD-92-32, Dec. 27, 1991)

As a result of the omnibus Budget Reconciliation Act of 1990, the Department of Veterans Affairs should be able to reduce pensions by about $174 million annually for veterans receiving Medicaid-supported nursing home care. If pending legislation that would include survivors is passed, VA could cut pensions by an additional $296 million. The combined $470 million cost would be transferred by VA to the Department of Health and Human Services and the states under the Medicaid program, resulting in a net federal savings of about $202 million annually. Passage of the bill would treat veterans and survivors in the same way. VA has not fully implemented the 1990 act. By not adequately controlling the case review process, VA did not reduce all affected veterans' pensions. VA is planning changes that eventually should identify all veterans' cases in which pensions should be reduced. If the proposed legislation reducing survivor benefits passes, significant savings could result. Thus, VA should revise its procedures to better ensure that survivor cases are reviewed and pensions reduced in a timely manner. VA also needs to improve its explanation of pension reductions to persons affected.

Fiscal Year 1992 GAO Reports on Issues Affecting Older Americans and Others

GAO issued 56 reports in fiscal year 1992 on policies and programs in which older Americans were one of several target groups. Of these, 4 were on employment, 22 on health, 4 on housing, 2 on income security, 20 on veterans issues, and 4 on other issues.

Employment

The Changing Workforce: Comparison of Federal and Nonfederal Work/Family Programs and Approaches (GAO/GGD-92-84, Apr. 23, 1992)

The tremendous growth in the number of women in the nation's workforce in recent decades has dramatically affected both government and private-sector employment. Most husbands and wives now work, so many families with children or elderly parents no longer have a caregiver at home during working hours. Yet traditional human resources policies are ill equipped to help workers balance work and family responsibilities. For example, federal employees are now prohibited from using any of their sick leave to care for parents with Alzheimer's disease. GAO found that nonfederal employers generally approach work/family issues strategically, establishing work/family offices or positions and forging their programs into an integrated support system designed to improve recruitment, retention, and productivity. In contrast, while individual federal agencies have undertaken work/family initiatives, no governmentwide work/family strategy exists. The federal government offers many of the same kinds of work/family programs found in the private sector, but the federal programs are often not as family supportive or fully utilized as they could be. Some programs are unavailable to federal workers. The primary barriers to such programs are cost, a lack of statutory or regulatory authority, and concerns about their appropriateness for federal employees. Nonfederal officials offered many suggestions on how to assess the need for and implement work/family programs.

The Changing Workforce: Demographic Issues Facing the Federal Government (GAO/GGD-92-38, Mar. 24, 1992)

A highly publicized 1987 report, Workforce 2000: Work and Workers for the 21st Century, issued dire warnings for the nation's employers in the next century, highlighting tight labor markets, mismatches between job requirements and workers' skills, and dramatic demographic changes. A companion report made similar predictions for the federal government. In examining the reports' implications for federal policymakers and workforce planners, GAO found that labor economists and other experts disagree that labor shortages and skill gaps are likely by the year 2000. Experts generally agree, however, that the demographic composition of

the labor force has changed and will continue to do so in the future. While many of these workforce changes and conditions seem to be more prevalent in the federal workforce, federal workforce planners should not assume that labor shortages and skill gaps are a given. GAO believes that changes in the number of women, minorities, and older workers in the federal government can be addressed through a variety of human resources programs, such as child care, flexible work schedules, and diversity training.

Federal Employment: How Federal Employees View the Government as a Place to Work (GAO/GGD-92-91, June 18, 1992)

GAO surveyed a random sample of government employees during 1991 about what their experiences in working for the government had been, how employment conditions compared with their expectations before they started working, what plans they had for staying or leaving, and what their views on possible employment policy changes were. While many employees believe that the government's employment programs fall short in meeting their needs, the many positive aspects of federal employment pointed out by the respondents are encouraging. For example, most respondents indicated that their work is more important than they thought when starting out in government—a belief that could help improve the public perception of government employment. Similarly, the willingness of many older workers to extend their careers if given the right incentives suggests that older workers could help meet future employment needs. The respondents' desire for more flexibility in federal employment programs, including flexitime, expanded leave sharing, and child care, indicates that government could be a much more attractive employer if it were to help employees balance work and family responsibilities.

Federal Workforce: Agencies' Estimated Costs for Counseling and Processing Discrimination Complaints (GAO/GGD-92-64FS, Mar. 26, 1992)

How much do federal agencies spend on discrimination complaint counseling and formal discrimination complaint processing? For this fact sheet, GAO surveyed 29 departments and agencies to find out how much they spent to counsel people, investigate and reach decisions on complaints, and generally administer the discrimination complaint processing system. GAO found that they spent about $139 million in fiscal year 1991, most of which went for counseling ($40 million) and performing original investigations of formal complaints of discrimination ($39 million). Most counseling took place before any formal complaint was filed. About one out of four individuals who were counseled later filed a formal complaint.

Health

Access to Health Care: States Respond to Growing Crisis (GAO/HRD-92-70, June 16, 1992)

States have taken the lead in expanding access to health insurance and containing the growth of health care costs. They have had a difficult time, however, overcoming federal legislation preempting state authority to regulate self-insured employer health plans. States that have tried to move toward coverage of all their citizens have had to work within the constraints of the federal law. One strategy used by Massachusetts and Oregon has been to create "play or pay" systems that rely on the state's power to tax. Employers who provide health insurance to employees generally receive a credit for the amount they spend on coverage; those who do not must pay a tax to help finance state-brokered insurance. These laws are expected to face legal challenges, however, and the outcome is uncertain. Some state initiatives have been more narrowly focused, creating programs to help specific groups, such as low-income children and adults. These programs have successfully extended coverage to some residents, but state budget problems have meant that only a fraction of the uninsured population is being served. State efforts to help the medically uninsurable and small business employees gain access to coverage through the private health insurance market have also achieved modest results. In addition, some states have implemented payment reforms to control medical inflation and reduce administrative costs. Maryland, for example, has lowered cost growth through its hospital rate-regulation system.

Access to Health Insurance: State Efforts to Assist Small Businesses (GAO/HRD-92-90, May 14, 1992)

Recognizing that employees of many small firms cannot obtain health insurance, states have increasingly sought to make health insurance for small businesses more affordable and accessible. Because of the difficulties in marketing new insurance policies to small firms and because most of the reforms have been introduced during the recession, it is too soon to tell whether the reforms will increase insurance coverage. Budget problems are limiting states' ability to adopt reform measures requiring substantial state subsidies or funding. As a result, states are tending to focus on reforms involving little or no cost to the state treasury. These reforms attempt to correct several serious problems in the market but have yet to significantly increase the number of small business employees with health insurance. Initiatives requiring state subsidization of the small business market are rarer, tend to be limited in scope and duration, and have produced limited results. Attempts to lower the cost of insurance by

waiving state-mandated benefits have also produced only modest employer responses. Ultimately, small business market reforms may do little to make health insurance more affordable because they do not address the underlying growth in health costs. Advanced medical technology, the cost of uncompensated care to hospitals, medical malpractice insurance costs, and consumer trends in buying medical services are among the major factors driving the costs of health care.

GAO summarized this report in testimony before the Congress; see Access to Health Insurance: States Attempt to Correct Problems in Small Business Health Insurance Market (GAO/T-HRD-92-30, May 14, 1992), by Mark V. Nadel, Associate Director for National and Public Health Issues, before the Subcommittee on Health and the Environment, House Committee on Energy and Commerce.

Breast Cancer, 1971-91: Prevention, Treatment, and Research (GAO/PEMD-92-12, Dec. 11, 1991)

Twenty years ago, President Nixon launched the "war on cancer" with the signing of the National Cancer Act. This report reviews progress in prevention and treatment of breast cancer over the past two decades and determines what kinds of research are needed to help prevent breast cancer and improve survival rates. GAO concludes that while many breast cancer patients are living longer and their quality of life has improved, the struggle against the "dread disease" has not been won. The expectation is that the coming year will see more women stricken with the disease and more women dying from it than two decades ago. On the positive side, medical detection, diagnosis, and treatment of breast cancer have improved because of widespread availability of technologies like mammography. In addition, breast cancer surgery has been refined, with the Halstead, or radical mastectomy—and its disfiguring results—becoming much rarer. However, GAO concludes that gaps in fundamental knowledge of breast cancer (causes and their mode of operation) are critical obstacles to more effective detection, diagnosis, and treatment. Further, identifying chains of events leading to the onset of breast cancer and learning how to interrupt those sequences are the primary prerequisites for preventive measures.

GAO summarized this report in testimony before the Congress; see Breast Cancer: Progress to Data and Directions for the Future (GAO/T-PEMD-92-4, Dec. 11, 1991), by Richard L. Linster, Director for Planning and Reporting in the Program Evaluation and Methodology Division, before the Subcommittee on Human Resources and Intergovernmental Affairs, House Committee on Government Operations.

Canadian Health Insurance: Estimating Costs and Savings for the United States (GAO/HRD-92-83, Apr. 28, 1992)	In a June 1990 report (GAO/HRD-91-90), GAO noted that if the United States were to adopt key elements of the Canadian health insurance system—universal insurance with no deductibles or copayments, controls on provider reimbursement, and administration by a single, public payer—the administrative savings could offset any added costs associated with a Canadian-style system. GAO updates that work with a detailed discussion of how it arrived at its estimates. Although analyses of how U.S. health spending would change under a Canadian-style system generally suggest that administrative savings could be significant, estimates vary more widely on possible costs arising from eliminating copayments. GAO compares these studies and the range of estimates. GAO also presents detailed information on the methodology it used to develop its savings and cost estimates for a Canadian-style system.
Community Health Centers: Administration of Grant Awards Needs Strengthening (GAO/HRD-92-51, Mar. 18, 1992)	The Community and Migrant Health Center program helps obtain adequate health care for people who would otherwise be without it. In fiscal year 1990, the Congress appropriated $530 million to support about 550 health center grantees under the program. In reviewing the Bureau of Health Care Delivery and Assistance's policies and procedures for awarding grants to health centers and national associations, GAO found that the Bureau has deviated from legislative and agency grant requirements concerning competitive awards, funding levels, and application reviews.
D.C. Government: District Medicaid Payments to Hospitals (GAO/GGD-92-138FS, Aug. 24, 1992)	A dozen hospitals in the District of Columbia filed suit against the D.C. government in October 1990, contending that the District's Department of Human Services had shortchanged them by $46 million for inpatient hospital services over a 5-year period. In a 1991 settlement, the District government agreed to pay the various claims. This fact sheet provides information on two aspects of the District of Columbia's Medicaid Program. GAO looks at (1) the causes of the legal action taken by D.C. hospitals against the Medicaid Program and (2) whether the District could be using federal Medicaid money to fund other District programs.
Drug Abuse Research: Federal Funding and Future Needs (GAO/PEMD-92-5, Jan. 14, 1992)	Federal support from the two principal agencies for drug abuse research—the Department of Health and Human Services (HHS) and the Department of Justice—increased more than 200 percent between 1980 and 1990 (more than 400 percent if funding related to acquired immunodeficiency syndrome (AIDS) is included). In contrast, outlays for national defense research and development rose by 83 percent while

nondefense research and development fell by 5 percent during that same period. Of the three categories of drug abuse research funding GAO studied—causality, prevention, and treatment—HHS' National Institute on Drug Abuse spent the most on treatment, followed by prevention and causality. Funding for studies on the causes of drug abuse has remained tiny, never exceeding .01 percent of the nation's drug control budget. The Department of Justice has spent as much on prevention studies as on causality and treatment studies combined. Expert researchers agree on the importance of more research on the psychological and social/environmental factors leading to drug abuse.

Employee Benefits: States Need Labor's Help Regulating Multiple Employer Welfare Arrangements (GAO/HRD-92-40, Mar. 10, 1992)

Rising health care costs during the last decade have made it hard for small companies to obtain health insurance for their workers, and more and more businesses have been turning to pooled funds, known as multiple employer welfare arrangements (MEWA), to provide health benefits. Many MEWAs have reneged on their obligations, however, leaving millions of dollars in medical bills unpaid and many people stranded without any insurance at all. This report focuses on (1) the nature and extent of MEWA failures to pay bills and other problems; (2) hindrances to state regulation and enforcement of MEWAs; and (3) Department of Labor efforts to prevent MEWA problems, protect MEWA participants and their beneficiaries, and assist state enforcement.

Federal Health Benefits Program: Open Season Processing Timeliness (GAO/GGD-92-122BR, July 8, 1992)

GAO reviewed the timeliness of changes to health insurance that had been requested by federal workers or retirees during "open season." Overall, GAO discovered that more than half of the 104,000 changes it reviewed were unrecorded on insurance carriers' records by the effective date of the change. Almost all changes were recorded, however, within 60 days of the effective date. Wide variation in recording changes suggests that some agencies and carriers may have better ways of processing changes than others. GAO has told the Office of Personnel Management (OPM) that recording times could be improved by using a comparison or "benchmarking" effort in which the processes used by the most timely agencies and carriers are examined. OPM agrees with GAO's suggestion and has laid out a three-part plan to improve the timeliness of processing changes.

Federal Health Benefits Program: Stronger Controls Needed to Reduce Administrative Costs (GAO/GGD-92-37, Feb. 12, 1992)

GAO believes that the administrative costs of the fee-for-service portion of the Federal Employees Health Benefits Program were higher than those costs for the other large health benefits programs GAO reviewed primarily because the carriers were not given enough incentive to cut their operational expenses. Although small in relation to benefit payments, the program's administrative costs—more than half a billion dollars in 1988—are significant. GAO estimates that the potential annual savings could range from at least $35 million in the short term, by improving Office of Personnel Management controls over the operational expenses of the fee-for-service plans, to about $200 million through legislative reforms that change the way contractors are chosen and paid. Incentives can be more effectively provided through the competitive selection of contractors. If the program were restructured to have competitively selected commercial insurers assume all or part of the insurance risk, GAO believes that the cost of the program's administrative services could be better controlled. Regardless of whether the program is legislatively reformed, however, OPM needs to do more to ensure that the carriers provide quality services at reasonable prices.

Health Care: Most Community and Migrant Health Center Physicians Have Hospital Privileges (GAO/HRD-92-98, July 16, 1992)

Most doctors at community and migrant health centers have admitting privileges at local hospitals. Those who do not often have not applied for privileges because (1) physicians prefer not to have an inpatient practice, (2) they do not meet a hospital's professional criteria, or (3) the distance from the doctor's residence or practice to the hospital is too far to allow for effective coverage of patients. In addition, 29 community and migrant health centers have no doctors with privileges. The lack of physician admitting privileges at a local hospital does not, however, prevent patients at these centers from gaining access to inpatient care. Alternative means, such as referrals to outside physicians with hospital privileges and to publicly funded hospitals, are used by the centers to help ensure that their patients have access to hospital services. Few doctors at the centers have been denied hospital admitting privileges because they failed to meet a hospital's criteria, although 42 centers indicated that they employ one or more doctors who have not applied for privileges because of doubts about whether they would meet professional or other hospital criteria.

Health Care Spending Control: the Experience of France, Germany, and Japan (GAO/HRD-92-9, Nov. 15, 1991)

France, Germany, and Japan achieve near-universal health insurance coverage with health care systems that, while extensively regulated, share three major traits with the U.S. system: (1) medical care is provided by private physicians and public hospitals, and patients are free to choose their physician; (2) most people receive health insurance coverage through their workplace; and (3) health insurance is provided by multiple third-party insurers. This report describes these countries' methods of providing universal coverage through their health insurance and financing systems, their policies intended to restrain increases in health care spending, and the effectiveness of these policies. While GAO does not endorse the specific health systems of the countries reviewed, the strengths and weaknesses in these systems could be instructive in helping resolve U.S. health care problems.

GAO summarized this report in testimony before the Congress; see Health Care Spending Control: The Experience of France, Germany, and Japan (GAO/T-HRD-92-12, Nov. 19, 1991), by Lawrence H. Thompson, Assistant Comptroller General for Human Resources Programs, before the Senate Special Committee on Aging and the Senate Committee on Governmental Affairs.

Health Care Spending: Nonpolicy Factors Account for Most State Differences (GAO/HRD-92-36, Feb. 13, 1992)

As it absorbs more and more of the national income, health care spending in the United States is coming under increasing scrutiny. Personal health care expenditures in this country totalled $585 billion, or $2,255 per capita, in 1990. Personal health care represented 10.7 percent of the U.S. gross national product in 1990, compared with 6.4 percent in 1970. To better understand what drives U.S. health care spending, this report determines the (1) per capita spending for health services in each state, (2) reasons for the differences in spending levels from one state to the next, and (3) extent to which state cost-containment policies have contributed to lowered health spending.

Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse (GAO/HRD-92-69, May 7, 1992)

Health industry officials estimate that fraud and abuse contribute to about 10 percent of the $700 billion-plus annual cost of U.S. health care. Weaknesses in the health insurance system allow unscrupulous health care providers—including medical equipment suppliers as well as practitioners—to bilk health insurance companies out of billions each year. At a time when financial ties are growing between health care facilities and the physicians who make referrals to them, health insurers, which operate independently, collaborate very little in confronting

fraudulent providers. Further, high legal costs are deterring prosecutions. If the efforts of independent private payers, public payers, and state insurance and licensing agencies as well as state and federal law enforcement agencies were better coordinated, GAO believes that the attack on health care fraud and abuse would be more fruitful. GAO recommends that the Congress establish a national health insurance fraud commission to analyze how insurers can standardize claims information and billing rules, how insurers can coordinate case development and prosecution efforts, whether and how to regulate unlicensed medical facilities, and what rules should govern physician referrals to medical facilities in which the doctor has a financial interest.

GAO summarized this report in testimony before the Congress; see Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse (GAO/T-HRD-92-29, May 7, 1992), 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.

Hired Farmworkers: Health and Well-Being at Risk (GAO/HRD-92-46, Feb. 14, 1992)

Hired farmworkers—a group of about 1.5 to 2.5 million laborers—are not adequately protected by federal laws, regulations, and programs, leaving their health and well-being at risk. Hired farmworkers often go into fields sprayed with pesticides without having any knowledge of the chemicals they are exposed to or the possible health consequences. Many farmworkers work in fields without drinking water, hand-washing facilities, or toilets—a situation with potentially serious health hazards. Young children are allowed to operate tractors and do other hazardous farm chores. In addition, they may be more susceptible than adults to the harmful effects of pesticides. Many hired farmworkers, particularly migrant farmworkers, may not get needed health care because they do not receive medical assistance from Medicaid and the Migrant Health Program. Hired farmworkers are also at greater risk than other workers of getting fewer Social Security benefits than they should, which means less financial support when they retire or become disabled.

Hispanic Access to Health Care: Significant Gaps Exist (GAO/PEMD-92-6, Jan. 15, 1992)

To make its September 1991 testimony on Hispanic access to health care more widely available, GAO has published its remarks as a blue cover report. For most Americans, the first step in accessing health care is acquiring health insurance. Hispanics, however, are much less likely than others to have such coverage. GAO found that type of employment and

income are key determinants of the high rates of noninsurance among Hispanics. Public health insurance—Medicaid—is one potential solution for persons who cannot afford private health insurance. However, Hispanics in some states, particularly Mexican-Americans, have problems in gaining access to Medicaid because of stringent state eligibility criteria. While data on the prevalence of disease among Hispanics are limited, it is clear that the high rate of noninsurance and an apparent scarcity of primary care facilities together make Hispanics particularly vulnerable to adverse health outcomes. Initial steps toward achieving a more rational health care delivery process for Hispanics involve more adequate health insurance coverage (both private and public), expanded neighborhood access to primary care, and major improvements in available data to allow appropriate planning and evaluation.

Medicaid: Oregon's Managed Care Program and Implications for Expansion (GAO/HRD-92-89, June 19, 1992)

Oregon's proposal for a managed health care delivery system that would serve more than 220,000 Medicaid clients statewide during the first year—triple the current enrollment—confronts a major hurdle in developing adequate health plan and physician capacity to handle a wave of new patients. Overall, Oregon's program has avoided many of the pitfalls encountered by other states. It is well accepted by providers and Medicaid clients, who are generally satisfied with access to and quality of care; program safeguards seem to be preventing inappropriate restrictions on health care access; and its quality assurance monitoring meets federal requirements. But GAO is concerned that Oregon may be unable to recruit enough doctors and health workers within the first year to deal with expanding patient rolls. Adequate capacity is needed if the project is to save enough money through managed care to extend Medicaid coverage to people without health insurance. In addition, the program could be improved by giving priority to improved child health screening services and by revising Oregon's client satisfaction surveys. Oregon also needs to beef up oversight of health plan insolvency and require better financial information from plans.

GAO summarized this report and discussed additional concerns about states' managed care programs in testimony before the Congress; see Medicaid: Factors to Consider in Managed Care Programs (GAO/T-HRD-92-43, June 29, 1992), 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.

Medical Malpractice: Alternatives to Litigation (GAO/HRD-92-28, Jan. 10, 1992)

Critics say the litigation system for resolving medical malpractice claims is flawed. Claims take a long time to be resolved, legal costs are high, and settlements and awards are unpredictable. In addition, many legitimate claims may never reach the courts. Frustrated by the litigation system and its impact on the costs of medical malpractice insurance, several states have passed laws establishing alternatives to litigation. This report describes voluntary arbitration, as well as other alternatives available in other states and from two private-sector health maintenance organizations—including mandatory arbitration, no-fault programs, and assessing compliance with approved standards of care.

Medical Technology: Quality Assurance Needs Stronger Management Emphasis and Higher Priority (GAO/PEMD-92-10, Feb. 13, 1992)

Despite regulations intended to prevent the production and distribution of unsafe or ineffective medical devices, some critical and life-supporting items like emergency ventilators and heart valves have been recalled from the market recently due to manufacturing defects. GAO found that the Food and Drug Administration's (FDA's) compliance program for medical devices, which assesses manufacturers' implementation of quality assurance requirements, has been plagued by weaknesses. Inspections have been too infrequent to meet statutory minimum requirements. When inspections have occurred, they often did not find problems that emerged later. When problems were identified and targeted, they often went unreported despite requirements to report them. In addition, FDA inspectors have not received enough training, and the agency's data systems contain major gaps.

GAO summarized this report in testimony before the Congress; see Medical Technology: Implementing the Good Manufacturing Practices Regulation (GAO/T-PEMD-92-6, Mar. 25, 1992), by Eleanor Chelimsky, Assistant Comptroller General for Program Evaluation and Methodology, before the Subcommittee on Oversight and Investigations, House Committee on Energy and Commerce.

Nonprescription Drugs: Over the Counter and Underemphasized (GAO/PEMD-92-9, Jan. 10, 1992)

In reviewing Food and Drug Administration regulations, GAO discovered several differences in how the agency ensures the safety and effectiveness of over-the-counter versus prescription drugs. GAO found that (1) unlike prescription drugs, many over-the-counter drugs have not been required to demonstrate their safety and effectiveness before being made available to the public; (2) during FDA inspections for compliance with current good manufacturing practices, FDA has statutory authority to inspect records and documents of prescription drug manufacturers but not those of

over-the-counter drug manufacturers; and (3) FDA collects less postmarketing surveillance information and conducts fewer product performance analyses for over-the-counter drugs than for prescription drugs. Postmarketing analyses routinely conducted for prescription drugs include patterns of usage, the magnitude of any identified problem and the appropriate level of response, and trends in adverse reactions.

Prescription Drug Monitoring: States Can Readily Identify Illegal Sales and Use of Controlled Substances (GAO/HRD-92-115, July 21, 1992)

Several hundred million doses of prescription drugs like morphine and codeine are diverted to illicit use each year, but several states have developed monitoring programs that seem to be effective in curbing the illegal practice. Drug diversions can involve the illegal sale of prescriptions by physicians, illegal dispensing by pharmacists, or "doctor shopping" by individuals who visit many doctors to obtain prescriptions. GAO reviewed the 10 existing state prescription drug monitoring programs and found that they save investigators' time and improve their productivity by providing information that allows them to identify potential cases of drug diversions. Prescription drug monitoring programs were not meant to measure their effect on reducing health care costs; however, two of the states with these programs have cut Medicaid prescription costs by an estimated $27 million over 2 years and $440,000 over 1 year, respectively. The other eight states were unable to estimate Medicaid savings. Claims by medical, pharmaceutical, and patient groups that prescription drug monitoring programs have harmed a doctor's ability to practice medicine or have compromised patient care or confidentiality have not been substantiated.

Prescription Drugs: Changes in Prices for Selected Drugs (GAO/HRD-92-128, Aug. 24, 1992)

Soaring prescription drug prices have burdened many Americans, particularly the elderly, who often must pay for these drugs out of pocket because they lack health insurance with drug benefits. Price increases for 29 widely used drugs that GAO reviewed exceeded the inflation rate for the 6-year period ended in 1991. Prices for 19 of the drugs, in fact, increased by more than 100 percent—with some surpassing 300 percent. By comparison, the rise in inflation for this same period was about 26 percent. Companies' explanations for the increases were vague and included few details because they consider information on pricing decisions to be confidential and proprietary. Among the factors they cited were increased research and development costs, expansion of manufacturing facilities, increasing product liability lawsuits, an accelerated approval process for generic drugs that shortens the period

when companies can recoup their research and development costs, and inflation.

Housing

Community Development: HUD Oversight of the Dallas Block Grant Program Needs Improvement (GAO/RCED-92-3, Nov. 27, 1991)

Newspaper articles have alleged that the city of Dallas poorly administered housing programs funded by the Dallas Community Development Block Grant program. GAO found that the Department of Housing and Urban Development (HUD) did not adequately oversee and monitor the program. This report focuses on HUD's monitoring of the city's (1) timely expenditure of program funds, (2) use of program funds for enforcement of local housing codes, (3) control over subrecipients, and (4) accounting for planning and administrative costs.

Homelessness: HUD's Interpretation of Homeless Excludes Previously Served Groups (GAO/RCED-92-226, Aug. 12, 1992)

The Department of Housing and Urban Development, under new criteria established in 1991, began limiting its funds to programs that serve people who are literally homeless, the only exception being people threatened with immediate homelessness. Although HUD has revised its guidance, some of the terms and definitions that govern HUD field offices and assistance providers remain vague. Terms describing individuals as "imminently" homeless or "in the later stages" of eviction have been interpreted differently by various HUD offices, leading to inconsistency and confusion concerning program eligibility. HUD's new eligibility criteria have made the following groups ineligible for funding: institutionalized mentally ill or retarded persons; persons doubled up with families or friends or living in substandard housing; and the rural homeless, who are often "hidden" in overcrowded or substandard housing.

Homelessness: Policy and Liability Issues in Donating Prepared Food (GAO/RCED-92-62, Dec. 9, 1991)

To what extent do federal laws, regulations, or policies hinder federal facilities like cafeterias from making prepared food that is uneaten available to the homeless? Of 14 federal departments that maintain food service facilities, 13 said that they had little unconsumed food to donate. The remaining agency—the Defense Department—has only just begun its donation policy and could not estimate how much food might be available. Almost all of the departments use food service contractors to run their facilities. These contractors are allowed to use their own discretion in donating food. None of the contractors GAO contacted had written policies

on donating unconsumed food, but they said they do donate some food on an ad hoc basis. States have enacted food donation statutes, called good samaritan laws, that provide food donors various degrees of immunity from civil or criminal liability should someone become ill after eating donated food. Federal food service facilities that choose to donate food are covered by these statutes.

Public and Assisted Housing: Linking Housing and Supportive Services to Promote Self-Sufficiency (GAO/RCED-92-142BR, Apr. 1, 1992)

This report discusses the implications of linking federal housing assistance to supportive services to promote self-sufficiency for low-income families. The Family Self-Sufficiency Program has been established within the Department of Housing and Urban Development (HUD) to promote local strategies for helping low-income families achieve greater self-sufficiency. GAO concludes that several factors will affect the evaluation and administration of the program. First, requiring public housing agencies (PHA) to report how many program participants have relinquished housing assistance and what alternatives to assisted housing they have found will permit meaningful and consistent assessments of the program's progress. Second, it is too early to tell whether HUD's proposed prohibition against the use of motivation as a factor in selecting program participants will affect how PHAs run their programs—including their ability to obtain needed support services. Finally, only limited data are available to determine the extent to which HUD's reimbursement of PHAs' administrative costs will cover the reasonable expenses that PHAs incur in running effective programs.

Income Security

Social Security: Beneficiary Payment for Representative Payee Services (GAO/HRD-92-112, June 29, 1992)

Under legislation intended to strengthen the Social Security Administration's (SSA) representative payee program, a 3-year program has been established to allow SSA-approved nonprofit groups to collect a fee from SSA beneficiaries for providing representative payee services. SSA appoints representative payees for about 5 million beneficiaries who cannot manage their own finances because of their youth or mental or physical impairments. Payees receive the benefits directly from SSA and must use them only for the beneficiaries' needs. While most payees are relatives of the beneficiaries, others may be court-appointed guardians or various public and private social service agencies. The representative payee fee program has been operating for only a short time, and its

effectiveness remains to be seen. This report discusses the advantages and disadvantages of such a fee.

Social Security: Racial Difference in Disability Decisions Warrants Further Investigation (GAO/HRD-92-56, Apr. 21, 1992)

During the past 30 years, blacks have been allowed benefits at consistently lower rates than whites under the Social Security Disability Insurance program. Under the Supplemental Security Income program, a similar racial difference has been apparent for at least the last 5 years. GAO studied the lower allowance rate among blacks and found that, within the general population, blacks were receiving benefits at a higher rate than whites; within the severely impaired population, blacks were receiving benefits at a rate comparable to that of whites. This is so notwithstanding the lower allowance rate among blacks who apply for benefits each year. For the most part, the lower black allowance rate in 1988 initial decisions for the two programs appears to be due to black applicants having less severe impairments and being younger than whites. For Supplemental Security Income applicants aged 18 to 24, however, the racial difference in initial decisions was almost twice that of any other age group. The racial difference was largely unexplained by differences in severity and type of impairment or in demographic characteristics.

Veterans-DOD

Defense Health Care: CHAMPUS Mental Health Benefits Greater Than Those Under Other Health Plans (GAO/HRD-92-20, Nov. 7, 1991)

The Department of Defense's (DOD) Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) pays for a substantial portion of the health care that civilian hospitals, physicians, and other providers give to DOD beneficiaries. This report compares the benefits for mental and substance abuse treatment available under CHAMPUS with similar benefits under private-sector plans and under the Federal Employees Health Benefits Program.

Defense Health Care: Implementing Coordinated Care—a Status Report (GAO/HRD-92-10, Oct. 3, 1991)

The Department of Defense health care costs have been escalating rapidly, particularly in the Civilian Health and Medical Program of the Uniformed Services, where costs increased from $1.4 billion in fiscal year 1985 to an estimated $3.6 billion in fiscal year 1991. In June 1990, DOD unveiled a plan, to be implemented over three years, for containing health care costs and improving beneficiaries' access to high-quality care. Coordinated Care, the plan's centerpiece, will essentially transform military health care into a

system of managed care similar to health maintenance organizations. Building on earlier testimony before the Congress (GAO/T-HRD-91-14), this report concludes that DOD has made significant advances in moving to a managed health care system, particularly in light of the magnitude and complexity of the undertaking. However, the effort is behind schedule because many complex organizational details and some policies still need to be developed and decided upon. For example, it is unclear exactly what will be expected of military hospital commanders or what additional resources will be needed to implement the program. One important issue raised by GAO in its March testimony—the need to provide for uniform benefits and cost sharing—is not addressed in the current Coordinated Care program. Enrolled beneficiaries who are able to get their medical care at a military hospital will pay less than $10 a day for inpatient service, while those who must use civilian providers will pay a large part of the bill, usually 25 percent.

Medical ADP Systems: Composite Health Care System Is Not Ready to Be Deployed (GAO/IMTEC-92-54, May 20, 1992)

Development problems with the Defense Department's plan to automate medical records at hundreds of military facilities worldwide could be jeopardizing patient safety as a result of doctors providing improper care, such as prescriptions, lab work, or radiation therapy, on the basis of incomplete information. GAO concludes that the Composite Health Care System, which is intended to improve the quality of DOD health care by integrating data used to manage and treat patients, is not ready to be deployed. Two critical system development and operational problems remain unresolved—multiple patient records and archiving of patient records. Clinical users often face slow response times, and limited progress has been made in developing an efficient way to enter doctors' inpatient orders. In addition, the scope and quality of system testing have been inadequate, and test results are inconclusive. Until DOD corrects these deficiencies, operational problems will persist and patient well-being may be threatened. Cost estimates for the system now exceed the $1.6 billion congressional cost cap by $400 million. Given its importance to U.S. servicemen and women, the system must meet development requirements to establish its safety and effectiveness and to ascertain that it is the most reasonable alternative for delivering needed medical support.

VA Health Care: Alternative Health Insurance Reduces Demand for VA Care (GAO/HRD-92-79, June 30, 1992)

Demand for inpatient services offered by the Department of Veterans Affairs (VA) could drop by about 18 percent if employers nationwide were required to either provide health insurance for their workers or pay a tax that would be used to obtain coverage. Similarly, demand for VA outpatient services could drop by about 9 percent. Demand for VA-sponsored nursing home care, however, would be largely unaffected because most reform proposals provide limited long-term care coverage. Under a nationwide universal health plan, the impact could be even greater, with demand for VA inpatient care plummeting by about 47 percent. Likewise, use of VA outpatient care could drop by about 41 percent. The actual decrease, including the impact on nursing home usage, could vary significantly depending on the type of universal coverage program adopted. Although many veterans would continue to seek VA treatment, the magnitude of the likely decrease in demand for VA-sponsored health care—should either employer mandates or universal coverage be enacted—suggests that the VA health system should be included in any debate on American health care reform.

VA Health Care: Compliance With Joint Commission Accreditation Requirements Is Improving (GAO/HRD-92-19, Dec. 13, 1991)

In April 1990, the Joint Commission on Accreditation of Healthcare Organizations told the Department of Veterans Affairs that VA medical centers did significantly worse than non-VA hospitals in accreditation surveys done from 1987 to 1989. These surveys also showed that medical centers failed many key quality assurance elements more often than their non-VA counterparts. GAO found that VA medical centers surveyed in 1990 did substantially better than those surveyed in 1989. In addition, their overall compliance scores were close to those received by non-VA hospitals in 1990. Also, VA medical centers scored substantially higher on many key quality assurance elements that constitute the overall scores. This was a direct result of efforts by the VA central office, regional offices, and individual medical centers to ensure that medical centers were following Commission requirements and properly documenting their quality assurance activities.

VA Health Care: Copayment Exemption Procedures Should Be Improved (GAO/HRD-92-77, June 24, 1992)

The Department of Veterans Affairs is supposed to collect a fee, or a copayment, whenever it provides health care to veterans with incomes above a certain level. Vietnam veterans, however, are exempt from this requirement when being treated for medical conditions possibly related to Agent Orange exposure. The six medical centers GAO visited are not adequately evaluating the copayment status of Vietnam veterans claiming exposure to Agent Orange. This situation may be resulting in lost

copayment revenues and unequal treatment of Vietnam veterans. Five of the centers routinely exempt all veterans who claim exposure without determining the validity of such claims. The other center routinely requires all veterans who claim exposure to comply with the copayment requirements, potentially depriving them of exemptions to which they are entitled. GAO estimates that the 159 centers could have collected as much as $2 million more in copayments in 1989 had physicians determined that treated conditions were unrelated to Agent Orange exposure.

VA Health Care: Delays in Awarding Major Construction Contracts (GAO/HRD-92-111, June 11, 1992)

The Department of Veterans Affairs (VA) fiscal year 1991 appropriation included funding for 16 major construction projects, each estimated to cost $3 million or more. The law mandates that working drawings contracts and construction contracts be awarded by certain deadlines. In a March 1992 letter to the Congress, VA pointed out 14 projects in which working drawings or construction contracts had not been awarded by the required deadlines. GAO does not believe that the contracting delays for the 14 projects constitute an impoundment of budget authority under the Impoundment Control Act. VA's actions, in GAO's view, show no intent to refrain from using the funds. The reasons most often cited by VA for the delays were (1) changes in the projects' scope or design, (2) receipt of bids exceeding the funds available, and (3) the fact that projects were funded before preliminary design work was completed. VA has awarded or expects to award contracts for 7 of the 14 projects by September 30, 1992.

VA Health Care for Women: Despite Progress, Improvements Needed (GAO/HRD-92-23, Jan. 23, 1992)

The Department of Veterans Affairs has made significant progress since 1982—when GAO last reported on this issue (see GAO/HRD-82-98)—in ensuring that female veterans receive the same access to health care as male veterans. The increased emphasis on identifying and correcting problems concerning care for women veterans followed both the creation of an Advisory Committee on Women Veterans at the VA Central Office and the appointment of a women veterans coordinator at each medical center. Yet problems remain. Physical examinations for women veterans, including cancer screenings, remain sporadic. VA medical centers are inadequately monitoring their in-house mammography programs to ensure compliance with quality standards. Center procedures are inadequate to ensure that patient privacy limitations affecting women patients are identified and corrected during facility renovations. VA medical centers could improve compliance with physical examination requirements if the VA Central Office ensured that information about best practices is disseminated and, where appropriate, implemented throughout the system.

VA Health Care: Inadequate Controls Over Scarce Medical Specialist Contracts (GAO/HRD-92-114, July 29, 1992)

More than 100 Department of Veterans Affairs medical centers contract with outside medical specialists, mainly for radiology and anesthesiology services. Contracting costs have mushroomed from $17 million in fiscal year 1985 to more than $80 million in fiscal year 1991. The VA Inspector General, citing inadequate contracting procedures as the cause, reported in 1987 that the medical centers were paying millions of dollars for services that either were unneeded or had never been delivered. VA needs to strengthen its oversight of medical specialist contracts. Due to a lack of data and evaluation criteria for contract proposals, however, it cannot identify medical centers with contracting problems. VA recognizes that major weaknesses persist in contracting for medical specialists and expressed a commitment to making necessary improvements.

GAO summarized this report in testimony before the Congress; see VA Health Care: Inadequate Controls Over Scarce Medical Specialist Contracts (GAO/T-HRD-92-50, Aug. 5, 1992), by David P. Baine, Director of Federal Health Care Delivery Issues, before the Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs.

VA Health Care: Modernizing VA's Mail-Service Pharmacies Should Save Millions of Dollars (GAO/HRD-92-30, Jan. 22, 1992)

The Department of Veterans Affairs could save millions of dollars by modernizing its mail-service pharmacies. Currently, VA runs too many mail-service pharmacies, which rely on labor-intensive processing of veterans' prescriptions. Also, because VA's pharmacies fill prescriptions in small quantities that are uneconomical, they incur unnecessary handling costs. VA recently began studying ways to change the basic structure of its mail-service pharmacies. The VA study, however, lacks an assessment of optimal prescription-dispensing quantities. VA will be unable to implement a systemwide modernization plan that maximizes cost savings unless it dispenses prescription medications in economical amounts.

VA Health Care: the Quality of Care Provided by Some VA Psychiatric Hospitals Is Inadequate (GAO/HRD-92-17, Apr. 22, 1992)

None of the four Department of Veterans Affairs (VA) psychiatric hospitals GAO visited is effectively collecting and using quality assurance data on a consistent basis to identify and resolve quality-of-care problems in the psychiatric and medical care that patients are receiving. As a result, questionable psychiatric practices may go unnoticed, and medical procedures or practices that are known to have contributed to deaths or medical complications may continue. VA and non-VA hospital systems GAO visited, both psychiatric and acute medical/surgical, differ little in their approach to identifying quality-of-care problems. The quality assurance mechanisms each uses to make sure that quality-of-care standards are met

are similar because most use the Joint Commission on Accreditation of Healthcare Organizations as its primary external review group. Further, many of the problems discovered in VA hospitals have also been found in non-VA hospitals.

VA Health Care: Use of Private Providers Should Be Better Controlled (GAO/HRD-92-109, Sept. 28, 1992)

The Department of Veterans Affairs continues to grapple with soaring medical costs. In fiscal year 1990, the agency spent about $112 million for outpatient medical care purchased from private health care providers on a fee-for-service basis. GAO found that VA is not adequately controlling medical centers' purchases of private outpatient medical care for veterans. Centers may turn to private providers only if the needed care is unavailable at the VA center or private providers are less expensive due to geography. VA, however, has not issued clear guidance to medical centers on how this requirement should be implemented. As a result, the cost-effectiveness of private care has not been evaluated, and centers may be needlessly buying millions of dollars of medical care from private providers when the care could be more economically delivered in VA facilities.

VA Health Care: VA Did Not Thoroughly Investigate All Allegations by the Froelich Trust Group (GAO/HRD-92-141, Sept. 4, 1992)

In an April 1991 letter to the Department of Veterans Affairs, an anonymous group of veterans, known as the Froelich Group, made a series of allegations about the Veterans Health Administration's (VHA) medical information resources management. Included were accusations that (1) software contained inaccurate patient records and (2) staff submitted fraudulent time and attendance reports and abused government funds. VHA's Medical Inspector did not thoroughly address the Froelich allegations about inaccurate medical data, including the effect of VA's software integration practices on the accuracy of its automated databases. The scope of the Inspector General's investigation into inaccurate medical data was too narrow. The review of software integration practices merely described VA's existing processes, and the Medical Inspector did not follow up on the large number of incomplete paper medical records identified during his review. VHA did substantiate several of the Froelich Group's claims, including allegations that the Decentralized Hospital Computer Program is slow and not user friendly and that its order entry/results reporting software does not follow physician logic. VA's Inspector General thoroughly investigated allegations about employee malfeasance, including a charge that the director of one center verbally abused employees. This allegation was substantiated when more than half of the

staff said that they either had seen or had been subject to verbal abuse; the rest of the allegations could not be substantiated.

VA Health Care: VA Plans Will Delay Establishment of Hawaii Medical Center (GAO/HRD-92-41, Feb. 25, 1992)

The Department of Veterans Affairs (VA) has no hospital in Hawaii, and because of this the acute care needs of veterans have traditionally been met through a VA sharing agreement with Tripler Army Medical Center and contracts with community hospitals. VA has plans on the drawing board for a medical center in Hawaii. With respect to the planned medical center, this report discusses whether (1) VA could increase its presence in Hawaii and provide acute and long-term care services to the state's veterans sooner than currently planned, (2) VA has accurately projected its acute care bed needs in light of the Hawaii health insurance mandates, and (3) excess bed capacity exists at Tripler Army Medical Center that could be used to meet those needs.

VA Health Care: Verifying Veterans' Reported Income Could Generate Millions in Copayment Revenues (GAO/HRD-92-159, Sept. 15, 1992)

Each year, the Department of Veterans Affairs provides medical care to about one million veterans whose disabilities are unrelated to military service. Among these veterans, those classified as having "higher incomes" must copay for any treatment they receive. GAO found that VA may have incorrectly determined the copayment status of more than 100,000 of these veterans in 1990. Although tax records revealed that these veterans had incomes above the threshold levels, VA relied solely on income reported by veterans to determine their copayment status. Had VA verified those amounts with other sources, it could have billed as much as $27 million for the health care it provided that year. VA cited data base and staffing limitations as the main barriers to using tax records. In addition, VA may have lost as much as $120 million in copayment revenues because it could not implement an income-verification system before its authority to use tax records expired in September 1992. Copayment losses in 1991 and 1992 may greatly exceed the estimated 1990 losses because of significantly lower income thresholds and higher copayment rates in those years. Despite this wasted opportunity to verify veterans' incomes, the Congress should extend VA's authority to use tax records.

VA Life Insurance: Administrative Costs for Three Programs Should Be Paid From Excess Funds (GAO/HRD-92-42, Mar. 10, 1992)

The government now spends more than $27 million annually on the administrative costs of three life insurance programs run by the Department of Veterans Affairs. Yet GAO found that these three long-standing insurance programs for U.S. veterans, which pay substantial dividends to policyholders, could comfortably pay their own administrative costs without risk of insolvency or increased premiums and with little impact on policyholder dividends. In GAO's view, because policyholders are not entitled to dividends by law or contract and they would experience only a slight dividend cut, it would be neither illegal nor unfair to have administrative costs paid out of excess program income. Because the law now requires the government to pay administrative costs, GAO supports legislation that would shift program administration costs from the federal government to the program.

VA Life Insurance: Premiums and Program Reserves Need More Timely Adjustments (GAO/HRD-92-71, July 20, 1992)

The Servicemen's Group Life Insurance Program (SGLI) is the largest of eight insurance programs run by the Department of Veterans Affairs (VA); SGLI is administered by Prudential Insurance Company of America, under contract with VA. SGLI's operating reserves totaled $165 million as of June 1991, and, according to GAO, needed to be increased by about $85 million as a result of recent legislation that doubled maximum coverage from $50,000 to $100,000 for each insured. At the same time, GAO believed that the program's $76 million in contingency reserves were about $51 million more than needed. GAO also thought that reserves in the $191 million revolving fund were too high. GAO found that military personnel covered by SGLI were overcharged premiums throughout the 1980s, and adjustments are needed. GAO made recommendations to the Secretary of Veterans Affairs to achieve the adjustments GAO feels would improve the financial position of SGLI. The Secretary did not concur with GAO's recommendations.

Veterans' Benefits: Millions in Savings Possible From VA's Matching Program With IRS and SSA (GAO/HRD-92-37, Dec. 23, 1991)

The Department of Veterans Affairs administers $30 billion in benefits and health care programs for veterans and their dependents. Eligibility for benefits and the level of benefits paid are often income dependent. GAO estimates that in 1984 VA may have made overpayments exceeding $157 million because it lacked access to tax data that could have verified income reported by pension recipients. VA has been granted access—until September 1992—to Internal Revenue Service (IRS) and Social Security Administration earnings records to verify the income reported by beneficiaries in the following four programs: (1) needs-based pension program, (2) parents' dependency and indemnity compensation program,

(3) unemployability compensation program, and (4) medical care. VA's first computer match of reported income with IRS data on unearned income (such as dividends and interest) for tax year 1989 revealed that nearly $340 million more in unearned income was reported to IRS than to VA by the same beneficiaries that year. VA officials also expect additional savings to result from matches with SSA earnings data. But VA needs to verify the income of its health care recipients in order to receive the full benefit from the matching program. While VA has tried to safeguard IRS and SSA data and protect the due process rights of its beneficiaries, the effectiveness of these measures should be reviewed periodically.

Vocational Rehabilitation: Better VA Management Needed to Help Disabled Veterans Find Jobs (GAO/HRD-92-100, Sept. 4, 1992)

Millions of veterans have disabilities resulting from military service, and some need help in finding and keeping jobs. The Department of Veterans Affairs' rehabilitation program traditionally stressed job training rather than job placement. The Congress overhauled the program in 1980 and made suitable employment for veterans the main objective. In practice, however, VA acted on this change only recently, and so far the agency has received little help from either the Department of Labor or state agencies in finding jobs for veterans. Of the more than 200,000 veterans enrolled in the program between 1983 and 1991, 71 percent dropped out. The significance of this trend is unclear because VA has not collected and analyzed meaningful data. Furthermore, VA standards for measuring service to veterans do not appear to challenge VA employees to provide better service. GAO believes that benchmarking performance, rather than setting rigid standards, would allow VA managers to continually improve services to veterans and measure progress toward achieving program objectives.

Vocational Rehabilitation: VA Needs to Emphasize Serving Veterans With Serious Employment Handicaps (GAO/HRD-92-133, Sept. 28, 1992)

Veterans with serious employment handicaps often have a hard time obtaining and keeping suitable jobs. Yet the Department of Veterans Affairs' vocational rehabilitation program makes no special effort to help such veterans. For example, it mails them the same information package that all veterans receive and schedules appointments for veterans on a first-come, first-served basis, without considering handicap. VA's productivity standards for its employees consider only the volume of cases handled and do not take into account the special effort often required in working with veterans with serious employment handicaps. If VA focused its outreach on veterans with serious handicaps, provided priority in scheduling appointments, and recognized in its productivity standards the additional effort required to serve these veterans, the program could serve

more veterans with serious employment handicaps. Fewer veterans with lower disability ratings may be served, however, if the same level of resources is maintained.

Other

Formula Programs: Adjusted Census Data Would Redistribute Small Percentage of Funds to States (GAO/GGD-92-12, Nov. 7, 1991)

A total of 100 federal programs providing grants at the state and local levels use population-related data in formulas that allocate all or part of program grant money. While these programs had total estimated obligations of about $116 billion in fiscal year 1991, the amount of funding influenced by population data was substantially less than that because some programs allocated only a small portion of their total grants according to population data. Of the 100 programs, 30 use data elements for which the decennial census is the only source of information. While hard to predict precisely, the general effect of using adjusted 1990 census population for federal funding purposes would likely be small as a percentage of total funding.

Using 1990 adjusted population data in place of the decennial census figures, GAO simulated allocations for three major federal programs—Social Services Block Grant, certain Federal Aid-Highway Programs in which population is a factor, and Medicaid. GAO found that the use of adjusted data would redistribute less than 0.5 percent of total funding. Some individual states, however, would incur estimated changes of more than $1 million in their allocations; the effect of such differences becomes more substantial when applied over an entire decade.

Redistribution of funds to localities could have a greater impact. Because of the time involved to complete the necessary methodological research, the Bureau believes that any intercensal population estimates incorporating a correction for census undercoverage could not be made available before mid-1992 or early 1993.

GAO summarized this report in testimony before the Congress; see Potential Impact of Using Adjusted Census Counts for Federal Formula Programs (GAO/T-GGD-92-5, Nov. 13, 1991), by L. Nye Stevens, Director of Government Business Operations Issues, before the Subcommittee on Government Information and Regulation, Senate Committee on Governmental Affairs.

Urban Poor: Tenant Income Misreporting Deprives Other Families of HUD-Subsidized Housing (GAO/HRD-92-60, July 17, 1992)

A computer match of IRS tax data with the income reported to local authorities by 175,000 households to establish their eligibility and rent payments for federally subsidized housing found 21 percent of the households may have under reported their incomes by as much as $138 million. The Department of Housing and Urban Development (HUD) provides more than $13 billion in housing subsidies to 4.6 million needy families, but millions of more needy families may be going without decent housing because HUD lacks an accurate, centralized system to verify eligibility and household income data for families living in subsidized units. The income underreporting uncovered by GAO resulted in excess federal subsidies of $41 million for 1989 alone. A centralized income and eligibility verification system could help HUD ensure that subsidized households are paying appropriate rents and that needy, very low-income families have access to subsidized housing.

Welfare Programs: Ineffective Federal Oversight Permits Costly Automated System Problems (GAO/IMTEC-92-29, May 27, 1992)

Three of the federal government's main welfare programs—Aid to Families With Dependent Children, Medicaid, and Food Stamps—provided more than $92 billion in benefits in 1990. These programs rely heavily on state-run computer systems to determine participants' eligibility and the amount of assistance they should receive. The federal government estimates that during the 1980s, it gave states close to $1 billion to develop and run these systems. Yet monitoring of states' automation efforts by the Department of Health and Human Services and the U.S. Department of Agriculture (USDA) have fallen short, allowing millions of dollars to be spent on systems that either do not work or do not meet requirements. In addition, poor coordination between HHS and USDA has sometimes resulted in contradictory directions to states. Despite explicit federal guidance, HHS and USDA have also failed to determine whether installed automated systems are working as intended and are yielding improvements. At this point, the federal government has no idea whether administrative costs and mistakes have been reduced because HHS and USDA have not measured automation's impact on welfare programs.

1990 Census: Limitations in Methods and Procedures to Include the Homeless (GAO/GGD-92-1, Dec. 30, 1991)

This report focuses on the Census Bureau's Shelter and Street Night (S-Night) Operation, which was meant to include the homeless population in the census. GAO concludes that the results of S-Night cannot be used to construct a count of the nation's homeless at any level of geography because S-Night was not designed to capture all of the nation's homeless population. In addition, the chosen method of enumerating selected shelter and street locations at night resulted in an unknown number of the

hidden homeless being missed and a lack of assurance that those counted were homeless and would not also be counted during other census operations. These methodological limitations, combined with the operational problems the Bureau experienced with the street count, resulted in S-Night street data that have limited value in meeting needs for information on the number of homeless and their characteristics.

Fiscal Year 1992 Testimonies Relating to Issues Affecting Older Americans

GAO testified 49 times before congressional committees during fiscal year 1992 on issues relating to older Americans. Of the testimonies, 2 were on employment, 26 on health, 3 on housing, 7 on income security, 3 on social services, 7 on veterans issues, and 1 on other issues.

Employment

Federal Affirmative Action: Status of Women and Minority Representation in the Federal Workforce (GAO/T-GGD-92-2, Oct. 23, 1991)

A basic personnel policy, set out by law, is to create a competent, honest, and productive federal workforce that reflects the nation's diverse population. While improvements have occurred, the federal civilian workforce still does not reflect the nation's diversity; white women and Hispanics in the federal workforce continue to lag behind their representation in the nation's civilian workforce. This testimony focuses on the representation status of women and minorities in the federal workforce, particularly at the upper grade levels and in jobs that typically lead to those grades. GAO also discusses the need (1) to improve the statistical criteria used to measure women and minority representation and (2) for more emphasis on collecting and/or analyzing recruiting, hiring, training and development, promotion, and separation data to better identify barriers to women and minorities.

The Changing Workforce: Demographic Issues Facing Employers (GAO/T-GGD-92-61, July 29, 1992)

The civilian labor force has changed dramatically in recent decades and is expected to change even more in the future. The most striking demographic change has been the wholesale entry of women into the workforce, particularly married women with children. Two other major demographic trends are the growing numbers of racial and ethnic minorities in the workforce and the greying of the labor force, driven largely by the aging of the baby boomers. In response, more and more employers are offering (1) child care, flexible work schedules, and other benefits to help employees balance work and family responsibilities; (2) diversity training; and (3) phased retirement or other strategies to utilize the skills of retirees. This testimony focuses on a series of recent GAO reports describing these changes to the workforce and programs developed by employers—including the federal government—in response to these changes.

Health

Access to Health Insurance: State Efforts to Assist Small Businesses (GAO/T-HRD-92-40, June 9, 1992)

Most states have proposed or already implemented programs to expand small businesses' access to health insurance coverage for their workers. Many of these initiatives have been adopted within the past 2 years, but early indications are that they have led to only modest gains in the number of firms offering health insurance because costs have not been reduced enough to induce small firms to offer it.

Access to Health Insurance: States Attempt to Correct Problems in Small Business Health Insurance Market (GAO/T-HRD-92-30, May 14, 1992)

GAO discussed state efforts to improve the availability and affordability of health insurance for small businesses. GAO noted that: (1) 43 states have initiated one or more insurance regulatory reforms aimed at improving access to affordable health insurance for small firms and their employees; (2) nearly half of the states have passed legislation reducing or eliminating mandated benefits and now permit insurance companies to offer lower bare bones cost health insurance policies to small firms; (3) insurers in most of those states have offered plans to the small group market with premiums up to 40 percent lower than existing small group policies; (4) some states have also tried to ease the financial burden confronting small firms in the insurance market by subsidizing insurance premiums through direct and indirect subsidies, including tax credits and premium tax waivers that allow employers to provide and for employees to purchase health insurance; (5) some states use such risk-pooling mechanisms as high-risk pools, reinsurance pools, and small employer pools to address small firms' inability to spread risks across a large number of employees and exert buying power in the health services market; and (6) although state initiatives have only been introduced within the past 2 years, early indications show that they have led to only modest gains in the number of firms offering health insurance.

Breast Cancer: Progress to Date and Directions for the Future (GAO/T-PEMD-92-4, Dec. 11, 1991)

GAO discussed progress in breast cancer prevention and treatment, focusing on: (1) changes in medical interventions, (2) requirements to improve survival rates, (3) research needed to help prevent breast cancer, and (4) the National Institutes of Health's (NIH) financial support for research on breast cancer compared with other support for research on other conditions. GAO noted that (1) there has been no progress in preventing breast cancer, (2) changes in medical intervention have led to a stabilization of breast cancer mortality rates, (3) mammography offers the

	only evidence of improving survival rates, (4) efforts to prevent breast cancer have little chance of success until factors that cause the disease are understood, (5) NIH research expenditures for breast cancer are equivalent or greater to other research conditions for serious conditions with the exception of acquired immune deficiency syndrome, and (6) earlier detection and more appropriate surgery have increased the likelihood and quality of survival.
Diabetes: Status of the Disease Among American Indians, Blacks and Hispanics (GAO/T-PEMD-92-7, Apr. 6, 1992)	While data are limited on the incidence of diabetes among minorities, the disease seems to be more prevalent among American Indians, blacks, and Hispanics than among whites. Certain environmental and lifestyle factors appear to trigger diabetes in genetically susceptible individuals, although it is unclear whether the natural history of the disease is the same or different across different population groups—a major shortcoming in existing research. Slightly more than half of all funds for diabetes research are targeted to minorities, but only a tiny fraction of all diabetes funding goes to studying prevention/behavioral and clinical research. Further, the National Institutes of Health data base cannot be used to determine the actual level of resources devoted to minority diabetes, and NIH makes no effort to collect information on the race of people donating blood for basic research.
Elderly Americans: Health, Housing, and Nutrition Gaps Between the Poor and Nonpoor (GAO/T-PEMD-92-10, June 24, 1992)	GAO discussed issues involving the elderly poor and near-poor population, focusing on: (1) the size and characteristics of the population; and (2) the relationship between poverty and various aspects of health care, housing, and nutrition. GAO noted that in 1990 the elderly poor and near-poor: (1) totaled 19 percent of the elderly population, or 5.7 million persons, excluding homeless and borderline poverty level elderly; (2) tended to be elderly women, minorities, and persons over 75 years of age; (3) relied on Social Security benefits as their major source of income; (4) received 95.7 percent of health insurance coverage through Medicare, but limitations and uncovered costs of the Medicare system account for major expense to elderly poor; (5) experienced a higher degree of negative health status; (6) renters benefit from public housing, section 8 certificates and vouchers, and section 202 housing; (7) nutritional intake is inadequate and data are limited; and (8) enrollment in government assistance programs is low.

Elderly Americans: Nutrition Information Is Limited and Guidelines Are Lacking (GAO/T-PEMD-92-11, July 30, 1992)	Most agree that the elderly are at high risk for malnutrition. Yet the federal government's national nutrition surveys are limited in many ways. At a minimum, their scope must be widened to include more complete data on the elderly and their eating habits. Furthermore, no adequate guidelines exist describing the nutritional needs of the elderly. Available data on people over 50 suggest that the recommended dietary allowances for such individuals should not be based on age alone but rather on a combination of factors, including level of activity, presence of chronic disease, and general health status. Improved nutrition data and nutritional guidelines are needed before definite conclusions can be drawn about the actual nutritional status of the elderly.
Federal Health Benefits Program: Stronger Controls Needed to Reduce Administrative Costs (GAO/T-GGD-92-20, Mar. 11, 1992)	GAO testified that the administrative costs of the fee-for-service portion of the Federal Employees Health Benefits Program are higher than the costs for other large health benefits programs, mainly because the carriers are not given enough incentive to cut their operational expenses. GAO estimates that potential annual savings could range from at least $35 million in the short term, if the Office of Personnel Management improves its controls over the operational expenses of fee-for-service plans, to as much as $200 million through legislative reforms that would provide a more uniform benefits structure and change the way contractors are chosen and paid.
Health Care Spending Control: the Experience of France, Germany, and Japan (GAO/T-HRD-92-12, Nov. 19, 1991)	GAO discussed the health care systems in France, Germany, and Japan. GAO noted that (1) France, Germany, and Japan provide universal access to health insurance while spending less on health care than the United States; (2) under the U.S. and the three countries' health care systems, multiple payers provide health insurance, people typically get health insurance for themselves and their dependents at their place of employment, people can choose their own physician on a fee-for-service basis, and both private and public hospitals deliver inpatient care; (3) health care system regulations in France, Germany, and Japan guarantee access to health insurance to all residents, standardize insurers' payments to physicians and hospitals, and control increases in health care spending; (4) the three countries use many insurers to achieve universal health care coverage, standardize rates for reimbursing providers without the government setting rates unilaterally, and moderate increases in health spending by putting entire health care sectors on a budget; and (5) budget controls neither relieve all spending pressures nor ensure quality or efficiency.

Health Insurance: More Resources Needed to Combat Fraud and Abuse (GAO/T-HRD-92-49, July 28, 1992)

Only a fraction of health care fraud and abuse is ever detected and prosecuted. Those cases, however, have involved substantial sums. Due to a lack of staff and money, effective investigation and pursuit of health care fraud has been impossible, allowing dishonest health care providers to stay in business. An essential health care goal must be to improve insurers' access to legal and punitive remedies to fraud and abuse. Yet more resources alone will not successfully overcome fraud and abuse. Structural issues like limitations on information sharing among insurers and incompatible data systems allow unscrupulous providers to move from one insurer to the next. GAO believes that the Congress should convene a national health care fraud commission composed of private and public payers, providers, and law enforcement agencies. In GAO's view, such a commission would be best able to weigh possible trade-offs, such as greater information sharing among insurers versus concerns about privacy and antitrust issues, greater regulation of provider ownership arrangements versus concerns about restraining competition, and investment of resources in health care fraud versus the devotion of resources to other criminal investigations.

Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse (GAO/T-HRD-92-29, May 7, 1992)

GAO discussed how fraud and abuse besets public and private health insurers. GAO noted that health insurance system vulnerabilities that allow unscrupulous health care providers to cheat health insurance companies and programs out of an estimated 10 percent of total health care spending each year include (1) insurers who operate independently with limited ability to collaborate on efforts to confront fraudulent providers, (2) growing financial ties between health care facilities and the practitioners who control referrals to those facilities, and (3) the high cost of pursuing fraud and abuse. GAO also noted that (1) health insurance fraud and abuse practices include overcharging for services, charging for services not rendered, accepting bribes for referring patients, and rendering inappropriate or unnecessary services; (2) insurers have problems detecting and pursuing fraud and abuse because of the difficulty in discerning wrongful acts amidst the multiple activities that take place during claims processing, privacy concerns that limit collaboration among industry members, and the lack of consensus concerning appropriate regulation of new provider types and financial arrangements; and (3) increased coordination of public and private insurers' efforts would facilitate the pursuit of health care fraud and abuse.

Long-Term Care Insurance: Actions Needed to Reduce Risks to Consumers (GAO/T-HRD-92-44, June 23, 1992)

While the National Association of Insurance Commissioners (NAIC) has developed model standards for selling long-term care insurance policies, consumers are still vulnerable for several reasons. First, many states and insurance companies have not adopted all NAIC standards. Second, several features of long-term care insurance with important consequences for consumers are poorly addressed by the standards. Third, low-income individuals have purchased policies even though such policies are expensive and the people may already be covered by a program like Medicaid. Companies that GAO reviewed do little to prevent the sale of this insurance to low-income individuals. GAO believes that additional standards are necessary. If states do not adopt the NAIC standards, the Congress may want to pass legislation setting minimum federal standards for long-term care insurance.

Long-Term Care Insurance: Better Controls Needed to Protect Consumers (GAO/T-HRD-92-31, May 20, 1992)

Although National Association of Insurance Commissioner standards have expanded, consumers are still vulnerable to considerable risks in buying long-term care insurance. Consumers are at risk for two main reasons. First, many states have not adopted key NAIC standards. Second, the NAIC standards themselves do not sufficiently address several features of long-term care insurance with important implications for consumers. For example, policy language on matters like eligibility criteria is often vague and inconsistent across policies, making it hard to compare policies and judge which provisions can reduce the likelihood that a policyholder will receive benefits. Consumers also face considerable financial risks, such as price hikes that could make it difficult for them to retain their policies. In addition to problems with insurance policies and standards, GAO's work at eight insurance companies revealed that, except for Medicaid recipients, the companies do little to prevent the sale of long-term care insurance to people who cannot afford it.

Long-Term Care Insurance: Consumers Lack Protection in a Developing Market (GAO/T-HRD-92-5, Oct. 24, 1991)

The model standards promulgated by the National Association of Insurance Commissioners for long-term care insurance provide greater consumer protection than existed before 1986, but two key problems remain. First, state standards have been improved, but many states have not adopted key NAIC standards, including those developed between 1986 and 1988. Insurers have adopted NAIC standards more quickly than states have but have not incorporated more recent NAIC standards, such as those for inflation protection, into their policies. Second, the model standards do not sufficiently address several significant areas. Terms and definitions are not uniform across policies for long-term care, making it hard or

impossible to compare policies and judge which policy provisions might prevent a policyholder from receiving benefits. Pricing is not a good indicator of value—premiums for policies that offer similar benefits may vary as much as 150 percent. In addition, setting premium prices in a new market without experience data requires periodic adjustments that could make long-term care policies unaffordable for some people. By letting their policies lapse, however, policyholders almost always lose their entire investment in premiums. Further, many agents earn high first-year sales commissions, and consumers are vulnerable to agents who push unnecessary policies for the sake of getting commissions.

Medicaid: Factors to Consider in Expanding Managed Care Programs (GAO/T-HRD-92-26, Apr. 10, 1992)

"Managed care," widely used in private-sector health care, refers to a health care delivery system with a single point of entry: a primary physician typically provides basic care and decides when a referral to a specialist or admission to a hospital is necessary. GAO testified that managed care in state Medicaid programs could improve access to quality health care. Because of the financial incentives of such programs and the vulnerability of Medicaid recipients, however, GAO cautions that safeguards must be instituted to adequately protect patients. These safeguards include a quality assurance system that requires client satisfaction and disenrollment surveys; a grievance procedure; and an outside, independent review of medical records. Further, states need to monitor (1) the financial arrangements between the contracting plan and its providers to spot excessive incentives to deny necessary services, (2) utilization data to determine if appropriate levels of service are being delivered, and (3) subcontractors in the same manner as contractors because the same problems can arise. Finally, effective state and federal oversight is needed along with prompt corrective actions when problems are discovered.

Medicaid: Factors to Consider in Managed Care Programs (GAO/T-HRD-92-43, June 29, 1992)

GAO discussed the role of managed care in state Medicaid programs. GAO noted that (1) adequate safeguards and oversight are crucial to the success of managed care programs; (2) it has previously identified problems with access to care, quality of services, and oversight of providers' financial reporting and solvency; (3) the Oregon managed care program does not place excessive financial risk on providers, because Oregon has safeguards in place to prevent inappropriate reductions in service delivery or quality; and (4) before expanding its program, Oregon should meet Medicaid ownership disclosure requirements, from which it is currently exempt, and improve its monitoring of providers' financial solvency.

Medicaid Prescription Drug Diversion: a Major Problem, but State Approaches Offer Some Promise (GAO/T-HRD-92-48, July 29, 1992)

State Medicaid agencies have become more aggressive in cracking down on the pervasive problem of fraudulent reselling of prescription drugs. Typically, "pill mills," which can be doctors' offices, clinics, or pharmacies, provide medically unnecessary prescriptions to Medicaid recipients, who then sell the drugs to a pharmacist or other intermediary for cash or merchandise. States like New York have adopted several promising approaches, including tighter controls on provider enrollment, electronic verification of claims, and earlier and more sophisticated analysis of provider and recipient profiles. Yet new schemes that elude detection are appearing constantly. Other steps that some states are taking include (1) enacting state laws making Medicaid fraud a felony, (2) strengthening their law enforcement efforts to apprehend responsible parties, (3) providing greater penalties for convicted providers, and (4) intensifying efforts to recover losses by penetrating the corporate veil and through practices, such as requiring performance bond postings and freezing assets.

Medical Technology: Implementing the Good Manufacturing Practices Regulation (GAO/T-PEMD-92-6, Mar. 25, 1992)

GAO discussed the Food and Drug Administration's (FDA) Good Manufacturing Practices (GMP) Compliance Program for medical devices. GAO noted that (1) in order to prevent the production and distribution of unsafe and ineffective medical devices, the GMP Compliance Program assesses manufacturers' implementation of the quality assurance requirements; (2) FDA continues to develop more stringent GMP quality assurance criteria and is working to harmonize GMP requirements with international quality assurance standards; (3) between fiscal years 1987 and 1989, the total number of device GMP inspections and the number of qualified inspections steadily declined, primarily due to the FDA prioritized inspection policy; (4) between fiscal years 1987 and 1990, FDA untimely inspected one-third of the 323 manufacturers that initiated the first recall of a device; (5) even when FDA completes inspections on time, the inspections do not always identify or target GMP violations; (6) FDA recommended and reported compliance action on only about one-half of identified GMP compliance violations; (7) about one-half of the manufacturers that received two or more GMP compliance violations notices did not correct the violations from one inspection to the next; (8) inspectors' investigative capability is limited by FDA assignment policies and inadequate training on device technology; and (9) information on both medical device manufacturers and their devices is unreliable and incomplete.

Medicare: Contractor Oversight and Funding Need Improvement (GAO/T-HRD-92-32, May 21, 1992)

Fraud, waste, and abuse are contributing to the health care cost spiral confronting the United States. Medicare faces program losses because of exploitation by unscrupulous providers, erroneous payments, and excessive reimbursement rates. While the Health Care Financing Administration (HCFA) has generally tried to remedy identified weaknesses, the Medicare program remains vulnerable to unwarranted losses. Unless contractors have clear incentives to manage program dollars efficiently and effectively, it is unlikely that they will take the initiative to perform resource-intensive safeguard activities on their own—from investigating beneficiary complaints to reducing backlogs of identified overpayments. Contractors need some assurance that funding for safeguard activities will be stable and adequate so that they can hire and train necessary staff. Funding for these activities, however, has not been stable, especially when viewed in light of increased claims volume. Moreover, recent program changes require more resources from contractors. Consequently, GAO supports modifying the budget process to enable adequate and stable funding for Medicare program administration. GAO also believes that HCFA must be more aggressive in holding contractors accountable for their performance in program administration. To monitor and direct contractor actions, HCFA may need to develop better information systems, more focused performance measures, and stronger contractor guidance.

Medicare: HCFA Needs to Take Stronger Actions Against HMOs Violating Federal Standards (GAO/T-HRD-92-11, Nov. 15, 1991)

GAO discussed the Health Care Financing Administration's efforts to address violations of Medicare requirements by the largest health maintenance organization (HMO) Medicare contractor. GAO noted that (1) the contractor's Medicare requirements violations involved marketing, claims payment, processing of beneficiary appeals, and implementation of an internal quality assurance system; (2) in fiscal year 1989, HCFA cited the contractor for violating Medicare standards to provide members with current information on the plan's rules, benefits, and costs; (3) over the last 3 years, HCFA found that the contractor inappropriately denied or delayed payment of claims for emergency services and urgently needed services outside the plan's service area; (4) HCFA found that the contractor did not always treat beneficiary appeals for claims as Medicare appeals; (5) the contractor violated quality assurance by not collecting enough ambulatory care data to systematically identify individual physicians with patterns of underservice to Medicare enrollees; and (6) HCFA has been reluctant to use its authority to impose sanctions on the HMOs that fail to comply with Medicare requirements because final regulations have not been issued. GAO believes that to become more effective in addressing violations, HCFA needs to (1) adopt policies for determining the

circumstances that warrant intermediate sanctions and (2) develop a standard for the HMOs that would specify an acceptable performance rate for paying claims.

Medicare: Improper Handling of Beneficiary Complaints of Provider Fraud and Abuse (GAO/T-HRD-92-2, Oct. 2, 1991)

GAO discussed Medicare's responsiveness to beneficiary complaints of provider fraud and abuse, focusing on (1) weaknesses in Medicare carriers' fraud and abuse detection efforts and (2) the Health Care Financing Administration's oversight of those carrier operations. GAO noted that (1) carriers often told beneficiaries to submit their complaints in writing or to resolve them with providers, even though the beneficiary described the complaint in detail over the telephone; (2) 15 of the 155 cases examined included substantial indications of potential fraud and abuse in that the provider had 2 or more similar, substantiated complaints within the last 2 years, or the current complaint, on its own, strongly suggested fraudulent or abusive behavior; (3) HCFA has not developed instructions for carrier staff who initially receive beneficiary complaints on how to identify and refer those complaints for investigation; (4) annual HCFA evaluations of carrier fraud and abuse detection efforts were inadequate for the five carriers reviewed; (5) carrier officials complained that they lacked sufficient resources to thoroughly investigate all complaints of provider fraud and abuse; and (6) budget reductions in the program safeguard area are undermining fraud and abuse detection activities and resulting in large program losses, but HCFA officials believe that funds for carrier personnel who answer these complaints will be reallocated within the fiscal year 1992 budget.

Medicare: Shared Systems Policy Inadequately Planned and Implemented (GAO/T-IMTEC-92-11, Mar. 18, 1992)

GAO commented on the Health Care Financing Administration's plans to implement the shared systems policy, an initiative to encourage contractors to share automatic data processing (ADP) systems. GAO noted that (1) despite the need for early planning, HCFA did not develop a list of minimum automation requirements for Medicare; (2) HCFA failure to perform system evaluations to assist contractors in identifying the most appropriate systems for sharing resulted in costly claims-processing problems; (3) HCFA focused primarily on administrative savings and ignored the effect that ADP systems would have on Medicare claims-processing effectiveness; and (4) HCFA did not define a long-term automation strategy to determine how best to process Medicare claims given current technology. GAO believes that HCFA should suspend further implementation of its shared policy until it addresses the identified deficiencies.

Nonprescription Drugs: Over the Counter and Underemphasized (GAO/T-PEMD-92-5, Apr. 8, 1992) and Over the Counter Drugs: Gaps and Potential Vulnerabilities in the Regulatory System (GAO/T-PEMD-92-8, Apr. 28, 1992)	While over-the-counter drugs are a common part of daily life, not all such drugs that reach the marketplace are safe or effective. GAO testified that (1) unlike prescription drugs, many over-the-counter drugs have not been proven safe or effective before being made publicly available; (2) the Food and Drug Administration has statutory authority to inspect records and documents of prescription drug manufacturers, but not those of over-the-counter manufacturers; and (3) FDA collects less postmarketing surveillance information and conducts less product performance analysis for over-the-counter drugs than for prescription drugs.
Screening Mammography: Quality Standards Are Needed in a Developing Market (GAO/T-HRD-92-3, Oct. 24, 1991)	GAO testified that many of the screening mammography providers it surveyed in an earlier report (GAO/HRD-90-32) lacked quality assurance programs to ensure that women receive safe and accurate mammograms. The Congress has been concerned that a new Medicare screening mammography benefit with a limit on provider charges might create "mammography mills" providing substandard care. Yet GAO discovered that high volume was associated with greater compliance with quality standards and that price was not indicative of the extent of quality control. GAO testified that strong federal standards are needed to ensure the quality of screening mammography.
Significant Reductions in Corporate Retiree Health Liabilities Projected If Medicare Eligibility Age Lowered to 60 (GAO/T-HRD-92-7, Nov. 5, 1991)	About 9 million retirees in the private sector rely on health benefits provided by companies. In the face of an aging workforce and spiraling health care costs, however, companies are becoming increasingly concerned about the expense of providing retiree health benefits. Furthermore, a new accounting rule will hit some companies hard by forcing them to acknowledge substantial unfunded retiree health liabilities. Several legislative proposals before Congress would lower the age of Medicare eligibility from 65 to 60. Such a measure would provide several benefits to both retirees and companies. It would (1) increase the security of retiree health benefits for early retirees (those who retire before age 65) by making Medicare the primary insurer; (2) make health insurance available to more retirees by extending Medicare coverage to early retirees of companies that do not now offer retiree health benefits; (3) substantially reduce companies' pay-as-you-go costs, accrued liabilities, and prefunding costs for retiree health benefits; and (4) spread the retiree health care burden among companies by helping those with older workforces and high retiree health costs become more competitive,

both domestically and internationally, with companies with younger workforces. Lowering the age of Medicare eligibility would dramatically reduce companies' health costs for early retirees because Medicare would pay a substantial portion of these retirees' costs. Yet such a change in eligibility age would also entail a substantial expansion of Medicare program costs, which would be borne in part by all employers and their employees through higher taxes.

Women's Health Information: HHS Lacks an Overall Strategy (GAO/T-HRD-92-51, Aug. 5, 1992)

Although responsible for providing health information to the public, the Department of Health and Human Services (HHS) lacks an overall strategy for delivering such information to women. GAO focused on six conditions that are of particular concern to women who are middle age and older—heart disease, breast cancer, osteoporosis, menopause, hormone replacement therapy, and urinary incontinence—and discovered that HHS has no plans for ensuring that the most needed and useful information reaches the public. Instead, information campaigns are left to the discretion of HHS's Public Health Service agencies, which operate largely independently of each other. Even when information for the public is produced and distributed, it is not always easily accessible. In contacting local Public Health Service offices, GAO obtained requested information or a referral phone number only about half the time. Moreover, HHS does not routinely evaluate the usefulness of the information produced and has no way of knowing whether it is being targeted to the women who need it most.

Housing

Mortgage Credit Enhancements: Options for FHA in Meeting the Need for Affordable Multifamily Housing (GAO/T-RCED-92-52, Apr. 3, 1992)

Mortgage credit enhancements—financing arrangements to ensure loan repayments by builders of multifamily rental properties—are among a broad range of mechanisms that the Federal Housing Administration (FHA) can use to expand the supply of affordable housing for lower-income tenants. If such enhancements are employed, they must be cost effective in achieving the desired result. Yet ensuring cost effectiveness depends on having accurate data on the costs and risks involved, and information on the performance characteristics of affordable multifamily housing loans is currently nonexistent. GAO suggests that Fannie Mae, Freddie Mac, and FHA—because they now hold large portfolios of multifamily mortgages or insure such mortgages and are also experienced in maintaining relevant

large data bases—would be good candidates for developing such information. Further, the bank regulatory agencies, the Federal Housing Finance Board, the Bureau of Economic Analysis, and various professional organizations representing mortgage originators could lend valuable insight in developing a national affordable housing data base.

Public Housing: Issues in Housing the Nonelderly Mentally Disabled With the Elderly (GAO/T-RCED-92-44, Mar. 27, 1992)

GAO testified that nonelderly mentally disabled people occupied about 9 percent of the public housing units for the elderly in 1990. Almost one-third of these households reportedly caused moderate or serious problems due to alcohol abuse or excessive noise and the presence of disruptive visitors. These situations result in problems for the public housing agency (PHA) management and in conflicts with elderly tenants. Under federal antidiscrimination laws, people with mental disabilities may not be lawfully excluded from or segregated in public housing for the elderly under the conventional public housing program. Various proposals have been put forth to address this situation, ranging from offering several housing options to mentally disabled persons to requiring that the Department of Housing and Urban Development (HUD) provide more detailed guidance to PHAs on how to determine whether nonelderly mentally disabled applicants will make suitable tenants. As it weighs these proposals, the Congress will have to consider the effect of antidiscrimination laws, the expected behavior of nonelderly mentally disabled people in different housing settings, and the availability of funds for providing alternative forms of subsidized housing and mental health services.

Supportive Housing: HUD Is Not Assessing the Needs of Elderly Residents (GAO/T-PEMD-92-12, Aug. 12, 1992)

How well does the Department of Housing and Urban Development assess the need for (1) supportive services for elderly residents in section 202 housing and (2) modernization and retrofitting of section 202 buildings? HUD neither collects data nor has a methodology for assessing the needs of section 202 housing residents. HUD contends that supportive services in section 202 housing are the responsibility of the Department of Health and Human Services. Given that a section 202 building's physical structure and its service component are fundamentally linked to the concept of supportive housing, some coordination between the two agencies on this issue might have been expected. This does not appear to have been the case; a draft memorandum of understanding between HUD and HHS has been around for years but has never been signed. Information on resident frailty and the need for building modernization and retrofitting can be used to target projects most deserving of available funding. Information on

resident frailty can also be used to determine the features that residents need in their buildings. Currently, HUD neither collects nor ensures that project sponsors collect data on these subjects. Although HUD periodically inspects the physical condition of 202 projects and rates building managers, limited staff and travel budgets mean that HUD cannot perform inspections annually. When inspections are done, no assessment is made of a facility's retrofitting requirements.

Income Security

Comments on the Social Security Notch Issue (GAO/T-HRD-92-46, July 23, 1992)

The Social Security "notch" refers to a perceived inequity in benefits for people born between 1917 and 1921, due to a change in benefit computation introduced in 1977 amendments to the Social Security Act. GAO testified that notch babies generally collect more benefits than most coming before or after them, and the perception that they receive less is based on a comparison with a group that got an unintended windfall from the system as a result of a flawed benefit formula. GAO believes that a "fix" is not warranted and that proposed legislation to address the notch issue should not be pursued.

Financial Condition of the Pension Benefit Guaranty Corporation (GAO/T-HRD-92-52, Aug. 11, 1992)

The Pension Benefit Guaranty Corporation's (PBGC) deficit has been spiraling upward in recent years and is expected to rise even further as underfunded pension plans insured by PBGC terminate in the future. PBGC's cash flow can handle current benefit payments, but this situation may not last. GAO urges serious discussion on ways to improve funding in underfunded plans to reduce the risk to PBGC from future terminations. Although the administration has put forth several proposals for reducing future claims against PBGC, none of them would reduce PBGC's existing deficit. GAO supports the goals of many of these proposals, but believes that more study should be given to how they may affect plan participants, plan sponsors, the adequacy of plan funding, and federal revenues. Other ways of cutting PBGC's potential claims and current deficit should be examined, such as improving funding in flat benefit plans, making greater use of PBGC's existing termination authority, and restructuring PBGC premiums to better reflect potential risks. PBGC is also burdened by significant internal operations problems.

Improving the Financial Condition of the Pension Benefit Guaranty Corporation (GAO/T-HRD-92-60, Sept. 25, 1992)	The Pension Benefit Guaranty Corporation's huge deficit has ballooned significantly in recent years and is expected to grow even larger. Fueling this deficit are underfunded pension plans that continue to terminate. At present, PBGC has enough cash flow to pay its current benefit obligations, but this may not always be the case. Now is the time for serious deliberations on how to improve funding in underfunded plans to cut PBGC's risk from future terminations. Pending legislation to improve funding in underfunded plans could significantly reduce PBGC's deficit over the long run. Underfunded plans not only threaten PBGC, they also pose a risk to plan participants because PBGC does not guarantee all pension benefits and , therefore some participants may lose benefits upon plan termination. PBGC has been burdened not only by its current deficit and looming potential claims, but also by significant internal operations problems. GAO has never been able to give an opinion on PBGC's financial statements because of these serious internal control and systems weaknesses. These problems suggest that PBGC needs to put more emphasis on its operations.
Pension Plans: Benefits Lost When Plans Terminate (GAO/T-HRD-92-58, Sept. 24, 1992)	Some pension plan participants lose benefits and the ability to qualify for potential future benefits when plans terminate, especially if the plans are underfunded. Despite federal insurance protection, participants in underfunded plans risk losing promised benefits. This testimony discusses the types of benefits participants lose and why.
Social Security Disability: Growing Funding and Administrative Problems (GAO/T-HRD-92-28, Apr. 27, 1992)	The Social Security fund that provides benefits to those who are too disabled to work is projected to run out of money by 1997 as the rate of successful claimants increases and movement off the rolls slows, partly because budget constraints have virtually eliminated screening for beneficiaries who no longer meet disability standards. The length of delays by State Disability Determination Services in processing applications for disability benefits is expected to reach seven months in 1993. Appeals of disability determinations already take 7 months. This testimony highlights some of the underlying factors, such as rising disability application rates as a result of the recession, that have affected the trust fund situation. GAO also discusses problems with program administration.

Social Security: Racial Difference in Disability Decisions (GAO/T-HRD-92-41, Sept. 22, 1992)

In the Social Security Disability Insurance and Supplemental Security Income (SSI) programs, the percentage of black applicants allowed disability benefits is lower than the percentage of white applicants. GAO analyzed applicants for benefits under the two programs and found that except for young SSI applicants, 80 percent of the racial differences in allowance rates at the initial decision level could be explained by factors other than race. Blacks had lower allowance rates mainly because they applied more often with less severe impairments and they had demographic characteristics associated with lower allowance rates, regardless of race. In the appeals decisions of administrative law judges, however, the racial differences were both larger and harder to explain than at the initial decision level. Despite the lower allowance rate among blacks applying for benefits, the only subgroup in which blacks actually may be receiving benefits at lower rates than whites is severely disabled people aged 18 to 24. Otherwise, blacks received benefits at rates equal to or higher than those of whites. GAO recommends that the Social Security Administration (SSA) further investigate the reasons for the racial differences in the initial decisions for young SSI applicants, as well as for all administrative law judge decisions. GAO also suggests that SSA review the evaluation of cases involving impairments, such as mental problems and respiratory orders, that showed relatively large racial differences in allowance rates.

Women's Pensions: Recent Legislation Generally Improved Pension Entitlement and Increased Benefits (GAO/T-HRD-92-20, Mar. 26, 1992)

This testimony focuses on how recent changes to the private pension rules have improved pension entitlement and benefits for working women and widows. GAO discusses (1) the impact of the vesting and distribution provisions under the Tax Reform Act of 1986, (2) widow's receipt of survivor pension income and the act's impact on their access to benefits, (3) the role of the private pension system in improving the economic condition of poor widows, and (4) recent Internal Revenue Service efforts to improve the effectiveness of pension documents important to the wives of private pensioners.

Social Services

Administration on Aging: Autonomy Has Increased but Harmonization of Mission and Resources Is Still Needed (GAO/T-PEMD-92-9, June 11, 1992)

GAO discussed the Administration on Aging (AOA), focusing on how a reorganization of the Department of Health and Human Services affected AOA. GAO noted that (1) HHS added personnel to AOA so that AOA could perform administrative functions that another HHS office previously performed; (2) the reorganization solidified the congressionally mandated direct reporting relationship between the Commissioner of AOA and the Secretary of Health and Human Services; (3) AOA has made progress in improving its ability to carry out its mission at headquarters, but suffered administrative, personnel, and funding problems in its regional offices; (4) the AOA methodology for gathering program participation data is flawed, and AOA has not adequately addressed the problem; (5) state and local agencies lack the necessary resources to target groups of elderly persons for AOA services, as the Older Americans Act requires; (6) AOA has not yet identified all states with critical needs for technical assistance; and (7) AOA intends to meet requirements that it collect data on utilization rates for board and care homes and on the impact of its ombudsman program.

Board and Care Homes: Medication Mishandling Places Elderly at Risk (GAO/T-HRD-92-16, Mar. 13, 1992)

GAO discussed the misuse and mismanagement of residents' medication in board and care homes for the elderly, focusing on whether (1) board and care staff were knowledgeable about the proper handling of medication; (2) staff followed proper procedures for storing, supervising and assisting residents with taking medications; and (3) residents received appropriate medications. GAO noted that (1) staff received little medication training, and frequently violated medication handling requirements; (2) state inspection procedures may not identify medication violations; (3) board and care home staff do not always maintain adequate medication records; and (4) in the homes visited, resident records included sufficient medical information to indicate that medications were appropriately prescribed for 20 of the 35 residents in its sample. GAO also noted that (1) residents in homes that were in states that were more regulated were in less risk of medication errors than residents in states with less regulation; and (2) the Department of Health and Human Services should help states address medication handling issues and develop medication training programs.

Public/Private Elder Care Partnerships: Balancing Benefit and Risk (GAO/T-HRD-92-45, July 9, 1992)

GAO discussed the public benefit and risk when corporations buy elder care services from area agencies on aging for company employees that care for elderly persons. GAO noted that (1) private partnerships offer the benefit of the infusion of private funds into an oversubscribed system of public services and a risk of possible neglect of activities to achieve the public mission under the Older Americans Act; (2) in 1990, the Administration on Aging asked state agencies to develop policies that would encourage corporate elder care among area agencies on aging while preserving the public mission; (3) all states developed policies on corporate elder care, although eight policies are not final; (4) 45 states and the District of Columbia permit agencies to enter into corporate elder care contracts and most encourage agencies to pursue these arrangements, but the 5 remaining states have policies stating they will not enter into elder care contracts with corporations; (5) in 41 states and the District of Columbia, state elder care policies fall short of protecting the public-mission responsibilities of area agencies on aging; and (6) state policies often did not address the need to target services to individuals with the greatest economic or social need.

Veterans-DOD

Health Care: Demonstration Project Concerning Future Structure of Veterans' Health Program (GAO/T-HRD-92-53, Aug. 11, 1992)

Under various health care reform proposals, including employer-mandated and universal health insurance, demand for Department of Veterans Affairs (VA) inpatient care could drop dramatically. The Congress, concerned about the resulting excess capacity at VA facilities, is considering legislation—H.R. 5263—that would authorize up to seven VA facilities with excess capacity to treat the Medicare-eligible dependents and survivors of military retirees. Medicare-eligible veterans now being denied care at facilities would also be able to participate in the demonstration project. The facilities would be allowed to obtain and retain reimbursements for covered services provided to program participants by Medicare. GAO agrees with the demonstration project's objective of testing the cost-effectiveness of such interagency sharing, but GAO believes that VA should proceed cautiously to ensure that the project's goals can be achieved.

Health Care: The Quality of Care Provided by Some VA Psychiatric Hospitals Is Inadequate (GAO/T-HRD-92-37, June 3, 1992)	None of the Department of Veterans Affairs' four psychiatric hospitals GAO visited is effectively collecting and using quality assurance data on a consistent basis to identify and resolve quality-of-care problems. As a result, counterproductive or ineffective psychiatric practices may go unnoticed and dangerous medical procedures may continue unchecked. The results of GAO's work are consistent with its findings at other VA hospitals. VA and non-VA hospital systems GAO visited—both psychiatric and acute medical/surgical—differ little in how they identify quality-of-care problems. The quality assurance mechanisms each uses to ensure that quality-of-care standards are met are similar because most use the Joint Commission on Accreditation of Healthcare Organizations as their primary external review organization. Further, many of the problems found in VA hospitals have also been seen in non-VA hospitals.
Health Care: VA's Implementation of the Nurse Pay Act of 1990 (GAO/T-HRD-92-35, June 3, 1992)	The Department of Veterans Affairs employs more than 39,000 nurses and nurse anesthetists who are paid according to the results of local salary surveys. GAO testified that VA is basing its nurses' salaries, which amount to more than $2 billion annually, on data that are gathered through questionable methods and are inadequately verified. GAO recommends that VA report its administration of the locality pay system to the Office of Management and Budget as a material internal control weakness. VA should also promptly develop a plan for correcting the deficiencies and establish a timetable for completing the corrective actions.
VA Health Care: Efforts to Improve Pharmacies' Controls Over Addictive Drugs (GAO/T-HRD-92-38, June 10, 1992)	More than 200 of the Department of Veterans Affairs pharmacies routinely dispense large amounts of prescription drugs—narcotics, depressants, and stimulants—with a strong potential for abuse and addiction. Large quantities of these drugs have been stolen in recent years because of inadequate controls at VA pharmacies. Since GAO reported on this problem in June 1991, VA has greatly improved controls over bulk supplies of addictive drugs stored in its pharmacies. These controls should make it harder to steal drugs from bulk supplies undetected, but VA's new controls over addictive drugs in dispensing areas have been less effective. Progress has been slowed by pharmacy managers' varying interpretations of VA's new policies, as well as reluctance to spend money to improve drug security. VA is working hard to upgrade controls over these supplies, but it will be months before all pharmacies are adequately controlling how supplies are dispensed. VA's inclusion of its addictive drug controls as material weaknesses in the 1991 Federal Managers' Financial Integrity Act

	Report should help ensure that VA's actions will succeed and help eliminate weaknesses in those controls.
VA Health Care for Women: Despite Progress, Improvements Needed (GAO/T-HRD-92-42, June 19, 1992)	During the past decade, the Department of Veterans Affairs has made significant progress in ensuring that female veterans have the same access to health care as do male veterans. Problems remain, however. Physical examinations, including cancer screening for women veterans, remain sporadic. VA medical centers are not adequately monitoring their in-house mammography programs for adherence to quality standards. VA medical centers have inadequate procedures to help ensure that privacy limitations affecting women patients are identified and corrected during facility renovations. VA agrees with GAO's findings and has cited specific actions it plans to take to improve services for women veterans.
VA Health Care for Women: Despite Progress, Improvements Needed (GAO/T-HRD-92-33, July 2, 1992)	The Department of Veterans Affairs has made significant progress during the past decade toward ensuring that veterans of both sexes have equal access to health care. Three problems remain, however. First, physical examinations, including cancer screenings for women veterans, continue to be sporadic. Second, VA medical centers are not adequately monitoring the quality of their in-house mammography programs. Third, inadequate accommodations for female patients—such as a lack of private rooms or toilets—may go unnoticed during VA medical center renovations due to inadequate procedures. GAO recommends that VA medical centers correct problems in providing complete physical examinations by disseminating information on successful practices and implementing them systemwide. VA agrees with GAO's findings and has taken steps to improve services for women veterans.
VA Health Care: Inadequate Controls Over Scarce Medical Specialist Contracts (GAO/T-HRD-92-50, Aug. 5, 1992)	GAO discussed the status of the Department of Veterans Affairs' efforts to strengthen its management controls over contracts for medical specialists. GAO noted that (1) VA still lacks management controls to ensure that medical centers are avoiding contracting problems, (2) VA needs to provide better staffing guidelines for medical centers and utilize reviewers to develop and evaluate contract proposals, (3) few VA centers provide adequate support and data required for the use of contract specialists and contract review, and (4) VA fails to provide follow-up procedures to ensure that required contract modifications are completed.

Other

Potential Impact of Using Adjusted Census Counts for Federal Formula Programs (GAO/T-GGD-92-5, Nov. 13, 1991)

GAO discussed the potential impact of using adjusted census counts for federal funding allocations. GAO noted that (1) 100 federal programs providing grants at the state and local levels use population-related data to allocate funds; (2) because some programs allocated only a portion of their total grants through formulas that included population data elements, the amount of funding influenced by population data was less than the estimated $116 billion in obligations for fiscal year 1991; (3) 30 of the 100 programs used data elements in their formulas for which the decennial census was the only source of information; (4) the effect of using adjusted fiscal year 1990 census population data for federal funding would be relatively small, since many factors affect the level of funding, including the type of population data used, whether nonpopulation data were used, and whether other formula provisions set minimum or maximum allocations; (5) simulated allocations for three federal programs indicated that using adjusted data as the basis for allocations would redistribute less than half of a percent of total funding to states; (6) some individual states could incur estimated changes of over $1 million in their allocations, by using the adjusted data; and (7) any intercensal population estimates incorporating a correction for census net undercount will not be available before mid-1992 or early fiscal year 1993.

Ongoing GAO Work as of September 30, 1992, Relating to Issues Affecting Older Americans

At the end of fiscal year 1992, GAO had 128 ongoing assignments that affected older Americans. Of these, 60 were on health, 7 on housing, 20 on income security, 6 on social services, an 35 on veterans-DOD issues.

Health

Access to and Quality of Care Provided to Health Pass Medicaid Beneficiaries

Alternatives for Improving the Distribution of Medicaid Funds

An Evaluation of Medicare Part B Claims Processing System

Are HCFA's Plans to Monitor Organizations With Deemed Status Adequate to Assure Medicare Requirements Are Met?

Canadian Drug Price Regulation

Case Management of Long-Term Care for the Elderly

Changes in Drug Prices

Chicago Medicaid HMOs

Conditions Affecting Utilization of Emergency Departments

Comparison of U.S./European Prescription Drug Prices

Costs and Services of End Stage Renal Disease Facilities

Effect of Long Hours on the Quality of Care Provided by Resident Physicians

Effect of Malpractice Costs on Medicare/Medicaid

Equity of and Access to Indian Health Service's Services

European Drug Price Regulation: Lessons for the U.S.

Evaluation of Long-Term Care Insurance Lapse Rates

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

FDA's Regulation of Hospital Quality Disinfectants and Specific Actions Against Sporicidin International

Federal Efforts to Collect Immunization Data

Geographic Adjustment to Durable Medical Equipment Fee Schedules

Government Response to Tuberculosis Problem

Has HCFA Adequately Evaluated JCAHO's Ability to Assure that Home Health Care Agencies Are Meeting Medicare Requirements?

Has HCFA Justified Its Acquisition of a Single Medicare Claims Processing System and Adopted a Prudent Acquisition Strategy?

Health Care in Rochester, NY: Lessons for the Nation

Health Center Malpractice Costs

HCFA's Physician Geographic Cost Adjustment Analysis

Health Insurance Products Sold to the Elderly

How is HCFA Determining that State Medicaid Management Information Systems Are Providing Reliable Data?

How Should the U.S. Reform its Medical Malpractice System?

Impact of Medicare Secondary Payer Extension for End Stage Renal Disease

Implementation Issues Associated With Health Care Reform

Improving Medicare Hospital Cost Reporting Systems

International Medical Malpractice

International Systems of Financing Long-Term Care

Medicaid Managed Care

Medicaid Pill Mill Deterrence

Incentives and Disincentives for Physicians to Pursue Careers in Primary Care

Medicare Contractor Management Review

Medicare Mammography Payments in Low Volume Settings

Medicare Postpayment Review Methodologies

Medicare Vulnerability Status Report

Patent Extension for Lodine

Physician Ownership of Diagnostic Facilities

Peer Review Organization Ambulatory Surgery Review

Professional Fees for Durable Medical Equipment Staff

Purchasing and Billing Practices for Outpatient Prescription Drugs Covered by Medicaid

Retiree Health Benefits

Review of Medicaid Transfer of Asset Policies

Review of the Medicaid Program's Eligibility Policies and Operations

Role of Medicaid in State Long-Term Care Programs

Rural Health Care Policy

State Regulation of Private Health Insurance

Study of the Blue Cross/Blue Shield System

Survey of Medicare's Flexibility Carriers

Survey of Organ Transplantation

Synthesis of GAO Drug Treatment Work

Tax Exempt Hospital Joint Ventures With Physicians

The District of Columbia's Medicaid Eligibility System

The Qualified Medicare Beneficiary Program

Use of Managed Care to Control Health Spending

Housing

Adequacy of HUD's Implementation of Fair Market Rents

Alternatives to Public Housing

An Evaluation of Supportive Service Housing Programs for the Elderly

Analysis of Options for Enhancing Mortgage Credit

Assessment of How Well Section 8 Vouchers Are Serving the Elderly

Assessment of Need for Additional Resources for Section 8 Rent Subsidies

Uses of McKinney Act Funding in Fiscal Year 1991

Income Security

Action Needed to Improve the Management of SSA

Annuitants From Pension Plan Terminations

Are SSA's Actions on Beneficiaries' Requests for Services Timely?

Department of Labor's Enforcement of the Employee Retirement Income Security Act of 1974

Evaluation of the District of Columbia's Pension Plan Unfunded Liability

Financial Audit of the Pension Benefit Guaranty Corporation—Fiscal Year 1992

High Risk Area 4: Impact on PBGC of Proposed Pension Restoration Act

IRS Refund Information Could Permit SSA to Credit Some Currently Uncredited Earnings to the Correct Accounts

Labor and IRS Actions on ERISA Violations Reported by Pension Plans

Magnetic Wage Reporting Problems

Pension Benefit Guaranty Corporation Exposure to Underfunded Pension Plans

Reliability and Validity of SSA's Quality Assurance Mechanisms for the Disability Insurance Program

Review of IRS Controls for Taxation of Social Security Benefits

SSA's Disability Program—Claim Backlogs, Increased Processing Times, and Trust Fund Shortage

SSA Disability Trends in Decision Making

State and Local Government Pension Funding During Fiscal Stress

Survey of the Effects of Lump-Sum Retirement on Agencies

Tax Counseling for the Elderly Program

Tax Policy: Tax Treatment of Long-Term Care Insurance

What Are the Busy Signal Rates at Local SSA Field Offices?

Social Services

An Evaluation of Administration on Aging's National Elder Care Campaign

Corporate Elder Care Policies

Government Elder Care Programs for Employees

Long Term Care Social Services Innovations

Older American's Act Formula Could Be Distributed More Equitably

Public-Private Partnerships Under the Older Americans Acts

Veterans-DOD

Are Veterans' Services in America Samoa Adequate?

Assessment of Health Care Services Available to Veterans at VA Medical Centers

Assessment of VA's Income Verification Procedures

Assessment of Waiting Times for Veterans Using VA Medical Centers

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

Delays in Awarding VA Construction Contracts as of September 30, 1992

DOD Compliance with Congressionally Mandated Military Medical Personnel Staffing Levels

Does VA Have Adequate Plans to Provide Care to Veterans Affected by the Closure of the Martinez Medical Center?

Downsizing the Military: Assisting New Veterans

Effects of the Implementation of the Nurses Pay Act on Recruitment and Retention of Nurses

Evaluation of the Impact of GAO Recommendations on VA's Quality Assurance Program

Federal Expenditures for Veterans' Health Care

Health Care Services Contracting in the Military

Hiring of Minority-Owned Businesses to Construct Detroit Veterans Hospital

Management of VA: Human Resources Management Vital to Success of the Secretary's Strategic Management Process

Military Personnel Retiring on Disability Who Are Eligible for Normal Retirement

Quality of Care in VA's Salem, Virginia Medical Center

Recovery of VA Nursing Home Costs from Veterans' Estates

Review of DOD's Management of Mental Health

Review of DOD's Mental Health Demonstration Project in Virginia

Review of VA Management of Construction Programs

Review of VA Medical Centers' Management of Scarce Medical Specialist Contracts

Review of VA Site Selection for East Central Florida Medical Center

Review of VA's Policies and Procedures for Detecting and Locating Missing Patients

Review of Veteran's Federal Health Care Benefits

Secretarial-Level Oversight of VA Programs and Administrative Activities

Survey of Case Managed Home Care Services Under CHAMPUS

Survey of CHAMPUS Adoption of the Resource Based Relative Value Scale Payment Methodology for Physicians and Other Providers

Survey of Licensing Issues Relating to U.S. Graduates of Foreign Medical Schools

Survey of Psychiatric Hospital Alleged Fraud and Abuse

VA and Affiliated Schools Sharing of Medical Resources

VA Program From Veterans in the Philippines

VA Reimbursement of Medical Centers' Medical Care Cost Recovery Activities

VA's Procedures for Protecting Workers and Patients From Tuberculosis Exposure

What Happens to Veterans When VA Denies Outpatient Care?

Related GAO Publications Affecting Older Americans

During fiscal year 1992, GAO issued four publications relating to older Americans.

Older Americans

Aging Issues: Related GAO Reports and Activities in Fiscal Year 1991 (GAO/HRD-92-57, Dec. 17, 1991).

Today, about 32 million Americans are age 65 or older. By the year 2000, that number will swell to more than 52 million, and almost 7 million will be age 85 or older. Although most of the nation's elderly are healthy and independent, a growing number need help 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. This report is a compilation of GAO's fiscal year 1991 reports and testimony as well as ongoing work on older Americans. Topics covered include health, housing, income security, social services, and veterans affairs.

Health Reports: June 1990 Through June 1992 (GAO/HRD-92-126, June 1992)

This publication is a list of titles of GAO reports and testimony issued during the last 2 years on health topics, ranging from drug abuse to health insurance to long-term care for the elderly. Summaries of some recently issued GAO reports and testimony are included along with an order form to request documents.

Housing and Community Development Products: 1990-91 (GAO/RCED-92-111, Mar. 1992)

This publication summarizes GAO reports and testimonies on housing and community development issues, such as prevention of homelessness and revitalization of blighted urban areas. Grouped under seven categories—home ownership assistance, rental and public housing, homelessness, community development, small and minority business, disaster assistance, and related topics—these abstracts profile GAO's work in this area during 1991. Order forms are provided to obtain specific reports or testimony.

Income Security: Reports Issued From FY 1988 Through June 1992 (GAO/HRD-92-122, July 1992)

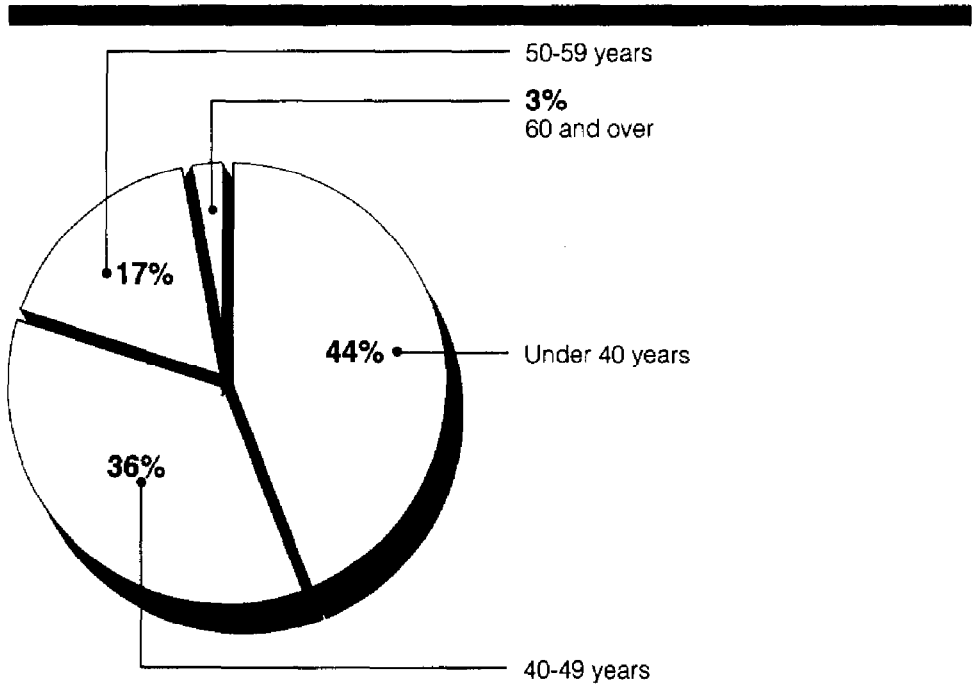
The $500 billion spent each year on income security programs, such as Social Security and welfare, account for more than 60 percent of the domestic federal budget. This document lists all GAO reports issued between fiscal year 1988 and June 1992 on income security issues. Reports issued in 1992 are accompanied by summaries, while earlier reports are

listed by title according to various subject areas, from "Financing Retirement Programs" to "Breaking the Poverty Cycle."

GAO Activities Regarding Older Workers

GAO appointed 438 persons to permanent and temporary positions during fiscal year 1992, of whom 62 (14 percent) were age 40 and older. Of GAO's total workforce of 5,549 on September 30, 1992, 56 percent were age 40 and older. Figure 1 displays GAO's workforce by four age groups.

Figure 1: GAO Personnel, by Age
(Sept. 30, 1992)



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 to employees nearing retirement. The counseling and seminars are intended to assist employees in

- calculating retirement income available through 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 insight 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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