United States General Accounting Office

GAO

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

December 1987

AGING

GAO Activities in Fiscal Year 1987

GAO/HRD-88-42

GAO

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

Human Resources Division

B-217195

December 15, 1987

The Honorable John Melcher
Chairman, Special Committee
on Aging
United States Senate

Dear Mr. Chairman:

This report is in response to your September 14, 1987, request for a compilation of our fiscal year 1987 activities regarding older Americans.

Appendix I lists 54 issued products—37 reports, 14 briefing reports (BR), and 3 fact sheets (FS). Reports and briefing reports may include conclusions and recommendations, while fact sheets contain only information and limited analyses. Appendix II lists 55 assignments that we had in process as of September 30, 1987.

In appendix III, we present our employment policies, which prohibit age discrimination. On September 30, 1987, 44.9 percent of our work force was 40 years of age or older. We continue to provide individual retirement counseling and group preretirement seminars.

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

Sincerely yours,

for Edward A Densmore

Richard L. Fogel
Assistant Comptroller General

Contents

Abbreviations

BR	briefing report
CDR	continuing disability review
DDS	Disability Determination Service
FEHBP	Federal Employees Health Benefits Program
FS	fact sheet
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
IRS	Internal Revenue Service
NIA	National Institute on Aging
OPM	Office of Personnel Management
PBGC	Pension Benefit Guaranty Corporation
SSA	Social Security Administration
VA	Veterans Administration

GAO Reports Relating to Issues Affecting the Elderly Issued From October 1, 1986, Through September 30, 1987

Following are brief descriptions of the GAO reports relating to the elderly issued during fiscal year 1987. An asterisk after the report title indicates that the review was performed at the request of Committees or Members of Congress.

Medigap Insurance: Law Has Increased Protection Against Substandard and Overpriced Policies (GAO/HRD-87-8, Oct. 17, 1986)*

Medicare pays much of the health care costs of the elderly, but beneficiaries are responsible for paying deductibles and coinsurance. Almost from the beginning of Medicare, private insurers have offered insurance contracts, called Medigap policies, that supplement Medicare benefits. In 1980 the Congress amended the Social Security Act to establish standards for Medigap insurance policies. To be certified by the Secretary of Health and Human Services, such policies must provide at least a minimum level of benefit coverage and include certain provisions and set minimum expected levels of benefit payouts, called loss ratios.

GAO found that Medigap policies sold by commercial insurers with more than $50 million in premiums and Blue Cross/Blue Shield plans generally met the loss ratio requirements. However, over 60 percent of the commercial insurance policies with premiums under $50 million in 1984 did not meet those requirements.

GAO reported that differences in benefit coverage and loss ratios among policies illustrate the importance of comparison shopping; to assist the elderly, the federal and state governments have made available information useful in shopping for Medigap insurance. Although abuses still occur in the sale of Medigap policies, many states have attempted to prevent abuse through such actions as monitoring sales and advertising practices, revoking or suspending insurance agent licenses, and issuing cease and desist orders to insurers.

Medicaid: Results of Certified Fraud Control Units (GAO/HRD-87-12FS, Oct. 21, 1986)*

This fact sheet includes information on the 36 states that had Medicaid fraud control units as of September 30, 1985. It presents the results of GAO's efforts to determine, for states with certified fraud control units,

- their expenditures, including the federal and state governments' share of the expenses, for fiscal years 1984-85;
- their results, including the number of convictions obtained, fines imposed, restitution ordered, and overpayments identified for calendar years 1984-85 and their deterrent effect; and
- changes that could strengthen their fraud control efforts.

GAO obtained information from two major sources: (1) quarterly statistical data submitted by the fraud units to the Department of Health and Human Services' (HHS) Office of the Inspector General and (2) a questionnaire sent to the 36 certified units in operation during fiscal year 1985.

Pensions: Plans With Unfunded Benefits (GAO/HRD-87-15BR, Oct. 22, 1986)*

The vested benefits of about 30 million people participating in about 110,000 pension plans are guaranteed, within certain limits, by a government insurance program. The program, established in 1974 by the Employee Retirement Income Security Act, is administered by the Pension Benefit Guaranty Corporation (PBGC). When a plan terminates with insufficient assets to pay guaranteed benefits, PBGC becomes plan trustee and assumes responsibility for paying the benefits. Claims from underfunded plans that are terminated are financed from annual premiums paid to the program by ongoing plans.

Between the act's enactment and the end of fiscal year 1985, about 1,100 plans terminated with claims against the program because they were underfunded. Claims, which have been especially large in recent years, have exceeded income, causing the insurance program to operate at a deficit—estimated at $1.3 billion as of September 30, 1985.

GAO's analysis of the extent of vested benefit underfunding in 1983 covered 14,581 of the universe of about 22,000 large defined benefit plans (those with 100 or more participants).

GAO concluded that the contingent liability to PBGC's insurance program is significant and growing. Considering the insurance fund's current deficit, GAO believes that the program could be in jeopardy if the recent trend in the termination of plans with large amounts of unfunded benefits continues.

Social Security: Adjusting Continuing Disability Review Priorities (GAO/HRD-87-4, Oct. 22, 1986)*

GAO reviewed the Social Security Administration's (SSA's) plans for resuming continuing disability reviews (CDRs) involving SSA's implementation of the medical improvement review standard. GAO was concerned that the limited CDR resources of the states' Disability Determination Services (DDSs) were not concentrated on the CDR cases that (1) would produce the most savings to the trust fund because medical improvement is highly possible and (2) involve claimants who have had actions pending on their cases for some time.

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monthly report on terminations with excess assets, categorizes a termination as a spinoff when a plan is separated into two plans and one is terminated, irrespective of how working participants' pension coverage is affected.

GAO concluded that to decide if changes should be made to mitigate the potential adverse effects of terminations with excess assets on participants' pension coverage, policymakers need data showing the types of continuing coverage, if any, that participants receive after spinoff terminations. PBGC does not provide such information, however, and some plan terminations reported by PBGC in 1985 as spinoffs included working participants who received no continuing pension coverage or different coverage that may give them higher or lower benefits than before.

Health Facilities: New York State's Oversight of Nursing Homes and Hospitals (GAO/HRD-87-24, Nov. 28, 1986)*

Nursing homes and hospitals in New York State are inspected by the State Department of Health to ensure that the facilities comply with federal standards for participation in the Medicare and Medicaid programs. These inspections are made under an agreement between the state and HHS.

This report was prepared because of allegations concerning defects in the state's inspection process—particularly in New York City—that could lead to the certification of substandard facilities to participate in the programs, thereby resulting in beneficiaries receiving substandard care.

GAO's review did not substantiate the allegations. GAO did identify, however, some problems with the state's processes for inspecting facilities and investigating complaints about them.

Medicare: Need to Strengthen Home Health Care Payment Controls and Address Unmet Needs (GAO/HRD-87-9, Dec. 2, 1986)*

While families and friends provide most home care assistance for the elderly, Medicare paid about $1.7 billion for home health care services in fiscal year 1985—more than six times the amount paid in 1976. The Medicare home health benefit is intended to provide skilled nursing assistance to the elderly. In addition to medical services, the benefit covers personal care and, to a limited extent, homemaker services (such as washing clothes and preparing meals).

Because adequate alternative sources of home care services are lacking, the Medicare home health benefit is also being used to meet the needs of the chronically ill. Limiting this benefit to short-term assistance could,

therefore, increase the unmet home care needs of chronically ill persons. The rapidly expanding elderly population heightens the need to consider alternative ways to meet these needs.

Reviews by GAO in 1981 and by HHS in 1984 identified material weaknesses in internal controls over payment for Medicare home health services. This report states that HHS has been slow to implement changes to strengthen management controls in response to GAO's 1981 recommendations.

This report also summarizes concerns expressed by the home health industry and others about the effects tighter program controls would have on Medicare beneficiaries' ability to obtain needed home care services. GAO points out that HHS, however, has not evaluated available data to determine what effect stronger controls would have on unmet need for home health care assistance.

Social Security Disability: Implementation of the Medical Improvement Review Standard (GAO/HRD-87-3BR, Dec. 16, 1986)*

This briefing report discusses SSA's and the state DDSs' implementation of the medical improvement review standard, which resulted from the Social Security Disability Benefits Reform Act of 1984.

GAO provides information on SSA's efforts in resuming CDRs and its future plans for conducting these reviews.

Medical Malpractice: Six State Case Studies Show Claims and Insurance Costs Still Rise Despite Reforms (GAO/HRD-87-21, Dec. 31, 1986)*

During the mid-1970's, the unavailability and increasing cost of medical malpractice insurance prompted 49 states to enact various reforms. GAO obtained views of organizations representing physicians, hospitals, insurers, and lawyers in six selected states on perceived malpractice insurance problems, such as the cost and availability of insurance, number of claims filed, and size of malpractice awards/settlements; actions taken to deal with them; the results of these actions; and the need for federal involvement.

GAO reported that reforms to deal with medical malpractice problems can focus on changing the tort system, changing the way public bodies and peer groups regulate health care providers, changing the way the insurance industry is regulated, and developing realistic consumer

expectations about the health care delivery system. Most of the changes made by the six states to respond to the crisis of the mid-1970's focused on tort reforms designed to assure the availability and to reduce the cost of malpractice insurance.

While it is possible that the reforms which focused on changing the tort laws moderated upward trends in some states, GAO data showed that since 1980, insurance costs for many physicians and hospitals increased dramatically, as did the number of malpractice claims filed and the average amounts paid.

Medical Malpractice: Case Study on Arkansas (GAO/HRD-87-21S-1, Dec. 31, 1986)*

Although medical malpractice insurance rates have increased since 1980, the cost of this insurance for physicians and hospitals in Arkansas was not viewed as a major current problem by the six interest groups GAO surveyed. Major problems were expected to develop in the future, however, regarding the cost and availability of malpractice insurance, legal expenses/attorneys' fees for malpractice claims, and physicians' actions to reduce or prevent malpractice claims.

Although the state enacted some tort reforms to address medical malpractice problems, the interest groups GAO surveyed believed the reforms had not had much effect. There was little support for federal involvement in the medical malpractice situation in Arkansas, and most groups believe that problems should be addressed at the state rather then the federal level.

Medical Malpractice: Case Study on California (GAO/HRD-87-21S-2, Dec. 31, 1986)*

California health care and insurance officials that GAO contacted generally believe that the state's comprehensive 1975 medical malpractice legislation, which has survived numerous constitutional challenges, has helped to moderate increases in malpractice insurance costs and malpractice awards/settlements. These officials told GAO that they expect the legislation to have a greater effect in the future since the California Supreme Court has upheld the major provisions as constitutional, and the U.S. Supreme Court has twice refused to hear cases regarding this legislation. Despite these efforts, however, physician and hospital malpractice premiums are continuing to rise, as are the number and size of malpractice claims and settlements.

The California Trial Lawyers Association believed that legislation had impaired the rights of the malpractice victim to receive fair compensation for injuries caused by health care providers' negligence.

California's health care providers and malpractice insurers still believe that there are major problems in the state regarding (1) the high cost of malpractice insurance, (2) the excessive size of malpractice awards/settlements, (3) the high legal costs associated with defending claims, and (4) the incentive to perform medically unnecessary procedures to reduce the risk of liability (i.e., defensive medicine).

There was no widespread support for any federal involvement among the groups GAO surveyed. Officials generally believed that malpractice problems should be addressed at the state level.

Medical Malpractice: Case Study on Florida (GAO/HRD-87-21S-3, Dec. 31, 1986)*

Florida's medical malpractice insurance crisis in the mid-1970's was one of availability, largely due to the withdrawal or threatened withdrawal of several large medical malpractice insurers in the state. By the mid-1980's, the problem had shifted to one of affordability.

The Florida legislature responded with legislation in 1974, 1975, 1976, 1985, and 1986. None of the interest groups GAO surveyed believed that the tort reforms enacted in the mid-1970's have had a major effect on the cost of insurance, the frequency of claims, and the size of awards/settlements. GAO data showed that the cost of insurance increased greatly between 1980 and 1986 and the frequency and size of claims also increased between 1980 and 1984, but somewhat less significantly.

Regarding the 1985 legislation, representatives of several interest groups believe certain aspects of the act, such as increased emphasis on risk management and disciplinary measures against physicians with malpractice histories, will have some benefit. A majority of the groups GAO surveyed expressed support for several provisions of the 1986 act, such as a cap on awards for pain and suffering and the elimination of joint and several liability for the noneconomic portion of damages.

Medical Malpractice: Case Study on Indiana (GAO/HRD-87-21S-4, Dec. 31, 1986)*

State officials generally believed that Indiana's Medical Malpractice Act of 1975 and subsequent amendments have greatly stabilized the malpractice insurance situation during the past 11 years by holding down premium costs and attracting additional companies into the state market. They pointed out that insurance costs for Indiana physicians and hospitals, before increases in 1985, were among the lowest in the nation, compared to the mid-1970's, when they were higher than most neighboring states.

A key provision of the act was the establishment of the Patient's Compensation Fund to pay malpractice awards or settlements in excess of $100,000, up to a $500,000 cap. To participate, physicians and hospitals pay a surcharge based on the premiums paid to their insurance companies for the basic coverage. Indiana officials were concerned that the increasing number and size of payments from the fund might adversely affect its solvency. According to the Indiana Department of Insurance, the fund was kept solvent in 1984 only by a transfer of $7.2 million from the reserves of the state's medical malpractice joint underwriting association.

Several actions have been taken in recent years to strengthen the fund's ability to remain solvent. These actions include (1) increasing surcharges, (2) allowing the Department of Insurance to hire private-sector lawyers and other personnel to help defend claims against the fund, and (3) permitting periodic payments in lieu of lump-sum payments.

Medical Malpractice: Case Study on New York (GAO/HRD-87-21S-5, Dec. 31, 1986)*

New York's medical malpractice insurance crisis in the mid-1970's was one of availability, primarily due to the withdrawal of two large insurers. By the 1980's, the problem shifted to affordability, as companies raised their rates. The New York state legislature responded to malpractice insurance problems by several legislative initiatives—the latest in 1985 and 1986. Although it is too early to tell how effective the latest reform will be, insurance rates have continued to climb for hospitals and physicians, particularly for high-risk specialties. The rates are among the highest in the nation.

Of the interest groups surveyed, New York's Hospital Association, Bar Association, and the Trial Lawyers Association supported additional actions to strengthen licensing and relicensing of physicians. To regulate the profession, the New York Bar Association favored setting insurance rates for physicians according to their malpractice claims and loss experience rather than revoking physician licenses.

There was no agreement among the interest groups surveyed that the federal government should assume a role in addressing medical malpractice insurance problems. Only the physician organizations surveyed supported a federal role to develop a uniform system for resolving medical malpractice claims.

Medical Malpractice: Case Study on North Carolina (GAO/HRD-87-21S-6, Dec. 31, 1986)*

Since 1980, medical malpractice insurance premiums have increased significantly for physicians and hospitals in North Carolina. The frequency of claims and the average paid claim also increased between 1981 and 1984 for physicians and hospitals.

Several interest groups identified major current medical malpractice problems regarding the increasing size of malpractice awards/settlements, the equity of awards/settlements for malpractice claims, and legal expenses for malpractice claims. The groups expect these problems to continue and anticipate that the cost of malpractice insurance and the number of claims filed would become major problems in the future. To address malpractice problems, four of the six interest groups GAO contacted strongly supported use of risk management programs designed to reduce the incidence of malpractice claims by eliminating problems that result in those claims.

The groups surveyed by GAO supported state rather than federal actions to address malpractice problems.

Posthospital Care: Discharge Planners Report Increasing Difficulty in Placing Medicare Patients (GAO/PEMD-87-5BR, Jan. 23, 1987)*

In this report, GAO summarizes information obtained from hospital discharge planners regarding their perceptions about problems in placing Medicare patients in posthospital care and the reasons for those problems.

This information was collected in a sample survey of 935 Medicare certified acute care hospitals. To GAO's knowledge, it is the first nationally representative study of changes believed to be occurring in Medicare patients' access to posthospital care.

Mental Health Care: Licensing and Certification Requirements for Staff in State Hospitals (GAO/HRD-87-38FS, Jan. 29, 1987)*

In this fact sheet, GAO reported information from 39 states on the minimum licensing and certification requirements for physicians, psychiatrists, psychologists, social workers, and nurses who work directly with patients in state mental hospitals.

The minimum licensing and certification requirements for these professionals varied among the 39 states.

Medicare: More Hospital Costs Should Be Paid by Other Insurers (GAO/HRD-87-43, Jan. 29, 1987)*

To help control rising Medicare costs, the Congress has required that, in certain cases, health and accident insurers covering Medicare beneficiaries pay medical claims ahead of Medicare. While the percentage of beneficiaries having insurance that pays before Medicare is relatively small (an estimated 4 percent), hundreds of millions of dollars in annual savings is achievable by billing such coverage.

In this review, GAO sought to determine whether HHS, which administers Medicare, could improve existing policies and procedures for identifying and billing other insurers that should pay for hospital claims before Medicare. GAO identified the problems that appeared to be the main hindrances to a more effective system for identifying and billing primary insurers and made several related recommendations to HHS.

Social Security: Demonstration Projects Concerning Interviews With Disability Claimants (GAO/HRD-87-35, Feb. 19, 1987)*

SSA's demonstration projects involve interviews with disability claimants at the initial decision level, before a final unfavorable decision is made by the state disability agencies. The claimants are initial applicants and beneficiaries whose claims are being examined for eligibility through continuing disability reviews. The demonstration projects were mandated by the Social Security Disability Benefits Reform Act of 1984.

For this report, GAO discussed implementation with officials from SSA and participating states, reviewed the scope of work for the contractor hired by SSA to evaluate the projects, and reviewed the contractor's design and analysis plan.

GAO found certain factors that may detract from a successful demonstration and made several recommendations to SSA to help ensure that the demonstration and its evaluation provide the Congress with objective and meaningful data.

Health Facilities: Problems at Harlem Hospital in Complying With Medicare Standards (GAO/HRD-87-58, Feb. 20, 1987)*

GAO obtained information on the Harlem Hospital Center's compliance with Medicare standards and determined the actions the New York State Department of Health and HHS's Health Care Financing Administration (HCFA) have taken in response to deficiencies found at the hospital.

These deficiencies were persistent and serious, with many involving actual or potential patient harm. As a result, the state fined the hospital for violating state hospital standards, and the hospital agreed to a corrective action plan. In addition, HCFA, which administers Medicare, (1) concluded that the hospital was not meeting Medicare standards and (2)

directed the state, which serves as HCFA's agent, to monitor the actions the hospital had taken to correct its deficiencies.

Budget Reduction: Effect of 1986 Sequestration on National Institute on Aging (GAO/HRD-87-54BR, Mar. 6, 1987)*

Under the Balanced Budget and Emergency Deficit Control Act of 1985, known as the Gramm-Rudman-Hollings Act, the National Institute on Aging's (NIA) fiscal year 1986 budget authority was reduced by 4.3 percent. In congressional testimony on the potential effects of this reduction, the Director of NIA anticipated that

- the reduction would result in each of NIA's seven budgetary line items being reduced by 4.3 percent,
- the total number of research grants would be reduced,
- the funding for the Alzheimer's disease research centers could not be protected, and
- delays would occur in funding certain Alzheimer's disease research projects.

In response to a congressional request, GAO reviewed NIA budget and grant information and interviewed various NIA officials and found that although the overall appropriation of $156.5 million was reduced by 4.3 percent, or 6.7 million, the anticipated effects did not materialize.

Medicaid: Lessons Learned From Arizona's Prepaid Program (GAO/HRD-87-14, Mar. 6, 1987)

In 1985, providing medical care for low-income persons through the federally funded, state-administered Medicaid program cost about $38 billion. Resulting financial strains on both the federal and state governments have sparked national interest in ways to constrain these costs.

One experiment to limit Medicaid costs is Arizona's Health Care Cost Containment System, under which the state contracts with prepaid health plans to provide comprehensive medical care for a set monthly fee per patient.

GAO reviewed the program's first 3 years of operation (Oct. 1982-Sept. 1985) to examine Arizona's approach to

- competitive bidding for procuring health plan contracts,
- collection of utilization data from the prepaid plans on the health care services provided, and
- financial oversight of the prepaid health plans.

The Arizona program experienced numerous start-up problems that prevented an assessment of the effectiveness of its cost containment feature. GAO believes other states considering prepaid Medicaid programs can learn from Arizona's problems and solutions.

Insurance Reserves: Strategies for Regulating the Federal Employees Health Benefits Program (GAO/HRD-87-10, Mar. 6, 1987)*

The Federal Employees Health Benefits Program (FEHBP) is administered by the Office of Personnel Management (OPM) through contracts with participating health plans. In 1985, the program insured more than 8 million federal employees, annuitants, and dependents through 212 health plans that received about $6.4 billion in premiums.

In 1985, FEHBP reserves were record-breaking, accumulating more than $2 billion in reserve surplus and precipitating the program's first refund. Just 4 years earlier, certain FEHBP health plans faced financial difficulties because their reserve holdings were near depletion.

FEHBP reserves have fluctuated widely from their targets, needing frequent and often substantial adjustments to keep them at, or near, the preferred levels. With the number of uncertainties inherent in estimating health care costs, GAO doubts that OPM and the plans can set premiums accurately enough to avoid these reserve fluctuations. Consequently, OPM needs to use the best means available to equitably adjust reserves.

OPM and the plans have three strategies to regulate reserves—adjusting future premiums, modifying future benefits, or giving refunds. These strategies can also be used in combination. In GAO's opinion, adjusting future premiums is the best strategy.

Social Security: Staff Reductions and Service Quality (GAO/HRD-87-66, Mar. 10, 1987)*

In January 1985, the administration announced its intention to reduce SSA staff by 17,000, or 21 percent, through fiscal year 1990.

This is the first of three required reports on SSA staff reductions and the quality of service provided to the public. The report (1) discusses changes in traditional SSA service level indicators, such as payment accuracy and claim processing time; (2) analyzes current and past SSA staffing levels; (3) presents the views of SSA employees, managers, and clients on the quality of SSA service; (4) analyzes workloads and processing times for 15 SSA field offices that experienced significant staff reductions; and (5) examines SSA staff reduction actions in implementing its fiscal year 1987 budget.

Overall, SSA's traditional performance measures through December 1986 generally showed stable performance since fiscal year 1984—the year before the start of the staff reduction program. Similarly, about 80 percent of SSA clients GAO surveyed said that overall the quality of SSA service was good. GAO found that the 6-year staff reduction program is generally on schedule.

Social Security Administration: Stable Leadership and Better Management Needed to Improve Effectiveness (GAO/HRD-87-39, Mar. 18, 1987)

In fiscal year 1986, SSA employed about 78,000 people and spent $3.9 billion to administer programs that paid $200 billion in benefits to about 37 million people. While aspects of social security policy, such as eligibility or benefit levels, have always received public and congressional attention, less attention has been given to SSA's management.

GAO reviewed SSA's management of its program operations and found that SSA has serious management problems that, while not clearly visible to the public, have contributed to crisis situations in the past and could interfere with SSA's ability to effectively accomplish its mission in the future.

This report contains many specific recommendations to the Social Security Commissioner to improve management of the agency, but the most important recommendations are to the Congress and the President.

Pension Plans: Government Insurance Program Threatened by Its Growing Deficit (GAO/HRD-87-42, Mar. 19, 1987)*

The Employee Retirement Income Security Act of 1974 established funding standards and an insurance program to protect the benefits of about 30 million participants in over 110,000 single employer defined benefit pension plans. As of September 1985, the insurance program reported a deficit of $1.3 billion, but in January 1987 the deficit was estimated to be about $4 billion. The Single Employer Pension Plan Amendments Act of 1986 included provisions to improve the program's financial condition. In this report, GAO assessed the causes of large claims against the program and the potential effects of the 1986 amendments on the program.

GAO concluded that the positive effects of the 1986 amendments may not be enough to ensure the program's long-term financial viability and further changes may be needed to control program claims and finance those that do occur.

Medicare and Medicaid: Effects of Recent Legislation on Program and Beneficiary Costs (GAO/HRD-87-53, Apr. 8, 1987)*

During the 1970's, Medicare and Medicaid program costs grew rapidly—Medicare costs rose from about $6.9 billion in fiscal year 1970 to about $28.2 billion in fiscal year 1979, while Medicaid expenditures rose from about $4.6 billion to about $20.5 billion. During the following 7 years, 1980-86, the Congress enacted more than 30 laws that affected these two health insurance programs.

This report provides GAO's analyses of the effects of major legislative changes from 1980 to 1986 on Medicare and Medicaid program costs and the out-of-pocket costs to the programs' beneficiaries.

Medicaid: Addressing the Needs of Mentally Retarded Nursing Home Residents (GAO/HRD-87-77, Apr. 15, 1987)

Established as a partnership between the federal and state governments, Medicaid finances care for the retarded in nursing homes. In addition to meeting the medical needs of their residents, nursing homes are required to provide services to their mentally retarded residents to help them function independently.

This report discusses GAO's review of Medicaid management controls and whether they adequately ensure that mentally retarded nursing home residents receive the services they need to help them function independently. In its review of three states' nursing homes, GAO found that mentally retarded residents' active treatment needs were not being identified and met.

Medical Malpractice: Characteristics of Claims Closed in 1984 (GAO/HRD-87-55, Apr. 22, 1987)*

Since national data on medical malpractice claims had not been collected since 1978, GAO undertook a review to obtain information that would answer the following questions:

- How many malpractice claims were closed?
- How many health care providers were involved?
- What were the allegations of negligence leading to the claims?
- How much was paid to those who filed claims?
- What were insurers' costs to investigate and defend the claims?

To do this review, GAO analyzed data from a random sample of malpractice claim files closed in 1984 by 25 insurers. The insurers were randomly selected from a universe of 102 insurers that wrote a total of $2.3 billion in direct premiums in 1983 for medical malpractice insurance.

Medicaid: Determining Cost-Effectiveness of Home and Community-Based Services (GAO/HRD-87-61, Apr. 28, 1987)

In passing the 1981 Omnibus Budget Reconciliation Act, the Congress authorized adding home and community-based services to the Medicaid program through the use of waivers. The intent was to offer alternatives to nursing home care without increasing Medicaid costs. In principle, by providing certain kinds of social services (such as help with cooking, housekeeping, or such personal care needs as bathing) to people living in the community, nursing home care can be avoided or postponed.

To provide these alternative services, traditional Medicaid requirements must be waived by the Secretary of HHS. The state must assure HHS that its estimated Medicaid costs with the added home and community-based services will not exceed its estimated costs had no waiver been approved. To evaluate the costs experienced by these alternative care programs, HCFA, the HHS component that administers Medicaid, requires states granted waivers to report cost and recipient data.

GAO reviewed reports from the states on the Medicaid home and community-based services program to see if accurate, complete, and useful information was being collected. GAO reported that HCFA had not obtained the information necessary to evaluate the Medicaid home and community-based services program. Information collected during the first 5 years of the program has been neither accurate nor consistently reported and consequently is not useful for evaluating the operating experience of most waiver programs.

To remedy these shortcomings, HCFA recently revised its reporting requirements and instructions. GAO believes the changes will improve the accuracy and usefulness of states' reports but recommended that HCFA develop information to measure the extent to which the program prevents or postpones the use of nursing home care. Without such information, the program's cost-effectiveness cannot be adequately evaluated.

Health Care: Patient Transfers From Emergency Rooms to D.C. General Hospital (GAO/HRD-87-31, Apr. 30, 1987)*

There have been many changes in the past 3 or 4 years concerning the way hospitals are reimbursed for care by the government and private insurers. Consequently, one of the concerns of many people has been that private hospitals may be "dumping" patients on public hospitals to escape having to treat people who may not have the financial means to pay for their care.

District of Columbia law requires that D.C. General Hospital treat all Washington, D.C., residents regardless of their ability to pay for the care

received. The D.C. government provides the hospital with funds to offset the cost of treating these residents. The hospital has adopted a transfer policy and procedures outlining the conditions under which it will accept transfers of D.C. residents from other hospitals' emergency rooms.

This report discusses

- the policy and procedures for transferring patients from other hospitals' emergency rooms to D.C. General,
- Washington metropolitan area hospitals' violations of the transfer policy and procedures,
- Washington metropolitan area hospitals' familiarity with the policy and procedures,
- characteristics of patients transferred to D.C. General, and
- how professional medical organizations view transfers and how other metropolitan areas across the country deal with them.

Medicaid: Interstate Variations in Benefits and Expenditures (GAO/HRD-87-67BR, May 4, 1987)*

The Medicaid program is jointly financed with state and federal funds. The latter are determined by a statutory formula that provides a higher federal share to states with lower per capita incomes. Within broad federal guidelines, each state designs and administers its own Medicaid program. Consequently, significant interstate variations exist along important program dimensions.

This briefing report provides information on the causes of interstate variations in Medicaid spending and the growth in overall spending. Using published and unpublished information, GAO identified trends and wide variations among states in Medicaid spending and compared (1) eligibility criteria used, (2) the scope of services offered, and (3) reimbursement to providers. GAO also reviewed and summarized other studies analyzing the underlying causes of the variations identified.

Medical Malpractice: A Framework for Action (GAO/HRD-87-73, May 20, 1987)*

Because of increases in the costs of medical malpractice insurance over several years, GAO was asked to assess the nature of the problems, how various states have tried to deal with them, and what federal and state actions may be warranted. The purpose of this report, the final one in a series of five, was to suggest actions that appear to GAO to be appropriate beginnings to address medical malpractice problems.

Overall, GAO's work showed that there are no clear causes for the increases in the cost of medical malpractice insurance. And there is no specific action that GAO could identify that would guarantee that insurance rates will not continue to increase.

But GAO suggests actions that all affected parties could take that have some promise of reducing the cost of insurance. These actions include reducing the incidence of medical malpractice by ensuring that physicians are held accountable by their peers and others for the manner in which they practice medicine; improving efficiency, predictability, and equity in the way medical malpractice claims are resolved; determining the extent to which regulatory agencies have and use information to make decisions about rates and solvency; and better educating patients as to what their expectations should be from the health care system.

Long-Term Care Insurance: Coverage Varies Widely in a Developing Market (GAO/HRD-87-80, May 29, 1987)*

In 1988, estimated nursing home expenditures will exceed $46 billion, of which the elderly and their families will pay about half. Private long-term care insurance is one method of financing these potentially catastrophic expenses.

The Medicare program and private Medicare supplemental insurance provide limited nursing home coverage for skilled care services. State Medicaid programs cover extended nursing home stays associated with chronic, debilitating disease, but only for those who meet strict eligibility standards based on income and resources.

Unlike the Medigap insurance market, no federal legislation defines guidelines for the long-term care insurance market. In this report, GAO provides information on the private long-term care insurance market. GAO focuses on policy benefits and premiums, policy limitations and restrictions, and the potential for abuse in the market.

Social Security: Staff Reductions and Service Quality (GAO/HRD-87-97BR, June 2, 1987)*

This briefing report was the second of three reports on staff reductions and service quality at SSA. Overall, SSA reduced its staff by 3 percent in the first half of fiscal year 1987, with field offices taking the largest reduction—about 5 percent.

In most cases, GAO found that SSA's key performance indicators showed stable or improved performance. For example, pending workloads for disability claims were down, processing times for initial claims were virtually unchanged, and Supplemental Security Income processing accuracy was slightly higher.

In other cases, GAO noted apparent temporary or seasonal declines in SSA performance. For example, due to a significant increase in requests for hearings, the pending hearings workload and the average processing time for hearings had increased.

VA Health Care: Financial and Quality Control Changes Needed in Domiciliary Care (GAO/HRD-87-57, June 18, 1987)

As part of its national health care system, the Veterans Administration (VA) operates 16 domiciliaries. VA has described domiciliary care as less intensive than hospital and nursing home care, but higher than that provided in a residential setting. During fiscal year 1986, VA domiciliaries operated about 7,000 beds at a cost of about $100 million.

Based on its review of three domiciliaries, GAO estimated that about 29 percent of the veterans had incomes that exceeded the $415 a month eligibility limit. However, the income limit for domiciliary eligibility has not been updated since 1980 and is significantly lower than limits for other VA health care programs.

In addition, the three domiciliaries had not always documented whether physical examinations had been performed and treatment plans properly developed. GAO could not conclude that the domiciliaries' lack of compliance with the required procedures affected the quality of care provided. GAO believes, however, that the lack of compliance increases the likelihood that veterans' medical needs would not be met.

Medicare: Comparison of Catastrophic Health Insurance Proposals (GAO/HRD-87-92BR, June 19, 1987)*

Public programs—financed primarily by Medicare, Medicaid, and VA—financed two-thirds of the elderly's estimated $120 billion in personal health care expenditures in 1984. Although the scope and coverage of medical services under Medicare is broad, considerable beneficiary cost sharing is required. Also, some health care expenses—such as outpatient drugs; vision, hearing, and dental care; and care provided in intermediate or custodial care facilities—are not covered at all.

Currently, there is no catastrophic limit on medical expenses paid by the beneficiary. The Secretary of HHS has described catastrophic illness expenses as those that cannot be borne by individuals and families without having to significantly change their life style or drastically modify their expectations of living standards in the future.

GAO reviewed 14 legislative proposals and found that 9 would establish a catastrophic limit above which the beneficiary would no longer be liable for Medicare deductibles and coinsurance. Two of the legislative proposals have been approved by the House Committee on Ways and Means and the Senate Committee on Finance; both have financing mechanisms that relate the amount beneficiaries pay for catastrophic coverage to their incomes. GAO reported that these bills, if enacted, would represent an important step in increasing the health insurance coverage available to the elderly, but significant gaps will remain. Providing further relief to the elderly who incur high out-of-pocket health care costs would obviously increase Medicare payments.

Medicare: Rehabilitation Service Claims Paid Without Adequate Information (GAO/HRD-87-91, July 9, 1987)

Since 1983, when Medicare began to phase in its hospital prospective payment system, outpatient rehabilitation has become an important alternative source of therapy because the system has given hospitals incentives to discharge beneficiaries to outpatient care as soon as medically appropriate.

In 96 percent of its sample cases, GAO found that the documentation available to the claims-processing contractors when they paid outpatient rehabilitation services claims was insufficient to determine whether the beneficiary was eligible for these services. Many cases in the sample were of types indicating that services probably were not eligible for coverage. For example, 16 percent of the cases were for beneficiaries with diagnoses that HCFA has identified as normally having little rehabilitation potential.

The report discusses HCFA's actions to strengthen controls over payments for outpatient physical therapy and services provided, but GAO believes that unless the documentation of claims is improved, these actions will not solve the problems.

Medicare: Preliminary Strategies for Assessing Quality of Care (GAO/PEMD-87-15BR, July 10, 1987)*

Medicare reimburses physicians, other practitioners, and suppliers on a fee-for-service basis and, until recently, paid all facility-based providers on a cost basis. This created incentives to overuse Medicare services.

The introduction of a payment system based on prospectively determined fixed amounts for acute care hospitals and the growth of prepaid health care programs (health maintenance organizations and competitive medical plans) created new incentives to increase efficiency by reducing unnecessary or inappropriate care. GAO found that incentives to increase efficiency in the delivery of health services may lead to the withholding of some useful, needed services, and that Medicare payment reforms have increased the potential for quality-of-care problems.

This briefing report summarizes GAO's analysis of Medicare's quality-of-care review system. Also in this document GAO identifies four short-term options and outlines three long-term strategies for producing comprehensive quality-of-care information.

Veterans Administration: VA Pensions to Medicaid Nursing Home Residents Should Be Reduced (GAO/HRD-87-111, July 10, 1987)

Under title 38 of the U.S. Code, a VA pension is reduced if the beneficiary enters a VA-supported nursing home and does not have a spouse or other dependent living in the community. A similar provision does not exist, however, when the beneficiary enters a nursing home as a Medicaid patient.

Because Medicaid recipients must apply any cash income and benefits they receive toward the cost of their care, the VA pensions do not generally benefit veterans and their survivors. Instead, they reduce Medicaid program costs. The primary beneficiaries of the reduced Medicaid costs are the states.

In this briefing report, GAO estimated, based on its review, that in fiscal year 1986, continuing VA pension payments to about 18,500 Medicaid nursing home residents in the eight states selected for this review cost the federal government about $27.2 million.

Social Security: Clients Still Rate Quality of Service High (GAO/HRD-87-103BR, July 14, 1987)*

This briefing report presents the final results of GAO's November 1986 nationwide survey of client satisfaction with the quality of service provided by SSA and compares the results with a similar survey GAO conducted 2 years earlier.

The 1986 survey was made because of concerns expressed about SSA services during implementation of the agency's plan—announced in January 1985—to reduce staff by 17,000 full-time equivalent positions through fiscal year 1990. Staff was reduced by about 4,500 full-time equivalent positions between the two surveys.

Comparing the results of the two surveys (using the same questionnaire for both) showed that clients rated the overall quality of service in 1986 about the same as, or better than, the service provided in 1984. Notably, no specific service aspects were rated significantly lower by 1986 respondents in comparison with 1984 respondents, and a number of aspects were rated higher. Several of the questions that drew more favorable responses in 1986 represented statistically significant differences.

Block Grants: Proposed Formulas for Substance Abuse, Mental Health Provide More Equity (GAO/HRD-87-109BR, July 16, 1987)*

In 1981, the Congress consolidated 10 project and formula grant programs into the Alcohol, Drug Abuse and Mental Health block grant. In fiscal year 1987, the current formula allocated over 91 percent of block grant funds to states based on their funding under the prior categorical programs, and the other 9 percent based on their relative funding needs and ability to pay. A draft bill would create separate programs for substance abuse and mental health, using separate formulas. Unlike the current formula, the proposed formulas would allocate all funds according to need and ability to pay and would use more precise measures of these two factors.

In this briefing report GAO concluded that the proposed formulas would substantially improve the equity of the distribution of federal funds. For substance abuse, they would help equalize service levels across states because higher funding levels would be allocated to states with the lowest spending and ability to pay. For mental health, the proposed formulas would preserve the targeting to poorer states that is provided by the current formula. Finally, in both substance abuse and mental health areas, the proposed formulas are designed to provide similar grants per person for states with similar abilities to pay.

Medicare: Prescription Drug Issues (GAO/PEMD-87-20, July 16, 1987)*

That the prescription drug costs are rapidly rising is an important fact for the millions of the elderly suffering from such conditions as diabetes, high blood pressure, various heart conditions, and some types of cancer. Because they depend on medication to help control these problems, buying prescription drugs is a major out-of-pocket health care expense for them.

This GAO report presents demographic information about prescription drug use and costs and then briefly discusses its coverage under Medicare, under Medicaid, and in states that have developed programs specifically to meet this need. The report also discusses how H.R. 2470 and S. 1127 would provide prescription drug benefits for the elderly and the population groups that would remain without benefits if these bills were enacted.

Medicare: Payments to Radiologists, Anesthesiologists, and Pathologists (GAO/HRD-87-114BR, July 20, 1987)*

This briefing report has information about the current Medicare payment mechanism for radiologists, anesthesiologists, and pathologists and the market structure for services provided by these physicians. GAO also looked at whether the financial interests of the Medicare program and its beneficiaries were considered when contracts were negotiated between hospitals and the physicians who specialize in these areas.

Medicare and Medicaid: Stronger Enforcement of Nursing Home Requirements Needed (GAO/HRD-87-113, July 22, 1987)*

Together, Medicare and Medicaid pay about half of the nation's nursing home costs. Because of continuing concern about the quality of care provided to nursing home residents, GAO was asked to determine the extent of repeated noncompliance with federal requirements that could affect resident health and safety and evaluate the adequacy of federal and state enforcement actions to correct reported deficiencies.

GAO reported that nursing homes can remain in the Medicare and Medicaid programs for years with serious deficiencies that threaten patient health and safety by taking corrective action to keep from being terminated each time they get caught. GAO analyzed the four most recent inspections (covering about a 4-year period) for nursing homes participating in the programs in November 1985. Forty-one percent of skilled nursing facilities and 34 percent of intermediate care facilities nationwide were out of compliance during three consecutive inspections with

one or more of the skilled or intermediate care facility requirements considered by experts to be most likely to affect patient health and safety. Determining the actual effects on patients' health and safety was beyond the scope of GAO's review.

Although a nursing home that has the same deficiencies in consecutive inspections without adequate justification should be terminated, according to Medicare and Medicaid regulations, neither HHS nor the states were enforcing this rule. No federal penalties currently apply to deficiencies, even if uncorrected, that do not pose an immediate threat to resident health and safety. The ability to avoid penalty even for serious or repeated noncompliance gives nursing homes little incentive to maintain compliance with federal requirements.

GAO believes additional sanctions are needed to strengthen federal and state enforcement options.

Medicare: Catastrophic Illness Insurance (GAO/PEMD-87-21BR, July 31, 1987)*

One of the most important issues of the late 1980's is how to protect the elderly and their families against the catastrophic expenses they may face when they have acute medical problems or when they need long-term care because of chronic illness and disabling conditions, such as stroke and Alzheimer's disease. Despite Medicare benefits and private insurance supplements to that program, out-of-pocket expenditures for medical care substantially burden many.

For this briefing report, GAO developed the following material:

- A comparison of major legislative proposals with the current Medicare program with respect to benefits to enrollees, their costs, and the program's financing mechanisms.
- A discussion of important issues that may still need attention.
- A synthesis of lessons learned from the operation of state-financed insurance programs for catastrophic illness that the Congress might consider in developing a federal program.

Pension Plans: Many Workers Don't Know When They Can Retire (GAO/HRD-87-94BR, Aug. 12, 1987)*

Millions of workers do not understand their pension plans' early and normal retirement eligibility requirements as described in their plans' documents.

GAO focused its review on assessing workers' knowledge of their pension plans, but it did not determine the causes for their lack of knowledge, nor did it address the extent to which this lack of knowledge could result in poor career and retirement planning decisions. GAO concluded, however, that unless employers provide and workers obtain accurate pension plan information before workers make decisions affecting their careers, the workers may make work and retirement decisions they later regret.

Protecting the Elderly: Federal Agencies' Role Concerning Questionable Marketing Practices (GAO/HRD-87-120FS, Aug. 26, 1987)*

Certain "aging organizations" have attempted to solicit funds, sell insurance, and offer direct-mail advertising of products in a manner that may frighten, threaten, or otherwise coerce the elderly into contributing money or buying products from these organizations.

In this fact sheet, GAO (1) identifies federal agencies with jurisdiction in reviewing the activities of organizations that use direct-mail advertising, (2) identifies federal statutes or regulations these agencies may use to protect the elderly, (3) discusses current activities of these agencies to protect the elderly, and (4) discusses agency educational activities to prevent possible abuses of the elderly.

Medicaid: Improvements Needed in Programs to Prevent Abuse (GAO/HRD-87-75, Sept. 1, 1987)

A small percentage of recipients and providers abuse Medicaid services. Abuse occurs when a provider prescribes services that are not needed or are too expensive or when a Medicaid recipient obtains drugs or other services at a frequency or in an amount not medically necessary.

The Medicaid law requires states to identify and investigate cases of suspected Medicaid abuse by reviewing recipients' and providers' use of Medicaid services. To facilitate reviews, in fiscal year 1985, state and federal costs for design, installation, and operation of the computerized information systems to operate the programs were about $430 million.

Although GAO and others have previously identified weaknesses in states' postpayment utilization review programs and HHS's oversight, GAO concluded HHS has not taken effective action to strengthen management controls. GAO found (1) some states reviewed were not effectively using their computerized management information systems to identify

potential Medicaid abuse, (2) some states were reviewing only a small portion of the potentially abusive recipients identified, and (3) most states have applied sanctions against few abusive Medicaid recipients.

Social Security: Telephone Accessibility (GAO/HRD-87-138, Sept. 16, 1987)*

SSA offices may be contacted by the public through 34 teleservice centers (SSA's primary telephone service facilities), 32 other central answering units, and telephone service directly from 627 local offices that are not supported by centralized answering facilities.

GAO tested accessibility to SSA by telephone by measuring the extent to which telephone calls to SSA's local offices and teleservice centers during a single workweek were answered directly, put on hold before being answered, got a busy signal, went unanswered, or were disconnected.

SSA representatives answered, during the test period, about two of every three calls from the public directly or within 2 minutes of being put on hold, by GAO estimates. As a group, local offices were more easily accessible than teleservice centers. Success in reaching SSA fluctuated by day of the week, with Monday being the most difficult day for getting calls answered.

Social Security: Staff Reductions and Service Quality (GAO/HRD-87-139BR, Sept. 17, 1987)*

This briefing report was the last of three reports on staff reductions and service quality at SSA during fiscal year 1987. It describes changes in staffing and performance for the third quarter of fiscal year 1987 and presents the results of GAO visits to 13 offices where allegations had been made about practices affecting reported office performance.

GAO reported that overall, key performance indicators showed stable performance as staff levels continued to decline. During GAO's visits to the 13 offices, SSA employees said that practices that can distort reported performance are occurring. But employees held a wide range of views as to the extent to which these practices were occurring. Internal controls to detect the practices generally rely on supervisors and office managers to monitor employees' work. While the potential exists, GAO found little evidence that the practices were used to conceal any direct harm to the public.

GAO determined that it is unclear to what extent the root causes of these improper practices were local management shortcomings, poor employee performance, or other factors cited by employees, such as insufficient staff or overemphasis on achieving certain productivity goals.

Social Security: More Must Be Done to Credit Earnings to Individuals' Accounts (GAO/HRD-87-52, Sept. 18, 1987)

Employers report employees' earnings to SSA and the Internal Revenue Service (IRS) at different times and for different purposes. IRS compares the annual total earnings employers reported to SSA for each employee with the total of the quarterly earnings employers reported to IRS. Subsequently, IRS tells SSA which employers may not have reported any or all earnings to SSA. In many cases, contacts with the employers are necessary to determine whether all earnings were reported.

GAO reported that the slow progress by SSA and IRS in reconciling differences in employee earnings has resulted in (1) Social Security beneficiaries receiving less in benefits than they were entitled to and (2) the Social Security trust funds' retaining $7.7 billion in tax money, as of March 1987, related to earnings not recorded in SSA records.

During 1978-84, SSA recorded about $58.5 billion less in employees' earnings than IRS. Although this represents only about 0.8 percent of all earnings that SSA recorded during this period and seems relatively small, the impact on those affected by uncredited earnings can be significant.

To insure the timely reconciliation of differences between the two agencies in employer-reported earnings, this report (1) included recommendations to the Secretaries of the Treasury and HHS and (2) suggested several matters for the Congress to consider.

Veterans' Benefits: Improving the Integrity of VA's Unemployability Compensation Program (GAO/HRD-87-62, Sept. 21, 1987)*

VA pays basic compensation benefits to veterans disabled by injuries or disease that were suffered or aggravated while on active military duty. Basic benefits can be increased if VA determines that the veteran is unemployable due to the service-connected disability. VA generally requires veterans to report their annual earnings because those with earnings above marginal amounts are not eligible for unemployability benefits.

GAO matched SSA's earned income file and VA's unemployability file to determine how access to tax information could help VA determine the extent of a veteran's earnings. GAO found (1) based on SSA's earned income files, over 90 percent of the veterans who should have reported their earnings to VA failed to do so, and (2) access to SSA's files would enable VA to identify those veterans not reporting their earnings as required.

GAO also found that VA does not routinely obtain all medical and vocational information needed to determine a veteran's ability to engage in a

substantially gainful occupation. As a result, GAO believes VA does not always have an adequate basis for awarding or denying a veteran's claim for unemployability benefits.

Medicare: Legislative Amendment Would Avoid Adverse Effects on Disabled Beneficiaries (GAO/HRD-87-135, Sept. 28, 1987)*

Section 9319 of the Omnibus Budget Reconciliation Act of 1986, effective January 1, 1987, amended Medicare law to require certain employer-sponsored group health insurers that cover disabled beneficiaries to pay the medical claims of such beneficiaries ahead of Medicare. A disagreement has arisen about whether this law applies to health plans sponsored by government employers.

GAO concluded that until this issue is resolved, disabled beneficiaries who have health coverage under Medicare and a government-sponsored plan can be faced with a situation in which neither will pay for services. Also, unless the law applies to government-sponsored plans, a portion of the Medicare savings that were projected when the law was passed will not be realized.

GAO believes that the Congress should amend the Social Security Act so that there can be no doubt that this provision applies to government-sponsored plans. This would eliminate the controversy and make the law consistent with similar provisions for other Medicare beneficiaries who are covered by government-sponsored health plans.

GAO Audits in Process Relating to Issues Affecting the Elderly

VA Health Care: Assuring Quality Care for Veterans in Community and State Nursing Homes*

Review of Appropriateness and Impact of Medicare Fee Schedules for Laboratory Services

HCFA's Ongoing Efforts to Assure the Appropriateness of Medicare's Diagnosis Related Group Payment Rates

Survey of Medicare Payments for Services Provided by Health Maintenance Organizations

Study of Variations in Medicare Payments to Teaching and Nonteaching Hospitals

Employers Not Covered Under Employer Health Insurance Programs*

Review of Medicare Carriers' Utilization Review Activities*

Review of HCFA Evaluation of Peer Review Organizations for Contract Renewal*

Survey of Costs and Use of Contracts with Noncertified Nursing Agencies to Provide Medicare Home Health Services*

Medicaid Fraud in the Dispensing of Controlled Substances

Impact of Applying Home Health Cost Limits by Discipline

Survey of Medicare and Secondary Payer Program for Disabled Beneficiaries

Adequacy of Intermediaries' and Carriers' Services to Medicare Beneficiaries and Providers

Survey of Contractors' Performance Under the Tri-State Fixed-Price Contracts for Medicare Part B*

Evaluation of Medicare Hospice Program

Review of Physician Incentive Plans Used by Health Maintenance Organizations With Medicare Risk Contracts*

Analysis of Medicare's Proposal to Contract With Employer-Based Plans*

Review of Hospital Indemnity and Specified Disease Insurance*

Evaluation of Medicare Part B Secondary Payer Program

Review of HealthChoices Marketing Activities Under Demonstration Contract With HCFA*

Survey of HCFA Management of Medicare Peer Review Organization Program*

Survey of Administration of Medicare's Tax Equity and Fiscal Responsibility Act Health Maintenance Organization Program*

Survey of Transfer of Medicare Patients to VA Hospitals

Analysis of HCFA's Health Maintenance Organization Activities*

Follow-up Review of the Effect of Federal Cost Containment Efforts on Medicare and Medicaid Programs

Assessment of Timeliness of Medicare Claims Payments for Deceased Beneficiaries

Evaluation of Quality of Service Under Medicare Program

Assistance to Senate Aging Committee in Determining Reasons for the Large Medicare Part B Premium Increases for 1987*

Effect of Prospective Payment System on the Closing of Rural Hospitals

Monitoring and Evaluating the Implementation of Philadelphia's Medicaid Health Insuring Organization (HealthPass)*

Review of Transfer of Assets for Persons to Become Eligible for Medicaid Nursing Home Care

Review of Application of Residents' Income to Offset Medical Costs in Nursing Homes

Survey of Benefits and Protections to Private Long-Term Care Insurance Policyholders*

Survey of Adequacy of Access to Nursing Homes for Medicaid Beneficiaries*

Review of Medicaid Nursing Home Residents' Savings Bond Holdings

Pension Plans: Possible Effects of Requiring Employers to Make Contributions Sooner*

How Can the Integrity of the Social Security Card Be Improved?*

Survey for Follow-up to the SSA Management Review

Survey of Alternatives for Nursing Home Residents Capable of Residing Outside Institutional Settings*

SSA Service Quality*

Evaluation of SSA Samples to Determine Retirement and Survivors' Insurance Payment Accuracy

Review of Railroad Retirement Board Administration of Certain Benefit Offset Provisions*

What Is the Impact of the Social Security Retirement Test?

Review of the Solvency of the Railroad Retirement Board Trust Funds*

Survey to Determine the Extent to Which SSA Accurately Maintains Social Security Earnings Records

Effects of Budget Constraints on SSA Disability Adjudication*

Role of Vocational Rehabilitation in the Social Security Disabled Program*

Development of Demographic Data on Various Groups of Disabled Persons*

Evaluation of SSA's Face-to-Face Demonstration*

Block Grants: Federal Set-Aside Provisions for Substance Abuse and Mental Health*

An Evaluation of HCFA's Collection, Interpretation, and Use of Mortality and Morbidity Outcome Data on Medicare Beneficiaries*

Modeling Factors Associated with the Effectiveness of Quality Assessment by Medicare Peer Review Organizations*

Simulating the Effectiveness of Alternative Medical Peer Review Quality Assurance Methods*

Alternative Ways of Looking at the Financial Position of the Social Security Trust Fund*

Strategies for Measuring and Monitoring the Quality of Care in the Medicare Program*

*Being performed at the request of Committees or Members of Congress.

GAO Activities Affecting Older Persons

During fiscal year 1987, GAO appointed 963 persons to permanent and temporary positions, of whom 112 were age 40 and older. As of September 30, 1987, GAO's work force totaled 5,786; 2,598 (44.9 percent) were 40 and older.

GAO employment policies prohibit discrimination based on age. GAO's Civil Rights Office continues to provide information and advice to persons regarding allegations of age discrimination.

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

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

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