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Preface

The General Accounting Office (GAO), an arm of the Congress, was established to independently audit government agencies. GAO's Health, Education, and Human Services (HEHS) Division reviews the government's health, education, employment, social security, disability, welfare, and veterans programs administered in the Departments of Health and Human Services, Labor, Education, Veterans Affairs, and some other agencies.

This booklet lists the GAO products issued on these programs. It is divided into two major sections:

- Most Recent GAO Products: This section identifies reports and testimonies issued during the past 2 months and provides summaries for selected key products.
- Comprehensive 2-Year Listings: This section lists all products published in the last 2 years, organized chronologically by subject as shown in the table of contents. When appropriate, products may be included in more than one subject area.

You may obtain single copies of the products free of charge, by telephoning your request to (202) 512-6000 or faxing it to (301) 258-4066. Additional ordering details, as well as instructions for getting on GAO's mailing list, appear at the end of this booklet.

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Contents

Abbreviations

AFDC	Aid to Families with Dependent Children
AIDS	acquired immunodeficiency syndrome
BLS	Bureau of Labor Statistics
CARE	Comprehensive AIDS Resources Emergency Act
CDC	Centers for Disease Control and Prevention
CDR	continuing disability review
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
DEA	Drug Enforcement Agency
DC	District of Columbia
DI	Disability Insurance
DIC	Dependency and Indemnity Compensation
DOD	Department of Defense
DOE	Department of Energy
EEO	Equal Employment Opportunity
EEOC	Equal Employment Opportunity Commission
EMA	eligible metropolitan area
ERISA	Employee Retirement Income Security Act of 1974
ESEA	Elementary and Secondary Education Act

FDA	Food and Drug Administration
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HEAF	Higher Education Assistance Foundation, Department of Education
HealthPASS	Philadelphia Accessible Services System
HEHS	Health, Education, and Human Services Division, GAO
HHS	Department of Health and Human Services
HIV	human immunodeficiency virus
HMO	health maintenance organization
HRD	Human Resources Division, GAO
IFA	individualized functional assessment
IHS	Indian Health Service
INS	Immigration and Naturalization Service
IRS	Internal Revenue Service
JOBS	Job Opportunities and Basic Skills program
JTPA	Job Training Partnership Act
NAFTA	North American Free Trade Agreement
NAGB	National Assessment Governing Board, Department of Education
NPR	National Performance Review
OBRA	Omnibus Budget Reconciliation Act of 1990
PATH	Projects for Assistance in Transition from Homelessness
PBGC	Pension Benefit Guarantee Corporation
PPI	producer price index for prescription drugs
SBA	Small Business Administration
SSA	Social Security Administration
SSI	Supplemental Security Income
T&A	time and attendance
TB	tuberculosis
TRICARE	DOD nationwide managed health care program
UMWA	United Mine Workers of America Combined Benefit Fund
VA	Department of Veterans Affairs
WIC	Special Supplemental Food Program for Women, Infants, and Children

Most Recent GAO Products (March - April 1995)

Health

Selected Summaries

Prescription Drug Prices: Official Index Overstates Producer Price Inflation (Report, 4/28/95, GAO/HEHS-95-90).

Recent research indicates that the producer price index for prescription drugs (PPI-Drugs) published by the Bureau of Labor Statistics (BLS), the official wholesale level index of U.S. drug prices, has overstated drug price increases substantially since at least 1984. This overstatement has three causes. First, before 1994, BLS used a market basket (sample) of drugs that underrepresented new and recently introduced drugs in the market. This sampling problem alone led PPI-Drugs to overstate drug inflation between 1984 and 1991 by an estimated 23 to 36 percent. Second, the index does not account for the cost savings incurred when consumers switch to lower priced substitutes, such as generics. Third, PPI-Drugs does not adequately separate pure price changes, which constitute inflation, from price changes that reflect different product characteristics, such as fewer side effects. Some progress has been made in addressing the causes of the overstatement. Regardless of the outcome of the PPI-Drugs debate, users should be aware of potential misuses of all price indexes.

Medicaid Managed Care: More Competition and Oversight Would Improve California's Expansion Plan (Report, 4/28/95, GAO/HEHS-95-87).

California plans a major expansion of its Medi-Cal managed care program in selected counties. Problems identified to date in a primarily voluntary enrollment program could be significantly magnified in a much larger program with mandatory enrollment. GAO is concerned about whether the state will monitor managed care plans effectively enough to minimize any adverse effects on the availability and quality of health care provided to Medicaid enrollees placed in mandatory managed care. A vital factor in the success of the program will be the capabilities of the state's contract management staff. GAO is also concerned that the state does not give enough attention to the extent that providers have financial incentives to limit needed care and that the state has difficulty verifying whether services it pays for are actually provided, including preventive care for children. GAO believes that any benefits of competitive managed care will be lessened by the state's decision to limit beneficiaries in selected areas to choosing between two health plans.

Indian Health Service: Improvements Needed in Credentialing Temporary Physicians (Report, 4/21/95, GAO/HEHS-95-46).

The Indian Health Service (IHS) has unknowingly allowed temporary physicians with disciplinary actions taken against their licenses to treat patients. As a result, these patients may have been placed at risk of receiving substandard care. IHS' credentials and privileges policy does not explicitly require verifying all active and inactive state medical licenses that a physician may have. Rather, the policy requires that a physician have a current medical license with no restrictions against it to practice medicine. Furthermore, most IHS facilities that have contracts with private companies that supply temporary physicians do not require the companies to inform IHS of the status of all medical licenses a physician may hold. IHS facilities do not have a formal network to share information on the performance of temporary physicians who have worked with the IHS medical system. Therefore, IHS facilities are not always aware of temporary physicians who have had performance or disciplinary problems.

Long-Term Care: Current Issues and Future Directions (Report, 4/13/95, GAO/HEHS-95-109).

Long-term care consists of many different services aimed at helping people with chronic conditions compensate for limitations in their ability to function independently. More than 12 million Americans—young and old—report some long-term care need, and more than 5 million are estimated to be severely disabled. Expenditures for long-term care, particularly institutional care, are high. In 1993, of nearly $108 billion spent, about 70 percent paid for institutional care. Both federal and state governments provide most of the money for long-term care through dozens of categorical funding streams. The financial burden on families, who pay over a third of the long-term care bill out of pocket, is also high. To guard against financial loss, a small but growing number of individuals are purchasing private long-term care insurance policies. Families also bear a considerable nonmonetary burden by caring for relatives. Recognizing this, some employers have begun to offer more flexible schedules and other assistance to help employees balance work and caregiving.

Ryan White Care Act of 1990: Opportunities Are Available to Improve Funding Equity (Testimony, 4/5/95, GAO/T-HEHS-95-126). Testimony on same topic (2/22/95, GAO/T-HEHS-95-91). Correspondence on same topic (2/14/95, GAO/HEHS-95-79R, and 3/31/95, GAO/HEHS-95-119R).

GAO found that the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990 funding formulas result in per case funding disparities that are, to a large extent, unrelated to service costs or to the ability of states and eligible metropolitan areas (EMA) to fund services from local sources. These funding disparities result from the fact that (1) EMA cases are inappropriately double counted in both the title I and II formulas, (2) the formulas contain no indicator that reflects differences in the cost of providing services in both states and EMAs, and (3) formula factors inappropriately measure caseloads and funding capacity. GAO believes that greater funding equity could be achieved by changing the structure of the two titles to correct the bias introduced by double counting EMA AIDS cases and by using more appropriate measures of EMA and state funding needs.

Medicaid: Spending Pressures Drive States Toward Program Reinvention (Report, 4/4/95, GAO/HEHS-95-122). Testimony on same topic (GAO/T-HEHS-95-129).

Medicaid costs are projected to increase from about $131 billion to $260 billion by the year 2000, according to the Congressional Budget Office. Between 1985 and 1993, federal Medicaid expenditures grew each year, on average, by 16 percent. In the mid-1980s, some states began using creative financing mechanisms to leverage additional federal dollars. More recently, states began seeking section 1115 waivers designed to contain the cost of their Medicaid programs through the use of capitated managed care delivery systems and expand coverage to uninsured individuals who would not normally qualify for Medicaid benefits. GAO's analysis of four states with approved waivers shows that Florida, Hawaii, and Oregon may obtain more federal funding than they would have likely received under their original Medicaid programs. While these expansions will extend health care benefits to more low-income individuals, the result could also be a heavier burden on the federal budget.

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

Different advantages and disadvantages for each of the three basic approaches to restructuring Medicaid—federal block grants, federalizing the program, or splitting responsibility between federal and state

governments—have been cited by observers and proponents. GAO found that all discussions identified to restructure Medicaid have focused on the altered financing arrangements and lacked information on how elements of program design would be structured. Further, little quantitative analysis has been done to determine any of the potential effects of restructuring. GAO's statistical analysis demonstrates the important influence of the business cycle on Medicaid spending. A rainy day fund could be one way to assist states during economic downturns if strong limits are placed on federal contributions. GAO found that in at least 22 states, including 8 of the 10 largest states, Medicaid spending is sensitive to state economic conditions. On average, Medicaid spending rises by 6 percent for every 1 percentage point increase in the unemployment rate.

Medicare: Tighter Rules Needed to Curtail Overcharges for Therapy in Nursing Homes (Report, 3/30/95, GAO/HEHS-95-23).

GAO found widespread examples of overcharges to Medicare for therapy services delivered to nursing home patients. Though the data do not exist to determine the extent of overcharging and its precise impact on Medicare outlays, billing schemes uncovered in recent years by state and federal investigations suggest the problem is national in scope and growing in magnitude. Extraordinary markups on therapy services can result from providers exploiting regulatory ambiguity and weaknesses in Medicare's payment rules. Because Health Care Financing Administration (HCFA) payment rules and procedures for thwarting abusive billings were developed when the therapy industry was much smaller and less sophisticated, they have proved no match for increasingly complex business practices that appear to be designed to generate increased Medicare revenue and skirt program controls. Although HCFA has been aware of this growing problem since 1990, it has yet to close the loopholes in Medicare therapy reimbursement policies.

Medicaid: Experience With State Waivers to Promote Cost Control and Access to Care (Testimony, 3/23/95, GAO/T-HEHS-95-115).

GAO found that a large number of states have expressed interest in implementing waivers, allowing them to expand Medicaid enrollment by requiring enrollees to participate in capitated managed care programs. Currently, only four states—Tennessee, Oregon, Hawaii, and Rhode Island—have waivers in place. Two additional states have received federal approval, but their plans still must be ratified by state legislatures. As states move into managed care, they face significant challenges with this

major shift in program focus away from the traditional fee-for-service system. More specifically, the emphasis that states place on program implementation and oversight may significantly affect the degree to which states' managed care programs are successful in containing costs while increasing access to quality health care.

Medicare and Medicaid: Opportunities to Save Program Dollars by Reducing Fraud and Abuse (Testimony, 3/22/95, GAO/T-HEHS-95-110).

GAO's work clearly demonstrated that Medicare (serving the elderly and disabled) and Medicaid (serving the poor) are overwhelmed in their efforts to keep pace with, much less stay ahead of, profiteers bent on cheating the system. Various factors, which converge to create a particularly rich environment for profiteers, include (1) strong incentives to overprovide services, (2) weak fraud and abuse controls to detect questionable billing practices, (3) few limits on those who can bill, and (4) little chance of being prosecuted or having to repay fraudulently obtained money. Solving these problems will require exploring options to make greater use of managed care strategies, such as preferred provider networks or health maintenance organizations (HMO), greater investment in the people and technology needed to ensure that federal dollars are spent appropriately, and more demanding standards for gaining authority to bill the federal programs, as well as exploring administrative reform options proposed in various bills introduced in the current and prior Congress.

Tuberculosis: Costly and Preventable Cases Continue in Five Cities (Report, 3/16/95, GAO/HEHS-95-11).

Costly and preventable tuberculosis (TB) cases are occurring across the nation. TB predominantly affects the poor and urban racial and ethnic minorities. In the cities GAO visited—Atlanta, Chicago, El Paso, Los Angeles, and Newark—TB rates are higher than the national average, and TB cases are growing most rapidly among those vulnerable populations. TB experts attribute the recent increases in cases to inadequate infection control measures, the effects of human immunodeficiency virus (HIV) infection, and the introduction of TB infection and cases by people from countries with high TB rates. Although the federal government has increased its assistance, state and local budgets for TB control have not increased at the same rate as the federal contribution. A weakened TB control infrastructure in health departments has reduced the ability of local TB programs to find and successfully treat infected people. GAO estimates that, unless control efforts are improved, the total national costs

for treating TB annually could more than double to $1.5 billion by the year 2000.

Other Health Products

Maine Practice Guidelines (Letter, 4/4/95, GAO/HEHS-95-118R).

Electromagnetic Interference with Medical Devices (Letter, 3/17/95, GAO/RCED-95-96R).

Cost of Health Care Task Force Related Activities (Testimony, 3/14/95, GAO/T-GGD-95-114).

Medicare Secondary Payer Program (Letter, 3/6/95, GAO/HEHS-95-101R).

Education

Selected Summaries

School Safety: Promising Initiatives for Addressing School Violence (Report, 4/25/95, GAO/HEHS-95-106).

The four school-based violence-prevention programs—in Anaheim and Paramount, California; Dayton, Ohio; and New York City—that we visited all show initial signs of success. Violence-prevention literature and experts consistently associate at least seven characteristics with promising school-based violence-prevention programs. These characteristics are (1) a comprehensive approach, (2) an early start and long-term commitment, (3) strong leadership and disciplinary policies, (4) staff development, (5) parental involvement, (6) interagency partnerships and community linkages, and (7) a culturally sensitive and developmentally appropriate approach. Although few violence-prevention programs have been evaluated, efforts are under way to identify successful approaches for curbing school violence. For example, for fiscal years 1993 and 1994, GAO identified 26 federal grants (approximately $28 million) that help to evaluate the effectiveness of various school-based violence prevention programs.

School Facilities: America's Schools Not Designed or Equipped for 21st Century (Report, 4/4/95, GAO/HEHS-95-95). Testimony on same topic (4/4/95, GAO/T-HEHS-95-127).

School officials in a national sample of schools reported that although most schools meet many key facilities requirements and environmental conditions for education reform and improvement, most are unprepared for the 21st century in critical areas. Most schools do not fully use modern technology. Over 14 million students attend about 40 percent of schools that reported that their facilities cannot meet the functional requirements of laboratory science or large-group instruction even moderately well. About 40 percent of schools reported that their facilities cannot meet the functional requirements of laboratory science or large-group instruction even moderately well. Although education reform requires facilities to meet the functional requirements of key support services, about two-thirds of schools reported that they cannot meet the functional requirements of before- or after-school care or day care. Moreover, not all students have equal access to facilities that can support education into the 21st century, even those attending school in the same district.

Department of Education: Information on Consolidation Opportunities and Student Aid (Testimony, 4/6/95, GAO/T-HEHS-95-130).

The Department of Education's budget, in fiscal year 1995, accounts for about $33 billion of the estimated $70 billion in federal education assistance. The Department administers 244 education programs, and 30 other federal agencies administer another 308. The Department has already proposed several programs as candidates for consolidation. Some portion of an additional 151 programs administered by both the Department and other federal agencies may also present an opportunity to streamline federal education spending. Additional factors need to be considered in determining maximum efficiency from consolidation. For example, determining how to achieve a coordinated delivery of services at the local level, therefore, needs to be considered. Concerning student aid, the Department's budget proposal may overstate the cost savings associated with fully implementing direct lending under credit reform rules, but substantial savings could still accrue. In addition, it is too early to evaluate the effectiveness of recent Department initiatives to improve its oversight of student aid programs.

Direct Student Loans: Selected Characteristics of Participating Schools (Testimony, 3/30/95, GAO/T-HEHS-95-123).

During the first year of the direct loan program, 102 postsecondary schools participated out of the approximately 1,100 that applied. The Department of Education estimated that the participating schools represent an aggregate of 5 percent of fiscal year 1991 student loan volume. Participating schools in year one were very satisfied with the Department's implementation of the direct loan program. For schools that the Department selected for year two, as of March 21, 1995, the aggregate loan volume was short of that year's 40-percent goal. Part of this shortfall may be attributed to the uncertainty regarding the future of the direct loan program.

Higher Education: Restructuring Student Aid Could Reduce Low-Income Student Dropout Rate (Report, 3/23/95, GAO/HEHS-95-48).

Grants and loans do not have equivalent effects on low-income students' staying in college, according to GAO's statistical results. Rather, on average, grants lower the probability of low-income students' dropping out, while loans have no statistically significant impact. The timing of grant aid influences students' probability of dropping out. For example, on average, for low-income students, grant aid is relatively more effective during the first school year than in subsequent years. GAO's statistical results, noting the limited experience with frontloading grants (i.e., making proportionately more grant aid available in the students' earlier years and more loans available in their later years) suggest that conducting a pilot program may be valuable to evaluate the effects, including possible costs, of frontloading on reducing dropouts among low-income college students.

Early Childhood Centers: Services to Prepare Children for School Often Limited (Report, 3/21/95, GAO/HEHS-95-21).

Early childhood experts agree that to be prepared for school, disadvantaged children need intellectual stimulation, parental support, and adequate health care and nutrition. Early childhood centers can help meet these needs by providing a full range of services—child development, actively involving parents in their children's learning, and health and nutrition. Most of the nation's disadvantaged children do not attend an early childhood center. By contrast, most children in high-income families do attend these centers. Of the disadvantaged children who attend centers, most attend the kinds of centers—school-sponsored, nonprofit, and for-profit—that are less likely than Head Start centers to provide a full

range of services. Head Start is administered by the Department of Health and Human Services (HHS) and provides funding to local grantees, who in turn, provide some disadvantaged children, with a full range of childhood services. Head Start centers are required to follow detailed performance standards. Most disadvantaged children do not receive services at early childhood centers because of the (1) limited number of places and subsidies and (2) narrow missions of programs.

Employment

Selected Summaries

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

GAO's work suggests that although the Department of Labor has accomplished much over its history, its current approaches to worker protection are dated and frustrate both workers and employers. What is needed, according to the employers and employees we spoke with, is a greater service orientation: improved communication, increased employers' and workers' accessibility to compliance information, and expanded meaningful input into the standard-setting and enforcement processes. By developing alternative regulatory strategies that supplement and in some instances might replace its current labor-intensive compliance and enforcement approach, Labor can carry out its statutory responsibilities in a less costly, more effective manner. Similarly, in the workforce development area, the nation's job training programs have become increasingly fragmented and unclear. What exists today, spread across many federal agencies, is a patchwork of federal programs with similar goals, conflicting requirements, overlapping populations, and questionable outcomes.

Other Employment Products

Federal Affirmative Employment: Progress of Women and Minority Criminal Investigators at Selected Agencies (Report, 4/25/95, GAO/GGD-95-85).

Federal Quality Management: Strategies for Involving Employees (Report, 4/18/95, GAO/GGD-95-79).

Administratively Uncontrollable Overtime (Letter, 4/14/95, GAO/GGD-95-129R).

Equal Opportunity: DOD Studies on Discrimination in the Military (Report, 4/7/95, GAO/NSIAD-95-103).

Equal Employment Opportunity: Group Representation in Key Jobs at the National Institutes of Health (Report, 3/16/95, GAO/GGD-95-83).

Federal Retirement Issues (Testimony, 3/10/95, GAO/T-GGD-95-111).

Federal Downsizing: The Administration's Management of Workforce Reductions (Testimony, 3/2/95, GAO/T-GGD-95-108).

Equal Opportunity: DOD Studies on Discrimination in the Military (Report, 3/95, GAO/NSIAD-95-103).

Social Security, Disability, and Welfare

Selected Summaries

Welfare to Work: Measuring Outcomes for JOBS Participants (Report, 4/17/95, GAO/HEHS-95-86).

HHS does not know whether the Job Opportunities and Basic Skills Training (JOBS) program is reducing welfare dependency because it does not gather enough information on critical program outcomes, such as the number of participants entering employment and leaving Aid to Families with Dependent Children (AFDC) annually. While little progress has been made in monitoring JOBS outcomes at the federal level, the picture is better at the state level. Nearly all states use some information on participant outcomes to manage their individual programs, although the extent to which states monitor outcomes varies widely. The current national interest in making welfare more employment focused, as well as requirements in the Government Performance and Results Act (GPRA) that performance monitoring become more outcome oriented governmentwide, indicate a need for HHS to move decisively to ensure that it meets its current schedule for developing outcome measures and goals for JOBS.

Supplemental Security Income: Recipient Population Has Changed as Caseloads Have Burgeoned (Testimony, 3/27/95, GAO/T-HEHS-95-120).

In 1994, over 6 million Supplemental Security Income (SSI) recipients received nearly $22 billion in federal benefits and over $3 billion in state benefits. SSI is one of the fastest growing entitlement programs; program costs have grown 20 percent annually in the last 4 years. Major factors contributing to growth include eligibility expansions, outreach, limited emphasis on return to work, and immigration. Since 1986, the number of disabled SSI recipients has increased an average of over 8 percent annually. Disabled recipients now account for nearly 80 percent of federal SSI payments. Three groups have accounted for nearly 90 percent of SSI's growth since 1991: adults with mental impairments, children, and noncitizens. SSI recipients now tend to be younger, receive larger benefits, and depend more on SSI as a primary source of income. Ways to improve SSI include increasing reviews of the disability status of current recipients and placing more emphasis on rehabilitation, employment assistance, and work incentives.

Social Security: New Functional Assessments for Children Raise Eligibility Questions (Report, 3/10/95, GAO/HEHS-95-66).

Changes in the regulations governing childhood eligibility for SSI have had a significant impact on the growth and composition of the childhood disability rolls. In particular, awards have been made to more than 200,000 children who did not meet SSA's listing of impairments but instead qualified for benefits based on the less restrictive individualized functional assessment (IFA) criteria. These awards account for about $1 billion a year in benefit payments. In our analysis, we found fundamental flaws in the IFA process. Specifically, each step of the process relies more heavily on adjudicators' judgments than on objective criteria from SSA, to assess the age-appropriateness of childrens' behavior. In addition, rapid program growth, particularly in the award of benefits to less severely impaired children, may have contributed to the public concern that parents could be coaching their children to fake mental impairments in order to qualify for benefits. Studies that GAO reviewed have found little evidence that coaching is widespread. These studies, however, relied solely on documentation in case files.

Social Security: Federal Disability Programs Face Major Issues (Testimony, 3/2/95, GAO/T-HEHS-95-97).

Each week, SSA sends out about $1 billion in cash payments to persons on Disability Insurance (DI) and SSI. These expenditures are particularly sobering in view of GAO's findings that (1) program growth between 1985 and 1994 has been tremendous; (2) annual expenditures, including medical benefits, now exceed $100 billion; (3) program integrity has been undermined by allegations of fraud and abuse; and (4) the programs virtually return no one to work. GAO's work shows that federal disability programs need improvement. GAO is working on identifying alternative ways in which federal disability programs can enhance the productive capacity of beneficiaries who want to work.

Child Care: Recipients Face Service Gaps and Supply Shortages (Testimony, 3/1/95, GAO/T-HEHS-95-96).

Subsidies can have a dramatic effect on drawing low-income mothers into the workforce. Yet the current subsidy programs have problems. The fragmented nature of child care funding streams, with entitlements to some client categories, time limits on others, and activity limits on others, produces unintended gaps in services. These gaps limit the ability of low-income families to achieve self-sufficiency and can harm the continuity of care for their children. These findings suggest certain benefits to be derived from consolidating federal child care funds as well as some cautions. In addition, GAO found that states currently have shortages of child care supply, particularly in the areas of infant care, part-time care, children with handicapping conditions, before- and after-school care, and care during late-night shift work. These findings suggest that expanding work requirements as part of welfare reform needs to proceed with an eye toward the capacities of the child care system.

Other Social Security, Disability, and Welfare Products

D.C. Disability Retirement Rate (Report, 3/31/95, GAO/GGD-95-133).

Federal Retirement Issues (Testimony, 3/10/95, GAO/T-GGD-95-111).

Veterans Affairs and Military Health

Selected Summaries

Veterans' Benefits: VA Can Prevent Millions in Compensation and Pension Overpayments (Report, 4/28/95, GAO/HEHS-95-88).

Despite its responsibility to ensure accurate benefits payments, VA continues to overpay veterans and their survivors hundreds of millions of dollars in compensation and pension benefits each year. For example, in 1994, VA detected about $372 million in overpayments to its beneficiaries. Based on our analysis of a survey of overpayments in May 1994, changes in income accounted for a large portion of overpayments, and receipt of Social Security benefits accounted for a significant share of income-related overpayments. VA has the capability to prevent millions of dollars in overpayments, but has not done so because it has not focused on prevention. For example, VA does not use available information, such as when beneficiaries will become eligible for Social Security benefits, to prevent the overpayments from occurring. VA does not systematically collect, analyze, and use information on the specific causes of overpayments that will help it target prevention efforts.

VA Health Care: Retargeting Needed to Better Meet Veterans' Changing Needs (Report, 4/21/95, GAO/HEHS-95-39).

Many veterans have health care needs that are not adequately addressed through current health care programs, including the VA health care system. VA cannot adequately address many of these health care needs because (1) it relies primarily on direct delivery of health care services in VA-owned and operated facilities, (2) its complex eligibility and entitlement provisions limit the services veterans can get from VA facilities, and (3) space and resource limitations prevent eligible veterans from obtaining covered services. In GAO's view, changes need to be made in the veterans' health care system to enable it to better meet veterans' needs. To make optimum use of limited health care resources, such changes would need to be designed to complement rather than duplicate coverage provided through other public and private health benefits programs. VA's plans for restructuring the VA health care system, however, focus primarily on preserving and expanding VA's acute care mission rather than retargeting VA programs and resources to enable VA to fill the gaps in veterans' coverage under other public and private health benefits programs.

Defense Health Care: DOD's Managed Care Program Continues to Face Challenges (Testimony, 3/28/95, GAO/T-HEHS-95-117).

Regional officials for the Department of Defense (DOD) nationwide managed health care program, called TRICARE, continue to be concerned that the program's administrative structure does not provide them with sufficient authority and control over funds and personnel because these resources remain under the control of the Services. TRICARE was intended to be used by military beneficiaries: active duty personnel, dependents, and military retirees under age 65. DOD has had many problems in obtaining civilian health care services because of a cumbersome and contentious procurement process. Officials in military hospitals are also concerned that important managed care information systems, such as those needed to support patient scheduling and referrals, may not be available by the time TRICARE is implemented in their regions. TRICARE may not fully address beneficiaries' concerns about equitable access to care and beneficiary cost-sharing (i.e., cost per hospital or clinic visit) because lower cost health care options will not be available in all areas; enrollment in the lowest cost-sharing option may be limited; and outpatient care from civilian providers requires cost-sharing, but care received from military providers does not.

Defense Health Care: Issues and Challenges Confronting Military Medicine (Report, 3/22/95, GAO/HEHS-95-104).

The Military Health Services System is one of the nation's largest health care systems, offering benefits to about 8.3 million people and costing over $15 billion annually. Its primary mission is to maintain the health of 1.7 million active-duty service personnel and to be prepared to deliver health care during times of war. In reporting on concerns about DOD's ability to meet its wartime mission, GAO and others have described problems such as inadequate training, missing equipment, and large numbers of nondeployable personnel as serious threats to DOD's ability to provide adequate medical support to deployed forces. DOD, in the past decade, has experienced many of the same challenges confronting the nation's civilian health care system—increasing costs, uneven access to health services, and disparate benefit and cost-sharing packages for similarly situated categories of beneficiaries. These experiences led DOD in 1993 to begin a nationwide managed care program called TRICARE to improve beneficiary access while containing cost growth.

Veterans' Benefits: Basing Survivors' Compensation on Veterans' Disability Is a Viable Option (Report, 3/6/95, GAO/HEHS-95-30).

When disabled veterans die, the support the Department of Veterans Affairs (VA) provides to surviving spouses decreases the most for the spouses of the most disabled and the least for the spouses of the least disabled. GAO studied benefit recipients' total income and benefits; the financial impact of veterans' deaths on Dependency and Indemnity Compensation (DIC) benefits. Most of the alternatives GAO assessed have substantial drawbacks in that they would dramatically reduce benefits to all recipients or substantially increase federal outlays. However, one alternative—basing DIC benefits on the level of veterans' basic disability compensation—would, without increasing program costs, increase benefits for about two-thirds of recipients while decreasing them for about one-third. This alternative would also ensure that when veterans die, VA support to their spouses changes more proportionately.

Other Veterans Affairs and Military Health Products

Concurrent Receipt (Letter, 4/27/95, GAO/HEHS-95-136R).

Barriers to VA Managed Care (Letter, 4/20/95, GAO/HEHS-95-84R).

Veterans Compensation: Offset of DOD Separation Pay and VA Disability Compensation (Report, 4/3/95, GAO/NSIAD-95-123).

Wartime Medical Care: Aligning Sound Requirements with New Combat Care Approaches Is Key to Restructuring Force (Testimony, 3/30/95, GAO/T-NSIAD-95-129).

Health (Comprehensive 2-Year Listing)

Access and Infrastructure

Ryan White Care Act: Access to Services by Minorities, Women, and Substance Abusers (Report, 1/13/95, GAO/HEHS-95-49).

Health Care: Federal and State Antitrust Actions Concerning the Health Care Industry (Report, 8/5/94, GAO/HEHS-94-220).

Health Professions Education: Role of Title VII/VIII Programs in Improving Access to Care Is Unclear (Report, 7/8/94, GAO/HEHS-94-164).

Health Reform: Purchasing Cooperatives Have an Increasing Role in Providing Access to Insurance (Testimony, 6/30/94, GAO/T-HEHS-94-196). Report on same topic (5/31/94, GAO/HEHS-94-142).

Primary Care Physicians: Managing Supply in Canada, Germany, Sweden, and the United Kingdom (Report, 5/18/94, GAO/HEHS-94-111).

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