United States General Accounting Office

GAO

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

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AGING ISSUES

Related GAO Reports and Activities in Fiscal Year 1993

GAO/HRD-94-73

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

Dear Mr. Chairman:

This report was prepared in response to the Committee's October 19, 1993, request for a compilation of our fiscal year 1993 products and ongoing work regarding older Americans and their families.

GAO's work in aging reflects the continuing importance of federal programs for older Americans. The 1990 Census reported over 31 million older Americans, and by the year 2020, that number will exceed 53 million. Because the elderly are one of the fastest growing segments of today's society, the Congress faces many issues involving income security and health policy in which the federal government will play an important role. These issues range from demographic changes affecting the traditional structure and role of the family to long-term care reform, which challenges the current institutional approach to delivering services to the elderly.

Our work during fiscal year 1993 covered a range of issues, including federal government activities in employment, health care, housing, income security, and veterans' issues. Some federal programs, such as Social Security and Medicare, are directed primarily at older Americans. Other federal programs target older Americans as one of several groups served, such as Medicaid or federal housing programs. We have organized the summaries of our fiscal year 1993 reports and related products accordingly.

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

- reports on policies and programs directed primarily at older Americans (see app. I),
- reports on policies and programs that affect older Americans as one of several target groups (see app. II),
- congressional testimonies on issues related to older Americans (see app. III), and
- ongoing work on issues related to older Americans (see app. IV).

The issues addressed by these products and ongoing work are presented in table 1. The table shows that income security and health were the leading issues addressed among reports focused primarily on older Americans. Veterans and health were the leading issues that affected both older Americans and other groups.

Table 1: GAO Activities Relating to the Elderly in Fiscal Year 1993

Issue	Reports focused on the elderly	Reports with the elderly as one of several target groups	Testimonies	Ongoing work as of 9/30/93
Employment	1	5	2	2
Health	10	19	11	49
Housing	1	5	1	4
Income Security	17	4	8	14
Veterans	2	21	5	30
Other	1	0	3	1
Total	**32**	**54**	**30**	**100**

Appendix I provides summaries of 32 issued reports on policies and programs directed primarily at older Americans. We include in this section reviews of employment, health, housing, income security, veterans, and other issues.

Appendix II provides summaries of 54 reports in which older Americans were one of several target groups for specific federal policies. Many of these policies are generally financed in conjunction with services to other populations. For example, Medicaid finances nursing homes and other types of long-term care, as well as medical care for poor persons of all ages.

Appendix III describes 30 testimonies given during fiscal year 1992 on subjects focused on older Americans. We testified most often on health issues.

In appendix IV, we have listed 100 studies related to older Americans that were ongoing as of September 30, 1993.

In addition to this bibliographic report, we issued other reports that summarized GAO reports and testimonies on aging, health, and income security issues. We also issued seven reports in a number of areas

spotlighting management problems and high-risk areas in the federal government that affect older Americans. These reports are shown in appendix V.

We have also provided information on GAO's employment of older Americans (see app. VI). As you are aware, our policies prohibit age discrimination. On September 30, 1993, about 59 percent of our work force was 40 years of age and older. We continue to provide individual retirement counseling and group preretirement seminars.

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

This report was prepared under the direction of Joseph F. Delfico, Director, Income Security Issues, who may be reached at (202) 512-7215 if you have any questions. Other major contributors are listed in appendix VII.

Sincerely yours,

Janet L. Shikles

Janet L. Shikles
Assistant Comptroller General

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Appendix II Fiscal Year 1993 GAO Reports on Issues Affecting Older Americans and Others

Abbreviations

AAA	area agencies on aging
AARP	American Association of Retired Persons
AIDS	acquired immunodeficiency syndrome
AOA	Administration on Aging
COLA	cost-of-living adjustment
DOD	Department of Defense
EEO	equal employment opportunity
EEOC	Equal Employment Opportunity Commission
FmHA	Farmers Home Administration
FY	fiscal year
HCA	Hospital Corporation of America
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HMO	health maintenance organization
HRSA	Health Resources and Services Administration
HUD	Department of Housing and Urban Development
IG	Inspector General
IRS	Internal Revenue Service
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
LSC	Legal Services Corporation
MRI	magnetic resonance imaging
PBGC	Pension Benefit Guaranty Corporation
SSA	Social Security Administration
SSI	Supplemental Security Income
UNOS	United Network for Organ Sharing
URO	utilization review organizations
USDA	Department of Agriculture
VA	Department of Veterans Affairs

Fiscal Year 1993 GAO Reports on Issues Primarily Affecting Older Americans

During fiscal year 1993, GAO issued 32 reports on issues primarily affecting older Americans. Of these, 1 was on employment, 10 on health, 1 on housing, 17 on income security, 2 on veterans issues, and 1 on other issues.

Employment Issues

Federal Personnel: Employment Policy Challenges Created by an Aging Workforce (GAO/GGD-93-138, Sept. 23, 1993)

A major demographic swing is under way in the government workforce. The "baby boomers" are approaching retirement eligibility, and a much smaller pool of workers is expected to follow. The federal government may have a hard time hiring the people it needs if, as expected, older workers start leaving the government in unprecedented numbers. Like most other employers, the federal government has not developed a strategy to deal with the effects of its aging workforce. Yet older-worker programs could hold great promise: many older federal workers have indicated that they might extend their careers if appropriate incentives were available. Not all older persons are willing, able, or qualified to remain in the workforce, however, and younger people will continue to need employment and advancement opportunities. Thus, care must be exercised in determining whether federal employment policies should be revised to make more effective use of older workers.

Health Issues

Cataract Surgery: Patient-Reported Data on Appropriateness and Outcomes (GAO/PEMD-93-14, Apr. 20, 1993)

Although cataract surgery, for many patients, dramatically improves vision, the potential exists for complications that can actually worsen eyesight. Another concern is that some patients may be undergoing cataract surgery when it is not really needed. About three-quarters of the Medicare patients GAO surveyed reported that before surgery, significant eyesight problems had interfered with their ability to drive, read, or watch television. By including symptoms like blurred vision and sensitivity to glare, the proportion of patients with substantial presurgical vision problems rose to 84 percent. Surgery may have been more questionable, however, for the remaining 16 percent of patients with "slight" symptoms. The overwhelming majority of respondents said that their surgery had been successful. For about two-thirds, the improvement was uniform across all dimensions; that is, the vision symptoms and functions that did

not get better at least stayed unchanged. Most of the other patients (30 percent) reported mixed results, with improvements in some symptoms or functional impairments and worsening in others.

GAO summarized this report in testimony before Congress; see: Cataract Surgery: Patient-Reported Data on Appropriateness and Outcomes, by Eleanor Chelimsky, Assistant Comptroller General for Program Evaluation and Methodology, before the Senate Special Committee on Aging (GAO/T-PEMD-93-3, Apr. 21, 1993).

Home Health Care: HCFA Properly Evaluated JCAHO's Ability to Survey Home Health Agencies (GAO/HRD-93-33, Oct. 26, 1992)

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is a nonprofit organization that evaluates and accredits both hospital-based and freestanding home health agencies. GAO found that the Health Care Financing Administration (HCFA) properly evaluated the commission's ability to ensure that home health agencies meet Medicare conditions of approval. Further, HCFA's evaluation was done in accordance with the proposed regulation governing the granting of deeming authority to accrediting organizations. As a result of its review, HCFA believed that some issues needed to be resolved before it could approve deeming authority for JCAHO. These issues were discussed with JCAHO and have been resolved to the satisfaction of both organizations.

Long-Term Care Insurance: High Percentage of Policyholders Drop Policies (GAO/HRD-93-129, Aug. 25, 1993)

From 1988 until the early 1990s, sales of long-term care insurance grew at about 32 percent annually. Although greater consumer protections are built into the long-term care policies being sold today, many Members of Congress are concerned about continuing abuses in this area and the need for more protections. This report provides information on (1) the percentage of policyholders that are expected to allow their policies to lapse and (2) the percentage of policyholders' premiums that are paid as sales commissions. GAO also discusses the adoption of consumer protection standards, such as benefits that provide a return of a portion of premiums paid on long-term care insurance policies that are terminated.

Long-Term Care Insurance: Tax Preferences Reduce Costs More for Those in Higher Tax Brackets (GAO/GGD-93-110, June 22, 1993)

A wide range of proposals have been made to increase incentives to buy long-term care insurance. Some of these proposals seek to clarify the tax treatment of payments from long-term care insurance policies and long-term care riders to life insurance policies. Others seek to liberalize tax treatment either by allowing long-term care insurance premiums to be deductible or by allowing payments from policies to be tax-exempt. This

report does not discuss specific proposals but instead examines generic types—including pension, life insurance, and health insurance—and shows how the related tax incentives would affect the price of long-term care insurance depending upon (1) the age and tax bracket of the consumers and (2) whether the coverage is employer provided or individually purchased. GAO also examines how these alternative tax treatments would affect the lifetime benefits and costs of individuals of different ages and tax brackets.

Medicaid Estate Planning (GAO/HRD-93-29R, July 20, 1993)

Pursuant to congressional requests, GAO determined the: (1) prevalence of Medicaid estate planning for purposes of becoming Medicaid-eligible; (2) value of assets sheltered through Medicaid estate planning; and (3) extent to which states are enforcing Medicaid requirements concerning Medicaid estate planning. GAO found that: (1) half of the Medicaid applicants converted assets from one form to another or transferred assets to another party; (2) asset conversions averaged $5,600 and typically involved setting aside money for burial arrangements; (3) other types of conversions included home repairs and automobile purchases; (4) asset transfers were far less frequent but involved larger amounts of money; and (5) half of the applicants that transferred assets were denied eligibility.

Medical Malpractice: Medicare/Medicaid Beneficiaries Account for a Relatively Small Percentage of Malpractice Losses (GAO/HRD-93-126, Aug. 11, 1993)

Although the precise extent to which medical malpractice has contributed to spiraling health care costs is unknown, the expenses associated with it total billions of dollars. Some proposed malpractice reforms target the Medicare and Medicaid programs. Beneficiaries of these programs account for more than one-third of the nation's health care costs, but little information exists on malpractice suits involving Medicare and Medicaid patients. This report (1) reviews the literature and existing data to compare the incidence and the outcomes of malpractice litigation involving Medicare and Medicaid patients with those of the rest of the population and (2) analyzes aggregate hospital data on malpractice losses for Medicare, Medicaid, and other hospital patients. GAO discovered that although Medicare and Medicaid beneficiaries represent more than 45 percent of hospital patients, they received only about one-fourth of the $2.3 billion of hospital malpractice awards during a 5-year period.

Medicare Part B: Reliability of Claims Processing Across Four Carriers (GAO/PEMD-93-27, Aug. 11, 1993)

How fair is the process used by insurance companies to approve or deny Medicare Part B claims? In its review of four insurance companies, GAO found that the computer programs used to evaluate claims produced consistent results and were economical. The programs, however, were not equipped to handle claims involving more subjective criteria, such as deciding whether medical care is appropriate or not. These cases were delegated to claims examiners, typically high-school graduates with no medical background who were expected to decide whether doctors' services were "medically necessary" on up to 400 claims daily. GAO concludes that three factors taken together—the time constraints under which decisions about medical necessity were made, the decentralized way in which medical policies were being developed and instituted, and weaknesses in some quality control methods—raise doubts about the system's ability to treat Medicare claims consistently.

Medicare Physician Payment: Geographic Adjusters Appropriate but Could Be Improved With New Data (GAO/HRD-93-93, July 20, 1993)

In January 1991, Medicare began using a new way to determine the amounts it will pay for physician services. Rather than basing payment on what doctors charge for services, Medicare now uses a fee schedule that incorporates a resource-based relative value scale. Under this new schedule, each service receives a value reflecting the work and other resources needed to furnish it. Geographic differences, such as staff salaries and office rents, are factored into the values. Some doctors, particularly those in areas with a high cost of living, have complained that the values do not reflect actual cost differences. GAO concludes that the Health Care Financing Administration's (HCFA) choices of data and methodology for developing the geographic adjusters were reasonable. Except for expanded malpractice data, however, HCFA had not planned to use different data sources to update the geographic adjusters for 1995. Internal Revenue Service (IRS) data may be useful in updating the geographic adjusters. HCFA is working with IRS to assess the feasibility of using IRS data in updating the practice-expenses adjuster. Because HCFA will need only summary data, taxpayer privacy concerns do not appear to be an issue.

Retiree Health Plans: Health Benefits Not Secure Under Employer-Based System (GAO/HRD-93-125, July 9, 1993)

Retiree health benefits under an employer-based health care system are not secure because employers can change both their employee and retiree health benefit plans at will. In response to rapidly rising health benefit costs, employers have generally tried to shift costs to participants. Only a small percentage of employers surveyed in studies GAO reviewed had actually eliminated medical services for retirees, but at least four

employers had announced plans to do so. The new accounting standard (FAS 106), which highlights the magnitude of the liabilities, has also spurred changes to retiree health benefit plans. Many companies claim that they have modified retiree health benefits because FAS 106 reduces reported income and shareholder equity. The Employee Retirement Income Security Act of 1974 authorizes the federal government to regulate retiree health benefits. Recent court decisions have allowed employers to modify or terminate health benefits for current and future retirees if they reserved the right to do so in benefit plan documents or collectively bargained agreements.

Screening Mammography: Higher Medicare Payments Could Increase Costs Without Increasing Use (GAO/HRD-93-50, Apr. 22, 1993)

Increasing the cap on Medicare payments to encourage physicians to offer mammography in their offices is not a cost-effective way to expand the use of screening mammography. A study by the Department of Health and Human Services shows that the United States already has more than enough mammography machines, even if all women received screening mammograms at intervals suggested by the National Cancer Institute. A substantial increase in the Medicare payment to support more low-volume machines is likely to increase excess capacity, increase prices for mammograms, and reduce the availability of affordable mammography services. In addition, inconsistent guidelines issued by the Health Care Financing Administration and differing Medicare regulations for diagnostic and screening mammography have led to confusion about the appropriate billing procedures for screening mammography provided under package leasing arrangements.

Housing Issues

Rental Housing: Serving the Elderly Through the Section 8 Program (GAO/RCED-93-12FS, Mar. 29, 1993)

The Department of Housing and Urban Development (HUD) provides rental housing assistance to families through its section 8 voucher and certificate programs. By subsidizing a portion of household rent, HUD hopes to enable more low-income families to live in private rental housing that is decent and safe. This fact sheet provides information on the following section 8 issues: (1) the demographic characteristics of elderly and nonelderly voucher and certificate recipients, including sex, race, handicapped status, adjusted income, and education; (2) the quality of the housing units rented by elderly voucher and certificate recipients; and (3) the proportion of income that elderly and nonelderly voucher recipients pay for rent.

Income Security Issues

District's Pensions: Billions of Dollars in Liability Not Funded (GAO/HRD-93-32, Nov. 30, 1992)

Pension obligations owed to current D.C. employees and retirees exceed the District's pension fund assets by nearly $5 billion. Further, the percentage of pension obligations covered by assets is lower than that reported by most of the comparable plans GAO examined. This inadequate funding results primarily from the federal government's transferring a $2 billion unfunded liability for pension benefits to the D.C. government more than a decade ago. There is no legal requirement to amortize this unfunded liability. Mandated federal and District contributions to the retirement funds, through 2004, will not stop the unfunded liability from increasing. It will reach an estimated $7.7 billion by that year. Under the D.C. Retirement Reform Act, the unfunded liability will never be eliminated, although the formula for determining District contributions will change beginning in 2005 and the liability should stop increasing, assuming the District makes the required contributions. In 2005, under the changed formula, the District's annual contribution could represent about 15 percent of the revenue collected by the District, compared with about 8 percent in 1991.

District's Workforce: Annual Report Required by the District of Columbia Retirement Reform Act (GAO/GGD-93-81, Mar. 31, 1993)

The federal government makes annual payments to the District of Columbia retirement fund for police officers and fire fighters. To encourage the District government to control disability retirement costs, these payments must be reduced when the disability retirement rate exceeds a certain limit. GAO concludes that no reduction is required in the fiscal year 1994 federal payment to the fund.

Financial Audit: Pension Benefit Guaranty Corporation's 1992 and 1991 Financial Statements (GAO/AIMD-93-21, Sept. 29, 1993)

Because of the Pension Benefit Guaranty Corporation's (PBGC) considerable progress in improving its internal controls, GAO is for the first time able to express an opinion on PBGC's financial statements. In GAO's view, PBGC's financial statements for fiscal years 1992 and 1991 present fairly PBGC's financial position, except for the Multiemployer Fund's liability for future financial assistance. In that case, a scope limitation precluded GAO from making a determination about whether the reported liability was presented fairly. PBGC's internal controls did not guarantee that PBGC properly recorded, processed, and summarized financial transactions for its financial statements and other reports. Internal

controls as of September 1992, however, reasonably ensured that assets were safeguarded against loss and that transactions were executed in accordance with management's authority and with laws and regulations. This report includes GAO's recommendation to improve PBGC's internal controls and discusses (1) GAO's concerns about the long-term viability of the Single-Employer Fund, (2) the reliability of the Multiemployer Fund's liability for future assistance, and (3) weaknesses in employee benefit plan audits and reports.

Financial Management: Estimate of Interest on Selected Benefits Received by Postal Service Retirees (GAO/AIMD-93-11, July 29, 1993)

The Postal Service is required to reimburse the government for some cost-of-living adjustments (COLA) and health benefits that Postal Service retirees received during fiscal years 1972-90. GAO estimated a total of $1,728.5 million in interest on the amount that the Postal Service is required to pay—$782.5 million higher than the amount in the President's 1994 budget proposal. The estimates differed because of the choice of interest rates and the principal balances used in the calculations. For the period covered by the calculations, GAO's interest rates averaged about 9 percent annually for COLAs and about 8 percent annually for health benefits, whereas the President's proposal used a 5-percent figure to calculate amounts. GAO applied its calculated interest rates to the $2.1 billion in the 1990 Omnibus Reconciliation Act, while the amount in the budget relied on the $3 billion figure that the administration had calculated.

Long-Term-Care Case Management: State Experiences and Implications for Federal Policy (GAO/HRD-93-52, Apr. 6, 1993)

The number of Americans age 65 and older is rising steadily and could exceed 52 million by 2020. Older people require more health and social services but are often confused about how to obtain them. Case management helps people define their service needs, locates and arranges for services, and coordinates the services of multiple providers. Congress has recently considered several bills dealing with long-term care; some of this legislation has proposed establishing a network of case managers to integrate long-term-care services and ensure that beneficiaries receive necessary care and support. This report discusses (1) what, in practice, constitutes case management; what roles case managers play; and what barriers they face in doing their jobs and (2) whether standards for case managers would best be defined in terms of professional qualifications, the functions of case management, or performance measures based on the experience of state officials and outstanding case managers.

Lump-Sum Retirements (GAO/GGD-93-2R, Oct. 20, 1992)

GAO evaluated the impact of increased federal employee retirement at the end of 1990 due to the suspension of the lump-sum retirement benefit. GAO found that: (1) the pattern of retirements for 1989 and 1990 were similar, except that the largest number of monthly retirements occurred in November of 1990, compared to December of 1989, because many employees retired earlier in the fiscal year than they originally had planned to; (2) the difference between the December 1989 rate of retirement and the November 1990 rate was 0.25 percent, but both were less than 1 percent of the full-time work force; (3) although on a calendar year basis an increase in retirements occurred, no increase showed on a fiscal year basis; and (4) agencies appeared to have no significant reductions in staffing, because new hires outpaced retirements.

Older Americans Act: Eldercare Public-Private Partnerships (GAO/PEMD-93-20, Apr. 16, 1993)

Shrinking resources and growing demands have led to contractual relationships between area agencies on aging and private corporations. The agencies provide eldercare services to private employers under these public-private partnerships. These arrangements have been criticized on the grounds that preference should be given to older individuals with the greatest economic and social needs, with particular attention given to low-income minority individuals. GAO found that by 1991-92, only a small portion of agencies had actually entered into public-private partnerships. Most of the agencies with such partnerships were not generating enough profits through these arrangements to finance significant amounts of additional services. Moreover, agencies with partnerships reported typically using existing staff to provide services to those referrals they received. Among the 31 agencies that reported both income and cost data for eldercare services provided in 1991, the median net profit was $0.

GAO summarized this report in testimony before Congress; see: Older Americans Act: Eldercare Partnerships Generate Few Additional Funds for Public Services, by Eleanor Chelimsky, Assistant Comptroller General for Program Evaluation and Methodology, before the Subcommittee on Human Resources, House Committee on Education and Labor (GAO/T-PEMD-93-4, May 27, 1993).

Pension Plans: Hidden Liabilities Increase Claims Against Government Insurance Program (GAO/HRD-93-7, Dec. 30, 1992)

The federal government's exposure to unfunded liabilities in private pension plans is much larger than the plans have indicated on their annual reports to the Internal Revenue Service. When a pension plan terminates with insufficient assets, the Pension Benefit Guaranty Corporation (PBGC) is likely to absorb unfunded liabilities considerably greater than the plan reported. PBGC has few tools to control its exposure from hidden liabilities. Plan sponsors with financial difficulties know that PBGC will protect the guaranteed pensions of their workers no matter how large the unfunded liabilities in their plans. Financially troubled sponsors sometimes take actions that increase the burden on PBGC, such as raising benefits in lieu of increasing wages or failing to contribute to their plans. Although PBGC could benefit from additional tools to control its hidden liabilities, such tools impose costs on plan participants, plan sponsors, or the federal government.

Pension Plans: Labor Should Not Ignore Some Small Plans That Report Violations (GAO/HRD-93-45, Mar. 26, 1993)

In a May 1991 report (GAO/HRD-91-87), GAO revealed fund abuses in pension plans for which the Pension Benefit Guaranty Corporation (PBGC) had assumed responsibility. GAO indicated that both the Labor Department and the Internal Revenue Service may not have acted on information, found in annual reports filed by pension plans, describing violations involving asset use and funding deficiencies. This report follows up on that work and discusses (1) whether the agencies have identified and acted on the information and (2) what the agencies' current procedures and practices are for dealing with violations. IRS procedures generally are effective in identifying pension plans, including small ones, that report funding deficiencies and provide reasonable assurance that appropriate actions will be taken. The Labor Department's procedures ignore some small plans, despite indications that violations are more common among such plans.

Pension Restoration Act (GAO/HRD-93-7R, Dec. 18, 1992)

GAO reviewed the impact of proposed legislation which would pay annuities to plan participants or their surviving spouses whose pension plans terminated before the enactment of the Employee Retirement Income Security Act, focusing on: (1) the number of pension losers or their surviving spouses; (2) the amount of annuities and administrative costs; (3) the impact on the Pension Benefit Guaranty Corporation's (PBGC) solvency; and (4) implementation difficulties. GAO found that: (1) the precise number of pension losers and their surviving spouses was unknown, but a 1979 Department of Labor study estimated that 67,000 participants were fully vested and survived to 1979; (2) in 1992, there were

47,000 to 52,000 surviving pension losers and spouses, with 38,000 to 39,000 participants immediately eligible for benefits; (3) present value annuity costs would range from $305 million to $406 million, and first-year administrative costs from $42 million to $44 million, with additional administrative costs to find and certify surviving participants and spouses having a present benefit value of $60 million; (5) PBGC liabilities would increase by $406 million under the proposed legislation, but its net cash flow would cover annuities through the end of the century; (6) the PBGC deficit would increase to $5.7 billion instead of $4.7 billion by 2001; and (7) the implementation would be difficult due to lack of documentation, since PBGC has no accurate information on individual pension losers or eligible participants.

Private Pensions: Protections for Retirees' Insurance Annuities Can Be Strengthened (GAO/HRD-93-29, Mar. 31, 1993)

Insurance regulators seized control of several large life insurance companies in 1991 because of solvency problems. These events have raised concerns about the adequacy of protection for the 3 to 4 million retirees and beneficiaries receiving annuities. In the wake of the seizure of the Executive Life Insurance Company, for example, 44,000 retirees received only 70 percent of their monthly annuities for more than a year. This report assesses (1) state guarantee coverage of insurance annuities received by retirees from private pension plans and (2) federal regulation and oversight of the selection of private pension plans of insurers to provide annuity benefits. GAO also discusses options to improve protection for retirees' insurance annuities.

Small Pension Plans: Concerns About the IRS Actuarial Audit Program (GAO/HRD-93-64, June 30, 1993)

After discovering that some highly paid professionals were reaping huge tax deductions by making extremely large contributions to their pension plans, the Internal Revenue Service (IRS) began in 1989 a nationwide audit of small defined benefit pension plans—those with one to five participants. IRS concluded that in many cases large tax deductions were being taken on the basis of unreasonably conservative actuarial assumptions used in calculating allowable pension contributions. Many taxpayers and their accountants complained that IRS was merely trying to generate federal revenues at the expense of small businesses. This report analyzes the impact of the IRS audit program on small business sponsors of defined benefit pension plans. GAO examines the validity of the complaints about IRS' reasons for undertaking the audit program, identifies whom the program targeted, and determines whether IRS considered taxpayer facts and circumstances before substituting its own actuarial assumptions.

Social Security: IRS Tax Identity Data Can Help Improve SSA Earnings Records (GAO/HRD-93-42, Mar. 29, 1993)

Each year, millions of workers pay social security taxes on earnings that cannot be credited to their social security accounts because the Social Security Administration (SSA) does not have enough information to identify the correct accounts for these earnings. As a result, workers may end up shortchanged years later when they begin receiving social security benefits. Through routine tax administration activities, the Internal Revenue Service (IRS) obtains taxpayer identity data that could help SSA resolve uncredited earnings recorded in its suspense file. In GAO's view, this information, which IRS requires as a condition for paying tax refunds, could greatly benefit SSA resolution efforts. IRS reports show that in 1989 more than 776,000 taxpayers responded to its requests about the identity question to obtain a release of their tax refunds. IRS does not, however, keep the taxpayer responses, and GAO was unable to estimate the potential suspense file resolution value to SSA. Spouse names from some joint tax returns would also help SSA credit earnings to workers' accounts. IRS data could be helpful when SSA's crediting problems relate to unreported changes in surnames. With this data, SSA could resolve an estimated 79,000 uncredited earnings cases valued at $556 million for tax year 1989 alone.

Social Security: Need to Improve Postentitlement Service to the Public (GAO/HRD-93-21, May 7, 1993)

Postentitlement services are those provided to Social Security beneficiaries and include replacement of lost or stolen checks, converting spouses to survivors' status, and making address changes to checks. About 64 million postentitlement actions were processed for individuals in 1990 in SSA's retirement, survivors, and disability programs, and another 12 million actions were processed for the supplemental security income program. GAO reviewed SSA's processing of these actions and found that check replacement services could be improved by changing the current policy of delaying missing check claims for two weeks and instead processing the claims more quickly. Procedures also contribute to delays in the completion of spouse conversions to survivors' status. In GAO's opinion, SSA's practice of not providing election forms to all currently entitled spouses with dual entitlement until much later in the processing cycle should be changed.

Social Security: Telephone Busy Signal Rates at Local SSA Field Offices (GAO/HRD-93-49, Mar. 4, 1993)

The Social Security Administration (SSA), seeking to improve telephone service for the public, instituted a nationwide, toll-free 800 number for its field offices in 1988. GAO's calls to local Social Security offices were often met with busy signals. Being disconnected or being transferred to answering machines were also problems, resulting in GAO being unable to complete 56 percent of the calls it placed. To provide a complete picture

of the public's ability to telephone SSA during this period, GAO also obtained busy signal data for SSA's nationwide 800 number. That number had an overall busy rate of about 25 percent. SSA does not maintain data that would allow GAO to develop a comparable call completion rate.

Status of Agency Use of SSA Death Information (GAO/HRD-93-31R, July 20, 1993)

GAO reviewed: (1) federal and state agencies' use of the Social Security Administration's (SSA) unrestricted state death information and (2) the estimated savings of sharing SSA restricted state death information. GAO found that (1) the largest federal agencies have made progress in obtaining and using SSA death information, but some federal agencies and most state agencies have not requested the information; (2) the Department of the Treasury is working with agencies to resolve problems that make it difficult to assess the results of beneficiary matches with SSA death information; (3) the Coast Guard is the only agency that has met the Treasury's reporting requirements and the Department of Defense is the only agency that has not submitted reports; (4) agencies' use of restricted state death information could result in substantial savings by preventing erroneous payments to decreased beneficiaries; and (5) SSA unrestricted death information is inaccurate to a significant extent.

Underfunded State and Local Pension Plans (GAO/HRD-93-9R, Dec. 3, 1992)

GAO commented on the pension-funding practices of state and local governments, focusing on the extent to which state and local governments: (1) failed to make appropriate contributions to plans; (2) changed actuarial assumptions or funding methods in order to lower required contributions; and (3) used pension funds to pay operating expenses. GAO noted that: (1) pension plan contributions by some state and local governments fell short of actuarially required amounts; (2) in some instances, state and local governments changed actuarial assumptions to lower required plan contributions; and (3) there was no evidence that state and local governments removed funds from pension plans for operating expenses.

Veterans Issues

Army Material Command: Factors Influencing Retirement Decisions During 1990 Reduction in Force (GAO/NSIAD-93-28BR, Dec. 31, 1992)

Congress is debating proposed legislation that would encourage more early retirements during the reduction of civilian employees at the Defense Department. This briefing report studies the retirements experienced by the Army Material Command as part of its 1990 reduction in force, during which specific authority was given to allow early retirements. GAO (1) determines the extent to which early retirements may have helped avoid involuntary separations in that instance, (2) identifies the main factors that differentiated employees who took early retirements in that reduction in force from those who did not, and (3) obtains insights on retirement-eligible employees' reactions to hypothetical retirement incentives. GAO also obtained the views of employees already eligible for standard retirement at the time of the Army Material Command's reduction in force.

VA Health Care: Potential for Offsetting Long-Term Care Costs Through Estate Recovery (GAO/HRD-93-68, July 27, 1993)

The Department of Veterans Affairs (VA) spent about $1.2 billion in fiscal year 1991 to provide nursing home and domiciliary care to 75,000 veterans in VA and community facilities. For nursing home care, VA is required to collect a fee, known as a copayment, from veterans with incomes above a certain level—about $19,000 for a single veteran. VA picks up the tab for other veterans receiving care. Although VA is able to recover any unpaid nursing home copayments from veterans' estates, VA is not authorized to recover its remaining costs—more than 90 percent of its total costs for providing nursing home and domiciliary care. In GAO's view, an estate recovery program could help ease the financial strains on the government's health care efforts. Estate recovery programs can be structured to recover costs without placing undue hardships on the elderly, are consistent with the government's commitment to provide medical care to veterans, and can more than pay for themselves. Oregon's Medicaid estate recovery program recoups about $13 for every $1 spent administering the program. Congress may want to consider allowing VA to recover from veterans' estates up to the full cost of providing nursing home and domiciliary care. These funds could be used to help offset rising operating costs and provide care for more veterans. VA may need the authority to prevent asset transfers to family members or others that would circumvent cost recovery.

Other Issues

Tax Administration: Information on Tax Counseling for the Elderly Program (GAO/GGD-93-90BR, Apr. 8, 1993)

This briefing report provides information on the Internal Revenue Service's (IRS) grants for the Tax Counseling for the Elderly Program. Under the program, trained volunteers, who provide tax help to the elderly, may be reimbursed for their expenses associated with assisting taxpayers. The American Association of Retired Persons (AARP) continues to be the dominant program sponsor, managing a nationwide Tax Counseling for the Elderly Program with 90 percent of all federal grant funds. AARP reported that in fiscal year 1992, its volunteers helped 1.5 million taxpayers at an average cost of $2 per person. GAO discusses how much the nonprofit sponsoring organizations received in fiscal year 1992, how the funds were spent by the five organizations receiving the largest grants, and how accountable these groups are to IRS for the funds spent.

Fiscal Year 1993 GAO Reports on Issues Affecting Older Americans and Others

GAO issued 54 reports in fiscal year 1993 on policies and programs in which older Americans were one of several groups. Of these 5 were on employment, 19 on health, 5 on housing, 4 on income security, and 21 on veterans' issues.

Employment Issues

Americans With Disabilities Act: Initial Accessibility Good but Important Barriers Remain (GAO/PEMD-93-16, May 19, 1993)

Before the Americans With Disabilities Act took effect, Congress asked GAO to begin a long-term evaluation to see whether the main objectives of the law were being met. Specifically, Congress was concerned about whether access by persons with disabilities to goods and services provided by the government and the private sector had increased and discrimination against such persons had decreased. GAO found the following: (1) although most features of business and government facilities were accessible to disabled persons, several significant barriers remained; (2) many managers and business owners reported that they were unaware of the law or their specific responsibilities under it; (3) most managers and owners viewed the removal of barriers as beneficial, with few mentioning burdens; and (4) barrier-removal efforts were not always sensible. Many facilities had barriers remaining, and some barrier-removal efforts were planned in areas where no barriers existed. GAO concludes that there is a need for continuing educational outreach and technical assistance for business and government agencies covered by the act.

Information on EEO Discrimination Complaints (GAO/GGD-93-6RS, Dec. 31, 1992)

GAO provided supplemental information on equal employment opportunity (EEO) discrimination complaints at smaller federal agencies. GAO noted that: (1) one agency corrected inaccurate data it reported in its EEO report; (2) it revised a table to reflect the corrected data; and (3) the reason for the inconsistencies was that complaints encompassed multiple issues, such as national origin, race, sex, handicap, age, or religion.

Monetary Payments in Federal EEO Cases (GAO/GGD-93-45R, May 25, 1993)

GAO provided information on payments that were made to federal employees and their attorneys resulting from discrimination complaint cases during fiscal years (FY) 1989 through 1992. GAO found that: (1) from FY 1989 through 1992, federal agencies paid at least $47.9 million to federal employees as the result of employee discrimination claims; (2) at least $24.4 million of the awards was for federal employees' back pay and

attorney fees; (3) the Judgment Fund made $23.5 million of the awards, of which approximately half went towards federal employees' attorney fees; (4) the cost information may be unreliable due to accuracy and completeness problems and variances in the Judgment Fund's identification codes; and (5) nongovernment employee cases accounted for about 3 percent of the total discrimination claims payments in 1992.

The Public Service: Issues Confronting the Federal Civilian Workforce (GAO/GGD-93-53, Mar. 16, 1993)

The federal government will spend about $150 billion on pay and benefits for civilian employees in 1993. The effectiveness and efficiency with which federal agencies carry out programs depends largely on the quality, motivation, and performance of these workers. Thus, the recruitment, hiring, training, management, and accountability of federal employees is critical to effective government. GAO issued 67 reports and 22 testimonies on federal public service during 1991. This report summarizes each of these documents, discusses agency responses to GAO's recommendations on everything from lobbying reform to health club memberships for federal workers, and examines key areas in which further action or monitoring is needed.

Vocational Rehabilitation: Evidence for Federal Program's Effectiveness Is Mixed (GAO/PEMD-93-19, Aug. 27, 1993)

The state-federal vocational rehabilitation program run by the Department of Education helps disabled persons become employed, become more independent, and be integrated into the community. This report discusses whom the program is serving and what the results are. GAO estimates the eligible population, contrasts those accepted and those not, describes the services that clients receive, and evaluates program outcomes. GAO found that only a small fraction of the millions of disabled Americans who are potentially eligible for state-federal rehabilitation services actually receive them and that rehabilitants' gains in employment and earnings fade substantially after about two years.

Health Issues

Emergency Departments: Unevenly Affected by Growth and Change in Patient Use (GAO/HRD-93-4, Jan. 4, 1993)

Patient caseloads in emergency rooms nationwide soared between 1985 and 1990. Nearly 85 percent of hospitals reported an upsurge in emergency room use by patients with nonurgent conditions—more than 40 percent of all emergency room patients in 1990. The largest rise in emergency room visits was by Medicaid patients, who traditionally have high rates of emergency room use for nonurgent conditions. Nonurgent use by

uninsured patients also contributed to the emergency room caseload growth during the 6-year period. Growth in emergency room use was most pronounced among patients whose medical care is often not fully reimbursed, such as Medicaid, Medicare, and uninsured patients. At the same time, however, little growth occurred in emergency room use by patients with private insurance. This disproportionate growth may make it harder for hospitals to absorb or offset losses due to unreimbursed emergency room care. GAO did observe some appreciable variations in emergency room conditions by community size. For example, emergency rooms in urban areas were most likely to have patients waiting a long time for treatment. Furthermore, these emergency rooms were the most likely to have a larger share of uninsured patients and increased visits due to AIDS, drug abuse, and violence.

Family and Medical Leave Cost Estimate (GAO/HRD-93-14R, Feb. 1, 1993)

GAO provided an estimate of the costs of the Family and Medical Leave Act of 1993, focusing on: (1) eligibility and length of leave allowed; (2) health insurance coverage and employer costs; and (3) the size of the population that would be eligible to take leave under the proposal. GAO noted that: (1) employer costs of continuing health insurance coverage for employees on unpaid family and medical leave would be $674 million annually; (2) an 80-percent increase in estimated employer costs resulted from the increase in employer health insurance costs and the growth in the number of likely beneficiaries; and (3) changes since 1986 in total employment, cost conditions facing employers, and the amount of leave allowed caused the $334 million increase in estimated costs.

Federal Health Care: Increased Information System Sharing Could Improve Service, Reduce Costs (GAO/IMTEC-93-33BR, June 29, 1993)

Sharing of health information among the Department of Veterans Affairs, the Defense Department, and the Indian Health Service offers many potential benefits, including improved service to patients, reduced costs, and better use of health care facilities. Despite these benefits, such sharing is limited and is generally paper-based; electronic exchange of information is nonexistent, and intra-agency exchange is limited. Before additional sharing can be achieved, several barriers must be overcome, with organizational barriers being the most challenging. Each agency has its own regulation, management information requirement, and clinical support operations that will have to be addressed. To facilitate additional sharing, consensus will be needed to standardize some of the agency-specific, health care functions and their implementation.

Health Care Access: Innovative Programs Using Nonphysicians (GAO/HRD-93-128, Aug. 27, 1993)

In 1992, about 22 million Americans lived in areas with shortages of doctors. Some experts have suggested that greater use of nonphysician providers could expand access to health care. Recent studies have shown that up to 90 percent of the diagnoses made in outpatient settings could be handled capably by physician assistants or nurse practitioners. Under a unique program sponsored by the Indian Health Service, Alaskans have been trained to provide emergency and primary care in remote villages that are sometimes hundreds of miles away from the nearest doctor. These individuals rely on procedures spelled out in an easy-to-read manual and consult daily by telephone or radio with a hospital-based doctor. Available data indicate that the program has generally been well-accepted by patients and that it has significantly improved the health status of Alaska natives. The federal government has assumed responsibility for any medical malpractice claims arising from the program. Pinellas County, Florida, has studied the Alaska program and has proposed a plan under which paramedics would provide primary care to medically needy persons during off-peak hours, following strictly defined procedures and consulting electronically with hospital-based physicians. Whether such a program can get off the ground is unclear because current laws do not allow paramedics to provide routine primary care services and because it is unclear who would assume medical liability for such paramedic services.

Health Care: Rochester's Community Approach Yields Better Access, Lower Costs (GAO/HRD-93-44, Jan. 29, 1993)

Rochester, New York, has succeeded in keeping health care costs lower than costs in other communities without sacrificing its residents' access to care. Health insurance costs per employee in Rochester were 33 percent lower than comparable costs in the nation, and Rochester residents were more likely to have health insurance. Relative to the general U.S. population, people in Rochester seem happier with their health care system and say that they have an easier time obtaining care. Recently, only 5 percent of Rochester residents—compared with 13 percent nationally—said that they had gone without needed care in the last year. These results are due to the interaction of several factors, beginning with a long history of community-based health planning. Local initiatives have limited the expansion of hospital capacity, controlled the diffusion of medical technology, and maintained the practice of community rating of health insurance. All of these efforts have benefited from the active support of Rochester's employers, who have worked with insurers, health providers, and government to control health care costs and improve access to care. The Rochester experience provides important insights for other communities trying to gain control over rising health care costs and

diminished access. In must be noted, however, that Rochester's successes have resulted from decades of effort. Further, many of the problems that Rochester has avoided, such as the excessive growth of hospital beds and the erosion of health insurance coverage, are entrenched elsewhere. It may be more difficult to change practices that people are accustomed to than it is to prevent them from taking hold in the first place.

Health Information Systems: National Practitioner Data Bank Continues to Experience Problems (GAO/IMTEC-93-1, Jan. 29, 1993)

The Department of Health and Human Services (HHS) created its National Practitioner Data Bank to help prevent unethical or incompetent doctors from moving across state lines and concealing their professional history. HHS' management of the data bank, however, has allowed weaknesses that undermine achievement of a timely, secure, and cost-efficient operation. The data bank usually does not give users responses to their questions for several weeks, which in turn delays that granting of privileges to health care practitioners. Further, poor internal controls have allowed use organizations to receive sensitive practitioner data to which they are not entitled. In addition, HHS has inadequately monitored the data bank contractor. Finally, although HHS intends to revamp the data bank, its plans have not incorporated a sound system development approach and are based on funding uncertainties. As a result, HHS may acquire a system that does not meet users' needs.

Indian Health Service: Basic Services Mostly Available; Substance Abuse Problems Need Attention (GAO/HRD-93-48, Apr. 9, 1993)

The five Indian Health Service area offices GAO visited—Aberdeen, Alaska, California, Navajo, and Portland—differed greatly in the way that they delivered health care services. Nonetheless, the areas reported generally similar levels in the availability of basic clinical services. The services most available were treatment services, such as routine prenatal care, and diagnostic services, such as biopsies for cancer diagnoses. Almost all patients seeking such services were able to receive them. Preventive care, such as diabetes education and dental care, was comparatively less available. Service unit officials generally named alcohol and substance abuse services as their greatest unmet health need. Despite recent increases in Indian Health Service funding for alcohol and substance abuse treatment services, the gap between the demand for and availability of services persists. In addition, the Indian Health Service lacks data on alcoholism rates among native Americans and the effectiveness of current prevention and treatment programs.

Medicaid: Changes in Drug Prices Paid by HMOs and Hospitals Since Enactment of Rebate Provisions (GAO/HRD-93-43, Jan. 15, 1993)

In 1990, in an effort to control Medicaid's increasing outlays for prescription drugs, Congress significantly changed the way that Medicaid pays for outpatient drugs. Medicaid had been paying near retail prices for outpatient drugs, while other purchasers, such as hospitals and health maintenance organizations (HMO), were able to negotiate big discounts with drug manufacturers. The new legislation required drug manufacturers to give state Medicaid programs rebates for outpatient drugs on the basis of the lowest prices available to any purchaser. In a September 1991 report (GAO/HRD-91-139), GAO discussed changes in prescription drug prices charged the Department of Veterans Affairs and the Defense Department. This report focuses on changes in drug prices charged hospitals and HMOs. GAO found that drug price changes experienced by HMOs and hospitals varied considerably since the enactment of the Medicare rebate provisions. Some prices increased substantially, while others declined. Price increases tended to be more common and more significant for outpatient drugs than for inpatient drugs, but few other clear patterns emerged. GAO could not determine the extent to which the price hikes were due to the new law.

Medicaid: Data Improvements Needed to Help Manage Health Care Program (GAO/IMTEC-93-18, May 13, 1993)

Although high-quality data are needed to help manage the Medicaid program and to provide critical input to urgent national health care issues, the Health Care Financing Administration (HCFA) has done little to ensure the data's accuracy and completeness. Many studies have shown that the data states are reporting from their Medicaid information systems are often inaccurate, inconsistent, and incomplete. HCFA has not fixed these problems because it has not viewed resolution of data deficiencies to be a high priority. As a result, the lack of quality data has made it hard to determine how well people are being served by Medicaid.

Medicaid Drug Fraud: Federal Leadership Needed to Reduce Program Vulnerabilities (GAO/HRD-93-118, Aug. 2, 1993)

Medicaid prescription fraud is widespread in the United States, contributing significantly to the government's $5.5 billion tab for prescription drugs in 1991. For example, some pharmacists routinely pad customer prescriptions, keeping the extra drugs to sell or use themselves. Clinics inappropriately give Medicaid recipients completed prescription forms that are then traded for merchandise from local pharmacies or sold on the street to the highest bidder; some pills costing 50 cents at the pharmacy have been resold for as much as $85. A common scheme is the so-called "pill mill," in which doctors, clinic owners, and pharmacists conspire to defraud Medicaid by prescribing drugs solely to obtain government reimbursement. Patients are often in on the scam, allowing the use of their Medicaid numbers in exchange for kickbacks of cash or

drugs. This organized network of physicians, patient brokers, and assorted middlemen frequently transferred money overseas via the notorious Bank of Credit and Commerce International. Recent initiatives in several states have shown signs of stemming these financial losses, but federal leadership and support are needed to ensure broader implementation of these initiatives.

GAO summarized this report in testimony before Congress; see: Medicaid Drug Fraud: Federal Leadership Needed to Reduce Program Vulnerabilities, by Leslie G. Aronovitz, Associate Director for Health Financing Issues, before the Subcommittee on Human Resources and Intergovernmental Relations, House Committee on Government Operations (GAO/T-HRD-93-28, Aug. 2, 1993).

Medicaid: Outpatient Drug Costs and Reimbursements for Selected Pharmacies in Illinois and Maryland (GAO/HRD-93-55FS, Mar. 18, 1993)

This fact sheet looks at the extent to which pharmacies that buy outpatient drugs at a discount from drug manufacturers pass on any of the savings to state Medicaid programs. GAO compares drug purchase costs and Medicaid reimbursements in two states—Illinois and Maryland—chosen because each (1) uses one of two basic formulas to reimburse pharmacies' drug purchase costs and (2) has relatively high expenditures for outpatient drug prescriptions. For each state, GAO compares the prices that hospital outpatient and nursing home pharmacies paid for specific outpatient drugs to the Medicaid reimbursements the pharmacies received. GAO also compares the prices the pharmacies paid to the drugs' average wholesale prices—the price manufacturers would pay if they did not receive discounts.

Medicare: Millions in End-Stage Renal Disease Expenditures Shifted to Employer Health Plans (GAO/HRD-93-31, Dec. 31, 1992)

Recent legislation changed Medicare coverage for some beneficiaries with kidney failure, known as end-stage renal disease. For these individuals, the law extended the period of time during which employer-provided group health plans would be expected to pay medical expenses before Medicare. This report discusses the (1) number and geographical distribution of beneficiaries affected by the extension, (2) amount of annual Medicare savings achieved, and (3) effect of the extension of access to employment and employment-based health insurance.

Medicare: Renal Facility Cost Reports Probably Overstate Costs of Patient Care (GAO/HRD-93-70, May 18, 1993)

Medicare helps patients suffering from kidney failure with the costs of dialysis treatments by paying dialysis facilities a predetermined amount per outpatient treatment. A full year of dialysis treatments at Medicare's average payment rates costs more than $19,000, of which the program pays 80 percent and the patient 20 percent. The dialysis industry believes that the Medicare dialysis payment rates should be raised, but the Health Care Financing Administration has proposed reducing the fees. This report answers the following questions: Are the definitions Medicare uses to define costs for payment rate-setting purposes adequate? What is the quality of the most recent audited cost data for rate-setting purposes? Do costs incurred by integrated and nonintegrated firms differ? (An integrated firm might run two or more dialysis facilities through a home or office or own related businesses, such as a laboratory or a supply company, to support its dialysis facilities.) GAO found that 1990 Medicare audits of dialysis facility cost reports were incomplete and poorly done. If the audits had been adequately done, additional unallowable costs would probably have been uncovered and removed from the cost reports, resulting in a further reduction of the median cost per treatment. GAO also found that integrated facilities provide dialysis treatments at substantially lower cost than nonintegrated firms.

Medicare: Separate Payment for Fitting Braces and Artificial Limbs Is Not Needed (GAO/HRD-93-98, July 21, 1993)

Medicare pays for braces and artificial limbs when beneficiaries need them due to injury or illness. Beginning in 1989, a fee schedule replaced the reasonable charge system as a way of paying for these items. GAO believes that because the fee schedule for braces and artificial limbs covers the costs of the devices as well as related professional services, there is no need to establish separate fees for orthotic and prosthetic practitioners. Also, contrary to industry concerns, physician charges had little effect on Medicare's initial fee schedule payment rates. GAO identified 42 items paid for under the orthotic and prosthetic fee schedule that did not require professional fabrication or fitting services. These items, including sterile saline solutions, ostomy supplies, and off-the-shelf braces, could be moved to a more suitable fee schedule category, saving an estimated $12 million annually. GAO also found considerable variation in coverage criteria for braces and artificial limbs among Medicare's claims-processing contractors. This variation could result in payments for the same item being authorized in some areas and denied in others. Recent steps taken by Medicare should remedy this problem.

Nonprofit Hospitals: For-Profit Ventures Pose Access and Capacity Problems (GAO/HRD-93-124, July 22, 1993)

During the 1980s, increasing numbers of hospitals and doctors became partners in for-profit joint ventures, such as outpatient surgery and diagnostic imaging. Concerns have been raised, however, that the profit motive inherent in these joint ventures can lead to excess capacity for some medical services without improving care for poor patients. Further, concerns about kickbacks and other illegal schemes have prompted federal and state regulators to regulate joint ventures more closely. This report determines the (1) rate at which nonprofit hospitals participate in joint ventures; (2) extent to which these ventures, compared with their parent hospitals, serve the poor; (3) extent that joint ventures can boost excess capacity for medical services in their communities; and (4) effect of recent federal and state regulatory action on joint ventures.

Organ Transplants: Increased Effort Needed to Boost Supply and Ensure Equitable Distribution of Organs (GAO/HRD-93-56, Apr. 22, 1993)

More than 10,000 people died waiting for organ transplants during a recent 5-year period. Although the technology for organ transplantation has improved dramatically, organ supplies have not kept pace with demand. Federal legislation has attempted to boost supplies of transplant organs and make their allocation more equitable, but patients have little assurance that organs are being distributed fairly. First, the Department of Health and Human Services (HHS) does not monitor the allocation practices of organ procurement organizations. Second, some organizations limit the pool of patients to be considered for transplant to a single transplant center. Third, some organizations do not document why good transplant candidates were skipped over. Fourth, despite a policy of the United Network for Organ Sharing that allocation practices should be uniform, compliance with this policy by organ procurement organizations is voluntary. HHS needs to develop federal regulations stipulating appropriate allocation practices and develop a measure of procurement success that would enable it to target technical assistance to less effective organ procurement organizations.

GAO summarized this report in testimony before Congress; see: Organ Transplants: Increased Effort Needed to Boost Supply and Ensure Equitable Distribution of Organs, by Mark V. Nadel, Associate Director for National and Public Health Issues, before the Subcommittee on Health and the Environment, House Committee on Energy and Commerce (GAO/T-HRD-93-17, Apr. 22, 1993).

Prescription Drug Prices: Analysis of Canada's Patented Medicine Prices Review Board (GAO/HRD-93-51, Feb. 17, 1993)

As the public debate about health care costs intensifies, congressional attention has focused on ways to curb the upward spiral of prescription drug prices. The last Congress saw 11 bills introduced that would have constrained drug prices, yet none of these was enacted. Some of these bills would have created a federal board, modeled after Canada's Patented Medicine Prices Review Board, to monitor prescription drug pricing. A September 1992 GAO report (GAO/HRD-92-110) found that manufacturers charge less for many drugs in Canada than in the United States and that the Canadian approach to regulating drug prices contributes to this price differential. This report (1) describes the purpose and the structure of Canada's Patented Medicine Prices Review Board as well as its guidelines and procedures, especially those used to determine if a drug price is excessive, and (2) summarizes the evidence about the effects of the Board's actions in Canada on the prices of new drugs, on price increases for existing drugs, and on pharmaceutical research and development.

Psychiatric Fraud and Abuse: Increased Scrutiny of Hospital Stays Is Needed for Federal Health Programs (GAO/HRD-93-92, Sept. 17, 1993)

In response to allegations that some Texas psychiatric hospitals paid kickbacks for patient referrals, falsified diagnoses to obtain insurance payments, and kept patients against their will in order to maximize payments, GAO reviewed the vulnerability of federal health programs to fraud and abuse by psychiatric hospitals. Investigators have found that crooked psychiatric hospitals are more likely to take advantage of patients covered by private insurance, which has higher reimbursement rates for mental health services than federal programs and is thus more profitable. Although federal programs have many controls in place to guard against unnecessary or poor quality care, some control weaknesses exist that render federal programs vulnerable to fraudulent and abusive psychiatric hospital practices. For example, although required by federal law, some state Medicaid programs do not independently evaluate the need for inpatient care. In addition, the Civilian Health and Medical Program of the Uniformed Services lacks adequate systems for ensuring that payments are limited to authorized psychiatric stays and for preventing duplicate payments.

Utilization Review: Information on External Review Organizations (GAO/HRD-93-22FS, Nov. 24, 1992)

Utilization review organizations (URO) significantly influence the provision of and payment for health care in this country. Because recommendations made by these organizations can impact the care approved for payment, a URO might affect a patient's access to health care. As a result, there is considerable interest in the health care community about who makes utilization decisions, their professional experience, and the review criteria

they use. This fact sheet provides information on (1) the size and ownership of UROs, (2) the professional qualifications of the staff involved in utilization review decisions, (3) the complexity of decisions made by various types of staff, (4) appeal procedures, (5) clinical review criteria used by UROs, and (6) quality assurance procedures implemented to ensure adherence to company directives. In short, GAO discovered the following: that UROs often employ physicians on a part-time basis or as consultants; registered nurses are heavily involved in first-level review decisions but doctors become more involved during the second-level review and appeals process; UROs generally use commercially developed review criteria when making their recommendations; most UROs have established appeal procedures; of the few utilization decisions that are appealed, many are successful; and UROs have implemented quality assurance procedures to ensure adherence to company directives.

Housing Issues

Assisted Housing: Evening Out the Growth of the Section 8 Program's Funding Needs (GAO/RCED-93-54, Aug. 5, 1993)

Housing subsidies provided under the government's Section 8 program have enabled nearly 3 million poor families to obtain decent and affordable housing from private owners. The Department of Housing and Urban Development makes this money available through more than 40,000 contracts with local housing agencies, state finance agencies, and private owners. Many of these contracts will expire within 5 years, and the estimated cost to renew them will soar to more than $15 billion. This report discusses (1) estimated budget authority needs to renew expiring Section 8 rental housing assistance contracts in fiscal years 1994-98, (2) ways to even out the growth in budget authority for contract renewals, and (3) the relationship between budget authority needs to fund contract amendments—additional budget authority for contracts with insufficient remaining funds—and budget authority needs to renew expiring contracts.

Homelessness: McKinney Act Programs and Funding Through Fiscal Year 1991 (GAO/RCED-93-39, Dec. 21, 1992)

This report provides a legislative history of the McKinney Act; a description of each McKinney Act program; and the amount of money provided under each program, by state, for fiscal year 1991. It also briefly describes newly authorized assistance programs for the homeless and significant changes to existing McKinney Act programs. Overall, about $2.4 billion was earmarked during fiscal years 1987-91 for federal

programs to help the homeless; 95 percent of the money went for food, shelter, and health care; the rest went for education and job training.

Public and Assisted Housing: Some Progress Made in Implementing HUD's Family Self-Sufficiency Program (GAO/RCED-93-78, Apr. 8, 1993)

The government's family self-sufficiency program was created in 1990 to coordinate federal public housing, Indian housing, and Section 8 rental housing assistance with public and private support services. The program, by linking housing assistance with support services, like education and job training, seeks to help lower income families attain economic independence and become homeowners. This report discusses (1) the program's status, (2) actions by the Department of Housing and Urban Development (HUD) to coordinate its efforts with those of other federal agencies that will fund the support services needed for the program, and (3) HUD efforts to determine how much to reimburse local housing agencies for the costs of operating their family self-sufficiency programs.

Public Housing: Low-Income Housing Tax Credit as an Alternative Development Method (GAO/RCED-93-31, July 16, 1993)

Under the National Affordable Housing Act of 1990, GAO is required to review different ways of developing public housing units. This report compares the approaches taken by public housing authorities in developing housing under the Public Housing Development Program and the Low-Income Housing Tax Credit Program. The former provides direct federal grants, while the latter allows public housing authorities to raise development funds by forming public-private partnerships with investors. The public housing authorities GAO reviewed used the tax credit program to serve kinds of tenants and to develop kinds of programs that differed from those in the public housing program. For example, the tax credit projects served smaller households and were more likely to be located in predominantly low-income households than were the public housing projects. Furthermore, if the cost inefficiencies suggested by GAO's case study in Montgomery County, Maryland, exist in other tax credit projects, the federal government may find the tax credit program to be the more costly alternative for helping very poor households. Nevertheless, the public housing authorities GAO reviewed found the tax credit program a valuable resource for developing public housing in this period of shrinking federal budgets.

Rural Housing: FmHA's Home Loan Program Not Meeting the Needs of All Rural Residents (GAO/RCED-93-57, June 14, 1993)

The Farmers Home Administration (FmHA), part of the Agriculture Department, makes home loans to rural residents who cannot afford homes through private financing. GAO found that although rural areas have the worst housing conditions, they receive a smaller percentage of housing assistance than areas close to urban centers. Program funds lent under FmHA's single-family housing program are concentrated in and around metropolitan areas and are disproportionately higher than the demand for housing in these areas warrants. Remote rural areas, on the other hand, receive a disproportionately low amount of funds in relation to housing needs. Congress has acted to ensure that remote rural areas are better served by the program, but these actions have not yet been implemented. FmHA has identified factors contributing to the low demand for program funds in remote areas, including low income limits difficult for remote rural families to meet and subjective application of criteria used to approve housing for the program. This report includes color photos of houses rejected for the program because of slight violations, such as having a fireplace or too many windows.

Income Security Issues

Legal Services Corporation: National Support Center Grantees' Activities (GAO/HRD-93-9, Feb. 5, 1993)

In response to congressional interest in congressional funds spent on programs involved, directly or indirectly, in political, cultural, institutional, ideological, and/or economic advocacy, this report provides information on the Legal Services Corporation (LSC). GAO presents data on the activities of the 16 grantees, referred to as national support centers, that received funds from LSC in 1990. GAO discusses (1) the amount and the sources of the centers' funding, (2) their principal activities, (3) the estimate of funds spent on lobbying activities, and (4) the makeup of their boards of directors. GAO also discusses recent findings of monitoring reviews done by LSC on each center's funded activities.

Long-Term Care Forum: Rethinking Service Delivery, Accountability, and Cost Control (GAO/HRD-93-1SP, July 13, 1993)

Public dissatisfaction with the existing long-term care system is mounting. Long-term care is seen widely as both expensive and failing to meet the needs of the disabled of all ages. In particular, many people take issue with long-term care's bias in favor of institutional rather than home- and community-based services. This discussion paper was prepared for a GAO forum on long-term care issues. The views presented, although not

necessarily the official position of GAO, are an attempt to pull together a wide variety of evidence and expert opinion on the key issues in long-term reform. GAO touches on the key elements of innovative long-term care programs in the United States and abroad that have developed a wider range of home- and community-based services for the elderly as well as younger disabled persons. These key elements include (1) service flexibility to meet the unique needs of individuals, (2) high standards of organizational accountability to taxpayers for money spent and the quality of services delivered, and (3) effective cost controls to stay within the budgets decided upon by elected officials.

Massachusetts Long-Term Care (GAO/HRD-93-22R, May 17, 1993)

GAO reviewed Massachusetts' long-term care programs for elderly and younger disabled persons, focusing on state and federal programs and their fiscal year (FY) 1992 funding. GAO found that: (1) in FY 1992, the federal government and Massachusetts spent about $3.3 billion on long-term care for all persons, with the state paying a little more than one-half of the funding; (2) Medicaid accounted for 60 percent of all funding, with numerous federal and state programs providing the rest of the funding; (3) the programs spent about two-thirds of the funding on long-term care in institutional settings; (4) Medicaid provided 80 percent of the $2.2 billion spent on long-term institutional care and about 33 percent of the $1 billion spent on home- and community-based long-term care; (5) home- and community-based long-term care programs covered persons and services not eligible for Medicaid; (6) the programs had differing eligibility requirements and objectives; (7) one Massachusetts agency provided most of the long-term care services to the elderly; and (8) the nonelderly disabled were served by different Massachusetts agencies depending on their age, which could result in disruption of appropriate care delivery.

Social Security Disability: SSA Needs to Improve Continuing Disability Review Program (GAO/HRD-93-109, July 8, 1993)

The Social Security Administration (SSA) has not met the legal requirements for conducting continuing disability reviews, which ensure that individuals receiving government disability benefits are eligible for them. Significant operational problems due to unprecedented increases in initial claims for social security benefits have prompted SSA to shift resources from conducting the reviews to processing these claims. Since fiscal year 1987, SSA has done only about half of the more than 2 million required reviews. Consequently, SSA will pay more than a billion dollars to beneficiaries who have improved enough to return to work. Further, the integrity of the trust funds is affected because thousands of ineligible

beneficiaries remain on the disability rolls. In 1991, SSA streamlined its continuing disability review process by being more selective about which beneficiaries are reviewed. SSA is evaluating ways to further refine its process. GAO believes that SSA should (1) continue to examine ways to better target reviews for beneficiaries who may have medically improved and (2) increase the number of reviews beyond those planned.

Veterans Issues

Defense Civilian Downsizing: Challenges Remain Even With Availability of Financial Separation Incentives (GAO/NSIAD-93-194, May 14, 1993)

GAO has been monitoring the Pentagon's management of civilian force reductions since 1991. This report (1) updates the status of the Defense Department's (DOD) civilian work force reductions; (2) updates some of the problems and consequences arising from DOD's approach to civilian downsizing, including the difference in how white-collar and blue-collar employees have been affected so far; and (3) provides a preliminary assessment of DOD's initial use of financial separation incentives. GAO also discusses some important constraints on DOD's planning for future force reductions.

Defense Force Management: Challenges Facing DOD as It Continues to Downsize Its Civilian Work Force (GAO/NSIAD-93-123, Feb. 12, 1993)

GAO testified last year that although the Defense Department (DOD) provided significant transition assistance and financial separation incentives to military personnel, it provided much less assistance to facilitate civilian downsizing. At another congressional hearing, GAO said that some Defense managers were concerned that DOD's reliance on hiring freezes to reduce its civilian work force was making it hard to respond to fluctuations in work load and creating the potential for imbalances in worker skills. This report builds on these testimonies by (1) reporting on the status of DOD's civilian work force reductions, (2) contrasting DOD's strategy for reducing the military work force with the strategy for reducing the civilian work force, and (3) providing information on DOD's implementation of the new authorizations for separation incentive programs.

DOD Health Care: Further Testing and Evaluation of Case-Managed Home Health Care Is Needed (GAO/HRD-93-59, May 21, 1993)

The Defense Department (DOD) has conducted two demonstration projects to see whether case-managed home care of military patients is a cost-effective way of providing health care for individuals with chronic or catastrophic medical problems. GAO found that neither project has yielded enough information to identify an effective structure for administering a permanent home health care benefit. Specifically, the projects have provided little insight into ways to identify potential home health care recipients, prevent program abuse, and determine when and how case management should be provided. Claimed savings under both projects are significantly overstated. DOD also needs to determine the extent to which the administration of the home care benefit can be integrated into the Coordinated Care program.

Homeownership: Appropriations Made to Finance VA's Housing Program May Be Overestimated (GAO/RCED-93-173, Sept. 8, 1993)

Under its Home Loan Guaranty Program, the Department of Veterans Affairs (VA) has partially guaranteed $389 billion in home loans made to veterans by private sector lenders. The outstanding balance on these loans was $171 billion as of September 1992. In an effort to pin down the actual cost to the government of guaranteeing the loans for their full life—up to 30 years—VA was required, beginning in fiscal year 1992, to estimate the subsidy cost associated with its new loan guarantees. The estimate determines the budgetary appropriations that are provided in the years that the loans are originated to cover all estimated future losses from those years' portfolios of mortgage loans. This report (1) estimates the costs, under different economic scenarios, to the federal government of guaranteeing VA's fiscal years 1992 and 1993 home mortgage loans and (2) compares GAO's estimates with estimates prepared by the administration.

Management of VA: Improved Human Resource Planning Needed to Achieve Strategic Goals (GAO/HRD-93-10, Mar. 18, 1993)

The Department of Veterans Affairs' (VA) approach to managing people does not effectively support its strategic management efforts. In the dynamic environment facing it today, VA needs a collaborative and future-oriented approach to human resource management, with proactive human resource planning as its cornerstone. Human resource planning is needed to focus VA's attention on the people dimension of its strategic vision. For example, VA might well need a different mix of jobs and skills to support the shift it envisions from inpatient care to an array of services—from outpatient to extended care—needed by an aging veteran population. Without Department-wide execution of the fundamentals of human resource planning, VA's goal of becoming the best-managed federal service organization will be difficult to achieve. VA needs to systematically

monitor and assess external environmental trends affecting its people, thereby anticipating emerging labor force issues before they become crises. It needs to identify and address the human resource concerns of its managers, such as concerns about the effectiveness of its system of rewards and incentives. VA also needs to help line managers project human resource needs to ensure that enough people with the right skills are available when—and where—needed.

Military Downsizing: Balancing Accessions and Losses Is Key to Shaping the Future Force (GAO/NSIAD-93-241, Sept. 30, 1993)

Although the military services have significantly reduced accession levels over those of previous years, they are also recruiting large numbers of personnel to better ensure a balanced force across the various pay grades and skill areas. Congress has prescribed reduction targets and provided other guidance to the Pentagon to facilitate downsizing, minimize involuntary separations, and preserve a balanced force. This report examines the Defense Department's (DOD) adherence to congressional guidance and authorization in military downsizing. GAO discusses (1) what progress DOD has made toward meeting reduction targets, (2) how downsizing actions are affecting new recruiting or accessions, (3) what range of voluntary and involuntary reduction actions are being taken to meet downsizing objectives, (4) how downsizing is being accomplished across various groupings of officer and enlisted personnel by years of service and how this is affecting future profiles, and (5) what issues might be important to future reduction decisions.

VA Health Care: Actions Needed to Control Major Construction Costs (GAO/HRD-93-75, Feb. 26, 1993)

Between fiscal years 1985 and 1992, the Department of Veterans Affairs (VA) received nearly $4 billion to build and modernize facilities; cost overruns during this period totaled more than $224 million. Although VA has tried to strengthen its construction program, the costs of the program are still too high because (1) factors affecting demand for VA health care services, such as incomes and insurance coverage of local veterans, are not considered in determining the need for VA construction; (2) less costly alternatives to VA construction, such as joint ventures with military facilities and use of state and local resources, are given short shrift in planning VA construction projects; and (3) projects exceed program needs, containing too many beds, too much space, or too costly designs. Also, projects increasingly receive construction funding before design development is complete and adequate cost estimates are developed. GAO believes that, because of the likelihood of national health care reform, VA should consider limiting construction of additional acute care capacity until future demand for VA health care services can be determined.

VA Health Care: Closure and Replacement of the Medical Center in Martinez, California (GAO/HRD-93-15, Dec. 1, 1992)	The Department of Veterans Affairs (VA), concerned that its Martinez, California, medical center could prove unsafe in a major earthquake, announced the emergency closure of the facility in August 1991. VA said that it intended to replace the 359-bed, full-service hospital, which served more than 400,000 veterans in northern California, with a facility on the campus of the University of California at Davis. In March 1992, however, VA told Congress that it was reconsidering its decision to move to Davis. Other options VA was looking into included working with the Air Force to add on to the medical center at Travis Air Force Base in Fairfield, California; building a VA medical center in Sacramento; and renovating the Martinez medical center. This report discusses factors that should be considered in selecting the site(s) for the replacement medical center(s). GAO reviews (1) past site selection analyses done by the Martinez medical center, VA's Western Region, and others, and (2) earlier GAO reports on site selection and the sharing of medical facilities and services.
VA Health Care: Comparison of VA Benefits With Other Public and Private Programs (GAO/HRD-93-94, July 29, 1993)	Because of the growth of public and private health insurance programs, most veterans now have coverage under multiple health care programs. These programs differ, however, in terms of the criteria used to establish eligibility, the services covered, the limits placed on the availability of those services, and the cost sharing between the program and its participants. This report (1) compares the health care benefits available under major public and private programs and (2) analyzes the potential effects of existing benefit differences on veterans' use of the Department of Veterans Affairs' health care system.
VA Health Care: Delays in Awarding Major Construction Contracts (GAO/HRD-93-101, May 26, 1993)	The Department of Veterans Affairs (VA) fiscal year 1992 appropriation included funding for 12 new major construction projects, each estimated to cost $3 million or more. The appropriation law required that VA award (1) construction documents contracts for these projects by September 30, 1992, and (2) construction contracts by September 30, 1993. In addition, VA's appropriation for fiscal year 1991 contained funding for 11 other projects for which VA was to award construction contracts by September 30, 1992. This report reviews the contracting delays of reportable projects for impoundment implications under the Impoundment Control Act. GAO also assesses whether VA had reported all projects funded through these acts for which it had not awarded contracts by September 30, 1992.

VA Health Care: Inadequate Enforcement of Federal Ethics Requirements at VA Medical Centers (GAO/HRD-93-39, Apr. 30, 1993)

Senior managers at nearly one-third of the Department of Veterans Affairs' (VA) medical centers reported receiving part-time employment incomes, averaging thousands of dollars, from medical schools that receive millions of dollars through VA contracts. Nevertheless, VA has allowed these managers to participate in awarding and administering these contracts. Such activities are prohibited under federal conflict-of-interest regulations and may violate federal criminal statutes. These activities, therefore, not only subject managers to possible prosecution, but also significantly impair the integrity of VA's procurement process.

GAO summarized this report in testimony before Congress; see: VA Health Care: Inadequate Enforcement of Federal Ethics Requirements at VA Medical Centers, by Lawrence H. Thompson, Assistant Comptroller General for Human Resources Programs, before the Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs (GAO/T-HRD-93-22, May 19, 1993).

VA Health Care: Medical Centers Are Not Correcting Identified Quality Assurance Problems (GAO/HRD-93-20, Dec. 30, 1992)

VA medical centers have had mixed success in resolving the quality assurance deficiencies noted by GAO and the Inspector General in earlier audits. Problems persist in reporting and investigating patient incidents and in documenting the supervision of residents. As a result, VA still cannot accurately analyze unexpected or unfavorable incidents involving patient care and recommend corrective action. Moreover, it still does not know whether its residents are being properly supervised. These problems continue because medical center personnel are not adhering to applicable policies and procedures. Further, VA's central office and regional offices are not adequately monitoring medical center efforts to correct these problems. On the other hand, recent VA initiatives in credentialing physicians have greatly improved medical center compliance with policies and procedures. VA is undertaking several systemwide initiatives to bolster its quality assurance programs, such as peer review of the quality of care being delivered at medical centers. Success, however, depends on VA ensuring that medical centers correct any problems identified through these initiatives.

VA Health Care: Problems in Implementing Locality Pay for Nurses Not Fully Addressed (GAO/HRD-93-54, May 21, 1993)

The Department of Veterans Affairs (VA) employs nearly 40,000 registered nurses and certified registered nurse anesthetists at its medical centers across the country. Like other health providers, VA has had continuing difficulty in recruiting and retaining nurses. VA is implementing a locality system for nurses in order to make salaries more competitive, but GAO found that the surveys done by VA medical centers in setting nurse salary rates fell well short of the standards set for Bureau of Labor Statistics surveys. As a result, VA's salary rates could easily be substantially higher or lower than justified. GAO believes that the potential for errors is so great that the process should be reported as an internal control weakness. VA attributes this shortcoming to the limited time available to implement locality pay. The problems were not, however, corrected during the second round of surveys, and most still have not been addressed 18 months after implementation of the system.

VA Health Care: Selection of a Planned Medical Center in East Central Florida (GAO/HRD-93-77, Mar. 1, 1993)

The Department of Veterans Affairs' (VA) decision to build its east central Florida medical center at the Crowntree Lakes site rather than as a joint venture is, in GAO's view, unjustified and will likely boost the government's overall construction and operating costs. The March 1992 VA study that recommended the Crowntree Lakes sites was significantly flawed and does not support VA's decision. Moreover, the estimated cost to build the medical center has mushroomed by about $80 million, and projected completion has been delayed by three years. GAO supports VA's 1991 conclusion that the North Viera site, which remains available for a joint venture, would better meet the needs of east central Florida veterans at a lower cost to the government. In addition, construction of a new VA outpatient clinic and nursing home at a site near Orlando to be donated by North Viera's developer would create a potential for sharing arrangements with the Navy. Such arrangements could include treatment of Orlando-area veterans on a space-available basis in unused acute care capacity at Orlando Naval Hospital.

VA Health Care: Variabilities in Outpatient Care Eligibility and Rationing Decisions (GAO/HRD-93-106, July 16, 1993)

Veterans' access to outpatient care at Department of Veterans Affairs (VA) medical centers varies widely. The reasons are twofold: first, medical centers throughout the country interpret VA outpatient eligibility criteria differently; and second, medical centers' rationing decisions vary, including whether to ration and what rationing method to use. This means that veterans with similar medical conditions or income status may receive outpatient care at some medical centers but not at others. As a result, veterans are often confused or frustrated when turned away by VA centers

without receiving needed medical care. GAO recommends that VA develop alternative eligibility criteria that produce more predictable eligibility decisions or provide better guidance to centers so that doctors make more consistent eligibility determinations. In addition, Congress may want to direct VA to modify its system for allocating resources to medical centers so that veterans with similar medical or economic status have more consistent access to outpatient care.

GAO summarized this report, along with GAO/HRD-93-123, in testimony before Congress; see: Veterans Affairs: Accessibility of Outpatient Care at VA Medical Centers, by David P. Baine, Director of Federal Health Care Delivery Issues, before the Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs (GAO/T-HRD-93-29, July 21, 1993).

VA Health Care: Veterans' Efforts to Obtain Outpatient Care From Alternative Sources (GAO/HRD-93-123, July 14, 1993)

During visits to six medical centers, GAO identified 198 veterans who had applied for Department of Veterans Affairs (VA) medical care during the first six months of fiscal year 1992 and were turned away without receiving all needed care. Each of these veterans was turned away for treatment of nonemergency conditions that VA staff considered to be unrelated to military service. GAO found that 168 of these 198 veterans later obtained the care initially sought, such as diagnostic evaluations or medical treatment, mostly from non-VA medical providers. The remaining 30 veterans did not receive further medical care, mainly because they could not afford it.

VA Housing Loan Program (GAO/RCED-93-129R, Mar. 29, 1993)

GAO reviewed an independent report on the Department of Veterans Affairs' (VA) Home Loan Guaranty Program, focusing on whether the: (1) report's recommendations were supported by sufficient evidence; and (2) report contained factual errors or analytical weaknesses. GAO found that: (1) the report did not adequately support six of the seven recommendations with sufficient evidence; (2) the report failed to sufficiently identify a supportable problem with the home loan program, explain the proposed problem's impact on the program, and show how the recommendation would redress the proposed problem; (3) without further explanation and supporting evidence, VA could not consider corrective action; (4) the report could be misleading due to inaccuracies and a questionable analytical methodology; and (5) VA fully implemented one of the report's recommendations and partially implemented two others.

Veterans' Affairs: Establishing Patient Smoking Areas at VA Facilities (GAO/HRD-93-104, May 3, 1993)

The Department of Veterans Affairs (VA) runs the nation's largest health care system, serving veterans in 158 medical centers. VA announced in 1989 its intent to prohibit smoking inside all these medical centers when outside smoking shelters were available. In November 1993, however, Congress passed legislation requiring VA to establish smoking areas in its facilities for veterans' use. This report examines the feasibility of establishing and maintaining the mandated smoking areas. GAO discusses (1) how the law might affect VA medical facilities' accreditations, (2) how much the facilities might spend to establish mandated smoking areas, and (3) how long the facilities might take to build these areas.

Veterans Benefits: Acquisition of Information Resources for Modernization Is Premature (GAO/IMTEC-93-6, Nov. 4, 1992)

The Department of Veterans Affairs' desire to invest in new information technology to improve service to veterans is laudable. Yet the plan by the Veterans Benefit Administration to proceed in acquiring $94 million in computer hardware and software, while at the same time grappling with basic changes in its business processes, is clearly premature for several reasons. First, it does not yet fully understand what managerial, operational, or technical problems need to be corrected. Second, effective leadership—capable of bringing together program managers and information technology specialists to reach consensus on problems and solutions—is lacking. Third, the agency's Chief Information Resources Officer does not have the authority to correct identified problems. To invest people, time, and money in acquiring information technology before fully understanding what the Veterans Benefit Administration's future business operation will look like risks a system that may not work as intended. Delaying further modernization procurement until the Veterans Benefit Administration has a clearer idea of where it is headed is the prudent, preferable alternative.

Veterans' Benefits: Availability of Benefits in American Samoa (GAO/HRD-93-16, Nov. 18, 1992)

Although citizens of American Samoa, including veterans, are eligible for essentially free medical care, the medical facilities in American Samoa are limited and financial problems have disrupted care at the only hospital. The Department of Veterans Affairs (VA) sends doctors to American Samoa on a quarterly basis, but their main purpose is to do examinations for benefit claims, not to treat patients. Under this arrangement, the psychiatric needs of veterans with posttraumatic stress disorder are not being met, some veterans claim that it is hard to obtain needed medical referrals, and veterans who need drug and alcohol treatment or readjustment counseling are not being served. A greater percentage of veterans in American Samoa (20 percent) receive VA compensation or

pension benefits than do veterans in the rest of the nation (10 percent). VA home loans, however, are unavailable to veterans in American Samoa due to problems in administering the program on communally owned lands.

Veterans' Compensation: Premature Closing of VA Office in the Philippines Could Be Costly (GAO/HRD-93-96, July 15, 1993)

The Department of Veterans Affairs' (VA) disability compensation and survivor benefit programs in the Philippines provide payments to Filipino veterans as a result of their service with U.S. armed forces during World War II. VA had planned to close its Manila office in March 1994 and move claims processing to Seattle, Washington. GAO concludes that VA should not make this change until it has ensured that only proper benefits are made and that only those eligible receive benefits. Even though it has been nearly 50 years since the end of World War II, many claims are still submitted for compensation benefits, most of which are denied by VA's Manila office because of an insufficient basis or because they involve fraud. Careful review by claims examiners knowledgeable of the local situation should continue until VA can develop an effective alternative to processing claims in Manila.

Fiscal Year 1993 Testimonies Relating to Issues Affecting Older Americans

GAO testified 30 times before congressional committees during fiscal year 1993 on issues relating to older Americans. Of the testimonies, 2 were on employment, 11 on health, 1 on housing, 8 on income security, 5 on veterans issues, and 3 on other issues.

Employment Issues

EEOC: an Overview (GAO/T-HRD-93-30, July 27, 1993)

The Equal Employment Opportunity Commission (EEOC) upholds a basic right of Americans: the right to equal employment opportunity regardless of race, color, religion, national origin, age, or disability. EEOC's world has changed drastically since the Commission was established in 1964, and questions have arisen about how well EEOC does its job. With substantial staff increases unlikely, will EEOC be able to respond effectively to the demands of its new environment—one characterized by increasing responsibility and workloads? In these times of shrinking resources, government agencies are rethinking their roles and how they do business. EEOC may also need to change. This testimony (1) briefly describes how EEOC operates, (2) discusses its increasing responsibility and workload, and (3) examines concerns about its operations.

Legislative Employment: EEO Complaint Processing by the House Office of Fair Employment Practices (GAO/T-GGD-93-30, May 27, 1993)

GAO reviewed the House Office of Fair Employment Practices' process for handling employment discrimination complaints. Instead of investigating complaints, the Office follows a three-step process that consists of (1) counseling and mediation; (2) formal complaint, hearing, and review; and (3) final review by an eight-member review panel. Since the Office started up in November 1988, it has received more than 1,200 inquiries or expressions of concern relating to fair employment practices and violations of the Fair Labor Standards Act. The employees most often alleged that they had been discriminated against on the basis of race, age, and/or color. The issue cited most often by the complainants was termination of employment. Although the number of complaints filed since the Office began operations is relatively small, it is unclear whether this reflects a high turnover rate among House employees, confidentiality concerns, a lack of meritorious cases, or problems with the Office's process.

Health Issues

Cataract Surgery: Patient-Reported Data on Appropriateness and Outcomes (GAO/T-PEMD-93-3, Apr. 21, 1993)

GAO discussed the results of its survey on cataract surgery. GAO noted that: (1) survey responses indicated that a high proportion of patients benefitted from surgery; (2) most patients reported that one or more symptoms improved after surgery with slight interim effects such as numbness or swelling; (3) patients reported one or more visual problems affecting their ability to drive, read, or watch television prior to cataract surgery; (4) medical necessity or inappropriateness has not been clearly defined; (5) survey results showed different amounts of questionable surgery based on different criteria for appropriateness; and (6) if the volume of inappropriate surgeries is reduced, financial savings could be realized and health services to individuals could improve.

Health Insurance: Remedies Needed to Reduce Losses From Fraud and Abuse (GAO/T-HRD-93-8, Mar. 8, 1993)

Health insurance experts estimate that fraud and abuse contribute to about 10 percent of the nation's $800-plus billion health care bill. Yet only a fraction of this fraud and abuse is ever identified and prosecuted. Without adequate resources, investigation and pursuit of much of the health care fraud is impossible. A shortage of staff and money dedicated to pursuing fraud and abuse has allowed dishonest providers to stay in business. More resources alone, however, will not overcome fraud and abuse in the health insurance industry. GAO believes that the efforts of independent private payers, public payers, and state insurance and licensing agencies as well as state and federal law enforcement agencies need to be better coordinated. This would help overcome the systemic obstacles that hamper efforts to address health care fraud.

Medicaid Drug Fraud: Federal Leadership Needed to Reduce Program Vulnerabilities (GAO/T-HRD-93-28, Aug. 2, 1993)

Medicaid prescription fraud is widespread in the United States, contributing significantly to the government's $5.5 billion tab for prescription drugs in 1991. For example, some pharmacists routinely pad customer prescriptions, keeping the extra drugs to sell or use themselves. Clinics inappropriately give Medicaid recipients completed prescription forms that are then traded for merchandise from local pharmacies or sold on the street to the highest bidder; some pills costing 50 cents at the pharmacy have been resold for as much as $85. A common scheme is the so-called "pill mill," in which doctors, clinic owners, and pharmacists conspire to defraud Medicaid by prescribing drugs solely to obtain government reimbursement. Patients are often in on the scam, allowing

the use of their Medicaid numbers in exchange for kickbacks of cash or drugs. This organized network of physicians, patient brokers, and assorted middlemen frequently transferred money overseas via the notorious Bank of Credit and Commerce International. Recent initiatives in several states have shown signs of stemming these financial losses, but federal leadership and support is needed to ensure broader implementation of these initiatives.

Medical Malpractice: Experience With Efforts to Address Problems (GAO/T-HRD-93-24, May 20, 1993)

Although the precise extent to which medical malpractice has contributed to the nation's spiralling health care bill is unknown, there is little question that the costs associated with it run into the billions of dollars. The United States faces higher costs for medical malpractice insurance and associated defensive medicine costs than other nations. Of equal importance are the profound effects that medical practice is having on the way medicine is practiced in the United States—effects that can be expected to grow in the future if the malpractice system is not reformed. GAO testified that reform of the medical malpractice system should address three fundamental issues: reducing the incidence of negligent care, fairly compensating individuals injured through medical negligence, and dealing with the complexities involved in efforts to enhance the overall quality of U.S. health care.

Medicare: Funding and Management Problems Result in Unnecessary Expenditures (GAO/T-HRD-93-4, Feb. 17, 1993)

Medicare's soaring expenditures underscore the need for the government to fund and manage the program judiciously. Among the many problems plaguing Medicare management, two stand out. First, the Health Care Financing Administration (HCFA), the agency that oversees Medicare, does not have an effective, national strategy to protect the program from making erroneous or wasteful payments. Second, budget constraints have led to the underfunding of the types of payment controls that prevent or detect losses due to waste, fraud, and abuse. For example, Medicare failed to adequately investigate complaints of fraud and abuse telephoned in by Medicare beneficiaries, little was done initially to claim more than $250 million in overpayments owed by hospitals, Medicare paid an estimated $2 billion in claims that may have been the responsibility of other health insurers, and loose controls over who can bill Medicare have allowed profiteers to exploit the program through fraud and abuse. GAO believes that Congress should continue to pursue modifying budget procedures so that funding for safeguards could be increased without having to cut spending elsewhere. In addition, GAO believes that HCFA needs to develop a national strategy to manage the Medicare safeguard program.

	This would entail assessing the appropriateness and effectiveness of individual contractors' controls and developing ways to ensure that controls that have proven effective are implemented nationwide.
Medicare: Physicians Who Invest in Imaging Centers Refer More Patients for More Costly Services (GAO/T-HRD-93-14, Apr. 20, 1993)	A study of referrals to diagnostic imaging centers, among the most popular kinds of physician-owned joint ventures, provides further evidence that physician involvement in medical facilities is linked to more frequent patient referrals to those facilities and higher health care costs. Often boasting expensive high-technology services like magnetic resonance imaging (MRI), these centers have proliferated in many parts of the country. GAO's analysis of 1990 Medicare claims in Florida reveals that doctors with a financial stake in nonhospital imaging facilities referred their patients more often and referred them for more costly imaging services than did other physicians. The differences were most pronounced among MRI referrals. Because its findings are based on a large-scale analysis of physician referral practices, GAO believes that they provide important new information for Congress as it considers legislation to extend current restrictions on physician self-referral.
Medicare Secondary Payer Program: Identifying Beneficiaries With Other Insurance Coverage Is Difficult (GAO/T-HRD-93-13, Apr. 2, 1993)	Under the Medicare secondary payer program, Medicare costs have been cut by billions of dollars. This effort has centered on (1) identifying working beneficiaries and their spouses whose other health insurance is the primary payer to Medicare and (2) recovering Medicare payments that should have been made by private insurers. To achieve these goals, however, Medicare relies on a process that is labor intensive, expensive, and often unreliable. Enforcing the Medicare secondary payer provisions has been a long-standing challenge, and despite efforts by the Health Care Financing Administration and the millions of dollars spent to identify primary payers, hundreds of millions of dollars go uncollected.
Organ Transplants: Increased Effort Needed to Boost Supply and Ensure Equitable Distribution of Organs (GAO/T-HRD-93-17, Apr. 22, 1993)	GAO discussed the effectiveness of the nation's organ procurement and allocation system. GAO noted that: (1) organ procurement organizations need to consider factors such as the likelihood of a successful transplant, how urgently a transplant is needed, and length of time on the waiting list when allocating the limited supply of organs; (2) 25 of 68 organ procurement organizations have altered the United Network for Organ Sharing's (UNOS) criteria when ranking potential recipients; (3) some organ procurement organizations have narrowed their pool of potential recipients to a particular transplant center, rather than considering

potential recipients from all area transplant centers, which is inconsistent with federal law requiring equitable distribution of organs; (4) there have been variations in the documentation of patients not selected for the organ transplants at 10 organ procurement organizations; (5) the Department of Health and Human Services needs to develop compliance policies for organ procurement organizations and transplant centers; (6) the Health Resources and Services Administration (HRSA) and UNOS do not monitor the organizations' procurement efforts or have an appropriate measure for assessing procurement effectiveness; and (7) HRSA and UNOS do not systematically target technical assistance to organ procurement organizations that may need help obtaining donors.

Overhead Costs: Unallowable and Questionable Costs Charged to Medicare by Hospital Corporation of America (GAO/T-NSIAD-93-16, June 23, 1993)

GAO examined $2.6 million in expenses incurred by the Hospital Corporation of America (HCA) and found that $1.1 million of that amount was unallowable or questionable. GAO believes that the general nature of the Medicare cost principles was the main reason for HCA including unallowable costs in its Medicare cost reports. The way in which HCA interpreted the cost principles also contributed to questionable costs being included in the report. HCA is not, however, the only health care provider that has included unallowable or questionable costs in Medicare cost reports. The Inspector General (IG) at the Department of Health and Human Services recently reviewed general and administrative expenses and employee fringe benefit costs at 19 hospitals and two corporate offices across the country. The IG identified $50 million in unallowable costs and more than $3 million in questionable costs included in their Medicare cost reports. Such inappropriate costs are boosting the cost of health care overall and Medicare in particular.

Prescription Drugs: Companies Typically Charge More in the United States Than in Canada (GAO/T-HRD-93-5, Feb. 22, 1993)

Drug manufacturers typically charge wholesalers more in the United States than in Canada. In studying prices for 121 widely dispensed drugs sold in both countries, GAO found that these drugs would cost 32 percent more in the United States than in Canada if a common prescription of each drug were purchased at its factory price. Differences between U.S. and Canadian drug prices can be explained largely by two factors that are unique to Canada: (1) federal regulations designed to restrain prices on patented drugs and (2) provincial drug benefit plans that pay for drugs for a large segment of the population. Differences in costs, whether of research, production, or distribution, are not a major factor in explaining differences in drug manufacturers' prices.

Private Health Insurance: Wide Variation in State Insurance Departments' Regulatory Authority, Oversight, and Resources (GAO/T-HRD-93-25, May 27, 1993)

The rapidly rising cost of health insurance and the growing number of uninsured have pushed the debate over health care reform to the forefront. Because most national health care reform proposals include provisions that could fundamentally alter the health insurance marketplace, states and their insurance departments could play a large role in enforcing new requirements should any of these proposals be adopted. Drawing on its nationwide survey of state insurance departments, GAO discusses (1) what portion of the health insurance market is regulated by state insurance departments; (2) the standards state insurance departments follow and the extent of their regulatory responsibilities; (3) the budget and staff resources state insurance departments commit to regulating health insurance; and (4) the key activities departments perform, including monitoring solvency, reviewing rates and policy forms, and responding to consumer complaints.

Housing Issues

Flood Insurance: Information on Various Aspects of the National Flood Insurance Program (GAO/T-RCED-93-70, Sept. 14, 1993)

A series of recent disasters—the December 1992 nor'easter, the March 1993 storm in Florida, and the record floods in the Midwest this summer—have virtually wiped out the National Flood Insurance Program, raising doubts about whether it will have enough money to meet current and future claims arising from flood damage. GAO found that the fund is not, nor is it required to be, actuarially sound, mainly because Congress authorized below-market insurance rates for policyholders without providing annual appropriations to cover the subsidy. This testimony reviews (1) the actuarial soundness of the fund and the implication of ending its subsidized flood insurance rates, (2) procedures used to set the program's flood insurance rates, and (3) financial management problems addressed in Inspector General audits of the fund.

Income Security Issues

Assessing PBGC's Short-Run and Long-Run Conditions (GAO/T-HRD-93-1, Feb. 2, 1993)

The risks to the Pension Benefit Guaranty Corporation (PBGC), as well as pension plan participants, from underfunded plans have become more apparent with the termination of several large pension plans sponsored by companies in declining industries. PBGC's administrative and accounting problems have added to concerns about the pension insurance agency. This testimony highlights the following three areas: (1) operational and administrative problems at PBGC, (2) the financial status of PBGC's single-employer insurance funds and the threat to it from currently underfunded private sector plans, and (3) the risks still faced by plan participants. Pension plan sponsors who fail to fully fund their plans put an undue burden on others—sponsors of well-funded plans who may have to pay higher PBGC premiums to cover the insured shortfall; participants in underfunded plans who may end up losing some of their benefits; and, under a worst-case scenario, the federal government, which could be forced to pay guaranteed benefits should PBGC be overwhelmed by a rash of large terminations during an economic downturn. Reducing plan underfunding would lower PBGC's future losses by targeting the greatest threat to the pension insurance agency. Congress should also consider making the variable rate premium more risk-related to cut future losses PBGC will most likely incur.

Older Americans Act: Eldercare Partnerships Generate Few Additional Funds for Public Services (GAO/T-PEMD-93-4, May 27, 1993)

GAO discussed whether public-private partnerships between area agencies on aging (AAA) and private corporations increased funding for aging services. GAO noted that: (1) less than 12 percent of AAAs have entered into public-private partnerships to provide information, referral, or case management services; (2) AAA public-private partnerships have often used vendors as intermediaries and referral sources; (3) the nature of services provided to employers or vendors has varied among the partnerships; (4) AAAs have provided additional services through partnerships with insurance companies; (5) the scope of AAA partnerships is limited and most partnerships do not meet their objective of generating the additional resources needed to finance other AAA activities; and (6) AAA partnerships have used existing staff to provide services to referrals which reduced the resources available for funding AAA services.

Pension Plans: Underfunded Plans Threaten PBGC (GAO/T-HRD-93-2, Feb. 4, 1993)

Several years ago, GAO placed the Pension Benefit Guaranty Corporation (PBGC) on its "high-risk" list of federal programs because of long-standing internal control weaknesses and potentially huge losses to taxpayers. This testimony discusses GAO's December 1992 high-risk series report on PBGC (GAO/HR-93-5). In GAO's view, successfully addressing the problems confronting PBGC involves management reforms, modification of the pension funding rules, and possible changes in the insurance premium structure. As long as pension plan underfunding persists, the pension insurance program and plan participants' benefits are at risk. GAO believes that this is the time—while PBGC still has a positive cash flow—to develop solutions to better fund pension promises. GAO supports more effective funding standards for defined benefit pension plans. Reducing underfunding would limit PBGC's future exposure and appropriately target the greatest threat confronting it—underfunded pension plans. In addition, Congress should consider whether the overall premium ceiling and existing variable premium rate best reflect the risk to PBGC. Raising premiums, by making the variable rate premium more risk-related, would cut PBGC's deficit.

Private Pensions: Most Underfunded Plan Sponsors Are Not Making Additional Contributions (GAO/T-HRD-93-16, Apr. 20, 1993)

Although most plans insured by the Pension Benefit Guaranty Corporation (PBGC) are well-funded, a significant minority of plans are underfunded and the level of underfunding in these plans is growing. The potential consequences of this trend are alarming. PBGC faces an increase in its exposure to the risk of terminating underfunded plans. Sponsors of financially sound plans may see their PBGC premiums increase to cover PBGC's growing losses. Plan participants may lose some benefits should their underfunded plans be terminated. Taxpayers may have to pay should PBGC exhaust the assets it has for paying its obligations. GAO concludes that the current funding rules need strengthening and that proposed legislation, while far from perfect, would substantially increase contributions for many plans.

Social Security as an Independent Agency (GAO-T/HRD-93-31, Sept. 14, 1993)

GAO has found no compelling reason to establish the Social Security Administraton (SSA) as an independent agency, although health care reform's impact on the Department of Health and Human Services could change the situation. GAO believes that, in any event, a single administrator would be the best management structure for an independent SSA. To provide greater agency continuity and institutional memory, GAO supports the appointment of career status staff in top management jobs at SSA. GAO also supports delegating SSA independent authority for personnel

	management, building maintenance and acquisition, and computer procurement. But regardless of its status, SSA needs to seriously reengineer its business practices, upgrade technology, and reorganize to better respond to its customers' needs.
Social Security: Rising Disability Rolls Raise Questions That Must Be Answered (GAO/T-HRD-93-15, Apr. 22, 1993)	In April 1993, trustees of the Social Security Disability Insurance Trust Fund reported that the fund could be exhausted by 1995, mainly because the number of beneficiaries has grown faster than expected. To keep the fund solvent through 2020, the trustees have proposed legislation that would give the fund a larger share of the Social Security payroll tax. This testimony discusses (1) the major factors contributing to the rapid increase in beneficiaries; (2) the changing composition of the disability insurance rolls; and (3) the uncertainty about whether recent trends will continue, level off, or reverse themselves.
Social Security: SSA Needs to Improve Service for Program Participants (GAO/T-HRD-93-11, Mar. 25, 1993)	This testimony explores the Social Security Administration's (SSA) efforts to improve service to the public. GAO touches on the long delays in processing claims for disability applicants and the reduction in the number of continuing disability reviews. GAO is concerned that state disability determination services' use of overtime and other short-term initiatives may not be adequate to reduce the disability application backlogs to acceptable levels. Also, the low number of continuing disability reviews being done results in losses to the trust funds and undermines program integrity. These short-term issues must be addressed. For the long term, SSA should complete work on its service delivery plan, which outlines how the agency will provide service in the future, before it embarks on piecemeal or costly fixes that freeze current processes in place.
Social Security: SSA's Processing of Continuing Disability Reviews (GAO/T-HRD-93-9, Mar. 9, 1993)	Growing financial and administrative problems have plagued the Social Security Administration's (SSA) disability programs in recent years. In fiscal year 1992, applications for disability benefits reached an all-time high, as did the time it took SSA to process them. To keep up with the surge in claims, SSA has shifted resources from its continuing disability reviews, which ensure that people receiving government disability benefits are still eligible. GAO remains concerned that SSA has not been doing all the continuing disability reviews required by law. Although SSA is developing ways to better target continuing disability reviews to make more efficient use of its resources, many individuals who are no longer disabled will continue to receive benefits for years to come unless more continuing

disability reviews are done. Even in the current environment of large workloads and tight budgets, SSA should continue to explore ways to refine its continuing disability review process and increase reviews beyond current levels.

Veterans Issues

VA Health Care: Inadequate Enforcement of Federal Ethics Requirements at VA Medical Centers (GAO/T-HRD-93-22, May 19, 1993)

GAO discussed whether the employment of Department of Veterans Affairs' (VA) medical center managers at medical schools participating in VA contracting activities created a conflict of interest, focusing on: (1) federal ethics laws and regulations; (2) VA policies and procedures; (3) outside employment activities of senior managers; and (4) VA contracting procedures and operating practices. GAO noted that: (1) federal ethics requirements limit the employment activities of federal employees who may have conflicting financial interests; (2) VA medical center managers who are most susceptible to potential conflict-of-interest violations are chiefs of staff and chiefs of individual medical services; (3) although VA policies and procedures require dually employed full-time VA managers to obtain prior approval for outside employment and provide sufficient information to assess the possibility of conflict of interest, few chiefs of staff and service chiefs have received prior approval; (4) VA headquarters rarely requested or received VA management responsibilities information; (5) part-time service chiefs are not required to seek prior approval for outside employment; (6) although VA has provided adequate guidance to medical center managers concerning dual employment, many senior managers are unaware of dual employment requirements and the potential for conflict of interest; and (7) VA needs to revise its dual employment policies and procedures, establish strengthened enforcement procedures, and develop appropriate guidance to assist medical center managers to avoid conflict of interest.

Veterans Affairs: Accessibility of Outpatient Care at VA Medical Centers (GAO/T-HRD-93-29, July 21, 1993)

GAO discussed veterans' access to outpatient care at the Department of Veterans Affairs' (VA) medical centers. GAO noted that: (1) veterans with similar medical conditions or economic status receive care at some centers but not at others; (2) VA medical centers' interpretations and use of statutory eligibility and rationing criteria vary widely; (3) medical center staff rely primarily on subjective judgments when deciding who is eligible

	for outpatient care due to inadequate VA guidance; and (4) medical center staff make rationing decisions based on locally-developed policies.
Veterans' Health Care: Potential Effects of Health Care Reforms on VA's Major Construction Program (GAO/T-HRD-93-19, May 6, 1993)	This testimony focuses on factors that could affect the need for and the size and the design of Department of Veterans Affairs' (VA) construction projects. These factors are (1) reform of the nation's health care financing system, (2) reform of VA health care eligibility for its beneficiaries, and (3) VA's role under a reformed health care system. GAO also discusses the extent to which VA considers construction alternatives, such as available state and community resources, when it determines the need for major construction projects, along with GAO's recently completed review of the management of VA's major construction program.
Veterans' Health Care: Potential Effects of Health Financing Reforms on Demand for VA Services (GAO/T-HRD-93-12, Mar. 31, 1993)	Demand for inpatient services at VA facilities could drop by as much as 18 percent if employers nationwide were forced either to offer health insurance for workers or pay a tax to finance nationwide coverage. Under a nationwide universal health plan, the impact could be even greater—demand for VA inpatient care could plummet by 47 percent. Yet the ultimate impact of U.S. health care or VA eligibility reforms on future demand for VA medical services will not be known for some time. The VA health care system should be included in discussions about health care reform, and GAO is encouraged that VA is represented on the President's task force on that subject. But GAO has a more immediate concern: if VA continues to build hospitals on the basis of current demand, the hospitals could have significant excess capacity before they even open.
Veterans' Health Care: Potential Effects of Health Reforms on VA Construction (GAO/T-HRD-93-7, Mar. 3, 1993)	Because it is unclear what effect reform of the nation's health care system and VA eligibility may have on the demand for VA health care, Congress should proceed cautiously with construction of more VA health care facilities. Any national health care reform that expands insurance coverage among veterans could cut in half demand for VA-sponsored care. Reform of VA's system for determining eligibility for health care could have a similarly dramatic effect on VA utilization, potentially boosting outpatient visits from about 22 million in fiscal year 1991 to as high as 57 million. A limitation on construction of additional VA health care facilities, however, need not interrupt the provision of health care to America's veterans. Rather, Congress and VA should test alternative ways of delivering services that could, at least on an interim basis, provide veterans acute care services in their home communities years earlier than could be provided

through new construction. Congress could consider authorizing VA to conduct such demonstration projects in areas, such as Hawaii, northern California, and east central Florida, that have unused capacity in community or military hospitals.

Other Issues

Government Management—Report on 17 High-Risk Areas (GAO/T-OCG-93-2, Jan. 8, 1993)

GAO discussed its high-risk series of reports, focusing on management problems and needed corrective action in the issue areas of: (1) lending and insuring; (2) contracting; and (3) accountability. GAO noted that: (1) six federal insurance, guarantee, and lending programs are highly vulnerable to fraud, waste, abuse, and mismanagement due to poor oversight, structural inefficiencies, reliance on others to perform key program activities, lack of financial and management controls, and congressionally imposed constraints; (2) five programs and activities involving contracting continue to suffer management problems due to organizational culture, poor oversight, inadequate data on contractor/provider operations, and restrictive contract provisions; (3) six federal programs and activities have accountability problems due to the lack of accurate and timely financial and other necessary management information, and agency practices permitting or condoning inefficient and ineffective program operations; (4) some agencies are recognizing problems and taking corrective actions to eliminate or mitigate them; and (5) beyond the 17 high risk areas discussed, problems in financial management, information management, and general management are pervasive throughout the government.

Government Management: Status of Progress in Correcting Selected High-Risk Areas (GAO/T-AFMD-93-1, Feb. 3, 1993)

GAO testified on 7 of 17 high-risk areas within the government that are particularly vulnerable to fraud, waste, abuse, and mismanagement. The seven areas involve the Pension Benefit Guaranty Corporation, the Internal Revenue Service, Medicare, the Customs Service, asset forfeiture, the Resolution Trust Corporation, and Superfund. This testimony focuses on program weaknesses; agency corrective actions; and recommendations for future actions by Congress, the administration, and agency officials.

Major Issues Facing a New Congress and a New Administration (GAO/T-OCG-93-1, Jan. 8, 1993)

GAO discussed the series of reports concerning the major issues facing the new Congress and the new President. GAO noted that: (1) important issues included the budget deficit, investment, and long-term economic growth; (2) because of defense budget reductions and changing world events, there is a $150 billion gap between Department of Defense planned projects and budgetary resources; (3) escalating health care costs have created a crisis in funding for many social programs and reforms, as well as long-term strategies to contain costs; (4) education and training services are highly fragmented and reform is needed to help students make the transition from school to work, provide employment and training assistance to economically disadvantaged workers, and assist dislocated workers; (5) investment is needed in the government's infrastructure, particularly in the areas of surface transportation, air traffic control and airline competition, and nuclear and nonnuclear energy; (6) a sound financial system and mutually beneficial international trade are essential to the national economy's stability and productivity; and (7) other important issues include strengthening social programs, strengthening core functions of government, changing government management, clarifying accountability and creating a results-oriented environment, having access to reliable financial and program data, emphasizing a long-term mission, and reforming the budget process and agency structures.

Ongoing GAO Work as of September 30, 1993, Relating to Issues Affecting Older Americans

At the end of fiscal year 1993, GAO had 100 ongoing assignments that affected older Americans. Of these, 2 were on education, 49 on health, 4 on housing, 14 on income security, 30 on veterans issues, and 1 on other issues.

Employment Issues

Federal Contractor Hiring

EEOC Enforcement of the Age Discrimination in Employment Act

Health Issues

Administrative Control Weaknesses Identified in Medicare Program HMOs

Adult Immunization Under Medicare

Assessment of Medicare's Flexibility Carriers

Analysis of the Scientific Foundation and Effectiveness of the National Cholesterol Education Program

Assessing the Accuracy of Cholesterol Measurement

Analysis of Medicare Support for Graduate Medical Education

Blue Cross/Blue Shield Medicare Part A and B Contracts

Changes in Best Prices for HMO and Hospital Outpatient Drugs

Characteristics of Physician Owners

Comparison of U.S./European Prescription Drug Prices

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

Evaluation of the Appropriateness of Establishing Medigap Loss Ratio Standards for the First Two Years

FDA's Regulation of Dietary Supplements

FDA's Oversight of Generic Drug Manufacturing Practices

Federal Mail Order Pharmacies

Foreign Medical Graduates

HCFA Payment Rate for Erythropoietin (EPO)

Health Insurance Products Sold to the Elderly

Impact of Extending Medicare Secondary Payer Provisions for End-Stage Renal Disease Beneficiaries—Phase II

Implementing Global Budgeting in Germany

International Systems of Financing Long-Term Care

Loss Ratio Experience for Medigap Insurance in 1990

Medicaid State Financing Mechanisms

Medicaid Utilization Systems

Medical Fraud Controls

Medical Care Cost Recovery

Medicare Part B Claims Processing

Medicare Postpayment Review Methodologies

Medicare Claims Processing System

Medicare—Issues in Capitated Rate Setting For HMOs

Model Nutrition Monitoring System

Monitoring Potentially Harmful Residues in Food

Nursing Home Billing Abuses

Paramedics As Secondary Responders to Volunteer Ambulance Services

Physician Credentialing

Provider Complaints of Payment Problems in Maryland

Review of Private Vendor Firms Used by Hospitals to Enroll Patients In the Medicaid Program

Review of the Implementation of the Safe Medical Devices Act of 1990

Robert Wood Johnson Public-Private Partnerships for Long-Term Care Insurance

Role of Medicaid in State Long-Term Care Programs

Safeguards Against the Inappropriate Use of Drugs in Nursing Homes

State Regulation of Private Health Insurance

Study of Medicaid Managed Care Programs in California

Study of VA Survivor's Benefits Program

Study of Titles VII and VIII Health Professions Program

Survey of Medical Technology Assessment and Medicare Coverage Issues

The Qualified Medicare Beneficiary Program

Trends in Health Care Costs in Hawaii

USDA's Food Safety and Inspection Service Residue Testing

Housing Issues

Flood Insurance Program

FmHA's 515 Program Demographics

Federal Home Loan Bank Affordable Housing Program

Impact of New Housing Programs on Section 8

Income Security Issues

Accuracy of Supplemental Security Income Records

AOA Compliance With The Interstate Funding Formula

Corporate Participation in Eldercare Programs

Economically Targeted Investments by State Public Pension Funds

Effectiveness of Restrictions Placed on Substance Abusers Receiving SSI Disability Benefits

Public Agencies' Eldercare Programs

Older Americans Act Formula Could Be Distributed More Equitably

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

Review of Operating Conditions at Disability Determination Services

Review of Pension Benefit Guaranty Corporation's IRM

SSA's Acquisition of 95,000 PCs

What Problems Do States Face in Providing Long-Term Care to the Elderly and Disabled in Rural Areas?

Supportive Services and Long-Term Care

Review of IRS Controls For Taxation of Social Security Benefits

Veterans Issues

Are Veterans' Health Care Needs Met?

Armed Forces Retirement Homes

Barriers to VA Managed Care

Chesapeake VA Nursing Home

DOD/VA Sharing

Downsizing the Military: Assisting New Veterans

Homeless Veterans

Locating Missing VA Patients

Merging VA Health Care

Military Personnel Retiring on Disability Who Are Eligible for Normal Retirement

Other Countries' Military Health

Quality of Care at IHS Hospitals

Report Cards

Restructuring VA Ambulatory Care

Review of VA Cost Studies

Review of the Administrative Complexity and Burden of Medicare Secondary Payer (MSP) Program

Review of Veterans Benefits Modernization-Stage 1 Contract

U.S. Eligibility and Benefit Types Compared to Five Other Countries

VA Appropriations Certification

VA Health Eligibility Reform

VA Physician Appraisals

VA Under National Health Reform

VA Worker/Patient TB Exposure

VA/DOD Medical Information Sharing

VA/Medical School Affiliations

Veterans Dependency and Indemnity Compensation Reform

Veterans Health Care Costs

Veterans' Satisfaction With Service From VA

Veterans' Compensation and Pension Claims Take Far Too Long to Process

Waiting Times at VA Medical Centers

Other Issues

The Americans with Disabilities Act: Public Transportation Compliance and Projected Costs

Related GAO Publications Affecting Older Americans

During fiscal year 1993, GAO issued three publications that summarized our work in aging, health, and income security issues. In addition, we issued seven reports in a number of areas spotlighting management problems and high-risk areas in the federal government.

Older Americans

Aging Issues: Related GAO Reports and Activities in Fiscal Year 1992 (GAO/HRD-93-57, Dec. 23, 1992)

By the year 2000, the number of older Americans will exceed 53 million, or 17 percent of the total population; 7 million will be age 85 or older. Although most of the nation's elderly are independent and in good health, a growing number need assistance to avoid institutionalization. This changing demography will challenge both government and the private sector in the 1990s and beyond. In fiscal year 1992, GAO's work touched on a range of topics affecting the elderly, from employment discrimination to Medicare financing of nursing home care to weaknesses in the nation's pension funds. This index lists GAO reports and testimony according to subject category along with summaries describing each document.

Health Reports (GAO/HRD-93-2W, Sept. 1993)

GAO presented a listing and selected summaries of health-related reports and testimonies it issued over the past 2 years, focusing on: (1) health financing and access; (2) Medicare and Medicaid; (3) managed care; (4) public health and education; (5) health quality and practice standards; (6) long-term care and aging; (7) substance abuse and drug treatment; (8) prescription drugs; (9) military and veterans health care; (10) employee and retiree health benefits; (11) environmental impact on health; (12) Food and Drug Administration; (13) medical malpractice; (14) occupational safety and health; (15) research; (16) social security disability; and (17) miscellaneous issues.

Income Security: Reports Issued During 1990-92 and Testimonies Delivered in 1992 (GAO/HRD-93-80, Mar. 1993)

The nation spends $500 billion a year on income security programs, such as social security, disability, and welfare, accounting for more than 60 percent of the domestic budget. In addition, tax expenditures of upwards of $48 billion—the largest in the federal budget—for tax-deferred pension contributions underscore the key role of pensions and retiree health costs in income security policy. This publication contains summaries of recent GAO reports on income security issues as well as titles of reports issued from 1990 to 1992 and testimony delivered in 1992.

GAO High-Risk Report Series

Medicare Claims (GAO/HR-93-6, Dec. 1992)

Pension Benefit Guaranty Corporation (GAO/HR-93-5, Dec. 1992)

Many GAO audit reports have spotlighted the effect of management failures in the federal government—waste, inefficiency, and even scandal. Political leaders have been forced to spend too much time reacting to surprises like the Department of Housing and Urban Development debacle rather than doing the work the agencies were created to do. GAO began its high-risk program to identify those high-dollar government programs most vulnerable to fraud, waste, abuse, and mismanagement. The resulting high-risk series of reports, which examine the federal government's efforts to identify and correct problems in 17 especially vulnerable areas, fall into three main categories: lending and insuring, contracting, and accountability. Many of the root causes of the problems afflicting these government programs are traceable to the absence of fundamental processes and systems. GAO urges that future congressional oversight focus on the agency reports and audited financial statements required by the Chief Financial Officers Act, agency management's progress in correcting material weaknesses in program internal control and accounting systems, and federal agency efforts to develop and implement performance standards.

The Comptroller General summarized the high-risk series in testimony before Congress; see: Government Management—Report on 17 High-Risk Areas, by Charles A. Bowsher, Comptroller General of the United States, before the Senate Committee on Governmental Affairs. GAO/T-OCG-93-2, Jan. 8, 1993.

GAO Transition Report Series

Health and Human Services Issues (GAO/OCG-93-20TR, Dec. 1992)

Health Care Reform (GAO/OCG-93-8TR, Dec. 1992)

Housing and Community Development Issues (GAO/OCG-93-22TR, Dec. 1992)

Labor Issues (GAO/OCG-93-19TR, Dec. 1992)

Veterans Affairs Issues (GAO/OCG-93-21TR, Dec. 1992)

The transition series, a set of 28 reports, summarizes GAO's findings on major problems confronting federal agencies, as well as economic and

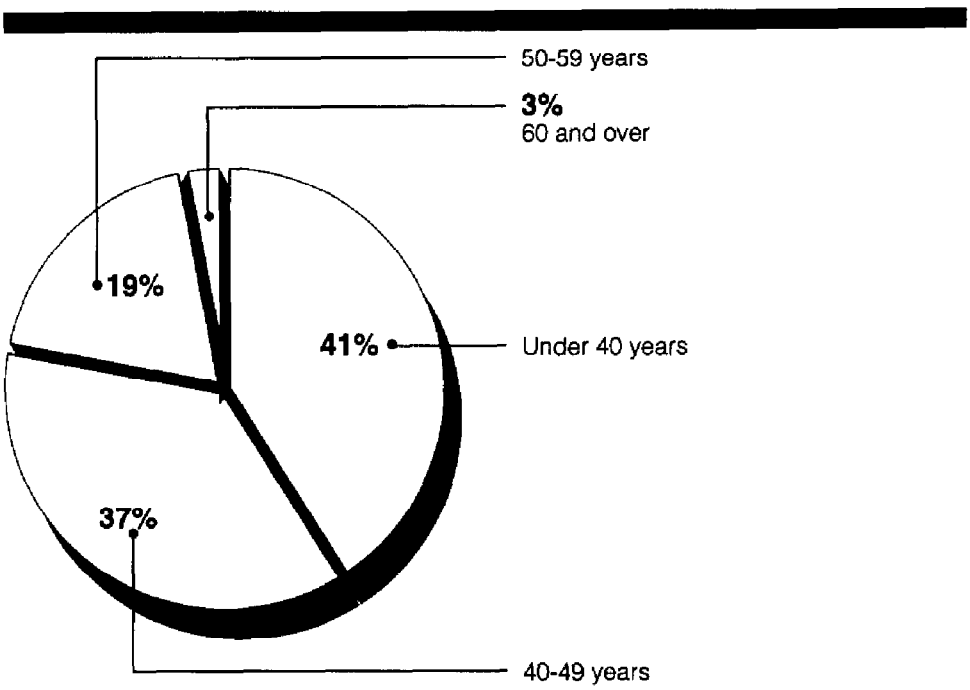
management issues facing Congress and the incoming Administration. One cluster of transition reports, including those on the budget deficit and investment, addresses broad policy issues affecting government as a whole and its relationship to the economy. Another group of reports addresses issues affecting specific federal agencies, such as the Defense Department and the Internal Revenue Service. A third group of reports looks at cross-cutting management issues—everything from financial management to information management. GAO highlighted many of these problems in a similar set of reports issued in 1988. In some instances, progress has been made; all too often, however, the problems have continued to fester and grow worse. In general, the state of management in the federal government is poor. Too many management ideas—and resulting agency structures and process—that worked well in the past now hinder government from responding quickly and effectively to a world in tremendous flux. Most agencies have no strategic vision of the future, lack sound systems to collect and apply financial and program information to gauge operational success and accountability, and too often do without people with the skills necessary to accomplish their missions.

The Comptroller General summarized the series in testimony before Congress; see Major Issues Facing a New Congress and a New Administration, by Charles A. Bowsher, Comptroller General of the United States, before the Senate Committee on Governmental Affairs (GAO/T-OCG-93-1, Jan. 8, 1993).

GAO Activities Regarding Older Workers

GAO appointed 83 persons to permanent and temporary positions during fiscal year 1993, of whom 20 (16.6 percent) were age 40 and older. Of GAO's total workforce of 5,301 on September 30, 1993, 59 percent were age 40 and older. Figure VI.1 displays GAO's workforce by four age groups.

Figure VI.1: GAO Personnel, by Age
(Sept. 1993)



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

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

- calculating retirement income available through Civil Service and Social Security systems and understanding options involving age, grade, and years of service;
- understanding health insurance and survivor benefit plans;

- acquiring information helpful in planning a realistic budget based on income, tax obligations, and benefits, and making decisions concerning legal matters;
- gaining insight and perspectives concerning adjustments to retirement;
- increasing awareness of community resources that deal with preretirement planning, second career opportunities, and financial planning; and
- increasing awareness of lifestyle options available during the transition from work to retirement.

Major Contributors to This Report

Human Resources Division, Washington, D.C.

Cynthia A. Bascetta, Assistant Director, (202) 512-7207
James C. Musselwhite, Assignment Manager
Benjamin C. Ross, Evaluator-in-Charge
Carolina L. Martinez, Evaluator
Amy L. Ward, Technical Assistant

Office of Information Management and Communication

Stephen F. Palincsar, Network Librarian

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