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United States General Accounting Office
Washington, DC 20548

November 21, 2003

The Honorable Larry E. Craig
Chairman
Special Committee on Aging
United States Senate

Subject: *Aging Issues: Related GAO Products in Calendar Years 2001 and 2002*

Dear Mr. Chairman:

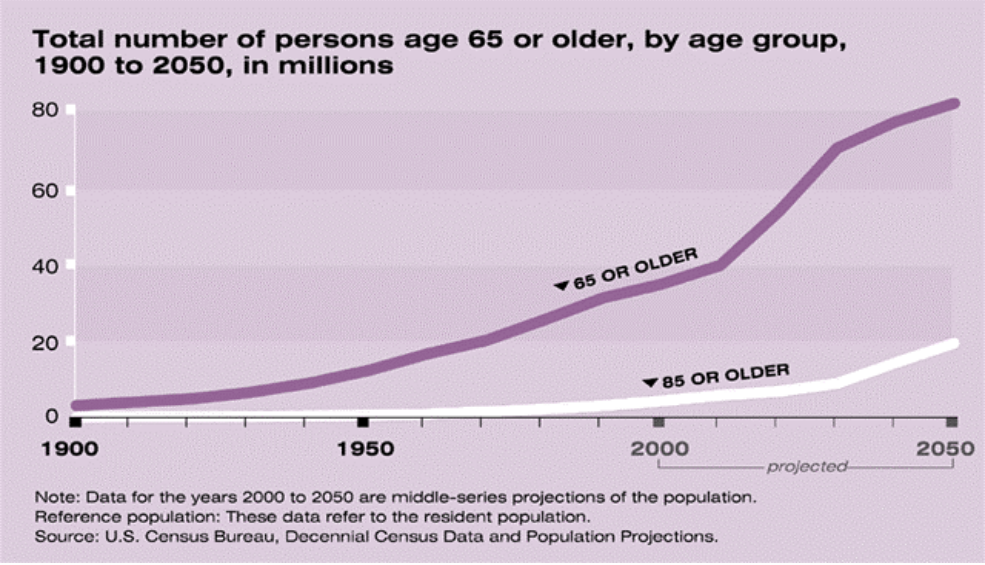
This report responds to the Committee's request for a compilation of our calendar years 2001 and 2002 products pertaining to older Americans and their families.

We are in the midst of one of the most profound changes in American history—America's population, estimated at over 288 million in 2002,[1] is growing older at a rapid pace. The number of Americans age 65 and older, estimated at 35 million in 2000, is expected to grow to 70 million by 2030 and to about 82 million in 2050, according to Bureau of the Census projections (fig. 1). Census projections also indicate that the fastest growing segment within the older population is individuals age 85 and older. This group, estimated at about 4 million in 2000, is expected to grow to 19 million by 2050.

The nation's aging population promises to have major policy and budgetary implications for the federal government. While there will be large increases in the number of older people who will be active and in very good health, there will also be growing numbers of older Americans requiring increased medical and long-term care. Health care has been one of the most rapidly rising elements of federal spending, growing at an average annual rate twice that of the rest of the federal budget over the last 10 years. Of particular concern is the growth in Medicare expenditures, estimated to total about $264 billion in 2002. Without changes, Medicare is expected to nearly double its share of the economy by 2030, crowding out other spending and economic activity of value.

[1]Population Division, U.S. Census Bureau, Table NA-EST2002-01–National Population Estimates: April 1, 2000 to July 1, 2002 (Release Date: December 31, 2002).

Figure 1: Total Number of Persons Age 65 or Older, by Age Group, 1900 to 2050 (in millions)



In addition, Social Security has long served as the foundation of the nation's retirement income system. About 39 million people receive Social Security retirement and survivor benefits. For one-fifth of the elderly, Social Security is the sole source of income. The declining ratio of workers to retirees will have fundamental implications for Social Security and the economy. Although Social Security payroll tax revenues currently exceed expenditures, projections suggest that beginning in 2017, spending will exceed revenues by growing proportions and that in 2041, the Social Security Trust Fund will be depleted. Addressing the needs of the elderly will likely become increasingly challenging and require sufficient knowledge about the issues facing this population.

One of our goals is to provide continued support of congressional and federal efforts relating to the health needs of an aging and diverse population and a secure retirement for older Americans. In striving to meet this goal, our work on aging-related programs and issues continues to reflect the broad range and importance of federal programs for older Americans. Our work during calendar years 2001 and 2002 primarily covered issues concerning health, income security, and veterans. In the compilation of work you requested, we describe two types of products that relate to older Americans:

- reports and correspondences (66 in total), and
- congressional testimonies (36 in total).

The product summaries included were prepared shortly after the products were issued and, therefore, reflect the results of our work at that time. The issues addressed by these products are presented in table 1 and the summaries themselves are in enclosure I.

Table 1: GAO Products Relating to the Elderly in Calendar Years 2001 and 2002

Elderly issues	Reports and correspondence	Testimonies
Health issues	35	21
Income security issues	15	4
Veterans/DOD issues	13	9
Other issues	3	2
Total	**66**	**36**

Source: GAO.

If you or your staff have any questions about the information in this report, please contact me at (202) 512-7215 or bovbjergb@gao.gov. Other key contributors to this report were Shelia D. Drake and Gwendolyn M. Adelekun.

Sincerely yours,

Barbara D. Bovbjerg
Director, Education, Workforce, and
Income Security Issues

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CALENDAR YEARS 2001 AND 2002, ISSUES AFFECTING OLDER AMERICANS

During calendar years 2001 and 2002, GAO issued 102 reports on issues affecting older Americans. Of these, 56 were on health issues, 19 were on income security issues, 22 were on veterans' issues, and 5 were other issues related to older Americans.

Reports and Correspondence: Calendar Years 2001 and 2002, Issues Affecting Older Americans

HEALTH ISSUES

Federal Employees' Health Plans: Premium Growth and OPM's Role in Negotiating Benefits (GAO-03-236, 31-DEC-02)

Federal employees' health insurance premiums have increased at double-digit rates for 3 consecutive years. GAO was asked to examine how the Federal Employees Health Benefits Program's (FEHBP) premium trends compared to those of other large purchasers of employer-sponsored health insurance, factors contributing to FEHBP's premium growth, and steps the Office of Personnel Management (OPM) takes to help contain premium increases compared to those of other large purchasers. GAO compared FEHBP to the California Public Employees' Retirement System (CalPERS), General Motors, and a large private employer purchasing coalition in California as well as data from employee benefit surveys.

FEHBP's premium trends from 1991 to 2002 were generally in line with other large purchasers--increasing on average about 6 percent annually. OPM announced that average FEHBP premiums would increase about 11 percent in 2003, 2 percentage points less than in 2002 and less than some other large purchasers are expecting. FEHBP enrollees would likely have paid even higher premiums in recent years if not for modest benefit reductions and enrollees who shifted to less expensive plans. Increasing premiums are related to the plans' higher claims expenditures. For FEHBP's three largest plans, about 70 percent of increased claims expenditures from 1998 to 2000 was due to prescription drugs and hospital outpatient care. Most of the increase in drug expenditures was due to higher plan payments per drug, while the increase in hospital outpatient care expenditures was due to higher utilization. OPM relies on enrollee choice, competition among plans, and annual negotiations with participating plans to moderate premium increases. Whereas some large purchasers require plans to offer standardized benefit packages and reject bids from plans not offering satisfactory premiums, OPM contracts with all plans willing to meet minimum standards and allows plans to vary benefits, maximizing enrollees' choices. Each year, OPM suggests cost containment strategies for plans to consider and relies on participating plans to propose benefits and premiums that will be competitive with other participating plans. OPM generally concurred with our findings.

Fruits and Vegetables: Enhanced Federal Efforts to Increase Consumption Could Yield Health Benefits for Americans (GAO-02-657, 25-JUL-02)

Fruits and vegetables are a critical source of nutrients and other substances that help protect against chronic diseases. Yet fewer than one in four Americans consumes the 5 to 9 daily servings of fruits and vegetables recommended by the federal Dietary Guidelines for Americans. Fruit and vegetable consumption by the general public as a whole has increased by about half a serving under key federal nutritional policy, guidance, and educational programs, as shown by the national consumption data compiled by federal agencies. But key federal food assistance programs have had mixed effects on fruit and vegetables consumption, as shown by national consumption data. However, increasing fruit and vegetable consumption is not a primary focus of these programs, which are intended to reduce hunger and support agriculture. A number of actions the federal government could take to encourage more Americans to consume the recommended daily servings have been identified. These include expanding nutrition education efforts, such as the 5 A Day Program; modifying the special supplemental Nutrition Program for Women, Infants, and Children to allow participants to choose from more of those fruits and vegetables; expanding the use of the Department of Defense Fresh Fruit and Vegetable Project in schools; and expanding farmers' market programs for food assistance participants and the elderly. These options could require additional resources or redirecting resources from other programs.

Health Care: Adequacy of Pharmacy, Laboratory, and Radiology Workforce Supply Difficult to Determine (GAO-02-137R, 10-OCT-01)

Concerns have been growing about the supply of health care workers and the future needs of an aging population. Shortages of nurses and nurse aides, the two largest categories of health care workers, are of particular concern. Although the number of pharmacists has grown during the past decade, the increasing demand for pharmacy services is outpacing the growth in supply, according to the Department of Health and Human Services. Provider and professional associations have reported high vacancy rates and a decline in new entrants to the laboratory and radiologic fields. However, employment and earnings data for laboratory and radiologic technologists and technicians do not indicate a clear picture about the current balance of supply and demand for these workers. Demographic changes, technological advances, and management decisions on how staff and technology are used will affect the future demand for health care workers.

Health Products for Seniors: 'Anti-Aging' Products Pose Potential for Physical and Economic Harm (GAO-01-1129, 07-SEP-01)

Evidence from the medical literature shows that a variety of frequently used dietary supplements marketed as anti-aging therapies can have serious health consequences for senior citizens. Some seniors have underlying diseases or health conditions that make the use of the product medically inadvisable, and some supplements can interact with medications that are being taken concurrently. Furthermore, studies

have found that products sometimes contain harmful contaminants or much more of an active ingredient than is indicated on the label. Unproven anti-aging and alternative medicine products also pose an economic risk to seniors. The Food and Drug Administration (FDA) and the Federal Trade Commission (FTC) have identified several products that make advertising or labeling claims with insufficient substantiation, some costing consumers hundreds or thousands of dollars apiece. Federal and state agencies have efforts under way to protect consumers of these products. FDA and FTC sponsor programs and provide educational materials for senior citizens to help them avoid health fraud. At the state level, agencies are working to protect consumers of health products by enforcing state consumer protection and public health laws, although anti-aging and alternative products are receiving limited attention. GAO summarized this report in testimony before Congress (GAO-01-1139T).

Long-Term Care: Availability of Medicaid Home and Community Services for Elderly Individuals Varies Considerably (GAO-02-1121, 26-SEP-02)

As the baby boomers age, spending on long-term care for the elderly could nearly quadruple by 2050. Medicaid, the joint federal state health financing program for low income individuals is currently the largest payer for long-term care services and is anticipated to face substantial increases in spending as demand for long-term care increases. Nursing home care traditionally has accounted for most Medicaid long-term care expenditures, but the high costs of such care and the preference of many individuals to stay in their own homes has led states to expand their Medicaid programs to provide coverage for home- and community-based long-term care. The case managers GAO contacted in four states for two hypothetical elderly individuals generally offered care plans that relied on in-home services rather than other residential care settings. However, the in-home services offered varied considerably. The care that case managers offered the two hypothetical individuals sometimes differed due to state policies or practices that shaped the availability of their Medicaid covered services. In two of the four states there was a waiting list for home and community based services and some states had caps or other practices that limited the amount of Medicaid in-home care that could be offered.

Mammography: Capacity Generally Exists to Deliver Services (GAO-02-532, 19-APR-02)

Breast cancer is the second leading cause of cancer deaths among American women. In 2001, 192,200 new cases of breast cancer were diagnosed and 40,200 women died from the disease. The probability of survival increases significantly, however, when breast cancer is discovered in its early stages. Currently, the most effective technique for early detection of breast cancer is screening mammography, an X-ray procedure that can detect small tumors and breast abnormalities up to two years before they can be detected by touch. Nationwide data indicate that mammography services are generally adequate to meet the growing demand. Between 1998 and 2000, both the population of women 40 and older and the extent to which they were screened increased by 15 percent. Although mammography services are generally available,

women in some locations have problems obtaining timely mammography services in some metropolitan areas. However, the greatest losses in capacity have come in rural counties. In all, 121 counties, most of them rural, have experienced a drop of more than 25 percent in the number of mammography machines in the last three years. Officials from 37 of these counties reported that the decrease had not had a measurable adverse effect on the availability of mammography services. By contrast, in 18 metropolitan counties that lost a smaller percentage of their total capacity, officials in half of the counties reported service disruptions. Officials from six other urban areas, including Houston and Los Angeles, reported that public health facilities serving low-income women had long waiting times. However, most women whose clinical exam or initial mammogram indicated a need for a follow-up mammogram were able to get appointments within one to three weeks.

Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns (GAO-02-817, 12-JUL-02)

States provide health care coverage to about 40 million uninsured, low-income adults and children under two federal-state programs--Medicaid and the State Children's Health Insurance Program (SCHIP). To receive federal funding, states must meet statutory requirements, including providing certain levels of benefits to specified populations. Under section 1115 of the Social Security Act, the Secretary of Health and Human Services (HHS) can waive many of the statutory requirements in the case of experimental, pilot, or demonstration projects likely to promote program objectives. From August 2001 through May 2002, HHS approved four waiver proposals from states to either expand health insurance to uninsured populations or extend pharmacy coverage to low-income seniors, consistent with the new goals. Of the nine proposals that were under review as of June 2002, five sought to expand coverage to uninsured populations, while four sought to provide pharmacy benefits for low-income seniors. GAO has both legal and policy concerns about the extent to which the approved waivers are consistent with the goals and fiscal integrity of Medicaid and SCHIP. The legal concern is that HHS has allowed Arizona to use unspent SCHIP funding to cover adults without children, despite SCHIP's objective of expanding health coverage to low-income children. GAO found that HHS' approval of the waiver to cover childless adults is not consistent with this objective, and it is not authorized. A related policy concern is that HHS used its waiver authority to allow Arizona and California to use SCHIP funds to cover parents of SCHIP and Medicare-eligible children with no regard to cost effectiveness when the statute provides that family coverage may be provided only if it is cost-effective to do so--that is, with no additional costs beyond covering the child. An opportunity for the public to learn about and comment on pending waivers has not been consistently provided in accordance with policy adopted by HHS in 1994. At the federal level, since 1998 HHS has not followed established procedures to publish notification of new and pending section 1115 waiver applications in the Federal Register with a 30-day comment period.

Medicare: Beneficiary Use of Clinical Preventive Services (GAO-02-422, 10-APR-02)

Preventive medicine, including immunizations for many diseases and screening for some types of cancer, holds the promise to extend and improve the quality of life for millions of Americans. Medicare now covers three preventive services for immunizations and seven for screenings, and the Centers for Medicare and Medicaid Services (CMS) sponsors "interventions" to increase the use of preventive services. GAO found that the use of preventive services varies widely by service, state, ethnic group, income, and education. The greatest differences among ethnic groups were for immunization rates. Cancer screening rates tended to differ according to income and education level. CMS pays for interventions that promote breast cancer screenings and pneumonia and flu shots. Most of the techniques being used, such as reminder systems that medical offices can use to alert doctors and patients to needed cancer screenings, have been effective. CMS is evaluating what its current efforts have accomplished and expects the results later in the year.

Medicare: Communications with Physicians Can Be Improved (GAO-02-249, 27-FEB-02)

Unlike other federal programs that make expenditures under the direct control of the government, Medicare constitutes a promise to pay for covered medical services provided to its beneficiaries by about one million providers. Given this open-ended entitlement, it is essential that appropriate and effective rules and policies be specified so that only necessary services are provided and reimbursed. Congress and the Centers for Medicare and Medicaid Services (CMS) have promulgated an extensive body of statutes, regulations, policies, and procedures on what shall be paid for and under what circumstances. Information that carriers give to physicians is often difficult to use, out of date, inaccurate, and incomplete. Medicare bulletins that carriers use to communicate with physicians are often poorly organized and contain dense legal language. Similarly, other means of communicating with physicians, such as toll-free provider assistance lines and websites, have problems with accuracy and completeness. Although all carriers issue bulletins, operate call centers, and maintain websites, each carrier develops its own communications policies and strategies. This approach results in a duplication of effort as well as variations in the quality of carrier communications. CMS provides little technical assistance to help carriers develop effective communication strategies. Neither CMS carrier oversight nor self-monitoring by the carriers is comprehensive enough to provide sufficiently detailed information that could either pinpoint specific communication problems or identify poorly performing carriers. CMS is working to improve its physician communications by consolidating new instructions and regulations and issuing them on a more predictable schedule to lessen the burden of frequent policy changes that physicians cannot anticipate. CMS is also enhancing its education programs for both physicians and carrier staffs and expanding its efforts to obtain physician feedback. Finally, CMS is improving its national website and intends to develop a single web-based source of information for physicians.

Medicare: Orthotics Ruling Has Implications for Beneficiary Access and Federal and State Costs (GAO-02-330, 22-MAY-02)

In the late 1980s and early 1990s, the Health Care Financing Administration (HCFA), now called the Centers for Medicare and Medicaid Services (CMS), became concerned that some suppliers were improperly billing Medicare for items that attach to wheelchairs and other equipment. Some suppliers were billing for such items using codes for orthodic devices, including arm, back, and neck braces that provide support for or immobilize weak or injured limbs, while others were billing using codes for durable medical equipment, which includes equipment such as wheelchairs and crutches that can withstand repeated use and is appropriate for home use. Whether an item is billed as an orthotic or DME device can affect whether such claims are paid. HCFA issued Ruling 96-1 to clarify the circumstances under which certain items would be classified as orthotics or as DME for Medicare part B payment purposes. A federal appellate court found that HFCA had followed appropriate procedures to issue the rule as an interpretation of Medicare policy, the interpretation in the ruling was wholly supportable, and the treating of seating systems as DME was consistent with congressional intent. HCFA's ruling that attached bracing devices were in the DME benefits category and could no longer be billed as orthotics affects beneficiaries residing in Medicare-certified skilled nursing facilities and other institutions primarily engaged in providing skilled nursing care (SNF). Because Medicare part B does not cover DME in SNFs and other institutions primarily engaged in providing skilled nursing care, claims for such items are no longer paid for residents in nursing homes. If HCFA's ruling were rescinded and Medicare's policy changed so that attached bracing devices were classified as orthotics, how much Medicare and Medicaid would spend for orthotics is uncertain. The distinction between DME and orthotics would become less clear, which could lead to inappropriate billing. Therefore, if the ruling were rescinded, additional controls, such as closely monitoring billing and reviewing medical justification for customized items prior to payment, would be vital to help curb potentially inappropriate billing.

Medicare: Payments for Covered Outpatient Drugs Exceed Providers' Costs (GAO-01-1118, 21-SEP-01)

Physicians are able to obtain Medicare-covered drugs at prices significantly below current Medicare payments, which are set at 95 percent of average wholesale prices (AWP). The difference between these prices and AWP for physician-administered drugs in GAO's sample varied by drug. For most physician-administered drugs, the average discount from AWP ranged from 13 percent to 34 percent; two physician-administered drugs had discounts of 65 percent and 86 percent. Other suppliers are also able to buy drugs at prices that are considerably less than the AWP used to establish the applicable Medicare payment with discounts ranging from 78 percent to 85 percent below AWP for two drugs in the sample. Also, suppliers generally receive a payment from Medicare for the durable medical equipment needed to administer the drug and supplies. Private and other public payers use different payment methods for drugs and their administration. Private health plans use their drug-purchase and

patient volume to negotiate favorable prices for drugs and physician and supplier services related to supplying or delivering the drugs. Other public payers also use their purchasing volume along with information about actual transaction prices from private payers to lower their drug payments.

Medicare: Program Designed to Inform Beneficiaries and Promote Choice Faces Challenges (GAO-01-1071, 28-SEP-01)

The Balanced Budget Act of 1997 (BBA) established the Medicare+Choice (M+C) program to expand health plan choices. BBA permitted Medicare participation by preferred provider organizations, provider-sponsored organizations, and insurers offering private fee-for-service plans or medical savings accounts. It also encouraged the wider availability of health maintenance organizations, which have long been an option for many beneficiaries. To help beneficiaries understand and consider all of their Medicare options, the National Medicare Education Program offers a toll-free help line, informational mailings to beneficiaries, an Internet site, and educational and publicity campaigns. During fiscal years 1998 through 2000, the Health Care Financing Administration (HCFA) spent an average of $107.8 million on the program annually. Most of the money came from user fees collected from M+C plans. Reaction to the program has generally been positive among beneficiaries and beneficiary advocacy groups, but representatives of M+C plans offered a mixed assessment. Program activities have increased the information available to beneficiaries on Medicare, the M+C program, and specific health plans. However, the extent to which the program has motivated beneficiaries to actively weigh their health plan options is unknown.

Medicare: Utilization of Home Health Care by State (GAO-02-782R, 23-MAY-02)

This report discusses the variation in Medicare home health use across states. Using home health claims for the first 6 months of 2001 from the Centers for Medicare and Medicaid, GAO compiled statistics on home health users, home health visits, home health episodes, and the percentage of home health users with multiple episodes for each state. A home health episode, the basis for Medicare payment under the prospective payment system, is up to a 60-day period of care during which any number of visits may be provided.

Medicare + Choice: Recent Payment Increases Had Little Effect on Benefits or Plan Availability in 2001 (GAO-02-202, 21-NOV-01)

The number of contracts under Medicare's managed care program--Medicare+Choice (M+C)--fell from 340 to 180 between 1998 and 2001. The reduction reflected decisions by some managed care organizations (MCOs) to terminate selected contracts or to discontinue service in some covered areas. Although nearly all MCOs renewed at least some of their Medicare contracts over this period, many reduced the geographic areas served. As a result, 1.6 million beneficiaries had to switch MCOs or return to Medicare's traditional fee-for-service program. Other MCOs plan either to terminate or reduce their participation in M+C at the end of 2001. Concerned about MCO

withdrawals, Congress sought to make participation in the program more attractive. As a result of the Benefits Improvement and Protection Act of 2000, aggregate Medicare+Choice payments in 2001 are estimated to have increased by $1 billion. The act permitted three basic uses for the higher payment. MCOs could (1) improve their health plans' benefit packages, (2) set aside money for future years in a benefit stabilization fund, or (3) stabilize or enhance beneficiary access to providers. Most MCOs reported that additional money would be used to stabilize or enhance beneficiary access to providers. A minority of MCOs reported that the money would go toward benefit improvements or be placed in a benefit stabilization fund. In 83 percent of M+C plans, MCOs stated that some or all of the additional money would be used to stabilize or enhance beneficiary access. The payment increases had little effect on the availability of M+C plans during 2001. Following passage of the act, three MCOs reentered counties they had dropped from their service areas, three MCOs expanded into counties that they previously had not served, and one MCO both reentered previously served counties and expanded into new ones.

Medicare+Choice: Selected Program Requirements and Other Entities' Standards for HMOs (GAO-03-180, 31-OCT-02)

Since the early 1980s, health maintenance organizations (HMO) have entered into risk-based contracts with Medicare and offered beneficiaries an alternative to the traditional fee-for-service (FFS) program. By 1997, 5.2 million Medicare beneficiaries were enrolled in an HMO. Although Medicare HMOs were available in most urban areas, they were often unavailable in rural areas. Medicare+Choice (M+C) has HMO requirements pertaining to benefit package proposals, the beneficiary enrollment process, marketing and enrollee communication materials, and quality improvement, among other areas. An HMO must annually submit a benefit package proposal to the Centers for Medicare and Medicaid Services (CMS) for each M+C health plan that the HMO intends to offer. M+C requirements for the beneficiary enrollment process specify the information that an HMO must include in its enrollment application and the checks that it must perform to ensure that beneficiaries who submit applications are eligible to enroll in the HMO's health plan. M+C marketing requirements prohibit HMOs from using inaccurate or misleading language in advertisements or materials distributed to enrollees. M+C requirements for quality improvements specify that HMOs must undertake multiyear projects intended to improve the quality of health care and must routinely gather and report performance data to CMS.

Medicare Home Health: Clarifying the Homebound Definition Is Likely to Have Little Effect on Costs and Access (GAO-02-555R, 26-APR-02)

Medicare's home health benefit provides skilled nursing and other services to eligible beneficiaries who are homebound. The Department of Health and Human Services (HHS) had a long-standing policy that beneficiaries who regularly attend adult day care were not considered homebound, particularly if the purpose of attending was to receive nonmedical or custodial care. In 2000, Congress specified that Medicare beneficiaries who attended adult day care could be considered homebound if they still met the other homebound requirements. GAO found that this clarification will

likely have little effect on program costs or access to services because the number of affected individuals is probably small. On the basis of National Long Term Care Survey data, GAO estimated that, as of 1999, 0.2 percent of elderly Medicare beneficiaries attended adult day care and had mobility or cognitive impairments that might make some eligible for Medicare home health services.

Medicare Home Health Agencies: Weaknesses in Federal and State Oversight Mask Potential Quality Issues (GAO-02-382, 19-JUL-02)

The 6,900 Home Health Agencies (HHAs) that serve Medicare beneficiaries must meet federal requirements, known as conditions of participation (COP), to ensure that they have the appropriate staff, are following the plan of care specified by a physician, maintain medical records to document the care provided, and periodically reassess each patient's condition. Although nationwide surveys done at HHAs since 1998 have identified a small proportion of agencies with serious deficiencies, the extent of the problem may be understated, and situations endangering the health and well being of home health patients may occur more often than documented. Shortcomings in the survey process and inconsistencies in state surveys make it difficult to assess the quality of care delivered and may mask potential problems. The ability to lodge complaints about an HHA and have them resolved promptly is important to protecting patient health and safety. HHA oversight by the Centers for Medicare and Medicaid Services (CMS) has been too limited to identify the problems GAO found in the survey process. CMS does not review state compliance with requirements for conducting HHA surveys, such as whether HHAs with COP-level deficiencies are surveyed annually rather than every 3 years or whether minimum patient visit and medical record review samples are adhered to.

Medicare Home Health Care: OASIS Data Use, Cost, and Privacy Implications (GAO-01-205, 30-JAN-0)

With the Health Care Financing Administration's (HCFA) implementation of a prospective payment system, efforts to protect patients from potential underprovision of care and to hold home health agencies (HHA) accountable are essential. Instituting the collection and reporting of Outcome and Assessment Information Set (OASIS) data is an important step in that direction. The use of OASIS data enhances consistency in the performance and documentation of patient assessments for home health services. As a result, information on patient outcomes will become available for the first time. Collecting such data is not without its costs. To varying degrees, the requirement to collect OASIS data on all home health patients increases the amount of staff time devoted to collecting and reporting patient assessment information. HHAs have been compensated for some of these costs through adjustments made to their payment rates. Moreover, because prospective payment system episode payment rates are based on historically high utilization levels, which have since declined, these rates should allow the completion of OASIS assessments. Protecting the privacy of home health care patients is also important. HCFA has made progress in this area by enhancing protections in the collection and

transmission of the OASIS data. The effectiveness of these policies and procedures will depend on how well they are implemented.

Medicare Home Health Care: Payments to Home Health Agencies Are Considerably Higher than Costs (GAO-02-663, 06-MAY-02)

The Balanced Budget Act of 1997 significantly changed Medicare's home health care payments to home health agencies (HHAs). Under a prospective payment system (PPS), HHAs are paid a fixed amount, adjusted for beneficiary care needs, for providing up to 60 days of care—termed a "home health episode." The act also imposed new interim payment limits to moderate spending until the PPS could be implemented. Although PPS was designed to lower Medicare spending below what it was under the interim system, GAO found that Medicare's payments for full home health care episodes were 35 percent higher than estimated costs in the first six months of 2001. These disparities indicate that Medicare's PPS overpays for services actually provided, although some HHAs facing extraordinary costs not accounted for by the payment system may be financially disadvantaged.

Medicare Physician Fee Schedule: Practice Expense Payments to Oncologists Indicate Need For Overall Refinements (GAO-02-53, 31-OCT-01)

Medicare's physician fee schedule establishes payments for more than 7,000 different services, such as office visits, surgical procedures, and treatments. Before 1992, fees were based on charges physicians billed for these services. Since then, the Health Care Financing Administration (HCFA), which administers Medicare, has been phasing in a new fee schedule on the basis of the amount of resources used to provide that service relative to other services. The development of the resource-based practice expense component of the fee, which is intended to pay for the costs of running a physician's practice, has been particularly controversial. HCFA adjusted the underlying data and basic method for calculating resource-based practice expense payments and payment changes were required to be budget-neutral—which means that total Medicare spending for physician services was to be the same under the new payment method as it was under the old one. As a result, Medicare payments to some specialties have increased while payments to other specialties have decreased. Oncologists claim that their practice expense payments are particularly inadequate for some office-based services, such as chemotherapy. Oncology practice expense payments in 2001 are eight percent higher than they would have been had charged-based payments continued. Oncology practice expense payments compared to their estimated practice expenses are about the same as the average for all physicians. HCFA's adjustments to the data and basic method reduced payments to oncologists.

Medicare Physician Payments: Medical Settings and Safety of Endoscopic Procedures (GAO-03-179, 18-OCT-02)

Every year millions of Americans covered by Medicare undergo endoscopic medical procedures in a variety of health care settings ranging from physicians' offices to

hospitals. These invasive procedures call for the use of a lighted, flexible instrument and are used for screening and treating disease. Although some of these procedures can be performed while the patient is fully awake, most require some form of sedation and are usually provided in health care facilities such as hospitals or ambulatory surgical centers. Some physician specialty societies have expressed concern that Medicare's reimbursement policies may offer a financial incentive to physicians to perform endoscopic procedures in their offices and that these procedures may be less safe because physicians' offices are less closely regulated and therefore there is less oversight of the quality of care. For the 20 procedures reviewed, there was no evidence to suggest that there was any difference in the level of safety of gastroenterological and urological endoscopic procedures performed on Medicare beneficiaries in either physicians' offices or health care facilities, such as hospitals and ASC's. There was also no evidence found to suggest that the resource-based site-of-service payment differential has caused physicians to conduct a greater proportion of gastroenterological or urological endoscopic procedures in their offices for Medicare beneficiaries. If Medicare coverage for the office procedures in the study were terminated, few access problems would occur in most of the country because physicians perform the vast majority of the procedures that were studied in health care facilities.

Medigap Insurance: Plans Are Widely Available but Have Limited Benefits and May Have High Costs (GAO-01-941, 31-JUL-01)

To protect themselves against large out-of-pocket expenses and help fill gaps in Medicare coverage, most beneficiaries buy supplemental insurance, known as Medigap; contribute to employer-sponsored health benefits to supplement Medicare coverage; or enroll in private Medicare+Choice plans rather than traditional fee-for-service Medicare. Because Medicare+Choice plans are not available everywhere and many employers do not offer retiree health benefits, Medigap is sometimes the only supplemental insurance option available to seniors. Medicare beneficiaries who buy Medigap plans have coverage for essentially all major Medicare cost-sharing requirements, including coinsurance and deductibles. Although various proposals have been made to add a prescription drug benefit to Medicare, relatively few beneficiaries buy standardized Medigap plans with this benefit. Low enrollment in these plans may be due to the fact that fewer plans are being marketed with these benefits; their relatively high cost; and the limited nature of their prescription drug benefit, which still requires beneficiaries to pay more than half of their prescription drug costs. Most plans offering this coverage have a $3,000 cap on prescription drug benefits. As a result, Medigap beneficiaries with prescription drug coverage continue to incur substantial out-of-pocket expenses for prescription drugs and other health care services.

Nursing Homes: Federal Efforts to Monitor Resident Assessment Data Should Complement State Activities (GAO-02-279, 15-FEB-02)

Nursing homes that participate in Medicare and Medicaid must periodically assess the needs of residents in order to develop an appropriate plan of care. Such resident

assessments are known as the minimum data set (MDS). According to officials in the 10 states with MDS accuracy review programs in operation as of January 2001, these programs were established because of the important role played by MDS data in setting Medicaid payments and identifying quality of care problems. Nine of the 10 states conduct periodic on-site reviews in all or a significant portion of their nursing homes to assess the accuracy of the MDS data. These reviews sample a home's MDS assessments to determine whether the basis for the assessments is adequately documented in residents' medical records. These reviews often include interviews of nursing home personnel familiar with residents and observations of the residents themselves. States with separate MDS review programs identified various approaches to improve MDS accuracy. State officials highlighted the on-site review process itself and provider education activities as their primary approaches. State officials also reported such remedies as requiring nursing homes to prepare a corrective action plan or imposing financial penalties on nursing homes when serious or extensive errors in MDS data are found.

Following the 1998 implementation of Medicare's MDS-based payment system the Federal government began building the foundation for its own separate review program to ensure the accuracy of MDS data. In the course of developing and testing various accuracy review approaches, widespread MDS errors were found that resulted in a change in the Medicare payment level for two-thirds of the resident assessments sampled. On site visits proved to be a very effective method of assessing accuracy. However as currently planned, federal MDS review activities are projected to involve roughly 1 percent of the estimated 14.7 million MDS assessments expected to be completed with on site reviews in fewer than 200 of the nations 17,000 nursing homes each year. While the federal approach may yield some broad sense of the accuracy of MDS assessments on an aggregate level, it appears to be insufficient to provide confidence about the accuracy of MDS assessments in the vast bulk of nursing homes nationwide. Given the substantial level of effort and resources already invested at the state and federal levels to oversee nursing home quality of care, including periodic inspections at each home nationwide, we recommend that CMS reorient its MDS accuracy program so that it complements and leverages existing state review activities and its own established nursing home oversight efforts.

Nursing Homes: More Can Be Done to Protect Residents from Abuse (GAO-02-312, 01-MAR-02)

Often suffering from multiple physical and mental impairments, the 1.5 million elderly and disabled Americans living in nursing homes are a highly vulnerable population. These individuals typically require extensive help with daily living, such as such as dressing, feeding, and bathing. Many require skilled nursing or rehabilitative care. In recent years, reports of inadequate care, including malnutrition, dehydration, and other forms of neglect, have led to mounting scrutiny from state and federal authorities, which share responsibility for overseeing the nation's 17,000 nursing homes. Concerns have also been growing that some residents are abused—pushed, slapped, or beaten—by the very individuals to whom their care has been entrusted.

GAO found that allegations of physical and sexual abuse of nursing home residents are not reported promptly. Local law enforcement officials said that they are seldom summoned to nursing homes to immediately investigate allegations of abuse and that few allegations are ever prosecuted. Some agencies use different policies when deciding whether to refer allegations of abuse to law enforcement. As a result, law enforcement agencies were never told of some incidents or were notified only after lengthy delays. GAO found that federal and state safeguards intended to protect nursing home residents from abuse are inadequate. No federal statute requires criminal background checks for nursing home employees. Background checks are also not required by the Centers for Medicare and Medicaid Services, which sets the standards that nursing homes must meet to participate in the Medicare and Medicaid programs. State agencies rarely recommend that sanctions be imposed on nursing homes. Although state agencies compile lists of aides who have previously abused residents, which can prevent an aide from being hired at another nursing home, GAO found that delays in making these identifications can limit the usefulness of these registries. GAO summarized this report in testimony before Congress; see GAO-02-448T.

Nursing Homes: Public Reporting of Quality Indicators Has Merit, but National Implementation Is Premature (GAO-03-187, 31-OCT-02)

GAO was asked to review the Centers for Medicare & Medicaid Services (CMS) initiative to publicly report additional information on its "Nursing Home Compare" Web site intended to help consumers choose a nursing home. GAO examined CMS's development of the new nursing home quality indicators and efforts to verify the underlying data used to calculate them. GAO also reviewed the assistance CMS offered the public in interpreting and comparing indicators available in its six-state pilot program, launched in April 2002, and its own evaluation of the pilot. The new indicators are scheduled to be used nationally beginning in November 2002.

CMS's initiative to augment existing public data on nursing home quality has considerable merit, but its planned November 2002 implementation does not allow sufficient time to ensure the indicators are appropriate and useful to consumers. CMS's plan urges consumers to consider nursing homes with positive quality indicator scores, in effect, attempting to use market forces to encourage nursing homes to improve the quality of care. However, CMS is moving forward without adequately resolving important open issues on the appropriateness of the indicators chosen for national reporting or the accuracy of the underlying data. To develop and help select the quality indicators, CMS hired two organizations with expertise in health care data—Abt Associates, Inc. and the National Quality Forum (NQF). Abt identified a list of potential quality indicators and tested them to verify that they represented the actual quality of care individual nursing homes provide. GAO's review of the available portions of the report raised serious questions about the basis for moving forward with national reporting at this time. NQF, which was created to develop and implement a national strategy for measuring health care quality, was hired to review Abt's work and identify core indicators for national reporting. To allow sufficient time to review Abt's validation report, NQF agreed to delay its

recommendations for national reporting until 2003. CMS limited its own evaluation of its six-state pilot program for the initiative so that the November 2002 implementation date could be met. Early results were expected in October 2002, leaving little time to incorporate them into the national rollout. Despite the lack of a final report from NQF and an incomplete pilot evaluation, CMS has announced a set of indicators it will begin reporting nationally in November 2002. GAO has serious concerns about the potential for public confusion by the quality information published, especially if there are significant changes to the quality indicators due to the NQF's review. CMS's proposed reporting format implies a precision in the data that is lacking at this time. While acknowledging this problem, CMS said it prefers to wait until after the national rollout to modify the presentation of the data. GAO's analysis of data currently available from the pilot states demonstrated there was ample opportunity for the public to be confused, highlighting the need for clear descriptions of the data's limitations and easy access to impartial experts hired by CMS to operate consumer hotlines. CMS has not yet demonstrated its readiness to meet these consumer needs either directly or through the hotlines fielding public questions about confusing or conflicting quality data. CMS acknowledged that further work is needed to refine its initiative, but believes that its indicators are sufficiently valid, reliable, and accurate to move forward with national implementation in November 2002 as planned.

Nursing Homes: Quality of Care More Related to Staffing than Spending (GAO-02-431R, 13-JUN-02)

Costs for nursing home care have almost doubled since 1990, from $53 billion to $92 billion in 2000. Much of that spending has been financed with public monies. Under the Medicare and Medicaid programs, the federal government financed 39 percent of the nation's nursing home spending in 2000, up from 28 percent in 1990. As federal outlays have grown, Congress has focused attention on the quality of care delivered and the level of staffing in nursing homes. GAO surveyed three states and found that nursing home expenditures per resident day varied considerably across Ohio, Mississippi, and Washington. Although the total level of spending varied, the average share devoted to resident-care activities, such as nursing care and medical supplies, was relatively stable. The share of spending devoted to buildings and equipment, by comparison, was more variable. Homes in Ohio and Washington that provided more nursing hours per resident day, especially nurses' aide hours, were less likely than homes providing fewer nursing hours to have repeated serious or potentially life-threatening quality problems. However, GAO found no clear relationship between a nursing home's spending per resident day and the number of serious quality problems.

Nursing Workforce: Emerging Nurse Shortages Due to Multiple Factors (GAO-01-944, 10-JUL-01)

The nation's hospitals and nursing homes rely heavily on the services of nurses. Concerns have been raised about whether the current and projected supply of nurses will meet the nation's needs. This report reviews (1) whether evidence of a nursing

shortage exists, (2) the reasons for current nurse recruitment and retention problems, and (3) what is known about the projected future supply of and demand for nurses. GAO found that national data are not adequate to describe the nature and extent of nurse workforce shortages, nor are data sufficiently sensitive or current to compare nurse workforce availability across states, specialties, or provider types. Multiple factors affect recruitment and retention problems, including the aging of the nurse workforce, resulting from reduced entry of younger people into the profession and nurses' job dissatisfaction. A serious shortage of nurses is expected in the future as demographic pressures influence both demand and supply.

Private Health Insurance: Access to Individual Market Coverage May Be Restricted for Applicants with Mental Disorders (GAO-02-339, 28-FEB-02)

About five percent of adults suffer from serious mental disorders. Although health insurance carriers in 11 states guarantee coverage for mental health treatment, in most states individuals with mental disorders face restrictions in purchasing private health insurance for themselves and their families. Eleven states require carriers to accept all applicants regardless of health status, but coverage options vary. Eight of these 11 states require all carriers to guarantee access to coverage sold in this market. In three states, laws apply only to some carriers, such as Blue Cross and Blue Shield, or certain periods of the year. Carriers in nine of the 11 states are also required to limit the extent to which premium rates vary between healthy and unhealthy individuals. In states without guaranteed coverage in the individual market, the seven carriers GAO reviewed would likely deny coverage more frequently for applicants with mental disorders than for applicants with other chronic health conditions. Specifically, for six mental disorders of generally moderate severity, carriers said that they would likely decline applicants 52 percent of the time. State-sponsored high-risk pools are the primary coverage option available to rejected applicants in most states. In 27 of the 34 states where carriers may deny coverage to applicants with mental disorders or other health conditions, high-risk pools offer coverage to applicants denied individual market coverage. The pools are subsidized—generally through assessments on carriers or state tax revenues—and premium rates are generally capped at 125 to 200 percent of standard rates for healthy individuals. Health benefits available under the pools are generally comparable to those available in the individual market, including similar restrictions on mental health benefits; however, benefits for mental disorders or other health conditions are not permanently excluded as they may be in the individual insurance market.

Retiree Health Benefits: Employer-Sponsored Benefits May Be Vulnerable to Further Erosion (GAO-01-374, 01-MAY-01)

In 1999, about 10 million retired people aged 55 or older relied on employer-sponsored health insurance as either their primary source of coverage or as a supplement to their Medicare coverage. Some of these persons are concerned about the continued availability of employer-sponsored coverage. Premium increases and forecasts for a potential economic slowdown could further erode employer-sponsored retired health benefits. In the long term, these factors, coupled with the

potential for Medicare reforms and the rising number of aging baby boomers, may produce even more uncertainty and cost pressures for employers. Consequently, as an increasing number of retirees lack employer-based coverage, those in poorer health may have difficulty finding affordable alternative health coverage.

Retiree Health Benefits: Examples of Employer-Reported Obligations in Selected Industries (GAO-02-639R, 29-APR-02)

In addition to providing an overview of a company's business operations, the annual reports submitted to the Securities and Exchange Commission present important information on an employer's estimated obligations for postemployment benefits, including retiree health benefits. However, the assumption used to estimate obligations for postemployment benefits vary across companies and are not comparable. Financial Accounting Standards Board guidelines give employers latitude in calculating these obligations. Moreover, changes in companies' benefit offerings or financial stability would likely alter companies' obligations for retiree health benefits. Most employers also reserve the right to change or terminate retiree health benefits.

Skilled Nursing Facilities: Available Data Show Average Nursing Staff Time Changed Little after Medicare Payment Increase (GAO-03-176, 13-NOV-02)

The nation's 15,000 skilled nursing facilities (SNF) play an essential role in our health care system, providing Medicare-covered skilled nursing and rehabilitative care each year for 1.4 million Medicare patients who have recently been discharged from acute care hospitals. In recent years, many analysts and other observers, including members of Congress, have expressed concern about the level of nursing staff in SNFs and the impact of inadequate staffing on the quality of care. The Congress temporarily increased the nursing component of the SNF Medicare payment rate by 16.6 percent. GAO's analysis of available data shows that, in the aggregate, SNFs' nurse staffing ratios changed little after the increase took effect. Overall, SNFs' average nursing time increased by 1.9 minutes per patient day, relative to their average in 2000 of about 3 and one-half hours of nursing time per patient day. For most SNFs, increases in staffing ratios were small. Further, GAO found that the share of SNF patients covered by Medicare was not a factor in whether facilities increased their nursing time. Similarly, SNFs that had total revenues considerably in excess of costs before the added payments took effect did not increase their staffing substantially more than others.

Skilled Nursing Facilities: Medicare Payments Exceed Costs for Most but Not All Facilities (GAO-03-183, 31-DEC-02)

This report addresses (1) the relationship between Medicare skilled nursing facility (SNF) payments and the costs of treating Medicare patients in freestanding SNFs, as well as the effect of Medicare SNF payments on the financial condition of these facilities, and (2) the relationship between Medicare SNF payments and the costs of

treating patients in hospital-based SNFs, as well as the factors that may account for cost differences between hospital-based and freestanding SNFs.

Under the prospective payment system (PPS), most freestanding SNFs' Medicare payments substantially exceeded the costs of caring for Medicare patients, contributing to facilities' overall positive financial condition. In 1999, the first full year under the PPS, the median freestanding SNF Medicare margin—a measure that compares Medicare payments with Medicare costs—was slightly over 8 percent. By 2000, when the temporary payment increases authorized by the Congress started to take effect, the median Medicare margin had risen to almost 19 percent. However, nearly one-quarter of SNFs in 2000 had Medicare margins exceeding 30 percent, while about one-fifth had negative Medicare margins; that is, the payments they received from Medicare did not cover their costs of providing care. Medicare margins were higher for freestanding SNFs affiliated with large, for-profit nursing home chains and for those with high occupancy. The median SNF total margin—which reflects total revenues and costs across all patients—was 1.3 percent in 1999 and 1.8 percent in 2000. A SNF's total margin tended to be higher when its Medicare margin was higher despite the fact that, in most SNFs, Medicare's share of patient days was small. The total margins for freestanding SNFs tended to be lower when a higher proportion of a SNF's patients had their care paid for by Medicaid. Unlike freestanding SNFs, about 90 percent of hospital-based SNFs reported significantly negative Medicare margins after Medicare's new SNF payment system was launched. The median hospital-based SNF Medicare margin was -53 percent in 1999. Under the PPS, per diem payments to hospital-based SNFs dropped considerably, reflecting the change from payments based on a facility's own costs to fixed payments based on average costs for all facilities. At the same time, hospital-based SNFs reported per diem costs rose from 1997 through 1999. This is in contrast to the experience of freestanding SNFs, which had lower per diem Medicare costs than hospital-based SNFs prior to the PPS and reduced their costs further after the shift to the PPS. The higher Medicare costs reported by hospital-based SNFs may stem in part from differences in services provided to patients. The higher costs may also reflect the historical allocation of overhead costs to the SNF from the hospital, an accounting practice that, while consistent with the payment incentives under the prior cost-based reimbursement system, means that hospital-based SNFs reported costs should be treated cautiously.

Skilled Nursing Facilities: Providers Have Responded to Medicare Payment System By Changing Practices (GAO-02-841, 23-AUG-02)

In 1998, the Health Care Financing Administration implemented a prospective payment system (PPS) for skilled nursing facility (SNF) services provided to Medicare beneficiaries. The PPS is intended to control the growth in Medicare spending for skilled nursing and rehabilitative services that SNFs provide by providing a predetermined payment for each day of care. The payment varies depending on the patient's payment group classification, which reflects expected resource use, but not the actual resource use. Two years after the implementation of the PPS, the mix of patients across the payment groups has shifted, as determined by the patients' initial assessments. More patients were classified into the high and

medium rehabilitation payment group categories, which were believed to be the most profitable, and fewer were initially classified into the most intensive (highest paying) and least intensive (lowest paying) rehabilitation payment group categories. The majority of patients in rehabilitation payment groups received less therapy than was provided in 1999. This was true even for patients within the same rehabilitation payment group categories. Across all rehabilitation payment group categories, fewer patients received the highest amounts of therapy associated with each payment group.

Skilled Nursing Facilities: Services Excluded From Medicare's Daily Rate Need to be Reevaluated (GAO-01-816, 22-AUG-01)

Congress and the Health Care Financing Administration recognized that certain services needed to be excluded from the skilled nursing facility (SNF) prospective payment system (PPS) rate to help ensure beneficiary access to appropriate care and to financially protect the SNFs that take care of high-cost patients. The criteria used to identify services—high cost, infrequently provided during a SNF stay and likely to be overprovided–and the services currently excluded appear reasonable. Even so, questions remain about whether certain other services should be excluded and how to modify the exclusions over time. Current exclusion policies raise three unintended consequences—beneficiary liability is higher for excluded services; beneficiaries may be required to receive excluded services in only certain facilities, which may be higher cost; and the broad definition of excluded emergency services may result in more care being classified as emergency. The Centers for Medicare & Medicaid Services (CMS) does not plan to collect data on all services provided to beneficiaries during their SNF stays. Without these data, CMS will have difficulty updating the exclusions over time and limit efforts to refine the payment system.

Title III, Older Americans Act: Carryover Funds Are Not Creating a Serious Meal Service Problem Nationwide (GAO-01-211, 09-JAN-01)

Under Title III of the Older Americans Act, the Administration on Aging (AoA) distributes grants to states on the basis of their proportional share of the total elderly population in the United States. Most states then disburse these grants to more than 600 area agencies nationwide. The grants are further subdivided by these agencies to more than 4,000 local service providers and are used to fund group and in-home meals, as well as support services, including transportation and housekeeping. AoA requires that states obligate these funds by September 30 of the fiscal year in which they are awarded. Also, states must spend this money within two years after the fiscal year in which it is awarded. During this time AoA does not limit or monitor the amount of unspent funds that states may carry over to the succeeding fiscal year. GAO examined whether states were using Title III carryover funds to expand their meal service programs for the elderly beyond a level sustainable by their annual allotments alone. GAO found that the buildup and use of Title III carryover funds to support elderly nutrition services does not appear to be a widespread problem. However, AoA does not monitor the states' buildup of carryover funds. As a result,

the agency has little assurance that it could identify meal service problems that could emerge in the future.

INCOME SECURITY ISSUES

*Answers to Key Questions about Private Pension Pla*ns (GAO-02-745SP, 18-SEP-02)

This primer on private pensions provides information on the basic features of the private pension plan system and the federal framework that governs how private plans must operate. GAO answers questions about the types of plans that private employers may sponsor, the benefits these plans provide, and the basic requirements that govern how these plans are administered.

Older Workers: Demographic Trends Pose Challenges for Employers and Workers (GAO-02-85, 16-NOV-01)

The impending retirement of the "baby boom" generation is receiving considerable attention. The number of older workers will grow substantially during the next two decades, and they will become an increasingly significant share of the U.S. workforce. For example, according to the 2001 Current Population Survey, there were 17.3 million workers over age 55 in the laborforce, and this number is expected to increase to 25.3 million or over 20 percent of the laborforce in 2015. Although older workers are less likely than younger workers to lose a job, when they do lose a job, they are less likely than younger workers to find other employment. To retain older workers and extend their careers, some public and a few private employers are providing options, including flexible hours and financial benefits, reduced workloads through the use of part-time or part-year schedules, and job-sharing. Most employers are not yet facing labor shortages or other economic pressures that would require them to consider flexible employment arrangements because the retirement of the baby boom generation will occur gradually during the next several decades.

Private Pensions: Improving Worker Coverage and Benefits (GAO-02-225, 09-APR-02)

Although pensions are an important source of income for many retirees, millions of workers lack individual pension coverage. Only half of the nation's workers have been covered by private employer-sponsored pensions since the 1970s. Traditional reforms to the voluntary, single-employer-based pension system have limited potential to expand pension coverage and improve worker benefits. These pension reforms have concentrated mainly on improving tax incentives and reducing the regulatory burden on small employers. Furthermore, efforts to increase retirement savings by restricting the use of lump-sum distributions could limit worker participation in and contributions to pension plans. Three categories of reform—pooled employer reforms, universal access reforms, and universal participation reforms—go beyond the voluntary, single-employer private pension system. Pooled employer reforms seek to increase the number of firms offering pension coverage by creating centralized third-party administration and increasing pension plan portability. Universal access reforms seek to boost savings by offering payroll-based accounts, albeit without mandating employer contributions. Universal participation

reforms would mandate pension availability and participation for all workers, similar to the existing Social Security system.

Private Pensions: IRS Can Improve the Quality and Usefulness of Compliance Studies (GAO-02-353, 12-APR-02)

The Internal Revenue Service (IRS) studied 401(k) plan compliance with Internal Revenue Code requirements for tax-qualified plans. GAO found that IRS's estimates of noncompliance were inaccurate. The study, which audited a sample of 401(k) plans, did not provide information on the severity of the compliance violations identified and did not determine the number of plan participants or the amount of assets associated with noncompliance errors. Only 27 of the 73 study questions identified as compliance indicators conclusively demonstrated whether a plan was compliant or not. Consequently, the 44 percent reported to have one or more instances of noncompliance is at best an upper limit on the extent of noncompliance found. IRS has chosen specific types of private pension plans to study in a manner similar to the one conducted on 401(k) pension plans. The data that IRS collects will be analyzed to determine the prevalence and types of noncompliance among the plans studied.

Private Pensions: Issues of Coverage and Increasing Contribution Limits for Defined Contribution Plans (GAO-01-846, 17-SEP-01)

Proposals to expand pension coverage and promote pension savings have recently received much attention. In the Economic Growth and Tax Relief Reconciliation Act of 2001, for example, Congress raised statutory limits on tax-deferred pension contributions and benefits and made other changes to the law governing qualified pension plans. Some believe that increasing these limits will encourage employers to start new plans and improve existing plan coverage, especially for employees of small businesses. Others contend that these measures will primarily benefit higher-paid individuals and may not improve pension coverage for low-or moderate-income workers. Forty-seven percent of all workers participated in a pension plan, and 36 percent of all workers participated in a defined contribution (DC) plan. Most pension plan participants had low or moderate earnings (less than $40,000 per year) and were men. About eight percent of all DC participants, or 3.1 million people, were likely direct beneficiaries of a simultaneous increase in all the statutory contribution limits GAO analyzed. Higher earners were more likely than low and moderate earners, and men were more likely than women, to benefit directly from such an increase; this was also true of increases in each of the separate dollar limits on contributions. About 721,000 DC participants, or 11 percent of eligible DC participants, were likely to benefit from a so-called "catch-up" provision allowing persons aged 50 or older to make additional contributions to DC plans. Higher earners were more likely to benefit directly from this option than were low and moderate earners. However, neither male more female DC participants were significantly more likely to benefit directly from this option.

Private Pensions: Participants Need Information on the Risks of Investing in Employer Securities and the Benefits of Diversification (GAO-02-943, 06-SEP-02)

The financial collapse of large firms and the effects on workers and retirees has raised questions about retirement funds being invested in employer securities and the laws governing such investments. Pensions are important source of income of many retirees, and the federal government has encouraged employers to sponsor and maintain pension and savings plans for their employees. The continued growth in these plans and their vulnerabilities has caused Congress to focus on issues related to participants investing in employer securities through employer-sponsored retirement plans. GAO's analysis of the 1998 plan data for the Fortune 1,000 firms showed that 550 of those companies held employer securities in their defined benefit plans or defined contribution plans, covering 13 million participants. Investment in employer securities through employer-sponsored retirement plans can present significant risks for employees. If the employees' retirement savings is largely in employer securities in these plans, employees risk losing not only their jobs should the company go out of business, but also a significant portion of their savings. Even if employers do not declare bankruptcy, employees are still subject to the dual risk of loss of job and loss of retirement savings because corporate losses and stock price declines can result in companies significantly reducing their operations. Under the Employee Retirement Income Security Act and the Securities Acts, the Department of Labor and Securities and Exchange Commission (SEC) are responsible for ensuring that certain disclosures are made to plan participants regarding their investments. Although employees in plans where they control their investments receive disclosures under the act regarding their investments, such regulations do not require companies to disclose the importance of diversification or warn employees about the potential risks of owning employer securities. SEC requires companies with defined contribution plans that offer employees an opportunity to invest in employer stock to register and disclose to SEC specific information about those plans. In addition, in most cases the underlying securities of those plans must be registered with SEC. However, SEC does not routinely review these company plan filings because pension plans generally fall under other federal regulation.

Retirement Savings: Opportunities to Improve DOL's SAVER Act Campaign (GAO-01-634, 26-JUN-01)

Many of today's workers may not be financially prepared for retirement when they stop working. Many people are counting on Social Security alone, without an additional retirement plan. The Savings Are Vital to Everyone's Retirement (SAVER) Act of 1997 requires the Department of Labor (DOL) to hold periodic national summits and run an outreach program to promote retirement saving. This report (1) identifies major accomplishments of the 1998 summit and issues that might affect future summits, (2) describes DOL's outreach program, and (3) determines what DOL knows about the effectiveness of the summit and outreach program. GAO found that the 1998 National Summit made progress in identifying problems that workers face in saving for retirement. DOL's Outreach Program--the Retirement Savings Education Campaign--targets of small business owners, women, minorities, and youth to change

the way they think about, and act on, their retirement saving needs. DOL has not tried to assess the extent to which outreach efforts from the 1998 National Summit and Pension and Welfare Benefits Administration have increased the public's knowledge and understanding of retirement savings.

Social Security: Program's Role in Helping Ensure Income Adequacy (GAO-02-62, 30-NOV-01)

Before Social Security, being old often meant being poor. Today, dependency on public assistance has dropped to a fraction of its Depression-era levels, and poverty rates among the elderly are now lower than for the population as a whole. At the same time, Social Security has become the single largest source of retirement income for more than 90 percent of persons aged 65 and older. Automatic adjustments were introduced in 1972 to reflect increases in the cost of living. Other program changes gradually increased social security coverage to larger portions of the workforce and extended eligibility to family members and disabled workers. Other benefit programs, such as Supplemental Security Income (SSI), Medicare, and Medicaid, have also been added over the years. With regard to measuring income adequacy, various measures help examine different aspects of this concept, but no single measure can provide a complete picture. For various subgroups of beneficiaries that have lower lifetime earnings, poverty rates have also declined. Although the Social Security benefit formula favors lower lifetime earners, their lower earnings and work histories can leave them with incomes below the poverty level when they retire or become disabled. The outlook for future Social Security benefit levels and income adequacy depend on how the program's long-term financing imbalance is addressed, as well as on the measures used. GAO concludes that reductions in promised benefits and increases in program revenues will be needed to restore the program's long-term solvency and sustainability. Possible benefit changes might include adjustments to the benefit formula or reductions in cost-of-living increases. Possible revenue sources might include higher payroll taxes or transfers from the Treasury's general fund.

Social Security Administration: Information Systems Could Improve Processing Attorney Fee Payments in Disability (GAO-01-796, 29-JUN-01)

To ensure that people claiming disability insurance benefits can obtain legal representation at a fair price, the Social Security Act requires that the Social Security Administration (SSA) regulate the fees that attorneys charge people to represent their disability claims before the agency. Inefficiencies in the current process increase both the time it takes to pay the attorney fees and the costs of administration. One segment of attorney fee processing—the fee approval process—was substantially simplified in 1991. Systems support could streamline the second segment of the processing—the fee payment—thus lowering the annual administrative costs and cutting processing time. By automating this final segment of the fee processing, SSA could help improve customer service for both claimants and their attorneys. GAO found that despite internal recommendations for a new system, SSA has repeatedly postponed its plans to improve the attorney fee payment process. Indeed, even though these improvements have been part of SSA's system's plans since 1998, SSA

has yet to establish a firm schedule for carrying out its plans. Additionally, although SSA has a draft plan for improving the process, agency officials told GAO that the details of the plan have not been completed and SSA has yet to complete a cost estimate for the project. There are also other gaps in the plan--such as not creating an attorney master file or establishing an electronic connection between the payment processing staff and the Office of Hearings and Appeals fee approval staff—where taking additional actions could improve the process. Furthermore, SSA's performance plan did not have goals related to attorney fees—neither for cost reduction of the program nor payment timeliness. SSA would need such goals as part of its current planning effort for improving the attorney fee payment process as well as for its future operations. Without such quantifiable goals, future efforts to track and oversee SSA's progress in these areas will be difficult.

Social Security Administration: Revision to the Government Pension Offset Exemption Should Be Reconsidered (GAO-02-950, 15-AUG-02)

Social Security benefits are payable to the spouses of retired, disabled, or deceased workers. The benefits often provide income to wives and husbands who have little or no Social Security benefits of their own. Until 1977, workers receiving pensions from government positions not covered by Social Security could receive their full pension benefit and their full spousal benefits as if they were nonworking spouses. Since then, a government pension offset has been in effect to equalize the treatment of workers covered by Social Security and those with noncovered government benefits. This report was prompted by a referral to GAO's Fraudnet that questioned a practice in which individuals in Texas were transferring to Social Security-covered positions for one day to avoid the offset. GAO found no central data on the use of the offset exemption by individuals, and time constraints did not permit in-depth audit work on the 2,300 state and local government retirement plans. However, GAO did establish that, as of June 2002, more than 4,800 persons in Texas and Georgia worked for brief periods in jobs covered by Social Security to qualify for the "last-day exemption." GAO estimates that the long-term Social Security payments to these individuals could be as high as $450 million. Such abuses of the offset exemption could be prevented by (1) changing the last-day provision to a longer minimum time period or (2) using a proportional approach based on the number of working years as a government employee spent in covered and noncovered employment to determine the extent to which the government pension offset applies.

SSA Disability: SGA Levels Appear to Affect the Work Behavior of Relatively Few Beneficiaries, but More Data Needed (GAO-02-224, 16-JAN-02)

The Social Security Administration's (SSA) Disability Insurance (DI) program paid $50 billion in cash benefits to more than five million disabled workers in 2000. Eligibility for DI benefits is based on whether a person with a severe physical or mental impairment has earnings that exceed the Substantial Gainful Activity (SGA) level. SSA terminates monthly cash benefit payments for beneficiaries who return to work and have earnings that exceed the SGA level—$1,300 per month for blind beneficiaries and $780 per month for all other beneficiaries. GAO found that the SGA

level affects the work patterns of only a small proportion of DI beneficiaries. However, GAO also found that the SGA may affect the earnings of some beneficiaries. About 13 percent of those beneficiaries with earnings near the SGA level in 1985 still had earnings near the SGA level in 1995, even though the level was increased during that period. The absence of key information identifying the monthly earnings of beneficiaries, their trial work period status, and whether they are blind limited GAO's ability to definitively identify a relationship between SGA levels and beneficiaries' work patterns. Data limitations also make the effect of the SGA on DI program entry and exit rates difficult to isolate. Although the rate of program entry increased in the years immediately following a 1990 increase in the SGA level, it then gradually declined to a level below the pre-1990 entry rates. Since 1990, DI exit rates continue to be driven largely by beneficiary death and conversion to retirement benefits. However, the percentage of all exits caused by improvements in medical conditions or a return to work increased slowly, from 1.9 percent in 1985 to 9.2 percent in 1996, and then rose dramatically to 19.9 percent in 1997. A substantial increase in the number of continuing disability reviews done by SSA may account, in part, for this 1997 upturn, but data limitations preclude GAO from obtaining a full understanding of the link between the SGA and exit behavior.

Social Security Programs: Scope of SSA's Authority to Deny Benefits to Fugitive Felons and to Release Information About OASI and DI Beneficiaries Who Are Fugitive Felons (GAO-02-459R, 27-FEB-02)

In response to concerns that individuals wanted in connection with a felony or violating terms of their parole or probation could receive benefits from programs for the needy, the Congress added provisions to the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 that prohibit these individuals from receiving Supplemental Security Income (SSI), Food Stamps benefits, Temporary Assistance for Needy Families (TANF), and federal housing assistance. To assist in the apprehension of fugitive felons, PRWORA also directs these programs to provide law enforcement agencies with information about program recipients for whom there are outstanding warrants. GAO was asked to determine if SSA has the authority under these provisions (1) to deny Old Age and Survivors Insurance (OASI) and Disability Insurance (DI) to fugitive felons, and (2) to give law enforcements agencies the current addresses and Social Security numbers of OASI or DI recipients who are fugitive felons. GAO found that SSA currently lacks the authority to deny OASI and DI benefits to fugitive felons who otherwise are eligible to receive them, and the Privacy Act authorizes but does not require SSA to provide information it collects about individuals, including OASI and DI recipients who are fugitive felons, to law enforcement agencies.

Social Security Reform: Potential Effects on SSA's Disability Programs and Beneficiaries (GAO-01-35, 24-JAN-01)

There has been little analysis of how the various Social Security reform proposals might affect the Social Security Disability Insurance (DI) program. This report assesses the potential impact of these proposals on the solvency of the DI trust fund

and on the benefits disabled beneficiaries receive. GAO found that most disabled beneficiaries would receive higher benefits under the various Social Security reform proposals it reviewed than under a solvency scenario that maintained payroll tax rates while reducing benefits. However, most of the disabled beneficiaries GAO studied would receive lower benefits under three of the reform proposals reviewed than under a solvency scenario that maintained current-law benefits while raising payroll taxes. The proposals GAO studied treat DI beneficiaries similar to Old-Age and Survivor Insurance beneficiaries. However, the circumstances facing disabled workers differ from those facing retired workers. The differences between disabled workers and retired workers suggest that Social Security reform proposals should be viewed not only in light of their effects on retired workers but also explicitly for their effect on disabled beneficiaries and their families.

Supplemental Security Income: Progress Made in Detecting and Recovering Overpayments, but Management Attention Should Continue (GAO-02-849, 16-SEP-02)

The Supplemental Security Income (SSI) program is the nation's largest cash assistance program for the poor. The program paid $33 billion in benefits to 6.8 million aged, blind, and disabled persons in fiscal year 2001. Benefit eligibility and payment amounts for the SSI population are determined by complex and often difficult to verify financial factors such as an individual's income, resource levels, and living arrangements. Thus, the SSI program tends to be difficult, labor intensive, and time consuming to administer. These factors make the SSI program vulnerable to overpayments. The Social Security Administration (SSA) has demonstrated a stronger commitment to SSI program integrity and taken many actions to better deter and detect overpayments. Specifically, SSA has (1) obtained legislative authority in 1999 to use additional tools to verify recipients' financial eligibility for benefits, including strengthening its ability to access individuals' bank account information; (2) developed additional measures to hold staff accountable for completing assigned SSI workloads and resolving overpayment issues; (3) provided field staff with direct access to state databases to facilitate more timely verification of recipient's wages and unemployment information; and (4) significantly increased, since 1998, the number of eligibility reviews conducted each year to verify recipient's income, resources, and continuing eligibility for benefits. In addition to better detection and deterrence of SSI overpayments, SSA has made recovery of overpaid benefits a high priority.

Sustained management attention should continue to ensure progress towards fully implementing crucial overpayment deterrence, detection, and recovery tools. Despite these efforts, further improvements in overpayment recovery are possible. The report includes recommendations that SSA address complex SSI program rules to better prevent payment errors, reassess its policies and procedures for imposing administrative penalties and sanctions, and ensure that overpayment waiver policies are designed and implemented in a way that maintains program integrity.

Welfare Reform: Implementation of Fugitive Felon Provisions Should Be Strengthened (GAO-02-716, 25-SEP-02)

In response to concerns that individuals wanted in connection with a felony or violating terms of their parole or probation could receive benefits from programs for the needy, Congress added provisions to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 that prohibit these individuals from receiving Supplemental Security Income (SSI), Food Stamp benefits, and Temporary Assistance to Needy Families (TANF) and make fugitive felon status grounds for the termination of tenancy in federal housing assistance programs. In addition, the Act directs these programs to provide law enforcement officers with information about program recipients for whom there are outstanding warrants to assist in their apprehension. Actions taken to implement the Act's fugitive felon provisions have varied substantially by program. In implementing provisions to prohibit benefits to fugitive felons, all but housing assistance programs include, at a minimum, a question about fugitive felon status in their applications. SSI and some state Food Stamp and TANF programs also seek independent verification of fugitive felon status by using computer matching to compare arrest warrant and program recipient files. To date, 110,000 beneficiaries have been identified as fugitive felons and dropped from the SSI, Food Stamp, and TANF rolls, and many have been apprehended. Computerized file matching has been responsible for the identification of most of these fugitive felons. Aggressive implementation of the Act's fugitive felon provisions poses a number of challenges for programs. First, centralized and complete national and statewide arrest warrant data for computer matching are not readily available. Second, because direct access to arrest warrants and criminal records is limited to law enforcement personnel, computer matching requires what many state TANF and Food Stamp officials view as a burdensome and complex negotiation process to obtain these records. Third, the absence of information and guidance about how to conduct file matching and overcome its logistical challenges has also hindered aggressive implementation of the law. Finally, there is evidence that individuals with outstanding warrants for felonies, or probation or parole violations, may continue to collect benefits because there may be differences in the interpretation of what constitutes a fugitive felon within the Food Stamp and TANF programs.

VETERANS/DOD ISSUES

DOD and VA Pharmacy: Progress and Remaining Challenges in Jointly Buying and Mailing Out Drugs (GAO-01-588, 25-MAY-01)

The Department of Veterans Affairs (VA) and the Department of Defense (DOD) have made important progress, particularly during the past year, in their efforts to jointly procure drugs to help control spiraling prescription drug costs. Although their collaborative efforts have been impressive, the two agencies have largely targeted generic drugs, which comprise less than 10 percent of their combined expenditures. More dramatic cost reductions could be achieved through procurements of high-cost brand-name drugs, although doing so can be more complex and time consuming to garner the necessary clinical support and provider acceptance on therapeutic interchangeability. Nonetheless, DOD's greatly expanded retiree drug benefit and the formularies being developed by both agencies should provide added joint procurement opportunities for such drugs. Also, VA and DOD have shown that flexible approaches to developing joint solicitations can take into account differences in their health systems while still maximizing drug discounts. In GAO's view, their joint activities could be further enhanced by periodically conferring with private managed care pharmacy experts and reporting to Congress on their joint procurement activities. Top management at DOD and VA need to stay focused on their joint procurement and distribution activities as leadership changes continue at the two agencies. VA and DOD have also made progress in their efforts to conduct a consolidated mail outpatient pharmacy pilot. The sooner the pilot proves feasible, the sooner DOD can begin to realize the financial and quality of care benefits associated with the transfer of its refill workload.

Financial Management: Department of Defense Regulations Establishing Methods to Calculate Amounts To Be Transferred from Department of Defense Medicare Eligible Retiree Health Care Fund (GAO-02-1061R, 30-AUG-02)

GAO reviewed regulations issued by the Department of Defense (DOD) to cover transfers from a new fund created by Congress to finance the cost of expanded health care programs' benefits for Medicare-eligible uniformed services retirees and their eligible dependents. These health care programs include pharmacy benefits and coverage of the deductible portion of Medicare benefits. The Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001 established the Department of Defense Medicare Eligible Retiree Health Care Fund in the U.S. Treasury. Beginning on October 1, 2002, the fund will finance DOD's liabilities under the uniformed services retiree health programs for Medicare-eligible beneficiaries. The legislation requires that (1) the Secretary of Defense establish by regulation the methods for calculating amounts to be transferred periodically from the fund to applicable appropriations that incur the programs' cost and (2) the Comptroller General report to the Secretary of Defense and to Congress on the adequacy and appropriateness of these regulations within 30 days of receiving them from the Secretary. GAO found that regulations establishing the methods for calculating transfers from the fund to finance eligible health care costs were issued in July 2002,

in sufficient time to begin making transfers upon activation of the fund on October 1, 2002. DOD regulations for establishing the methods for calculating transfers from the fund are adequate and appropriate, and they provide a framework for the transfers to be implemented upon activation of the fund. Under these regulations, there are to be daily transfers from the fund to cover amounts disbursed to non-DOD providers, such as civilian health care providers and retail pharmacies, based on claims transactions. The regulations also provide the methodology for calculating transfers to cover the cost of military treatment facilities care to the intended beneficiaries. However, the reliability of the underlying cost and patient clinical data could limit DOD's ability to reliably assign costs and bill DOD for services to DOD Medicare-eligible retirees and their eligible dependents.

VA Drug Formulary: Better Oversight Is Required, but Veterans Are Getting Needed Drugs (GAO-01-183, 29-JAN-01)

During the last three years, the Department of Veterans Affairs (VA) has made significant progress in establishing its national drug formulary, which has generally met with prescriber acceptance. Most veterans are receiving the drugs they need. However, VA oversight has not been sufficient to ensure that the Veterans Integrated Service Networks (VISN) and medical centers comply with formulary policies and that the flexibility given to them does not compromise VA's goal of formulary standardization. Contrary to VA formulary policy, some facilities omitted national formulary drugs or modified the closed drug classes. Although a limited number of drugs to supplement the national formulary is permitted, formulary differences among facilities are likely to become more pronounced, as more drugs are added by VISNs, decreasing formulary standardization. VA recognizes the trade-off between local flexibility and standardization, but it lacks criteria for determining the appropriateness of adding drugs to supplement the national formulary and therefore may not be able to determine whether the decrease in standardization is acceptable.

VA Health Care: Allocation Changes Would Better Align Resources with Workload (GAO-02-338, 28-FEB-02)

The Department of Veterans Affairs (VA) spent $21 billion in fiscal year 2001 to treat 3.8 million veterans--most of whom had service-connected disabilities or low incomes. Since 1997, VA has used the Veterans Equitable Resource Allocation (VERA) system to allocate most of its medical care appropriation. GAO found that VERA has had a substantial impact on network resource allocations and workloads. First, VERA shifted $921 million from networks located primarily in the northeast and midwest to networks located in the south and west in fiscal year 2001. In addition, VERA, along with other VA initiatives, has provided an incentive for networks to serve more veterans. VERA's overall design is a reasonable approach to allocate resources commensurate with workloads. It provides a predetermined dollar amount per veteran served to each of VA's 22 health care networks. This amount varies depending upon the health care needs of the veteran served and local cost differences. This approach is designed to allocate resources commensurate with each network's workload in terms of veterans served and their health care needs. GAO

identified weaknesses in VERA's implementation. First, VERA excludes about one fifth of VA's workload in determining each network's allocation. Second, VERA does not account well for cost differences among networks resulting from variation in their patients' health care needs. Third, the process for providing supplemental resources to networks through VA's National Reserve Fund has not been used to analyze how the need for such resources is caused by potential problems in VERA's allocation, network inefficiency, or other factors.

VA Health Care: Expanded Eligibility Has Increased Outpatient Pharmacy Use and Expenditures (GAO-03-161, 08-NOV-02)

The Department of Veterans Affairs (VA) spent about $3.0 billion on its outpatient pharmacy benefit in fiscal year 2001. After VA implemented the Veterans' Health Care Eligibility Reform Act in 1999, more veterans could use VA outpatient care, including the pharmacy benefit, than before. Increased eligibility contributed to a doubling of the number of Priority 7 veterans using VA health care. Priority 7 veterans are primarily veterans with higher incomes and no service-connected disability. GAO was asked to report on Priority 7 veterans' use of the outpatient pharmacy benefit and VA's expenditures to provide this benefit. To do this, GAO reviewed VA pharmacy data on use and costs from fiscal years 1999 through 2001.

VA spent $418 million on the outpatient pharmacy benefit for Priority 7 veterans in fiscal year 2001. VA pharmacy expenditures for Priority 7 veterans in this year were offset by copayments for drugs. In fiscal year 2001, VA collected approximately $41 million in drug copayments from Priority 7 veterans by charging $2 for a 30-day or less supply. This reduced VA's net expenditures to $377 million. After VA implemented eligibility reform in 1999, Priority 7 veterans' use of the pharmacy benefit increased rapidly from about 11 million 30-day equivalents of drugs or supplies in fiscal year 1999 to about 26 million 30-day equivalents in fiscal year 2001. This resulted in more than a doubling of VA's net pharmacy expenditures for these veterans. Yet, net pharmacy expenditures for Priority 7 veterans remain a relatively small share of VA's total net spending for outpatient drugs and supplies. Most of VA's increased pharmacy spending during this period was for all other veterans--those with service-connected disabilities, low incomes, or certain other recognized statuses such as former prisoners of war. In fiscal year 2001, 87 percent of VA's net pharmacy expenditures were for these veterans.

VA Health Care: Implementation of Prescribing Guideline for Atypical Antipsychotic Drugs Generally Sound (GAO-02-579, 29-APR-02)

The Department of Veterans Affairs (VA) provides health care services to veterans who have been diagnosed with psychosis--primarily schizophrenia, a disorder that can substantially limit their ability to care for themselves, secure employment, and maintain relationships. These veterans also have a high risk of premature death, including suicide. Effective treatment, especially antipsychotic drug therapy, has reduced the severity of their illnesses and increased their ability to function in society. VA's guideline for prescribing atypical antipsychotic drugs is sound and

consistent with published clinical practice guidelines used by public and private health care systems. VA's prescribing guideline recommends that physicians use their best clinical judgment, based on clinical circumstances and patients' needs, when choosing among the atypical drugs. Most Veterans Integrated Service Networks (VISN) and facilities use VA's prescribing guideline; however, five VISNs have additional policies and procedures for prescribing atypical antipsychotic drugs. Although these procedures help manage pharmaceutical cost, they also have the potential to result in more weight given to cost than clinical judgment, which is inconsistent with the prescribing guideline.

VA Health Care: More National Action Needed to Reduce Waiting Times, but Some Clinics Have Made Progress (GAO-01-953, 31-AUG-01)

In fiscal year 2000, roughly four million patients made 39 million outpatient visits to more than 700 health care facilities nationwide, run by the Department of Veterans Affairs (VA). However, excessive waiting times for outpatient care have been a long-standing problem. To ensure timely access to care, VA established a goal that all nonurgent primary and specialty care appointments be scheduled within 30 days; clinics were to meet this goal by 1998. Yet, three years later, reports of long waiting times persist. Waiting times at the clinics in the 10 medical centers GAO visited indicate that meeting VA's 30-day standard is a continuing challenge for many clinics. Although most of the primary care clinics GAO visited (15 of 17) reported meeting VA's standard for nonurgent, outpatient appointments, only one-third of the specialty care clinics visited (18 of 54) met VA's 30-day standard. For the remaining two-thirds, waiting times ranged from 33 days at one urology clinic to 282 days at an optometry clinic. Although two-thirds of the specialty clinics GAO visited continued to have long waiting times, some were making progress in reducing waiting times, primarily by improving their scheduling processes and making better use of their staff. These successes were often the result of collaborative efforts with the Institute for Healthcare Improvement (IHI) a private contractor VA retained in July 1999—to develop strategies to reduce patient waiting times. Medical centers and clinics participating in VA's IHI project have received valuable information and strategies for successfully reducing waiting times. However, VA has only recently contracted with IHI to disseminate best practices agency-wide and VA has not established a national set of referral guidelines that could alleviate waiting times for specialty care.

VA Long-Term Care: Implementation of Certain Millennium Act Provisions Is Incomplete, and Availability of Noninstitutional Services Is Uneven (GAO-02-510R, 29-MAR-02)

The Department of Veterans Affairs (VA) spent about $3.1 billion on long-term care in fiscal year 2001. This amount is likely to increase as the veteran population ages. VA provides or pays for long-term care in institutional settings, such as nursing homes, or in veteran's own homes and other community locations. The Veterans Millennium Health Care and Benefits Act of 1999 required VA to offer long-term care services to eligible veterans, including in noninstitutional settings. More than two years after the act's passage, VA has not completely met the act's requirement that all eligible

veterans be offered adult day health care, respite care, and geriatric evaluation. Although VA published draft regulations that would make these three services available, the regulations were not finalized as of March 2002. To respond to the act's requirements before its draft regulations were finalized, VA issued a policy directive making these three services available in noninstitutional settings. At the time of GAO's review, however, access to these services was far from universal. Moreover, the availability of all VA noninstitutional long-term care services, including the newly required services, is uneven across the VA system.

VA Long-Term Care: Oversight of Community Nursing Homes Needs Strengthening (GAO-01-768, 27-JUL-01)

The Department of Veterans Affairs (VA) spent about $1.9 billion—or about 10 percent of its health care budget—to provide nursing home care to veterans in fiscal year 2000. VA will likely see increasing demand for nursing home care during the next decade. The number of veterans age 85 and older is expected to triple—from 422,000 veterans in 2000 to nearly 1.3 million in 2010. Among the very old, the prevalence of chronic health conditions and disabilities increases markedly. In addition, VA is required to provide long-term care to some veterans, which may further increase veterans' demand for nursing home care. Almost 73 percent of VA's nursing home care in fiscal year 2000 went to VA's 134 nursing homes; the rest went to state-owned and operated veterans' nursing homes (15 percent) or to community nursing homes under local or national contract to VA (12 percent). VA generally requires its medical center staff to conduct annual inspections of state veterans' homes and community nursing homes; it also requires monthly staff visits to veterans in community nursing homes. GAO found that VA's adherence to its oversight policies for state veterans' homes and community nursing homes has been mixed because of a lack of VA monitoring and oversight. VA medical staff are required to inspect each state veterans' home annually, and of the 86 inspections reviewed by GAO, about 85 percent were done within the time frame or shortly thereafter. VA lacks a departmentwide approach to monitoring medical centers' community nursing home oversight activities and enforcing VA's oversight policies--particularly regarding locally contracted homes, which make up about 75 percent of the community nursing homes under contract to VA—and individual medical centers vary in how well they have overseen community nursing homes. Under its planned policy change, VA would eliminate the requirement for annual inspections of community nursing homes and instead would rely on Medicare and Medicaid certification inspections. Local VA medical centers' staff will review state inspection reports and CMS data to evaluate community nursing homes. However, the quality of state inspections of nursing homes varies, and CMS is unable to accurately assess state inspection results in all cases.

Medicare Subvention Demonstration: DOD Costs and Medicare Spending (GAO-02-67, 31-OCT-01)

The Balanced Budget Act of 1997 authorized the Department of Defense (DOD) to conduct the Medicare subvention demonstration for a three-year period. Under this

demonstration, DOD formed Medicare managed care organizations—collectively called TRICARE Senior Prime—at six sites that provided the full range of Medicare-covered services as well as additional DOD-covered services, notably prescription drugs. The Medicare program was to pay DOD for Medicare-covered care of the enrolled military retirees if DOD continued to spend on all aged military retirees at least as much as it had historically. Under the subvention demonstration, Senior Prime enrollees' care in 1999 cost DOD far more than the Medicare capitation rate that was established for the demonstration. This mainly resulted from enrollees' heavy use of medical services, but DOD coverage of prescription drugs—not included in the Medicare benefit package—also contributed to its high costs. Without the demonstration, Medicare spending in 1999 for retirees who enrolled in Senior Prime would have been, on average, about 55 percent of the Senior Prime capitation rate. This was partly because Senior Prime enrollees were somewhat healthier than comparable Medicare beneficiaries, but mainly because Medicare would have paid for only part of the enrollees' care. DOD would have provided much of their care, which would not have been reflected in Medicare's spending on their behalf. The Balanced Budget Act's payment rules resulted in no Medicare payment to DOD in 1999. This was because they were designed to prevent the government from paying twice for the same care—once through DOD appropriations and again through Medicare. The rules also required that the payment be adjusted to account for Senior Prime enrollees' health status. Together, these two requirements resulted in Medicare paying nothing for care provided in 1999. Even without these two requirements, Medicare would have paid DOD less than the monthly capitation rate of $320 per person, because Congress had capped the Medicare payment for all enrollees at $60 million for 1999.

Medicare Subvention Demonstration: DOD's Pilot HMO Appealed to Seniors, Underscored Management Complexities (GAO-01-671, 14-JUN-01)

This interim report reviews the implementation of the Department of Defense (DOD) Medicare Subvention Demonstration. GAO found that the demonstration sites were successful in operating Medicare managed care plans. Officials put substantial effort into meeting Medicare managed care requirements and, according to Health Care Financing Administration reviewers, were generally as successful as other new Medicare managed care plans in this regard. Most sites reached the enrollment limits they had established for retirees already covered by Medicare. DOD officials indicated that the demonstration's effect was positive. Enrollees received a broader range of services from DOD than in the past, when they got care only when space was available in DOD facilities. Officials also noted that providing more comprehensive care to seniors helped sharpen the skills of military clinical staff, which contributed to their readiness for supporting combat or other military missions. Some challenges encountered in the demonstration reflect larger DOD managed care issues and may have implications for DOD managed care generally. Although access to care was generally good, the demonstration experienced some problems in maintaining adequate clinical staff.

Medicare Subvention Demonstration: Greater Access Improved Enrollee Satisfaction but Raised DOD Costs (GAO-02-68, 31-OCT-01)

In the Balanced Budget Act of 1997, Congress established a three-year demonstration, called Medicare subvention, to improve the access of Medicare-eligible military retirees to care at military treatment facilities (MTF). The demonstration allowed Medicare-eligible retirees to get their health care largely at MTFs by enrolling in a Department of Defense (DOD) Medicare managed care organization known as TRICARE Senior Prime. During the subvention demonstration, access to health care for many retirees who enrolled in Senior Prime improved, while access to MTF care for some of those who did not enroll declined. Many enrollees in Senior Prime said they were better able to get care when they needed it. They also reported better access to doctors in general as well as to care at MTFs. Enrollees generally were more satisfied with their care than before the demonstration. However, the demonstration did not improve enrollees' self-reported health status. In addition, compared to nonenrollees, enrollees did not have better health outcomes, as measured by their mortality rates and rates of "preventable" hospitalizations. Moreover, DOD's costs were high, reflecting enrollees' heavy use of hospitals and doctors.

Medicare Subvention Demonstration: Pilot Satisfies Enrollees, Raises Cost and Management Issues for DOD Health Care (GAO-02-284, 11-FEB-02)

The Department of Defense's (DOD) Medicare subvention demonstration tested alternate approaches to health care coverage for military retirees. Retirees could enroll in new DOD-run Medicare managed care plans, known as TRICARE Senior Prime, at six sites. The demonstration plan offered enrollees the full range of Medicare-covered services as well as additional TRICARE services, with minimal copayments. During the demonstration period, the program parameters were changed, allowing military retirees age 65 and older to become eligible for TRICARE coverage as of October 1, 2001, and Senior Prime was extended for one year. The demonstration showed that retirees were interested in enrolling in low-cost military health plans and that DOD was able to satisfy its Senior Prime enrollees. By the close of the initial demonstration period, about 33,000 retirees were enrolled in Senior Prime, and more were on waiting lists. When nonenrollees were asked why they did not join Senior Prime, more than 60 percent said that they were satisfied with their existing health coverage; few said that they disliked military care. Although the demonstration had positive results for enrollees, it also highlighted three challenges confronting the military health system in managing patient care and costs. First, care needs to be managed more efficiently. Although DOD satisfied enrollees and gave them good access to care, it incurred high costs. Second, DOD's efforts were hindered by limitations in its data and data systems. Finally, the demonstration illustrated the tension between the military health system's commitment to support military operations and promote the health of active-duty personnel and its commitment to provide care to dependents of active-duty personnel, retirees and their families, and survivors.

OTHER ISSUES

Electronic Transfers: Use by Federal Payment Recipients Has Increased but Obstacles to Greater Participation Remain (GAO-02-913, 12-SEP-02)

In 2001, the Department of the Treasury made 764 million payments valued at $549 billion to beneficiaries of federal programs, primarily programs administered by the Social Security Administration. Of these payments, 76 percent were made using electronic funds transfers (EFTs), potentially saving the government millions of dollars in costs associated with disbursing paper checks. In 1996, Congress passed legislation, which required that federal payments except tax refunds be made electronically as of January 1999. The act also required that each person affected by this mandate have access to an account at a financial institution at a reasonable cost and with certain consumer protections. To meet this requirement, Treasury developed the Electronic Transfer Account (ETA). Most recipients of federal benefits have their payments deposited electronically. The number of recipients using EFT climbed steadily throughout the 1990s, rising from around half to more than three-quarters of all beneficiaries. Treasury and the Social Security Administration (SSA) have undertaken activities to increase the use of direct deposit, including developing marketing material and directly notifying check recipients of the advantages of using EFT, particularly safety and convenience. Although information describing the characteristics of these EFT users is limited, GAO determined that participation rates are highest for those 65 and older. The primary obstacle to using EFT was that many federal check recipients did not have a bank account. GAO's analysis of the Survey of Income and Program Participation's 1998 data indicated that 11 million benefit recipients, over half of all federal benefit check recipients in 1998, were unbanked. The ETA has not been widely accepted by banks or unbanked beneficiaries despite Treasury's efforts to promote it. Since initiation of the program in 1999, 36,000 ETAs have been opened, representing fewer than 1 percent of unbanked beneficiaries. Based on discussions with representatives from Treasury, SSA, financial institutions, and consumer groups, GAO identified several approaches that Treasury could consider to increase the use of electronic transfers. These approaches include increasing cooperation between banks and local SSA offices to more effectively enroll beneficiaries for ETAs; exploring other electronic payment options besides the ETA to deliver benefits; partnering with banks to provide information on the general availability of low cost banking products, especially in areas with low ETA coverage; and conducting further research to determine why certain states have low direct deposit participation rates.

Information Technology Management: Social Security Administration Practices Can Be Improved (GAO-01-961, 21-AUG-02)

The Social Security Administration (SSA) needs to identify strengths and weaknesses within its agency-wide operational and managerial capabilities to enable the delivery of high-quality customer service in the face of increases in both workloads and in the number of retirements from its experienced workforce. Evaluating SSA's management of information technology (IT) is critical to assess whether the agency is

adequately addressing these capabilities. This report reviews SSA's IT policies, procedures, and practices in the following five areas: investment management, enterprise architecture, software acquisition and development, information security, and human capital. GAO found that SSA had many important IT management policies and procedures in place in each of these five key areas but did not always implement them consistently. In some areas, SSA had not established key policies, procedures, or practices essential to ensure that its IT was effectively managed. GAO found weaknesses in all of the five key areas of IT management—particularly in investment management and human capital management.

Record Linkage and Privacy: Issues in Creating New Federal Research and Statistical Information (GAO-01-126SP, 01-APR-01)

This study focuses on privacy issues related to record-linkage—a computer-based process that combines multiple of existing data on individual persons. Federally sponsored linkage projects conducted for research and statistical purposes have many potential benefits, such as informing policy debates; tracking program outcomes; or contributing knowledge that, in some cases, might benefit millions of people. Examples of record linkage in GAO's study include the use of administrative and survey data on the aging to provide a better understanding of health care and income security issues relevant to this population. Despite these benefits, concerns about personal privacy are relevant because linkages often involve data on identifiable persons. GAO describes (1) how record linkage can create new research and statistical information related to the aging and other populations, (2) why linkage heightens certain privacy issues, and (3) how data stewardship might be enhanced.

Testimonies: Calendar Years 2001 and 2002, Issues Affecting Older Americans

HEALTH ISSUES

Flu Vaccine: Steps Are Needed to Better Prepare for Possible Future Shortages (GAO-01-786T, 30-MAY-01)

Until the 2001 flu season, the production and distribution of influenza vaccine generally went smoothly. Last year, however, several people reported that they wanted but could not get flu shots. In addition, physicians and public health departments could not provide shots to high-risk patients in their medical offices and clinics because they had not received vaccine they ordered many months in advance, or because they were being asked to pay much higher prices for vaccine in order to get it right away. At the same time, there were reports that providers in other locations, even grocery stores and restaurants, were offering flu shots to everyone--including younger, healthier people who were not at high risk. This testimony discusses the delays in production, distribution, and pricing of the 2000-2001 flu vaccine. GAO found that manufacturing difficulties during the 2000-2001 flu season resulted in an overall delay of about six to eight weeks in shipping vaccine to most customers. This delay created an initial shortage and temporary price spikes. There is no system in place to ensure that high-risk people have priority for receiving flu shots when supply is short. Because vaccine purchases are mainly done in the private sector, federal actions to help mitigate any adverse effects of vaccine delays or shortages need to rely to a great extent on collaboration between the public and private sectors.

Health Insurance: Proposals for Expanding Private and Public Coverage (GAO-01-481T, 15-MAR-01)

Various approaches have been proposed to increase private and public health care coverage of uninsured persons. The success of these proposals will depend on several key factors. The impact of tax subsidies on promoting private health insurance will depend on whether the subsidies reduce premiums enough to induce uninsured low-income individuals to buy health insurance and on whether these subsidies can be made available at the time the person needs to pay premiums. The effectiveness of public program expansions will depend on states' ability and willingness to use any new flexibility to cover uninsured residents as well as develop effective outreach to enroll the targeted populations. Although crowd-out is a concern with any of the approaches, some degree of public funds going to those currently with private health insurance may be inevitable to provide stable health coverage for some of the 42 million uninsured Americans.

Health Products for Seniors: Potential Harm From 'Anti-Aging' Products (GAO-01-1139T, 10-SEP-01)

Dietary supplements marketed as anti-aging therapies may pose a potential for physical harm to senior citizens. Evidence from the medical literature shows that a variety of frequently used dietary supplements can have serious health consequences for seniors. Particularly risky are products that may be used by seniors who have underlying diseases or health conditions that make the use of the product medically inadvisable or supplements that interact with medications that are being taken concurrently. Studies have also found that these products sometimes contain harmful contaminants or much more of an active ingredient than is indicated on the label. Although GAO was unable to find any recent, reliable estimates of the overall economic harm to seniors from these products, it did uncover several examples that illustrate the risk of economic harm. The Food and Drug Administration (FDA) and the Federal Trade Commission (FTC) have identified several products that make advertising or labeling claims with insufficient substantiation, some costing consumers hundreds or thousands of dollars apiece. The potential for harm to senior citizens from health products making questionable claims has been a concern for public health and law enforcement officials. FDA and FTC sponsor programs and provide educational materials for senior citizens to help them avoid health fraud. At the state level, agencies are working to protect consumers of health products by enforcing state consumer protection and public health laws, although anti-aging and alternative products are receiving limited attention. This testimony summarized a September report (GAO-01-1129).

Health Workforce: Ensuring Adequate Supply and Distribution Remains Challenging (GAO-01-1042T, 01-AUG-01)

This testimony discusses (1) the shortage of healthcare workers and (2) the lessons learned by the National Health Service Corps (NHSC) in addressing these shortages. GAO found that problems in recruiting and retaining health care professionals could worsen as demand for these workers increases. High levels of job dissatisfaction among nurses and nurses aides may also play a crucial role in current and future nursing shortages. Efforts to improve the workplace environment may both reduce the likelihood of nurses and nurse aides leaving the field and encourage more young people to enter the nursing profession. Nonetheless, demographic forces will continue to widen the gap between the number of people needing care and the nursing staff available. As a result, the nation will face a caregiver shortage very different from shortages of the past. More detailed data are needed, however, to delineate the extent and nature of nurse and nurse aide shortages to assist in planning and targeting corrective efforts. Better coordination of NHSC placements, with waivers for foreign U.S.-educated physicians, could help more needy areas. In addition, addressing shortfalls in the Department of Health and Human Services (HHS) systems for identifying underservice is long overdue. HHS needs to gather more consistent and reliable information on the changing needs for services in underserved communities. Until then, it will remain difficult to determine whether

federal resources are appropriately targeted to communities of greatest need and to measure their impact.

Long-Term Care: Aging Baby Boom Generation Will Increase Demand and Burden on Federal and State Budgets (GAO-02-544T, 21-MAR-02)

As more and more of the baby boomers enter retirement age, spending for Medicare, Medicaid, and Social Security is expected to absorb correspondingly larger shares of federal revenue and threatens to crowd out other spending. The aging of the baby boomers will also increase the demand for long-term care and contribute to federal and state budget burdens. The number of disabled elderly who cannot perform daily living activities without assistance may double in the future. Long-term care spending from public and private sources--about $137 billion for persons of all ages in 2000--will rise dramatically as the baby boomers age. Without fundamental financing changes, Medicaid--which pays more than one-third of long-term care expenditures for the elderly--can be expected to remain one of the largest funding sources, straining both federal and state governments.

Long-Term Care: Baby Boom Generation Increases Challenge of Financing Needed Services (GAO-01-563T, 27-MAR-01)

The confluence of the aging baby boom generation, longer life expectancies, and evolving options for providing and financing long-term care services will require substantial public and private investment in long-term care and the development of sufficient capacity to serve this growing population. Spending for long-term care was about $134 billion in 1999. Medicaid and Medicare paid for nearly 58 percent of these services, contributing about $59 billion and $18 billion, respectively. Private long-term care insurance is viewed as a possible way to reduce catastrophic financial risk for the elderly needing long-term care and to relieve some of the financing burden now shouldered by public long-term care programs. Yet private insurance represents only about 10 percent of long-term care spending. Questions remain about the affordability of policies and the value of the coverage relative to the premiums charged. Although many states have adopted standards for long-term care policies, it is uncertain whether these standards have bolstered consumer confidence in the reliability of long-term care insurance. If long-term care insurance is to have a more significant role in addressing the baby boom generation's upcoming chronic health care needs, consumers must view the policies being offered as reliable, affordable products with benefits and limitations that are easy to understand.

Long-Term Care: Elderly Individuals Could Find Significant Variation in the Availability of Medicaid Home and Community Services (GAO-02-1131T, 26-SEP-02)

As the baby boomers age, spending on long-term care for the elderly could nearly quadruple by 2050. The growing demand for long-term care will put pressure on federal and state budgets because long-term care relies heavily on public financing, particularly Medicaid. Nursing home care traditionally has accounted for most

Medicaid long-term care expenditures, but the high costs of such care and the preference of many individuals to stay in their own homes has led states to expand their Medicaid programs to provide coverage for home- and community-based long-term care. GAO found that a Medicaid-eligible elderly individual with the same disabling conditions, care needs, and availability of informal family support could find significant differences in the type and intensity of home and community-based services that would be offered for his or her care. These differences were due in part to the very nature of long-term care needs--which can involve physical or cognitive disabling conditions--and the lack of a consensus as to what services are needed to compensate for these disabilities and what balance should exist between publicly available and family-provided services. The differences in care plans were also due to decisions that states have made in designing their Medicaid long-term care programs and the resources devoted to them. The case managers GAO contacted generally offered care plans that relied on in-home services rather than other residential care settings. However, the extent of in-home services offered varied considerably.

Long-Term Care: Implications of Supreme Court's Olmstead Decision Are Still Unfolding (GAO-01-1167T, 24-SEP-01)

In the Olmstead case, the Supreme Court decided that states were violating title II of the Americans with Disabilities Act of 1990 (ADA) if they provided care to disabled people in institutional settings when they could be appropriately served in a home or community-based setting. Considerable attention has focused on the decision's implications for Medicaid, the dominant public program supporting long-term care institutional, home, and community-based services. Although Medicaid spending for home and community-based service is growing, these are largely optional benefits that states may or may not choose to offer, and states vary widely in the degree to which they cover them. The implications of the Olmstead decision--in terms of the scope and the nature of states' obligation to provide home and community-based long-term care services--are still unfolding. Although the Supreme Court ruled that providing care in institutional settings may violate the ADA, it also recognized that there are limits to what states can do, given the available resources and the obligation to provide a range of services for disabled people. The decision left many open questions for states and lower courts to resolve. State programs also may be influenced over time as dozens of lawsuits and hundreds of formal complaints seeking access to appropriate services are resolved.

Medicare: Cost Sharing Policies Problematic for Beneficiaries and Program (GAO-01-713T, 09-MAY-01)

Medicare provides valuable and extensive health care coverage for beneficiaries. Nevertheless, significant gaps leave some beneficiaries vulnerable to sizeable financial burdens from out-of-pocket expenses. Medigap is a widely available source of supplemental coverage. This testimony discusses (1) beneficiaries' potential financial liability under Medicare's current benefit structure and cost-sharing requirements, (2) the cost of Medigap policies and the extent to which they provide additional coverage, and (3) concerns that Medigap's so-called "first dollar" coverage

undermines the cost control incentives of Medicare's cost-sharing requirements. GAO found that Medicare's benefits package and cost-sharing requirements leave beneficiaries liable for high out-of-pocket costs. Medigap policies pay for some or all Medicare cost-sharing requirements but do not fully protect beneficiaries from potentially significant out-of-pocket costs such as prescription drug coverage. Medigap first-dollar coverage eliminates the ability of Medicare's cost-sharing requirements to promote prudent use of services.

Medicare: Financial Outlook Poses Challenges for Sustaining Program and Adding Drug Coverage (GAO-02-643T, 17-APR-02)

The lack of outpatient prescription drug coverage may leave Medicare's most vulnerable beneficiaries with high out-of-pocket costs. Recent estimates suggest that, at any given time, more than a third of Medicare beneficiaries lack prescription drug coverage. The rest have some coverage through various sources--most commonly employer-sponsored health plans. Recent evidence indicates that this coverage is beginning to erode. The short- and long-term cost pressures facing Medicare will require substantial financing and programmatic reforms to put future Medicare on a sustainable footing. In the absence of a drug benefit, many Medicare beneficiaries obtain coverage through health plans, public programs, and the Medigap insurance market. The price, availability, and level of such coverage varies widely, leaving substantial gaps and exposure to high out-of-pocket costs for thousands. Despite pressures to adopt a prescription drug benefit, the rapidly rising cost of current obligations argues for careful deliberation and extreme caution in expanding benefits. GAO's long-term simulations show that the aging of the baby boomers and rising per capita health care spending will, absent meaningful reform, lead to massive fiscal challenges in future years.

Medicare: New Spending Estimates Underscore Need for Reform (GAO-01-1010T, 25-JUL-01)

Although the short-term outlook of Medicare's hospital insurance trust fund improved in the last year, Medicare's long-term prospects have worsened. The Medicare Trustee's latest projections, released in March, use more realistic assumptions about health care spending in the years ahead. These latest projections call into question the program's long-term financial health. The Congressional Budget Office also increased its long-term estimates of Medicare spending. The slowdown in Medicare spending growth in recent years appears to have ended. In the first eight months of fiscal year 2001, Medicare spending was 7.5 percent higher than a year earlier. This testimony discusses several fundamental challenges to Medicare reform. Without meaningful entitlement reform, GAO's long-term budget simulations show that an aging population and rising health care spending will eventually drive the country back into deficit and debt. The addition of a prescription drug benefits would boost spending projections even further. Properly structured reform to promote competition among health plans could make Medicare beneficiaries more cost conscious. The continued importance of traditional Medicare underscores the need to base adjustments to provider payments on hard evidence rather than on anecdotal

information. Similarly, reforms in the management of the Medicare program should ensure that adequate resources accompany increased expectations about performance and accountability. Ultimately, broader health care reforms will be needed to balance health care spending with other societal priorities.

Medicare: Use of Preventive Services is Growing but Varies Widely (GAO-02-777T, 23 -MAY-02)

Preventive health care services can extend lives and promote the well being of the nation's seniors. Medicare now covers 10 preventive services—three types of immunizations and seven types of screenings—and legislation has been introduced to cover additional services. However, not all beneficiaries avail themselves of Medicare's preventive services. Some may simply choose not to use them, but others may be unaware that these services are covered by Medicare. Although the use of Medicare preventive service is growing, it varies from service to service and by state, ethnic group, income, and level of education. To ensure that preventive services are delivered to those who need them, the Centers for Medicare and Medicaid Services (CMS) sponsors activities to increase their use. CMS now funds interventions to increase the use of three services—breast cancer screening and immunizations against the flu and pneumonia--in each state. CMS also pays for interventions to increase use of services by minorities and low-income beneficiaries with low usage rates. CMS is evaluating the effectiveness of current efforts and expects to have the evaluation results later in 2002.

Medicare Hospital and Physician Payments: Geographic Cost Adjustments Important to Preserve Beneficiary Access to Services (GAO-02-968T, 23-JUL-02)

This testimony discusses Medicare program payment adjustments to hospitals and physicians that account for geographic differences in costs. Because Medicare's hospital and physician payment systems are based on national rates, these geographic cost adjustments are essential to account for costs beyond providers' control and to ensure that beneficiaries have adequate access to services. If these adjustments are not adequate, this could affect providers' financial stability and their ability or willingness to continue serving Medicare patients. Medicare's payments to hospitals vary with the average wages paid in a hospital's labor market. Yet, some hospitals believe that the labor cost adjustment applied does not reflect the average wage in their labor market area. Medicare's labor cost adjustment does not adequately account for geographic differences in hospital wages in some areas because a single adjustment is applied to all hospitals in an area, even though it may encompass multiple labor markets or different types of communities within which hospitals pay significantly different average wages. Geographic reclassification addresses some inequities in Medicare's labor cost adjustments by allowing some hospitals that pay wages enough above the average in their area to receive higher labor cost adjustments. However, some hospitals can reclassify even though they pay wages that are comparable to the average in their area. To help ensure that beneficiaries in all parts of the country have access to services, Medicare adjusts its physician fee schedule on the basis of indexes designed to reflect cost differences

among 92 geographic areas. The adjustment is designed to help ensure that the fees paid appropriately reflect the cost of living and operating a practice in that area.

Medicare Management: Current and Future Challenges (GAO-01-878T, 19-JUN-01)

Medicare is a popular program that millions of Americans depend on for covering their essential health needs. However, the management of the program has fallen short of expectations because it has not always appropriately balanced or satisfied the needs of beneficiaries, providers, and taxpayers. For example, stakeholders expect that Medicare will price services prudently; that providers will be treated fairly and paid accurately; and that beneficiaries will clearly understand their program options and will receive services that meet quality standards. In addition, there are expectations that the agency will be prepared to implement restructuring or added benefits in the context of Medicare reform. Today's Medicare, although successful in some areas, may not be able to meet these expectations effectively without further congressional attention to its multiple missions, capacity, and flexibility. The program will also need to do its part by implementing a performance-based approach that articulates priorities, documents resource needs, and holds managers accountable for accomplishing program goals.

Medicare Outpatient Drugs: Program Payments Should Better Reflect Market Prices (GAO-02-531T, 14-MAR-02)

In some cases, Medicare pays significantly more for covered outpatient drugs than the actual costs to the physicians and pharmacy suppliers. Attempts to reduce these payments have been met with provider claims that overpayments for the drugs are needed to cover underpayments for administering or delivering them. Medicare's method for establishing drug payments is flawed. Medicare pays 95 percent of the average wholesale price (AWP), which, despite its name, is neither an average nor a price that wholesalers charge. Instead, it is a number that manufacturers derive using their own criteria. There are no requirements or conventions that AWP reflect the price of actual drug sales. Widely available prices for drugs in 2001 were substantially below AWP. For both physician-billed drugs and pharmacy supplier-billed drugs, Medicare payments often far exceeded widely available prices. Physicians and pharmacy suppliers contend that the excess payments for covered drugs are necessary to offset what they claim are inappropriately low Medicare payments or no such payments for services related to the administration or delivery of these drugs. Although physicians receive an explicit payment for administering drugs, Medicare's payment policies for delivering pharmacy supplier-billed drugs and related equipment are uneven. Pharmacy suppliers billing Medicare receive a dispensing fee for one drug type--inhalation therapy drugs--but not for other covered drugs, such as infusion therapy or covered oral drugs. Other payers and purchasers, such as private health plans and the Department of Veterans Affairs (VA), use different approaches to pay for or buy drugs that may be instructive for Medicare. In particular, VA uses the leverage from the volume of federal drug purchases to secure verifiable data on actual market transactions, and it uses the prices paid by manufacturers' best customers to set Federal Supply Schedule prices.

Medicare Physician Payments: Spending Targets Encourage Fiscal Discipline, Modifications Could Stabilize Fees (GAO-02-441T, 14-FEB-02)

Congress implemented a physician fee schedule and a fee update formula to moderate spending growth relative to specified Medicare spending targets. These spending targets increase annually to reflect higher costs for physician services, the growth in the overall economy, and changes in the number of Medicare beneficiaries. Physician fees are adjusted for changes in the costs of providing services and on actual cumulative spending compared to the cumulative targets. The annual update may increase or decrease fees depending on whether actual spending fell below or exceeded the targets. In November 2001, the Centers for Medicare and Medicaid announced that Medicare's fees would decline 5.4 percent from what was paid in 2001, despite an estimated 2.6 percent increase in the cost of physician inputs. This reduction occurred because historical cumulative spending exceeded the target by $8.9 billion, or 13 percent of estimated 2002 spending. Several factors contributed to the disparity between actual and targeted spending, including the correction of substantial errors in past spending estimates and the revision of targets for prior years. The current update mechanism could be modified to moderate fluctuations in physician fees and to ensure adequate payments, while retaining the fiscal discipline created by a spending target. Such modifications would need to balance concerns about preserving fiscal discipline on physician spending with the need to maintain adequate payment rates to ensure that beneficiaries have access to physician services. Because the paramount consideration in setting payment rates is ensuring appropriate beneficiary access to services, timely and detailed data on Medicare beneficiary service use are essential to achieving this balance.

Medicare Reform: Modernization Requires Comprehensive Program View (GAO-01-862T, 14-JUN-01)

Medicare faces many challenges. The overarching issue is how to sustain the program for future generations. Meeting that challenge will require difficult decisions that will affect beneficiaries, providers, and taxpayers. However, the financing issue should not obscure other important challenges. Medicare’s current cost-sharing arrangements do not encourage the efficient use of services without discouraging necessary care. Moreover, the lack of catastrophic coverage can leave some beneficiaries liable for substantial Medicare expenses. Finally, some aspects of Medicare’s program management are inefficient and lag behind modern private sector practices. Changes in Medicare's program management could improve both the delivery of health care to beneficiaries and the program’s ability to pay providers appropriately. Some view restructuring of the relationship between parts A and B as an important element of overall Medicare reform. Fundamentally, assessing the program as a whole is an important first step in addressing Medicare’s challenges. Solutions to many of these challenges could be crafted without restructuring. However, restructuring may provide opportunities to implement desired reforms--with or without unifying the Hospital Insurance and Supplemental Medical Insurance trust funds--while undoubtedly raising issues that will have to be considered.

Medigap: Current Polices Contain Coverage Gaps, Undermine Cost Control Incentives (GAO-02-533T, 14-MAR-02)

Medicare provides valuable and extensive health care coverage for 40 million elderly and disabled beneficiaries. Nevertheless, significant gaps leave some beneficiaries vulnerable to sizeable out-of-pocket expenses. Medicare provides no limit on out-of-pocket spending and no coverage for most outpatient prescription drugs. Most beneficiaries have supplemental coverage that helps to fill Medicare coverage gaps and pay some out-of-pocket expenses. Privately purchased Medigap policies are a widely available source of supplemental coverage. The other sources—employer-sponsored policies, Medicare + Choice plans, and Medicaid—are not available to all beneficiaries. Medigap policies help to fill in some of Medicare's gaps but also have shortcomings. In 1999, premiums paid for Medigap policies averaged $1,300, with more than 20 percent going to administrative costs. Medigap plans typically cover Medicare's required deductibles, coinsurance, and copayments but do not fully protect beneficiaries from potentially significant out-of-pocket costs. Medigap policies offering prescription drug coverage can be inadequate because beneficiaries still pay most of the cost and the Medigap benefit is capped.

Nursing Homes: Many Shortcomings Exist in Efforts to Protect Residents from Abuse (GAO-02-448T, 04-MAR-02)

Often suffering from multiple physical and mental impairments, the 1.5 million elderly and disabled Americans living in nursing homes are a highly vulnerable population. These individuals typically require extensive help with daily living, such as such as dressing, feeding, and bathing. Many require skilled nursing or rehabilitative care. In recent years, reports of inadequate care, including malnutrition, dehydration, and other forms of neglect, have led to mounting scrutiny from state and federal authorities. Concerns have also been growing that some residents are abused--pushed, slapped, or beaten--by the very individuals to whom their care has been entrusted. GAO found that allegations of physical and sexual abuse of nursing home residents are not reported promptly. Local law enforcement officials said that they are seldom summoned to nursing homes to immediately investigate allegations of abuse and that few allegations are ever prosecuted. Some agencies use different policies when deciding whether to refer allegations of abuse to law enforcement. As a result, law enforcement agencies were never told of some incidents or were notified only after lengthy delays. GAO found that federal and state safeguards intended to protect nursing home residents from abuse are inadequate. No federal statute requires criminal background checks for nursing home employees. Background checks are also not required by the Centers for Medicare and Medicaid Services, which sets the standards that nursing homes must meet to participate in the Medicare and Medicaid programs. State agencies rarely recommend that sanctions be imposed on nursing homes. Although state agencies compile lists of aids who have previously abused residents, which can prevent an aide from being hired at another nursing home, GAO found that delays in making these identifications can limit the usefulness of these registries. This testimony summarizes a March report (GAO-02-312).

Nursing Workforce: Multiple Factors Create Nurse Recruitment and Retention Problems (GAO-01-912T, 27-JUN-01)

While comprehensive data are lacking on the nature and extent of current difficulties recruiting and retaining nurses, current evidence suggests an emerging shortage. Several factors, including nurses' decreased levels of job satisfaction, are combining to constrain the current supply of nurses. Furthermore, like the general population, the nurse workforce is aging, and the average age of a registered nurse (RN) increased from 37 years in 1983 to 42 in 1998. Additionally, enrollments in registered nursing programs have declined over the past 5 years, shrinking the pool of new workers to replace those who are leaving or retiring. The problem is expected to become more serious in the future as the aging of the population substantially increases the demand for nurses.

Retiree Health Insurance: Gaps in Coverage and Availability (GAO-02-178T, 01-NOV-01)

In 1999, about 10 million Americans aged 55 and older relied on employer-sponsored health benefits until they became eligible for Medicare or to pay for out-of-pocket expenses not covered by Medicare. However, the number of employers offering these benefits has declined considerably during the past decade. Despite the recent strong economy and the relatively low increases in health insurance premiums during the late 1990's, the availability of employer-sponsored health benefits for retirees has declined. Two widely cited surveys found that only about one-third of large employers and less than 10 percent of small employers offer such benefits. Alternative sources of health care coverage for retirees may be costly, limited, or unavailable. Retirees not yet 65 may be eligible for coverage from a spouse's employer or continuation coverage, known as "COBRA," from their former employer. Other retirees not yet 65 may seek coverage in the individual insurance market, but these policies can be expensive or may offer more limited coverage, especially for those with existing health problems. Nearly one-third of retirees eligible for Medicare have employer-sponsored supplemental coverage, but many others buy private supplemental coverage known as "Medigap." It costs an average of $1,300 per year and more for Medigap policies that include prescription drug coverage. Neither Medicare nor private insurance covers a significant share of long-term care expenses.

INCOME SECURITY ISSUES

Private Pensions: Key Issues to Consider Following the Enron Collapse (GAO-02-480T, 27-FEB-02)

The collapse of the Enron Corporation and the resulting loss of employee retirement savings highlighted several key vulnerabilities in the nation's private pension system. Asset diversification was a crucial lesson, especially for defined contribution plans, in which employees bear the investment risk. The Enron case underscores the importance of encouraging employees to diversify. Workers need clear and understandable information about their pension plans to make sound decisions on retirement savings. Although disclosure rules require plan sponsors to provide participants with a summary of their plan benefits and rights and to notify them when benefits are changed, this information is not always clear, particularly in the case of complex plans like floor-offset arrangements. Employees, like other investors, also need reliable and understandable information on a company's financial condition and prospects. Fiduciary standards form the cornerstone of private pension protections. These standards require plan sponsors to act solely in the interest of plan participants and beneficiaries. The Enron investigations should determine whether plan fiduciaries acted in accordance with their responsibilities.

Social Security: Issues in Evaluating Reform Proposals (GAO-02-288T, 10-DEC-01)

This testimony discusses the long-term viability of the Social Security program. Social Security's Trust Funds will not be exhausted until 2038, but the trustees now project that the program's cash demands on the rest of the federal government will begin much sooner. Aiming for sustainable solvency would increase the chance that future policymakers would not have to face these difficult questions on a recurring basis. GAO has developed the following criteria for evaluating Social Security reform proposals: financing sustainable solvency, balancing adequacy and equity, and implementing and administering reforms. These criteria seek to balance financial and economic considerations with benefit adequacy and equity issues and the administrative challenges associated with various proposals. GAO's recent report on Social Security and income adequacy (GAO-02-62) makes three key points. First, no single measure of adequacy provides a complete picture; each measure reflects a different outlook on what adequacy means. Second, given the projected long-term financial shortfall of the program, it is important to compare proposals to both benefits at currently promised levels and benefits funded at current tax levels. Third, various approaches to benefit reductions would have differing effects on adequacy.

Social Security: Long-Term Financing Shortfall Drives Need for Reform (GAO-02-845T, 19-JUN-02)

Social Security not only represents the foundation of our retirement income system; it also provides millions of Americans with disability insurance and survivor's benefits. Although the Social Security Trustees now project that under the intermediate or "best estimate" assumptions the combined Social Security Trust

Funds will be exhausted 3 years later than in last year's estimates, the magnitude of the long-term funding shortfall is virtually unchanged. Without reform, Social Security, Medicare, and Medicaid are unsustainable, and the long-term impact of these entitlement programs on the federal budget and the economy will be dramatic. Social Security reform is part of a larger and significant fiscal and economic challenge. Absent reform, the nation will ultimately have to choose between persistent, escalating federal deficits, significant tax increases, or dramatic budget cuts. Focusing on trust fund solvency alone is not sufficient. Aiming for sustainable solvency would increase the chance that future policymakers would not have to face, on a recurring basis, the difficult questions of whether the government will have the capacity to pay future claims or what else will have to be squeezed to pay those claims. Comparing the beneficiary impact of reform proposals solely to current Social Security promised benefits is inappropriate since all current promised benefits are not funded over the longer term. Reform proposals should be evaluated as packages. If the focus is on the pros and cons of each element of reform, it may prove impossible to build the bridges necessary to achieve consensus. Acting sooner rather than later helps to ease the difficulty of change. Waiting until Social Security faces an immediate solvency crisis will limit the scope of feasible solutions and could reduce the options field to only those choices that are the most difficult and could also delay the really tough decisions on Medicare and Medicaid.

Social Security Administration: Systems Support Could Improve Processing Attorney Fee Payments in the Disability Program (GAO-01-710T, 17-MAY-01)

To ensure that people claiming disability insurance program benefits can obtain legal representation at a fair price, the Social Security Administration (SSA) is required to regulate the fees that attorneys charge people to represent their disability claims before the agency. Balancing the needs of the claimants with those of their attorneys, the law limits the amount of fees that attorneys can charge claimants, but also guarantees that those fees will be paid from the claimants' past-due benefits. Inefficiencies in the current process increase both the time it takes to pay the attorney fees and the cost of administration. One segment of attorney fee processing--the fee approval process--was substantially simplified in 1991. Systems support could streamline the second segment of the processing--the fee payment--thus lowering the annual administrative costs and cutting processing time. Automation of this final segment of the fee process could help improve customer service for both claimants and their attorneys.

VETERANS/DOD ISSUES

VA and Defense Health Care: Potential Exists for Savings through Joint Purchasing of Medical and Surgical Supplies (GAO-02-872T, 26-JUN-02)

The Department of Veterans Affairs (VA) spent $500 million and the Department of Defense (DOD) spent $240 million for medical and surgical supplies in fiscal year 2001. To achieve greater efficiencies through improved acquisition processes and increased sharing of medical resources, VA and DOD signed a memorandum of agreement in 1999 to combine their buying power. VA and DOD saved $170 in 2001 by jointly procuring pharmaceuticals, agreeing on particular drugs to be purchased, and contracting with the manufacturers for discounts based on their combined larger volume. However, VA and DOD have not awarded joint national contracts for medical and surgical supplies as envisioned by their memorandum of agreement, and it is unlikely that the two departments will have joint national contracts for supplies anytime soon. The lack of progress in jointly contracting for medical and surgical supplies has, in part, been the result of different approaches VA and DOD have taken to standardizing medical and surgical supplies. Other impediments to joint purchasing have been incomplete procurement data and the inability to identify similar high-volume, high-dollar purchases. Nevertheless, a few VA and DOD facilities have yielded modest savings through local joint contracting agreements.

VA and DOD Health Care: Factors Contributing to Reduced Pharmacy Costs and Continuing Challenges (GAO-02-969T, 22-JUL-02)

The Department of Veterans Affairs (VA) and the Department of Defense (DOD) pharmacy expenditures have risen significantly, reflecting national trends. The increase in pharmacy costs would have been even greater if not for the efforts taken by VA and DOD. GAO identified four important factors that have contributed to reduced pharmacy spending by VA and DOD. First, the two departments have used formularies to encourage the substitution of lower-cost drugs that are determined to be just as effective as higher-cost drugs. Second, VA and DOD have been able to effectively employ different arrangements to pay for or purchase prescription drugs at substantial discounts. Third, VA has significantly reduced the cost of dispensing prescription refills by using highly automated and less expensive consolidated mail outpatient pharmacy (CMOP) centers to handle a majority of the pharmacy workload. Fourth, VA and DOD have reduced costs by leveraging their combined purchasing power through joint procurement of generic prescription drugs. Nevertheless, one of the most important challenges is the joint procurement of brand name drugs. Although brand name drugs account for the bulk of prescription drug expenditures, most of VA/DOD joint contracts have been for generic drugs. Generic drugs are easier to contract for because these products are already known to be chemically and therapeutically alike. Contracting for brand name drugs is more difficult because of the scientific reviews needed to gain clinical agreement on therapeutic equivalence of competing drugs. Joint purchasing of brand name drugs is also more difficult due to the significant differences between the VA and DOD health care systems in patient

populations, national formularies, and prescribing patterns of providers, some of whom are private physicians.

VA Health Care: Changes Needed to Improve Resource Allocation (GAO-02-685T, 30-APR-02)

The Veterans Equitable Resource Allocation (VERA) system allocated $17.8 billion of its $20.3 billion health care budget to 22 regional health care networks in fiscal year 2001. Before VERA resources were allocated to facilities on the basis of their historical expenditures. By aligning resources with workloads VERA shifted about$921 million among VA's networks in fiscal year 2001. VERA's design is reasonable for equitably allocating resources, but improvements could better allocate comparable resources for comparable workloads. VERA's allocations are based primarily on network workload, with adjustments made for factors beyond the control of network management. These include the health care needs of veterans and some local cost differences. VERA's design also protects patients from the effects of network budget shortfalls. However, GAO found that $200 million annually that could be reallocated to better align network resources with workloads. First, VERA's measurement of network workload is not accurate enough to determine each network's allocation because VERA excludes most veterans with higher incomes who do not have service-connected disabilities--about one-fifth of VA's workload. Second, VERA does not accurately adjust for cost differences among networks for differences in patients' health care needs or case mix across networks. GAO also found that the Veterans Administration has not analyzed whether the networks' need for supplemental resources--provided through the National Reserve Fund--is the result of potential problems in VERA, network inefficiency, or other factors. Without such information, VA can neither ensure the appropriateness of supplemental funding nor take corrective action.

VA Health Care: Changes Needed to Improve Resource Allocation to Health Care Networks (GAO-02-744T, 14-MAY-02)

The Department of Veterans Affairs (VA) spent $21 billion in fiscal year 2001 to treat 3.8 million veterans--most of whom had service-connected disabilities or low incomes. Since 1997, VA has used the Veterans Equitable Resource Allocation (VERA) system to allocate most of its medical care appropriation. GAO found that VERA has had a substantial impact on network resource allocations and workloads. VERA shifted $921 million from networks primarily in the northeast and midwest to networks in the south and west in fiscal year 2001. VERA, along with other VA initiatives, has provided an incentive for networks to serve more veterans. In GAO's view, VERA's overall design is a reasonable approach to allocating resources according to workloads. It provides a predetermined dollar amount per veteran served to each of VA's 22 health care networks. This amount varies depending upon the health care needs of the veteran served and local cost differences. However, GAO identified weaknesses in VERA's implementation. First, VERA excludes about one fifth of VA's workload in determining each network's allocation. Second, VERA does not account well for cost differences among networks resulting from variation in

their patients' health care needs. Third, the process for providing supplemental resources to networks through VA's National Reserve Fund has not been used to analyze how the need for such resources is caused by potential problems in VERA's allocation, network inefficiency, or other factors. This testimony is based on an April report (GAO-02-338).

VA Health Care: Community-Based Clinics Improve Primary Care Access (GAO-01-678T, 02-MAY-01)

This testimony discusses the Veterans Health Administration's (VHA) efforts to improve veterans' access to health care through its Community-Based Outpatient Clinics Initiative. Overall, through its clinics, VHA is steadily making primary care more available within reasonable proximity of patients who have used VHA's system in the past. However, the uneven distribution of patients living more than 30 miles from a VHA primary care facility suggests that access inequities across networks may exist. Also, the improvements likely to result from VHA's planned clinics indicate that achieving equity of access may be difficult. In addition, GAO's assessment suggests that new clinics may have contributed to, but are not primarily responsible for, the marked rise in the number of higher-income patients who have sought health care through VHA in recent years. Although the clinics have undoubtedly attracted some new patients to VHA, GAO's analysis suggests that new patients would have sought care at other VHA facilities in the absence of the new clinics. Enhanced benefits and access improvements afforded by eligibility reform may have attracted more new patients, including those with higher incomes.

VA Health Care: Continuing Oversight Needed to Achieve Formulary Goals (GAO-01-998T, 24-JUL-01)

Although the Department of Veterans Affairs (VA) has made significant progress establishing a national formulary that has generally met with acceptance by prescribers and patients, VA oversight has not fully ensured standardization of its drug benefit nationwide. The three medical centers GAO visited did not comply with the national formulary. Specifically, two of the three medical centers omitted more than 140 required national formulary drugs, and all three facilities inappropriately modified the national formulary list of required drugs for certain drug classes by adding or omitting some drugs. In addition, as VA policy allows, Veterans Integrated Service Networks (VISN) added drugs to supplement the national formulary ranging from five drugs at one VISN to 63 drugs at another. However, VA lacked criteria for determining the appropriateness of the actions networks took to add these drugs. In addition to problems standardizing the national formulary, GAO identified weaknesses in the nonformulary approval process. Although the national formulary directive requires certain criteria for approving nonformulary drugs, it does not prescribe a specific nonformulary approval process. As a result, the processes health care providers must follow to obtain nonformulary drugs differ among VA facilities on how requests are made, who receives them, who approves them, and how long it takes to obtain approval. GAO found that the length of time to approve nonformulary drugs averages nine days, but it can be as short as a few minutes in some medical

centers. Some VISNs have not established processes to collect and analyze data on nonformulary requests. As a result, VA does not know if approved requests meet its established criteria or if denied requests are appropriate. This testimony summarizes the December 1999 report, HEHS-00-34 and the January 2001 report, GAO-01-183.

VA Long-Term Care: The Availability of Noninstitutional Services Is Uneven (GAO-02-652T, 25-APR-02)

Noninstitutional long-term care services are delivered by the Department of Veterans Affairs (VA) to veterans in their own homes and other community locations. The Veterans Millennium Health Care and Benefits Act requires VA to offer long-term care services to eligible veterans, including services provided in noninstitutional settings. More than two years after the act's passage, VA has yet to offer eligible veterans adult day health care, geriatric evaluation, or respite care. Although VA published proposed regulations that would make these services available in noninstitutional settings to eligible veterans, the regulations had not been finalized as of April 17, 2002. To be responsive before its draft regulations were made final, VA issued a policy directive requiring that these three services be available in noninstitutional settings. GAO found, however, that both the services required by the act and VA's other noninstitutional services were unevenly available across the VA system.

Veterans' Health Care: Observations on VA's Assessment of Hepatitis C Budgeting and Funding (GAO-01-661T, 25-APR-01)

The Department of Veterans Affairs (VA) requested and received $195 million for Hepatitis C screening and treatment in fiscal year 2000. VA's budget documentation showed that it had spent $100 million on Hepatitis C screening and treatment, leaving a difference of $95 million between its estimated and actual expenditures. However, GAO's review revealed that the difference was actually much larger--$145 million. VA's documentation showed that only $50 million was used for budgeted activities and $50 million was used for an activity not included in its original budget--treatment of conditions related to Hepatitis C. It appears that VA is unable to develop a budget estimate that can reliably forecast its Hepatitis C funding needs at this time. However, VA's Veterans Health Administration (VHA) appears to be taking reasonable steps to improve future budget estimates and thereby minimize the potential for large differences. Such steps include developing a Hepatitis C patient registry that could provide the critical data needed to improve budgetary estimates. However, this registry could take as long as 15 months to become operational, which suggests that it may not provide budgetary data in time to formulate the 2004 budget. In the meantime, VHA's ongoing efforts to upgrade its data collection systems should help improve budget estimates for fiscal year 2002. These efforts, however, have provided only minimal help in the development of VA's 2002 budget for Hepatitis C spending. As a result, it is not possible to conclude with certainty whether VA's fiscal year 2002 spending estimate of $171 million is appropriate.

Veterans' Health Care: Standards and Accountability Could Improve Hepatitis C Screening and Testing Performance (GAO-01-807T, 14-JUN-01)

Three years ago, the Department of Veterans Affairs (VA) characterized hepatitis C as a serious national health problem that needs early detection to reduce transmission risks, ensure timely treatment, and prevent progression of liver disease. In a 1988 letter, VA outlined the process clinicians should use when (1) screening veterans for known risk factors for exposure to hepatitis C and (2) ordering tests to detect antibodies and diagnose hepatitis C infection as part of a plan to evaluate and assess risk factors for VA patients. This testimony discusses VA's progress in screening and testing veterans for hepatitis C during fiscal years 1999 and 2000. GAO found that VA missed opportunities to screen as many as three million veterans when they visited medical facilities during fiscal years 1999 and 2000, potentially leaving as many as 200,000 veterans unaware that they have hepatitis C infections. Of those screened, an unknown number likely remain undiagnosed because of flawed procedures. Although the pace of screening and testing appears to be improving, many currently undiagnosed veterans may not be identified expeditiously unless VA (1) establishes early detection of hepatitis C as a standard for care and (2) holds facility managers accountable for timely screening and testing of veterans who visit VA medical facilities.

OTHER ISSUES

Budget Issues: Long-Term Fiscal Challenges. (GAO-02-467T, 27-FEB-02)

Combating terrorism and ensuring homeland security have created urgent claims on the nation's attention and on the federal budget. At the same time, the fiscal pressures created by the retirement of the baby boomers and rising health care costs continue unchanged. Because the longer-term outlook is driven in large part by known demographic trends, the outlook 20 years from now is surer than the forecast for the next few years. The message of GAO's updated simulations remains the same: absent structural changes in entitlement programs for the elderly, persistent deficits and escalating debt will overwhelm the budget in the long term. Both longer-term and new commitments undertaken after September 11 sharpen the need for careful scrutiny of competing claims and new priorities. A fundamental review of existing programs and activities is necessary both to increase fiscal flexibility and to make government fit the modern world. Stated differently, there is a need to consider the proper role of the federal government in the 21st century and how government should do business. The fiscal benchmarks and rules that moved the country from deficit to surplus expire this fiscal year. Any successor system should include a debate about reprioritization today and a better understanding of the long-term implications of different policy choices. Many things that the nation may be able to afford today may not be sustainable in the future.

Homelessness: Improving Program Coordination and Client Access to Programs. (GAO-02-485T, 06-MAR-02)

Many people are homeless for only a short time and get back on their feet with minimal assistance, but others are chronically homeless and need intensive and ongoing assistance. Fifty federal programs exist to help the homeless with housing. Sixteen of these are targeted exclusively to the homeless, and the others are mainstream programs. Targeted programs were funded at $1.7 billion in fiscal year 2001. GAO found that the Department of Housing and Urban Development (HUD) has been unable to ensure that adequate coordination occurs among the programs without creating undue administrative burdens for the states and communities. Steps have been taken to improve the coordination of homeless assistance programs within communities and to reduce some of the administrative burdens caused by separate programs. Although low-income populations face barriers to obtaining services provided by mainstream programs, these barriers are compounded by homelessness. In addition, the underlying structure and operations of federal mainstream programs do not ensure that the special needs of homeless people are met. Consolidating HUD's McKinney-Vento programs could help reduce the administrative burden. However, to end chronic homelessness in 10 years, federal agencies must strive to eliminate the barriers that homeless people encounter as they seek services from mainstream programs.

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