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160522

Health, Education and Human Services Division

B-279926

May 20, 1998

The Honorable Nancy L. Johnson
Chairman, Subcommittee on Oversight
Committee on Ways and Means
House of Representatives

Subject: Implementation of HIPAA: State-Designed Mechanisms for Group-to-Individual Portability

Dear Madam Chairman:

This letter responds to your request for information on alternative state approaches to implementing the group-to-individual portability provision of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). As you know, we recently reported that,[1] during the first-year implementation of HIPAA, some consumers encountered access barriers and high premiums while trying to exercise their portability rights in the individual markets of the 13 states to which the federal rules apply.[2] However, states could also choose to implement group-to-individual portability through an "alternative mechanism" approach. States choosing to do so were to submit a mechanism, which must adhere to minimum criteria set by federal law and regulations, to HCFA by April 1, 1997. Generally, an alternative mechanism must (1) offer a choice of

[1]The Health Insurance Portability and Accountability Act of 1996: Early Implementation Concerns (GAO/HEHS-97-200R, Sept. 2, 1997), and Health Insurance Standards: New Federal Law Creates Challenges for Consumers, Insurers, Regulators (GAO/HEHS-98-67, Feb. 25, 1998).

[2]These rules are commonly referred to as the "federal fallback" approach. Two of the 13 states (Mass. and Mich.) submitted an alternative mechanism to HCFA. However, their legislatures have not enacted implementing legislation. HCFA has not yet made an official finding that they are not implementing an acceptable alternative mechanism.

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guaranteed-access coverage to all eligible individuals,[3] (2) impose no preexisting condition exclusions, and (3) adopt one of several approaches relating to risk spreading. These approaches include a standard high-risk pool approach (which includes a 200-percent premium cap) and any other approach that provides for risk adjustment, risk spreading, or a financial subsidy to eligible individuals.

Because of concerns about the access barriers and premium rates encountered in those states operating under the federal rules, you asked us to describe the other states' alternative mechanisms and their risk-spreading and other approaches to making coverage more affordable for HIPAA-eligible people. Accordingly, this correspondence discusses the two types of alternative mechanism:

- high-risk pools, which some states use to guarantee HIPAA-eligibles' access to more affordable coverage; and

- guaranteed-issue requirements and the related methods of moderating premiums, which other states have adopted.[4]

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[3]Federal law and regulations require that eligible individuals have access to a choice of coverage. The coverage must include at least one "policy form" comparable to either comprehensive coverage in the state's individual health insurance market or standard coverage under the state's group- or individual-market laws. An eligible individual is defined as one with at least 18 months of prior coverage, most recently under a group plan, and with no break in coverage of more than 63 days. Furthermore, the individual must first exhaust any continuation coverage available, such as that established under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA); not be eligible for any other group coverage, Medicare, or Medicaid; and not have lost group coverage because of nonpayment of premiums or fraud. (States may choose to define an eligible individual more broadly than federal law and regulations do.)

[4]A high-risk pool is typically a state-created, nonprofit association that offers comprehensive health insurance to individuals with preexisitng health problems who could not obtain coverage in the individual market or could do so only at premium rates considered prohibitively expensive. Risk pools generally receive a subsidy–often in the form of assessments on carriers in the state–to keep premiums more affordable than they otherwise would be. Under a guaranteed-issue requirement, carriers must offer coverage to all eligible individuals–regardless of health status.

Enclosure I summarizes the characteristics of each state's proposed approach as submitted to HCFA.

To develop this information, we visited the Health Care Financing Administration (HCFA) and reviewed documents and correspondence that each state submitted concerning its planned mechanism. We did not review each state's insurance statutes, but based our analyses on the documentation submitted by the states and used by HCFA as the basis for its acceptance of the mechanism. We supplemented these data with discussions with HCFA officials and state insurance regulators and reviewed other sources of information concerning state insurance regulation. We did not evaluate the states' actual implementation experience with the alternative mechanisms. Also, because our primary data source–HCFA files–pertains to planned approaches as reported to HCFA in 1997, this correspondence does not reflect features of any state's mechanism that may have been modified subsequently. However, any significant changes must be provided to HCFA and, according to a HCFA official, it has not been notified of any such changes. We conducted our review during April 1998 in accordance with generally accepted government auditing standards.

In summary, most states include as part of their alternative mechanisms regulations of premium rates, a requirement for risk spreading, or a subsidy. Designed to moderate the high rates anticipated for the less healthy, high-cost HIPAA-eligibles, these methods are used in almost all of the 37 alternative mechanism states–of which 22 employ a high-risk pool and 15 have a guaranteed-issue requirement for carriers.[5] In contrast, the federal rules, under which 13 states operate, do not address premium rates or contain an explicit risk-spreading requirement under all circumstances.[6]

Under the risk-pool approach, eligible individuals who have lost group coverage are guaranteed a choice of coverage options within a state's high-risk pool program. Most of the 22 states using high-risk pools had them in place before HIPAA was enacted; to meet federal criteria for an acceptable alternative mechanism, states merely had to modify certain rules. Each state using the risk-pool approach caps premium rates for coverage in the pool at 200 percent or less of the rate that a healthy individual would pay in the individual

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[5]The District of Columbia is included among the alternative mechanism states. Kentucky received a temporary exemption from HIPAA rules and consequently is not counted among the federal fallback or alternative mechanism states.

[6]For details, see GAO/HEHS-98-67, Feb. 25, 1998, p. 9.

insurance market. Seven states have a 200-percent cap, 14 states have a 125- to 175-percent cap, and 1 state has a 100-percent cap (that is, those enrolled in the high-risk pool are to be charged the same as healthy people in the individual market). A subsidy mechanism, typically assessments on health insurance carriers, spreads the additional costs of the less healthy across multiple carriers.

Under the guaranteed-issue approach in 15 states, certain carriers must offer individual market coverage to HIPAA-eligible individuals, similar to the federal fallback approach. However, in contrast to some federal fallback states, most states with the guaranteed-issue requirement also try to moderate rates, often as part of state insurance reforms predating HIPAA. Some of these states regulate premium rates and others explicitly require risk spreading. Six states subject coverage available to HIPAA-eligible individuals to some form of community rating; that is, with limited exceptions, all individuals are charged the same price for coverage. Three states use rate banding or other premium regulations that allow rates to vary within specified bounds. Three states cap premium rates at 150 or 200 percent of the standard rate. Another two states do not regulate rates directly but use an explicit risk-spreading requirement that may moderate rates for HIPAA-eligible individuals indirectly. Finally, two states' alternative mechanisms contain neither premium rate regulation nor an explicit risk-spreading requirement.

HIGH-RISK POOLS AS AN ALTERNATIVE MECHANISM INCLUDE CAPS ON PREMIUMS

Twenty two states use a high-risk pool to guarantee access to coverage for HIPAA-eligible individuals.[7] These risk pools generally were operating before HIPAA was enacted; the states merely had to modify certain rules to use the risk pool as the alternative mechanism.[8] As a result, most risk pools now offer coverage to both HIPAA-eligibles and non-HIPAA-eligible high-risk individuals. However, for HIPAA-eligibles, the pools may operate under a different set of rules that meet the test of an acceptable alternative mechanism. For example, risk pools generally impose a preexisting condition exclusion period–commonly 6 months–on new enrollees. States had to waive this requirement for HIPAA-eligibles. In addition, some states that offered only one plan under the risk

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[7]Three of the 22 states use a high-risk pool in combination with guaranteed-issue or mandatory conversion coverage.

[8]Only one state, Alabama, created a high-risk pool exclusively for use as an alternative mechanism.

pool had to make a second coverage option available to HIPAA-eligibles to provide a choice of coverage options. Finally, several risk pools contain a minimum state residency period clause that must be waived for HIPAA-eligibles.

Premiums Capped at 200 Percent or Less of the Standard Rate

Premium caps limit the cost of coverage, while a subsidy mechanism is used to cover any excess losses. Federal law and regulations require that high-risk pool alternative mechanisms meet the standards in a model approach set forth by the National Association of Insurance Commissioners (NAIC). This model includes a premium cap of 200 percent of the standard rate. That is, coverage for high-risk individuals through the pool may cost no more than 200 percent of what a similar but healthy individual would be charged in the individual insurance market. Seven of the 22 high-risk pool states have a 200-percent cap, while another 14 impose a lower cap–between 125 and 175 percent of standard rates. One risk pool limits premiums for HIPAA-eligibles to the standard rate.

Because premium caps may result in benefit costs exceeding premium revenues, a subsidy mechanism is needed to cover the excess costs. Most risk pools make use of an annual, proportional assessment on carriers selling health coverage in the state to cover such losses. As a result, the excess costs of insuring high-risk individuals are spread in a predictable manner across multiple carriers. Nineteen of 22 state high-risk pool alternative mechanisms rely exclusively on carrier assessments. One state funds its high-risk pool from state revenues, and two others use some combination of carrier assessments, state revenues, or taxes on or reduced payments to providers.

MOST STATES THAT IMPOSE GUARANTEED-ISSUE REQUIREMENTS ON CARRIERS ALSO SEEK TO MODERATE PREMIUMS

To ensure access to coverage for HIPAA-eligibles, the remaining 15 states require certain carriers to guarantee that they will issue health insurance products to HIPAA-eligible applicants. Twelve of these states rely exclusively on such a requirement. Like high-risk pools, these requirements were generally in effect as part of earlier state insurance market reforms. To make existing guaranteed-issue requirements acceptable as an alternative mechanism, some states only had to make minor modifications. For example, Maine had to delete its length of residency requirement for HIPAA-eligibles. Two states had to modify requirements pertaining to the length of allowable gaps in coverage; New Hampshire had permitted no gap in coverage, while New Jersey had permitted a gap of up to 30 days. Both states had to provide for the HIPAA-

specified 63-day gap, at least when the guaranteed-issue requirement applies to HIPAA-eligible individuals.

Pennsylvania requires only Blue Cross and Blue Shield plans to provide coverage to HIPAA-eligibles.[9] Consistent with the plans' historic role of insurer of last resort in that state, each of four "Blues plans" operating in Pennsylvania must issue individual-market coverage to HIPAA-eligible applicants.

Three states combine a guaranteed-issue requirement in the individual market with another mechanism. Georgia, Florida, and Ohio have a two-tiered approach keyed to whether the individual's prior group coverage was insured by a carrier or self-funded by the employer. If the prior group coverage was through a carrier, that carrier must offer eligible individuals a choice of mandatory conversion plans. If the prior coverage was self-funded, eligible individuals have access to coverage in the individual market.[10] This dual approach results in the excess costs of high-risk individuals being spread among more carriers in both the individual and group markets.

Most Guaranteed-Issue Approaches Include Premium Regulation or Risk- Spreading

Seeking to moderate premiums for HIPAA-eligible individuals, 12 of the 15 individual market guaranteed-issue states also regulate premium rates. Six states require various degrees of community rating in the individual market. Under community rating, carriers must set the same premium for all enrollees, with limited adjustments in some instances for cost-related factors such as age, gender, or geographic location. Three states use a rate-band approach or other premium rate regulations that allow rates to vary more widely, although within specified bounds. Finally, three states include premium rate caps of 150 or 200 percent–a method similar to that used with high-risk pools.

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[9]Michigan had intended to use a similar approach. However, since necessary state legislation did not pass in 1997, the federal fallback approach became effective by default, and with enforcement left to HCFA.

[10]Ohio allows eligible individuals to choose either the mandatory conversion option or guaranteed issue by individual market issuers.

In two of the four[11] states with no direct regulation of premiums, explicit risk-spreading requirements may moderate rates for HIPAA-eligible individuals indirectly. Florida does not regulate premium rates in the individual market guaranteed-issue portion of its alternative mechanism. However, Florida's requirement that precludes carriers from selling an insurance product with fewer than 2,000 enrollees may prevent or minimize the impact of any segregation of HIPAA-eligibles into separate pools. Pennsylvania requires Blues plans to subsidize individual market coverage from group market contracts. This would help spread the costs of less-healthy HIPAA-eligibles across a larger base of enrollees.

Finally, two alternative mechanism approaches, which are modeled on the federal rules, contain neither premium rate regulations nor an explicit risk-spreading requirement. In the District of Columbia, carriers must issue to eligible individuals at least two products being marketed to other individuals. In Virginia, carriers must issue to eligible applicants all individual market coverage that the carriers sell. Consequently, under these two approaches, health insurance products may not be created for and marketed to HIPAA-eligibles exclusively. However, depending on how carriers interpret these requirements and how the states enforce them, the possibility exists that eligible individuals could be segregated from others for rating purposes. That is, while HIPAA-eligibles may have access to the same coverage options as other individuals, they may be placed in separate pools for purposes of determining premium rates. (This has occurred in several federal fallback states.) This formation of separate pools could result in HIPAA-eligibles' premiums being significantly higher than the standard rates, as has occurred in some federal fallback states.

AGENCY COMMENTS

In commenting on a draft of this correspondence, HCFA stated that the draft characterized fairly the state alternative mechanisms as of July 1, 1997. HCFA emphasized that although this correspondence describes the states' proposed mechanisms, some states may not have implemented these mechanisms as they were proposed. In addition, HCFA cited limited resources as impeding its monitoring of state legislative action and enforcement regarding HIPAA. HCFA

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[11]Florida is counted twice because its guaranteed-issue requirement contains two components–one includes a premium rate cap and the other includes an explicit risk-spreading requirement.

also provided technical comments, which we incorporated as appropriate. Enclosure II contains HCFA's comments.

This information was developed by Randy DiRosa under the direction of Jonathan Ratner. Please call me at (202) 512-7114 if you or your staff have any questions concerning this correspondence.

Sincerely yours,

William J. Scanlon
Director, Health Financing and
Systems Issues

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SUMMARY OF STATE ALTERNATIVE MECHANISMS

State	Effective date	General approach	Explicit risk-spreading or subsidy mechanism	Premium rate controls[a]	Health plan options
Ala.	1/1/98	High-risk pool.	Subsidy from annual assessments on carriers selling health coverage.	125- to 150-percent initial premium, 200-percent cap.	Two plans: one major medical plan with various deductibles and one health maintenance organization (HMO) plan.
Alaska	1/1/98	High-risk pool.	Subsidy from annual assessments on carriers selling health coverage.	200-percent cap.	Comprehensive plan with multiple deductibles.
Ark.	7/1/97	High-risk pool.	Subsidy from annual assessments on carriers selling health coverage.	150-percent cap.	Comprehensive preferred provider organization (PPO) plan with a choice of coinsurance and deductible levels.
Conn.	7/1/97	High-risk pool.	Subsidy from annual assessments on carriers selling health coverage.	125-percent initial premium, 150-percent cap.	Comprehensive HMO and PPO plan.
D.C.	1/1/98	Guaranteed issue of individual market coverage.	None.	None.	For each individual market carrier, (1) all of its individual market plans, (2) its two most popular plans, or (3) two representative plans with a higher and a lower level of coverage.

State	Effective date	General approach	Explicit risk-spreading or subsidy mechanism	Premium rate controls[a]	Health plan options
Fla.[d]	1/1/98	Two-tiered approach:			
		Eligible individuals whose prior group coverage was fully insured have guaranteed access to conversion coverage offered by the group carrier.	Carriers must include at least 2,000 individuals in each policy form, deterring the segregation of HIPAA-eligibles into separate pools.	200-percent cap.	Standard state conversion plan or a standard plan offered by carrier in the small group market.
		Individuals whose prior coverage was self-funded have guaranteed access to individual market plans.	Carriers must include at least 2,000 individuals in each policy form, deterring the segregation of HIPAA-eligibles into separate pools. Also, an individual market reinsurance pool is available to spread risks more broadly among carriers.	None.	At least the two most popular products of each individual market carrier.

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State	Effective date	General approach	Explicit risk-spreading or subsidy mechanism	Premium rate controls[a]	Health plan options
Ga.	1/1/98	Two-tiered approach:			
		Eligible individuals whose prior coverage was through a carrier have access to mandatory conversion coverage from the group carrier.	None.	150-percent cap.	At least two state standardized plans.
		Individuals whose prior coverage was self-funded have guaranteed access to coverage offered by an individual market carrier.	Eligible individuals are randomly assigned to a carrier. Risk is thereby distributed among all individual market carriers.	150-percent cap.	At least two state standardized plans
Idaho	1/1/98	Guaranteed issue of individual market coverage.	Carriers have access to state reinsurance program.	Restrictions on premium variation.	At least three plans comparable to small-group plans from each individual market carrier.
Ill.	7/1/97	High-risk pool.	Subsidy from annual assessments on carriers selling health coverage.	150-percent cap.	Comprehensive standard and PPO plan with multiple deductibles.
Ind.	1/1/98	High-risk pool.	Subsidy from annual assessments on carriers selling health coverage.	150-percent cap.	Three comprehensive plans.
Iowa	7/1/97	High-risk pool.	Subsidy from annual assessments on carriers selling health coverage.	150-percent cap.	One comprehensive and one limited-benefit plan with multiple deductibles.

State	Effective date	General approach	Explicit risk-spreading or subsidy mechanism	Premium rate controls[a]	Health plan options
Kans.	7/1/97	High-risk pool.	Subsidy from annual assessments on carriers selling health coverage.	150-percent cap.	One high- and one low-option plan.
La.	1/1/98	High-risk pool.	Subsidy from annual assessments on carriers selling health coverage.	200-percent cap.	Comprehensive plan with at least two deductible options and a managed care option.
Maine	1/1/98	Guaranteed issue of individual market coverage.	None.	Modified community rating.	All health plans sold in the individual market.
Minn.	1/1/98	High-risk pool.	Subsidy from annual assessments on carriers selling health coverage and proceeds from a state tax on hospitals and providers.	125-percent cap.	Comprehensive plan with two deductibles.
Miss.	7/1/97	High-risk pool.	Subsidy from annual assessments on carriers selling health coverage.	175-percent cap.	Comprehensive major medical coverage with two deductibles.
Mont.	10/1/97	High-risk pool.	Subsidy from annual assessments on carriers selling health coverage.	150-percent cap.	Two comprehensive plans.
Nebr.	7/1/97	High-risk pool.	Subsidy from annual assessments on carriers selling health coverage.	135-percent cap.	Two comprehensive plans (standard and PPO) with multiple deductibles.
Nev.[b]	7/16/97	Guaranteed issue of individual market coverage by "risk-assuming carriers."	Carriers that elect not to guarantee issue products must pay assessments to a reinsurance pool to cover losses of risk-assuming carriers.	Restrictions (rate bands) limit premium variation.	All plans offered by risk-assuming carriers, which must include at least a basic and a standard plan.

State	Effective date	General approach	Explicit risk-spreading or subsidy mechanism	Premium rate controls[a]	Health plan options
N.H.	1/1/98	Guaranteed issue of individual market coverage.	None.	Community rating, with limited adjustments permitted for age only.	All products offered in the individual market.
N.J.	1/1/98	Guaranteed issue of individual market coverage.	All carriers that offer health coverage in the state must offer individual coverage on a guaranteed-issue basis or pay an assessment to cover the losses of those that do.	Community rating.	Indemnity carriers must offer five standard plans–four comprehensive plans of increasing value and one basic plan. HMO carriers must offer one standard plan.
N.M.	4/11/98	Two-tiered approach:			
		High-risk pool.	Subsidy from annual assessments on carriers selling health coverage.	150-percent cap.	Four comprehensive plans with multiple deductibles.
		Guaranteed issue of individual market overage through carrier members of state health insurance alliance.	Reinsurance program funded by assessments on carriers selling health coverage.	Restrictions limit premium variation of alliance plans.	Several comprehensive and HMO plans with multiple deductibles.
N.Y.	7/1/97	Guaranteed issue of individual market coverage.	None.	Community rating with limited adjustments for geographic location.	All plans offered in the individual market, which must include two state standardized comprehensive plans.
N.D.	7/1/97	High-risk pool.	Subsidy from annual assessments on carriers selling health coverage.	135-percent cap.	One comprehensive plan with two deductibles.

State	Effective date	General approach	Explicit risk-spreading or subsidy mechanism	Premium rate controls[a]	Health plan options
Ohio	7/1/97	Two-tiered approach:			
		Mandatory conversion coverage for those leaving fully insured group plans OR	None.	200-percent cap.	State-established basic and standard plan.
		Guaranteed issue of individual market coverage.	Reinsurance program funded by assessments on carriers.	200-percent cap.	State-established basic and standard plans.
Okla.	5/12/97	High-risk pool.	Subsidy from annual assessments on carriers selling health coverage.	125-percent initial premium, 150-percent cap.	Comprehensive plan with multiple deductibles.
Oreg.	1/1/98	Two-tiered approach:	None.		
		Mandatory conversion coverage for those leaving fully-insured group plans.[c]	None.	100 percent of standard individual market rates with limited variation.	At least two standard comprehensive plans.
		High-risk pool for those leaving self-insured plans.	Subsidy from annual assessments on carriers selling health coverage.	100-percent cap.	At least two standard comprehensive plans.
Pa.	1/1/98	Guaranteed issue by four Blue Cross and Blue Shield plans.	Surcharge on Blues plans' group policies subsidizes individual market premiums.	None.	All individual market coverage sold by Blues plans.
S.C.	3/31/97	High-risk pool.	Subsidy from annual assessments on carriers selling health coverage.	200-percent cap.	Comprehensive standard and PPO plan.

State	Effective date	General approach	Explicit risk-spreading or subsidy mechanism	Premium rate controls[a]	Health plan options
S.D.	7/1/97	Guaranteed issue of individual market coverage.	Limits on the number of eligible individuals each carrier must accept intended to distribute eligibles among all carriers.	Restrictions (rate bands) limit variation of individual market premiums.	One standard and one basic plan comparable to those sold in the small-group market.
Tex.	1/1/98	High-risk pool.	Subsidy from annual assessments on carriers selling health coverage.	150-percent initial premium, 200-percent cap.	A choice of coverage comparable to standard coverage under group laws.
Utah	5/1/97	Two tiered approach:			
		High-risk pool for highest-risk eligibles.	Annual subsidy from state revenues.	150-percent cap.	A choice of coverage comparable to standard coverage under small-group and individual laws.
		Guaranteed issue of individual market coverage for lower-risk eligibles.	None.	None.	All individual market coverage offered.
Vt.	1/1/98	Guaranteed issue of individual market coverage.	None.	Community rating with limited exceptions.	All individual market coverage offered.
Va.	1/1/98	Guaranteed issue of individual market coverage.	None.	None.	All individual market coverage offered.
Wash.	1/1/98	Guaranteed issue of individual market coverage.	None.	Adjusted community rating.	All individual market coverage offered.
Wisc.	1/1/98	High-risk pool	Subsidized by state contributions, assessments on carriers, and reduction in payments to providers.	200-percent cap.	Choice of two plans, at least one of which is comprehensive.

State	Effective date	General approach	Explicit risk-spreading or subsidy mechanism	Premium rate controls[a]	Health plan options
Wyo.	1/1/98	High-risk pool.	Subsidy from annual assessments on carriers selling health coverage.	200-percent cap.	Choice of comprehensive coverage.

Note: The data in this table are based primarily on the documentation states submitted to HCFA in 1997 for approval of their alternative mechanism. Any subsequent modifications to states' mechanisms are not shown.

[a]Premium rate caps are most commonly expressed as a percentage of standard rates–generally the rate a similar healthy individual would pay in the individual insurance market.

[b]This state "grandfathered in" individuals who qualified as HIPAA-eligible between July 1, 1997, and January 1, 1998. These individuals were allowed to purchase coverage under HIPAA protections as of January 1, 1998.

[c]Carrier may offer its individual market products on a guaranteed-issue basis in place of the two conversion products.

COMMENTS FROM THE HEALTH CARE FINANCING ADMINISTRATION

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

MAY 18 1998

Mr. William J. Scanlon
Director, Health Financing and Systems Issues
U.S. General Accounting Office
441 G Street, N.W.
5th Floor
Washington, D.C. 20548

Dear Mr. Scanlon:

Thank you for the opportunity to review the draft report by the U.S. General Accounting Office (GAO), State Implementation of HIPAA: State-Designed Mechanisms for Group-to-Individual Portability (GAO publication number GAO/HEHS-98-161R). The report summarizes major provisions of state alternative mechanisms (SAMs), which were submitted to the Health Care Financing Administration (HCFA) to indicate individual states' plans to provide eligible individuals with guaranteed availability of coverage under the individual market provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Section 2741 of the Public Health Service (PHS) Act, as added by HIPAA, contains requirements for making individual health insurance coverage available to "eligible" individuals. These requirements are referred to as the "Federal fallback standards" because they only apply to a state that does not implement an alternative mechanism as permitted by section 2744 of the PHS Act.

We believe the report is a fair characterization, overall, of the provisions of the SAMs that were provided to HCFA as of July 1, 1997. We do, however, have some technical comments, which are attached.

HCFA believes it is important to highlight the point made on page 3 of the GAO report, which indicates that the GAO report "does not evaluate the actual implementation experience with the alternative mechanisms . . ." The report presents a snap-shot of the intentions of 37 of the 40 states that submitted SAMs to enact conforming legislation to meet HIPAA requirements. Readers therefore may erroneously assume that all such states have implemented their SAMs as they proposed them and that HIPAA implementation is running smoothly in their individual markets. That is not necessarily true. For example, we understand that three states submitted SAMs but have not yet passed the necessary legislation to implement them. There is no requirement in the statute that states inform us of their legislative enactments. Moreover, as the GAO noted in it's earlier report on HIPAA implementation, HCFA has not had the resources to

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follow up with the other 37 states to determine what exactly each of them enacted and whether the provisions are being enforced. We have asked the Congress for resources to do this, and Congress recently enacted a Fiscal Year 1998 supplemental appropriations bill that will enable us to begin this work.

We look forward to working with you and your staff to achieve the objectives of HIPAA over the coming months. We would be happy to answer any questions or provide additional information.

Sincerely,

Nancy-Ann Min DeParle
Administrator

(101736)

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