

THE WHITE HOUSE  
WASHINGTON

February 19, 1997

*H. Care - Medicaid - Gag Rule*

**MEDICAID "ANTI-GAG" PATIENT PROTECTION ANNOUNCEMENT**

DATE: THURSDAY, FEBRUARY 20, 1997  
LOCATION: OVAL OFFICE  
TIME: 11:00 A.M. - 11:45 A.M.  
FROM: CHRIS JENNINGS  
BARBARA WOOLLEY

**I. PURPOSE**

You are directing the Department of Health and Human Services to send a letter to all state Medicaid directors informing them that rules that restrict medical communication between health care providers and their patients, so-called "gag rules," are strictly prohibited. In addition, this event will reaffirm your support of bipartisan "anti-gag" legislation for private health plans.

**II. BACKGROUND**

Reports of the use of "gag rules" in private health plans prompted the need to clarify that Medicare and Medicaid providers' relationships with their patients remain open. In December 1996, you took action to clarify that all Medicare beneficiaries have this protection. Today, you clarify that Medicaid beneficiaries are also protected.

You have long supported bipartisan legislation to prohibit the use of "gag rules" in private health plans. You referenced this issue throughout the campaign and explicitly referenced it during your second debate with Senator Dole. Your support of this legislation has received wide spread support from the provider and consumer community, in general, and the American Medical Association, the American Nurses Association, the American Association of Retired Persons, and the Consumers Union, in particular.

**III. PARTICIPANTS**

- ◆ POTUS
- ◆ The Vice President
- ◆ Secretary Donna Shalala, Department of Health and Human Services

(In addition, the audience in the Oval Office will include: Representative Ed Markey (D-MA), Representative Pete Stark (D-CA), Representative Greg Ganske (R-IA), Representative Tom Coburn (R-OK), Representative Ellen Tauscher (D-CA), and Representative Sherrod Brown (D-OH); Bruce Vladeck, Administrator, Health Care Financing Administration; Bruce Fried, Director, Office of Managed Care, Health Care Financing Administration; representatives from the American Academy of Family Physicians, the American College of Physicians, the American Medical Association, and the American Nurses Association; and White House staff, including Chris Jennings, Barbara Woolley, and Nancy-Ann Min).

#### **IV. PRESS PLAN**

Open press.

#### **V. SEQUENCE OF EVENTS**

- ◆ The Vice President makes opening remarks and introduces Secretary Donna Shalala, Department of Health and Human Services.
- ◆ Secretary Donna Shalala makes remarks and introduces you.
- ◆ You make remarks.

#### **VI. REMARKS**

To be provided by speech writers.

## **PRESIDENT CLINTON ANNOUNCES NEW STEPS TO PROTECT MEDICAID BENEFICIARIES FROM "GAG RULES"**

Today, President Clinton announced that he has directed the Department of Health and Human Services (HHS) to send a letter to all state Medicaid directors reminding them that "gag clauses" -- rules under which health care providers are restricted in what they may tell their patients about medical procedures not covered by their health insurance -- are strictly prohibited. This action builds on President Clinton's efforts in December 1996 to protect Medicare beneficiaries from these so-called "gag clauses." The President also called again on Congress to enact bipartisan legislation to prohibit gag clauses in all health plans -- public and private.

### **Ensuring Quality in Medicare and Medicaid**

There have been reports that some physicians and other health care professionals who have contracts with managed care plans have been limited in their ability to share all treatment options with their patients. While we have no evidence that so-called gag rules are a problem in the Medicare or Medicaid programs, the Clinton Administration is taking today's action to ensure that these vital programs are not exposed to these communication constraints and that health care provider-patient relationships remain open and unobstructed.

Today's action will help to ensure open communication between Medicaid beneficiaries and physicians, nurses, and other health care providers. Since January 1, 1993, enrollment in Medicaid managed care plans has increased by more than 170 percent, including a 33 percent increase from 1995 to 1996. As of June 30, 1996, 13.3 million Medicaid beneficiaries were enrolled in managed care plans, representing 40 percent of all beneficiaries.

In December 1996, HHS, under President Clinton's direction, sent a letter to all 350 Medicare managed care plans making clear that gag rules are not permitted under Medicare. This action affected the approximately 5 million Americans enrolled in Medicare managed care plans. The number of Medicare beneficiaries enrolled in managed care plans has increased by about 108 percent since 1993.

### **Renewing the Call for Bipartisan Legislation**

President Clinton today also called for quick action on bipartisan legislation to prohibit the use of gag rules in all health plans -- public and private. Legislation to prohibit gag rules was introduced in the last Congress in both the House and the Senate, but Congress was unable to complete action on this important issue. Bipartisan legislation to ban gag rules has been reintroduced in the current Congress.

### **Building on a Strong Record of Improving Patient Protections**

Since taking office, President Clinton has worked to improve health care quality by:

- Signing the Kassebaum-Kennedy legislation into law, ending pre-existing condition exclusions and expanding access to health insurance.
- Signing legislation ending the practice of "drive-through deliveries" by requiring plans to allow women a minimum hospital stay after giving birth.
- Issuing regulations to protect Medicare and Medicaid beneficiaries by limiting physician incentive arrangements with health plans that could influence physicians' care decisions.
- Supporting legislation to ensure that women can remain in the hospital for 48 hours after undergoing a mastectomy and 24 hours after undergoing a lumpectomy.

## **Medicaid Gag Rule Talking Points**

**The President's commitment to improving the quality of health care provided in the U.S. is clear.** In the past four years, the President has taken numerous actions to protect and improve the quality of health care delivered to Americans. These actions include signing the Kennedy-Kassebaum Act; guaranteeing women at least 48 hours in the hospital after giving birth; limiting the use of "physician incentives" that could influence medical decisions; seeking legislation to guarantee women at least 48 hours in the hospital after a mastectomy; and prohibiting the use of "gag clauses" in Medicare, Medicaid, and private health insurance.

**Gag Rules interfere with a patient's relationship with her/his health care provider.** By prohibiting a health care professional from discussing certain treatment options with a patient, gag rules interfere with the doctor-patient relationship and can damage the quality of care delivered.

**There is strong bipartisan support for eliminating gag rules.** In the last Congress, legislation was introduced in both houses of Congress by members of both political parties to prohibit gag rules in health care plans. While the Congress did not complete action on this legislation in 1996, new bills have been introduced in 1997 and the President called for quick action on this legislation.

**The Clinton Administration is determined to protect the quality of care in Medicare and Medicaid.** As part of his balanced budget proposal, President Clinton will continue to improve the quality of care delivered to Medicare and Medicaid beneficiaries. The budget would expand coverage of preventive benefits including annual mammograms, colorectal cancer screening, diabetes screening and management training, respite care for caregivers of Alzheimer's disease patients, and increased reimbursement for flu shots, pneumonia and Hepatitis vaccines.

## Medicaid Gag Rule Questions and Answers

Question

Why are you taking this action?

Answer

We are determined to protect the quality of care that our Medicare and Medicaid beneficiaries receive. Gag rules threaten the relationship between patients and their health care professionals. They have no place in medicine and they have no place in Medicare and Medicaid. We have acted to protect beneficiaries of those two programs and we are asking Congress to join us in protecting all Americans.

Question

Is there a problem in Medicare or Medicaid?

Answer

There is no direct evidence of gag rules being used in Medicare or Medicaid health plans. However, there is clear evidence that such rules exist in the private sector and we are acting to ensure that this virus doesn't infect Medicare and Medicaid.

Question

Earlier in this Administration, you spoke very positively about managed care. In fact, the President's health reform plan had a heavy emphasis on managed care. Now, you seem to take every opportunity to bash managed care. Why the change?

Answer

We have consistently said that managed care, when properly constructed, provides consumers with important benefits including a greater emphasis on prevention, more coordinated care, and better cost containment. But we have also said that protecting the quality of care delivered in all settings is of paramount importance. The steps we have been taking and are taking today are aimed at improving the quality of care provided to all Americans, including those in managed care.

Question

Isn't this another unfunded mandate?

Answer

No. This will not cost the states additional money. It will protect the quality of care provided to Medicaid beneficiaries who are enrolled in managed care plans. We believe the governors will welcome this action.

Question

Why is the Administration acting so haphazardly in this area. First it was drive-thru deliveries, then mastectomies, now gag rules. Do you have a strategy?

Answer

Yes, we do have a strategy. The President has announced plans to create an Advisory Commission on Consumer Protection and Quality in the Health Care Industry. That panel, which will be named shortly, will help us to develop a framework to address these kind of concerns in the future. However, when there are egregious examples of bureaucratic interference with the practice of high-quality medicine, we will not hesitate to act. That is what we are doing today.

Question

When will the President name the Advisory Commission?

Answer

While it has taken longer than any of us expected, we are currently going through final clearances on the individuals who will serve on this important panel and we expect to be able to announce the membership within the next month.



FEB 20 1997

Dear State Medicaid Director:

The purpose of this letter is to clarify Federal law and regulations regarding physicians' and other health care providers' advice and counsel to beneficiaries enrolled in Medicaid managed care plans. A similar letter was sent in November 1996, to Medicare-contracting health maintenance organizations (HMOs) and competitive medical plans (CMPs).

Federal law and regulations state clearly that beneficiaries enrolled in Medicaid HMOs must have access to the same services available to Medicaid beneficiaries in the fee-for-service (FFS) program. Medicaid contracting HMOs must make the services they provide under their contracts "accessible . . . to the same extent as such services are made accessible to individuals . . . not enrolled with the organization." (See Section 1903(m)(1)(A) of the Social Security Act.) In addition, relevant regulations require Medicaid managed care plans with risk contracts to make services accessible to Medicaid HMO enrollees to the same extent that those services are available to Medicaid beneficiaries not enrolled in an HMO.

Beneficiaries are entitled to the full range of their health care providers' opinions and counsel about the availability of medically necessary services under Medicaid FFS or managed care programs. Any contractual provisions -- including so-called gag rules -- that restrict a health care provider's ability to advise patients about medically necessary treatment options violate Federal law and regulations.

In order to ensure that all Medicaid beneficiaries have access to the same advice and counsel from their health care providers, I encourage you to review relevant contract provisions, as well as the policies and procedures of HMOs contracting with the State, to ensure that health care providers' advice and counsel regarding medically necessary treatment are unrestricted.

Thank you for your attention to this important matter. Please contact Rachel Block, Director of the Medicaid Managed Care Team, if you require additional information.

Sincerely,

Bruce Merlin Fried  
Director

# HHS FACT SHEET

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

February 19, 1997

Contact: HCFA Press Office  
(202) 690-6145

## MANAGED CARE IN MEDICARE AND MEDICAID

***Overview:** Since 1993, the number of Medicare and Medicaid beneficiaries enrolled in managed care plans has experienced unprecedented growth. The Health Care Financing Administration (HCFA), which administers these two programs, is now the largest purchaser of managed care in the country, accounting for about 18 million Americans. As a result, HCFA is taking new steps to protect beneficiaries in managed care, as it always has in its fee-for-service programs. These steps include banning "gag clauses" on what physicians can say to patients about treatment options, requiring state-of-the-art member satisfaction surveys and measurement of health plan performance, and limiting financial incentives for physicians so that efforts to control costs do not curtail needed care. The Clinton Administration has worked in close partnership with the states to provide maximum flexibility through the waiver of Federal rules to expand the availability of managed care plans to Medicaid beneficiaries. The Administration has also worked to expand choices for Medicare beneficiaries and to ensure that all beneficiaries enrolled in managed care receive quality care.*

*As part of his seven-year balanced budget proposal, President Clinton would further expand the availability of managed care to Medicare and Medicaid beneficiaries by increasing the number of Medicare options available and providing states with additional flexibility to enroll Medicaid beneficiaries in such plans without requesting a waiver of federal Medicaid rules.*

### MEDICARE

As of February, 1997, 5 million Medicare beneficiaries were enrolled in a total of 358 managed care plans, accounting for 13 percent of the total Medicare population. That represents a 108 percent increase in managed care enrollment since 1993. In 1996, an average of 80,000 Medicare beneficiaries voluntarily enrolled in risk-bearing HMOs each month. Medicare beneficiaries can enroll or disenroll in a managed care plan at any time and for any reason with only 30 days notice.

Managed care plans can serve Medicare beneficiaries through three types of contracts: risk, cost, and health care prepayment plans (HCPPs). All plans receive a monthly payment from the Medicare program.

- **Risk plans** are paid a per capita premium set at approximately 95 percent of the projected average expenses for fee-for-service beneficiaries in a given county. Risk plans assume full financial risk for all care provided to Medicare beneficiaries. Risk plans must provide all Medicare-covered services, and most plans offer additional services, such as prescription drugs and eyeglasses.

With the exception of emergency and out-of-area urgent care, members of risk plans must receive all of their care through the plan. However, as of January 1, 1996, risk plans can provide an out-of-network option that, subject to certain conditions, allows beneficiaries to go to providers who are not part of the plan. Since Jan. 1, 1993, enrollment in risk plans has grown more than 170 percent. Currently, 86 percent of Medicare beneficiaries in managed care are in risk plans. As of January 1, 1997, risk plans made up 248 of the 350 managed care plans participating in Medicare.

- **Cost plans** are paid a pre-determined monthly amount per beneficiary based on a total estimated budget. Adjustments to that payment are made at the end of the year for any variations from the budget. Cost plans must provide all Medicare-covered services but do not provide the additional services that some risk plans offer. Beneficiaries can also obtain Medicare-covered services outside the plan without limitation. When a beneficiary goes outside the plan, Medicare pays its traditional share of those costs and the beneficiary pays Medicare's coinsurance and deductibles.
- **Health Care Prepayment Plans (HCPPs)** are paid in a similar manner as cost plans but only cover part of the Medicare benefit package. HCPPs do not cover Medicare Part A services (inpatient hospital care, skilled nursing, hospice, and some home health care) but some do arrange for services and may file Part A claims for their members.

Nationally, three-fourths of beneficiaries have a choice of at least one managed care plan while more than half have a choice of two or more plans. Medicare managed care enrollment varies greatly depending on geographic location. The majority of beneficiaries enrolled in such plans live in California, Florida, Oregon, New York, Arizona, and Hawaii.

HCFA recently launched the "Medicare Choices" demonstration project designed to allow beneficiaries to join a wider variety of managed care plans and to extend managed care options to rural areas. Enrollment is now underway in six participating plans. They include four provider sponsored networks (PSNs), a preferred provider organization (PPO), and a "triple option" hybrid that lets members see gatekeeper physicians, other plan providers without going through the gatekeeper, or providers outside the plan. An additional 13 demonstration plans are expected to begin enrollment during 1997. This "Choices" project is also testing new payment methods, such as partial capitation and adjustments based on the actual health needs of beneficiaries.

## MEDICAID

Enrollments in Medicaid managed care enrollment have also increased significantly. Since Jan. 1, 1993, enrollment in Medicaid managed care plans has increased by more than 170 percent, including a 33 percent increase from 1995 to 1996. As of June 30, 1996, 13.3 million Medicaid beneficiaries were enrolled in managed care plans, representing 40 percent of all beneficiaries.

Currently, 48 states offer some form of managed care. Since 1993, states have utilized federal Medicaid waivers to increase enrollment in managed care and to develop other innovative changes to their Medicaid programs. Several states have used the resulting savings from managed care enrollment to expand the number of individuals covered by Medicaid and/or the number of services covered under their programs.

The federal government grants two kinds of Medicaid managed care waivers: Section 1915(b) waivers and Section 1115 demonstrations. Section 1915(b) waivers permit states to require beneficiaries to enroll in managed care plans. To receive such a waiver, states must prove that these plans have the capacity to serve Medicaid beneficiaries who will be enrolled in the plan. States often use Section 1915(b) waivers to establish primary care case management programs and other forms of managed care. There are 94 active Section 1915(b) waivers in 41 states.

Section 1115 demonstrations allow states to test new approaches to benefits, services, eligibility, program payments, and service delivery, often on a statewide basis. These approaches are frequently aimed at saving money to allow states to extend Medicaid coverage to additional low-income and uninsured people. Since January 1, 1993, comprehensive health care reform demonstration waivers have been approved for 15 states and nine have already been implemented. When all 15 are implemented, 2.2 million previously uninsured individuals are expected to receive health coverage.

## QUALITY

As the number of beneficiaries enrolled in managed care plans has increased, the Clinton Administration has been working closely with states, insurers, health care professionals, and consumers to assure the quality of care provided in that setting. Several initiatives are already underway. For example:

**Medicaid Health Plan Employer Data Information Set (HEDIS)** was developed in partnership with the National Committee for Quality Assurance (NCQA) to provide states, managed care plans, health care professionals, and consumers with the information and tools they need to assure high quality in managed care plans serving Medicaid beneficiaries. Medicaid HEDIS is an adaptation of the commercial sector's HMO performance measurement system used by more than 300 private plans.

**Medicaid HEDIS** will provide states with information on the performance of their Medicaid managed care contractors, assist managed care plans in quality improvement efforts, support efforts to inform Medicaid beneficiaries about managed care plan performance, and promote standardization of managed care plan reporting across the public and private sectors. Medicaid HEDIS was released to the states in February 1996.

**Medicare HEDIS** is a parallel effort in partnership with the Kaiser Family Foundation to establish a proven performance measurement system that will minimize reporting burdens on managed care plans serving Medicare beneficiaries. The new measures will help plans to improve the quality of their care and support efforts to improve the health status of beneficiaries. HCFA began requiring plans to submit Medicare HEDIS data as of January, 1997.

**Foundation for Accountability (FAcct)** is a collaboration of private and public health care purchasers (including HCFA) and consumer groups working to develop outcomes measures that will allow comparison of the quality of care delivered in managed care settings to that provided in fee-for-service settings. This summer, Facct endorsed three condition-specific outcome measures, diabetes, depression and breast cancer, which HCFA is having tested by the RAND Corp.

**Quality Assurance Reform Initiative (QARI)** is a collaborative effort of HCFA, states, the managed care industry, consumer advocates and others to design practical and credible approaches to monitoring and improving the quality of Medicaid managed care services. In July 1993, QARI issued *A Health Care Quality Improvement System for Managed Care*, providing states with a broad range of Federally-recommended guidelines for building and operating quality assurance and improvement systems. These guidelines were tested in three states in 1993-95 by the Kaiser Family Foundation and the results were issued in 1995 through the National Academy for State Health Policy's *Quality Improvement Primer for Medicaid Managed Care*. In 1995, QARI published *Health Care Quality Improvement Studies in Managed Care*, in partnership with the National Center for Quality Assurance (NCQA).

**Physician Incentive Rules**, effective as of January, 1997, require plans to disclose financial incentives and pay for stop-loss insurance so that no more than 25 percent of a physician's income is at risk under capitation. The regulations also ban any incentive arrangements that include payments to doctors to limit or reduce medically necessary services. These rules are designed to make sure incentives to discourage unnecessary services do not go too far.

**HHS Interagency Managed Care Forum** is chaired by HCFA Administrator Bruce C. Vladeck, and is made up of representatives from operating and staff divisions of the Department of Health and Human Service. The forum meets regularly to share information concerning ongoing managed care activities and to coordinate managed care policy on cross-cutting issues before the Department. Managed care quality is a top priority for this group.

## DEMOGRAPHICS ON MEDICARE AND MEDICAID

The demographic profile of the Medicare population in 1995 shows more women (57 percent) are enrolled than men (43 percent), and many live on modest incomes.

### ***MEDICARE***

#### **Men:**

- There are 16.1 million males enrolled in Medicare, with 8.1 million between the ages of 65-74. Males aged 75-84 total 4.3 million, and those over age 85 total 1.1 million.
- The disabled male population totals 2.7 million, with 1.7 million ages 35-54 and 959,000 ages 55-64.
- Among the elderly, White males comprise 13.8 million Medicare enrollees, followed by Black males at 1.4 million enrollees. The Hispanic enrollment is 215,000, Asian/Pacific is 80,000 and the native American is 19,000.

#### **Women:**

- There are 21.6 million women enrolled in Medicare. They outnumber men primarily because women live longer than men. There are 19.8 million women ages 65-74 in Medicare, 10.1 million ages 75-84, and 2.8 million – more than twice as many women as men – over age 85.
- There are 1.8 million disabled women in Medicare. Almost 600,000 are under age 45, 490,000 are ages 45-54, and 712,000 are ages 55-64.
- There are 18.5 million White females in Medicare, 1.9 million African American, 221,000 Hispanic, 103,000 Asian/Pacific, and 17,000 Native American.

#### **Income:**

- In 1994, the median income for all U.S. households was \$32,264 but for senior citizen households was \$18,095. Overall, 0.9 percent of senior citizens had no health care coverage; whereas, 3.7 percent of those above the poverty level had no coverage.
- Disabled beneficiaries tend to report lower incomes than elderly beneficiaries. In 1993, almost 41 percent of disabled enrollees reported incomes of \$10,000 or less.

### ***MEDICAID***

- There are 13.2 million male and 21.2 million female Medicaid beneficiaries. Of this population, 16.5 million are White, 9 million are Black, 6.2 million are Hispanic, 810,000 are Asian/Pacific, 291,000 are Native American, and the race of 3.5 million is unknown.
- Of the 36.2 million total enrollees, 18.7 million are under age 21, 11.4 million are 21-64, and 6.1 million are age 65 and over.
- In 1995, following eligibility expansions for children, Medicaid covered 60.9 percent of children under age six in families with incomes below 150 percent of the federal poverty level.
- Nearly 6 million beneficiaries are dually eligible for Medicare and Medicaid.

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