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California's Prepaid Health Plan Program: Can the Patient Be Saved?

By DAVID F. CHAVKIN* and ANNE TRESEDER**

In 1971 the state of California began encouraging the widespread development of prepaid health plans\(^1\) to meet the health needs of Medi-Cal recipients.\(^2\) These plans would theoretically improve the quality of health services available and at the same time reduce the costs of such health care to the state. These dual goals would be realized by encouraging the practice of preventive medicine, thereby reducing the need for costly inpatient services.

This article reviews the development of the prepaid health plan program in California beginning with the enactment of Medi-Cal in 1965. The Medi-Cal program restructured California's system of health care for indigents and expanded both the number of persons eligible and the scope of services available. One provision of this new

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1. As used in this article, the term "prepaid group practice" refers to a medical group which provides comprehensive health care services to a defined population in exchange for prepayment on a per capita basis. Such an entity thus profits to the extent that actual health care expenditures are less than capitation payments, but must absorb the loss if the cost of medical services rendered exceeds income. This term is often used interchangeably with the term "health maintenance organization" since the emphasis in a prepaid group practice is theoretically on maintaining the health of its patient community. See Ellwood, Health Maintenance Organizations: Concept and Strategy, 45 Hospitals 53-54 (1971).

The term "prepaid health plan" (PHP) refers to those prepaid group practices which contract with the State of California to provide medical care for Medicaid recipients in exchange for monthly capitation payments.

The delivery of Medicaid benefits through a PHP is to be distinguished from the Medicaid "fee-for-service" model in which the amount of reimbursement paid by the state to the provider of care is determined by the amount and type of service actually rendered by the provider.

2. Medi-Cal is the name commonly used to refer to the California Medical Assistance Program for indigents.
legislation mandated the development of prepaid health plans to provide all health services to Medi-Cal recipients.

After more than a year elapsed without the actual development of prepaid health plans, the California legislature authorized the implementation of pilot projects by the state to test various structures for prepayment. Limited pilot projects were conducted by the state over the next few years.

During this period of experimentation with prepayment, costs under the Medi-Cal fee-for-service program rose dramatically. Although the actual magnitude of this cost increase was subject to widely varying estimates, a fiscal crisis was precipitated within the state. The Reagan administration, then in power in Sacramento, seized on the prepaid health plan (PHP) concept as a means of stemming these rising costs. The establishment of PHPs on a large scale was included as a major feature of the broad reform of the Medi-Cal program enacted in 1971.

Major problems soon arose in the PHP program. Massive enrollment fraud and poor quality services characterized the operations of many plans. Numerous reports alleged widespread profiteering, conflict of interest, and mismanagement by plan administrators and by the state agency responsible for supervision of the program. In 1972 the California legislature enacted measures designed to curb many of these abuses. When these initial controls proved inadequate the legislature expanded and refined the governing legislation in largely futile attempts to bring the program under control.

The advent of the Brown administration in 1975 renewed hopes that existing PHP statutes and regulations would be vigorously enforced and that new concepts would be developed. Those hopes have not been realized, however. Administrative mismanagement, enrollment fraud, poor quality care, and political favoritism have continued to flourish.

The PHP program is indeed ailing. After reviewing the history of the program in California, two questions must therefore be answered. First, is the PHP program worth saving? Second, if it is worth saving, what can and should be done to make the program viable?

The Enactment of Medi-Cal

The California Medical Assistance Program (Medi-Cal) was signed into law on November 12, 1965, by then Governor Edmund G.
Brown, Sr.³ This legislation implemented the recently enacted federal Medicaid program⁴ in California.

Prior to the enactment of Medi-Cal, health services were provided to California's indigents under a variety of state programs. The two largest of these, Public Assistance Medical Care (PAMC)⁵ and Medical Assistance for the Aged (MAA)⁶ provided health care to needy children, the disabled, the aged, and the blind. The PAMC program provided coverage primarily for outpatient service;⁷ the MAA program provided inpatient services in hospitals and nursing homes for people over 65.⁸ Both programs were enacted pursuant to federal enabling legislation which provided federal money to match state expenditures.⁹


Like the other federal grant-in-aid programs, matching funds are available under the Medicaid program to those states which submit a plan in accordance with governing legislation. The federal government will pay between 50% and 83% of the total amounts expended for medical assistance under the state plan. 42 U.S.C. §§ 1396b(a) (1), 1396d(b) (Supp. V, 1975). Federal financial participation is also available to defray some of the state's administrative costs. 42 U.S.C. §§ 1396b(a)(2)-(6) (Supp. V, 1975).

Medical assistance may be extended to individuals receiving aid to families with dependent children (AFDC) and supplemental security income. 42 U.S.C. § 1396a (a)(10)(A) (Supp. V, 1975). Needy children and their caretaker relatives are eligible for AFDC if they are deprived of parental support or care by reason of death, continued absence, or physical or mental incapacity of a parent or parents or by reason of the unemployment of the father. 42 U.S.C. §§ 606(a), 607 (1970). Individuals are eligible for supplemental security income (SSI) if they are aged, blind, or disabled. 42 U.S.C. §§ 1381-1385 (1970). At the time the Medicaid program was enacted, aged, blind, and disabled individuals received assistance under state programs funded through federal grants-in-aid similar to the AFDC program. On January 1, 1974, the administration of those state programs was taken over by the federal government through the Social Security Administration. Individuals applying for AFDC and SSI must also meet certain criteria for income and resources.

Medical assistance may also be extended under state plans to "categorically-related medically needy" individuals. These individuals are said to be categorically-related because they are related to one of the categories of public assistance by age, blindness, disability, or deprivation of parental support or care. These individuals have either chosen not to apply for financial assistance or have excess income or resources. 42 U.S.C. § 1396a(a)(10)(C) (Supp. V, 1975).


California's indigents who were ineligible for PAMC or MAA remained largely dependent on the county hospitals for health care. Cal. Stat. 1937, ch. 464, § 1, at 1406, as amended, Cal. WELF. & INST'NS CODE § 17000 (West 1972).

For an excellent discussion of the provision of health care services to indigents in California prior to the enactment of Medi-Cal, see M. GREENFIELD, MEDI-CAL,
Assembly Bill 5, the Medi-Cal bill, was enacted during an Extraordinary Session of the California legislature convened on September 20, 1965. Despite concern expressed by some legislators over possible costs of the program, the legislation was passed overwhelmingly by both the senate and the assembly.

Several sections of A.B. 5 became effective immediately as an urgency measure; most of the provisions took effect on March 1, 1966. Much of the impetus for the rapid enactment of the Medi-Cal program was fiscal—the increased availability of federal matching funds.

Assembly Bill 5 repealed both the PAMC and MAA programs. In their place, a single program was established for both outpatient and inpatient services, while at the same time, both the number of individuals eligible and the scope of services provided were greatly in-
creased. As the legislature declared:

The intent of the Legislature is to provide, to the extent practicable, through the provisions of this chapter, for basic health care for those aged and other persons, including family persons who lack sufficient annual income to meet the costs of health care, and whose other assets are so limited that their application toward the costs of such care would jeopardize the person or family's future minimum self-maintenance and security.19

After the passage of A.B. 5, Governor Brown stated:

Of all the factors which create and sustain poverty among our people, poor health is one of the most nagging and pervasive. With this bill, we can offer to the poor services which will help prevent illness and medical care which will cure illness in a consistent, comprehensive fashion, which recognizes the individual's need for total medical care.20

Governor Brown went on to caution, however, that the legislation proposed "no new structures to meet the previously unmet need of poor and low income Californians for quality, comprehensive care."21

The Advent of Prepayment

Despite Governor Brown's disclaimer, the stage was in fact set for an experiment in the provision of health services to indigents through new structures—prepaid health plans. Section 2 of A.B. 5 provided that, "After December 31, 1966, [health care under Medi-Cal] shall,
to the extent feasible, be provided through a system of prepaid health care or contracts with carriers.\textsuperscript{22}

To assist the Health and Welfare Agency in fulfilling this statutory mandate, the legislature authorized the promulgation of standards to determine the income of persons not receiving public assistance. This averaging of income would facilitate the establishment of rates of payment to PHPs by the state and by those Medi-Cal recipients who had to contribute to their health care.\textsuperscript{23}

Pursuant to Welfare and Institutions Code section 14104, the Health and Welfare Agency was authorized to contract with carriers to provide health benefit plans.\textsuperscript{24} These "carriers" were defined to include group arrangements with private insurance companies, medical societies or other medical groups, associations of insurers, nonprofit hospital service plans, nonprofit membership corporations, or other plans authorized under state law.\textsuperscript{25}

The administrator of the Health and Welfare Agency was also authorized to notify eligible Medi-Cal beneficiaries of the availability of such health benefit plans and the benefits provided thereunder.\textsuperscript{26} At the same time, the Health Review and Program Council\textsuperscript{27} was to study the provision of health services under such plans with emphasis on the costs of such plans and the quality of care provided.\textsuperscript{28}

These provisions of A.B. 5 were not the first step in the development of prepayment in California, however. In 1917, the state legislature passed and submitted to the voters a constitutional amendment which would have established a program of health insurance

\textsuperscript{22} Cal. Stat. 1965, 2d Ex. Sess., ch. 4, § 2, at 104.
\textsuperscript{23} Those Medi-Cal recipients who do not receive financial assistance from the state and who have income above a specified maintenance need level must contribute to their costs of health care. Cal. Stat. 1965, 2d Ex. Sess., ch. 4, § 2, at 106 (now Cal. Welf. & Inst'ns Code §§ 14005.7-05.12 (West 1972)). The maintenance need level is similar to the deductible in a private insurance policy and is known as the Medi-Cal liability.
\textsuperscript{25} Id. at 112.
\textsuperscript{26} Id. at 117.
\textsuperscript{27} The Health Review and Program Council was established by Cal. Stat. 1965, 2d Ex. Sess., ch. 4, § 2, at 118 (now Cal. Welf. & Inst'ns Code §§ 14125.1-126 (West 1972 & Supp. 1976)). The purposes of the council included improving the quality of care, providing planning assistance to the Health and Welfare Agency, and grading the performance of health insurance prepayment plans. Id.
\textsuperscript{28} The council was renamed the California Health Care Commission in 1971. Cal. Stat. 1971, ch. 577, § 37.7, at 1127.
for those persons whose incomes were insufficient to meet the costs of illness. This amendment was the result of a proposal by a state commission created in 1915 by Governor Hiram Johnson for the study of social insurance. The amendment was overwhelmingly rejected in the November 1917 general election.

By 1965 a number of private prepayment plans were already in operation in California. In 1929 Drs. Ross and Loos established the state's first prepaid group practice, the Ross-Loos Health Plan and contracted to provide care to the employees of the Los Angeles Water Department.

In 1933 an independent doctor established a health plan which was later taken over by the Kaiser Industrial Organization to provide comprehensive care for its construction workers and their families in the Mojave Desert. The Kaiser Foundation Health Plan opened its membership to the general public after World War II and became the first prepaid group practice to be implemented on a large scale.

In the 1957 Regular Session, the California legislature enacted the PAMC program. Section 1 of that act provided:

[T]he State Department of Social Welfare may contract for one or more indemnity or service-type partial or full prepayment or group payment programs to provide medical care or any aspect thereof, with any [qualified] agency or organization . . .

This provision was also contained in the 1961 legislation enacting the MAA program.
Beginning in 1963, California Physicians' Services (Blue Shield) contracted on behalf of the Santa Barbara Medical Society with the County of Santa Barbara for the delivery of medical services to PAMC and MAA recipients on a capitation basis. An evaluation of this project for the California Office of Health Care Services, however, revealed that the program did not vary significantly from the fee-for-service PAMC programs in neighboring counties.

Under the Santa Barbara Plan, California Physicians' Services provided administrative services on a no-profit, no-loss basis. No party, it appeared, was responsible for providing services if costs exceeded capitation payments, a result inconsistent with the concept of prepayment. The study reported that costs, especially administrative costs, were probably higher under this program than under the fee-for-service equivalents in adjoining counties. The report concluded that while "the concept of prepayment is not totally without merit . . . the Santa Barbara experience revealed the problems of putting this theory into practice."

Thus, by the time that A.B. 5 was enacted, during the Second Extraordinary Session of 1965, little had been done to experiment with

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38. Initial responsibility for administering the Medicaid program in California was assigned to the Health and Welfare Agency. Within this agency an Office of Health Care Services was developed to supervise the program. This office was later renamed the Department of Health Care Services. Effective on July 1, 1973, the health programs in the state were consolidated under the administration of the Department of Health of the Health and Welfare Agency. For a history of the struggle over which agency would have responsibility for administering the Medi-Cal program, see Greenfield, supra note 9, at 12-14, 24-30.

40. Id.
41. Id. at 4.
42. Id. at 5.
43. Id.
44. Legislation had been proposed earlier in the year. In the 1965 regular session, Assemblyman Casey introduced A.B. 760. Assembly Daily Journal, 1965 Reg. Sess., Feb. 2, 1965, at 422. This legislation became the vehicle for an attempted revision of the entire program of health care for indigents. Section 2 of A.B. 760 would have established a program of medical assistance for aged and other persons, including family groups, without sufficient income to meet the costs of health care. This section also provided: "After June 30, 1966, such care shall, to the extent feasible, be provided through a system of prepaid health care benefits." A.B. 760, as amended, Assembly Daily Journal, 1965 Reg. Sess., May 24, 1965, at 3872.

When the 1965 regular session closed, however, no final action had been taken
the delivery of services to indigents through PHPs. Furthermore, the little experience that was available suggested a less than optimistic prognosis for the practicability of such plans. Despite those facts, the Health and Welfare Agency had been mandated by the legislature to provide health care under Medi-Cal through a system of PHPs to the maximum extent feasible after December 31, 1966.

**The Pilot Projects**

December 31, 1966, came and went without implementation of a PHP program. To reemphasize the intent of A.B. 5 that prepaid health care was to be the system for the delivery of health services, the legislature enacted amendments to the Medi-Cal program during the following year.

The amendments, embodied in A.B. 1140, remandated the Health and Welfare Agency to begin experimenting "to the extent feasible" with prepaid health plans. In addition, Welfare and Institutions Code section 14000(e) was added to provide that PHP contracts with carriers could be for any number of enumerated health services and

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45. The Health and Welfare Agency had been created to fulfill the federal requirement that a single state agency be responsible for the administration of the medicaid program within the state. 42 U.S.C. § 1396a(a)(5) (Supp. V, 1975).


49. Id. § 1, at 4261.
could establish coverage "on the basis of the class of recipient, class of benefit, geographical area, or any other reasonable classification." Finally, one of the amendments directed that the programs to be established provide services as efficiently as possible, utilize "different methods of providing health care services," emphasize methods for preventative care and review, and "provide incentives for using the most economical level of care."

The first pilot project in prepayment was established on February 1, 1968, by a contract between the Department of Health Care Services and the San Joaquin Foundation for Medical Care. The Foundation is a wholly owned corporation of the San Joaquin County Medical Society. Under the San Joaquin project, a Medi-Cal recipient maintained freedom of choice in selecting providers as required by state and federal law. Recipients in the four counties covered by the San Joaquin project could continue to see the provider of their choice, whether or not the provider was a member of the Foundation.

The objective of the pilot project was to test the cost control potential of a medical care foundation managing a limited prepayment program for Medi-Cal recipients. The contract initially provided for coverage of physician services only.

The pilot project originally involved 22,000 recipients of aid to the blind, aid to the disabled, and aid to families with dependent children in Amador, Calaveras, San Joaquin, and Tuolumne Counties. The Foundation was paid a monthly capitation payment or premium by the state for all qualifying residents in the four-county area. In the initial contract period, for example, the Foundation received $6.25 per month for each recipient of aid to families with dependent children. This

50. *Id.* at 4262 (now codified as CAL. WELF. & INST'NS CODE § 14000(f) (West 1972)).
51. CAL. WELF. & INST'NS CODE § 14000(f) (West 1972).
52. CALIFORNIA DEP'T OF HEALTH CARE SERVICES, ANNUAL REPORT TO THE LEGISLATURE ON MEDI-CAL PILOT PROJECTS, Attachment 1, at 1 (1970) [hereinafter cited as 1969 PILOT PROJECT REPORT].
53. D. Harrington, System of Medi-Cal Administration and Health Care Delivery Based Upon the Individual Practice System 2 (prepared for discussion at the 1970 National Health Forum) [hereinafter cited as Harrington].
56. *Id.*
57. *Id.*, Attachment 3, at 2.
58. CALIFORNIA DEP'T OF HEALTH CARE SERVICES, ANNUAL REPORT TO THE LEGISLATURE ON MEDI-CAL PILOT PROJECTS 20 (1971) [hereinafter cited as 1970 PILOT PROJECT REPORT].
capitation rate compared to a statewide monthly average of $6.35 for physician services reimbursed by the state on a fee-for-service basis during the following year. Generally, the premium rates were comparable to the statewide costs for the same types of covered services.

Under the renewed contract effective on August 1, 1970, capitation payments to the Foundation were 10 percent below the statewide fee-for-service average for the previous year. The department concluded in 1971 that the pilot project had shown "a significant improvement in the control of costs of physician services" while maintaining a high quality of care.

The main cost control device used by the Foundation was peer review. Peer review was established as a means for identifying and controlling the insufficient, excessive, or inappropriate use of medical services and for monitoring fees charged by providers. The Foundation found that peer review could control costs in three ways. First, the prospect of review could deter the provision of unnecessary services or the billing of improper charges. Second, upon actual review, many charges could be disallowed or reduced before payment. Finally, the peer review process could help to educate the provider in proper procedures.

In practice, the Foundation physician completed a claim form each time he or she treated a Foundation patient. From this claim form the Foundation assembled profiles of the services received by each patient and the services provided by each physician. These treatment profiles were then reviewed by claims examiners to discover improper treatment patterns.

Claims examiners evaluated all claims against criteria established for the most frequently seen conditions by the Quality and Cost Review Committee of the Foundation. Those claims that did not meet the

59. Id.
63. See Harrington, supra note 53, at 4.
64. 1970 PILOT PROJECT REPORT, supra note 58, at 15.
66. Id.
67. Foundation for Medical Care, San Joaquin Medical Society, Progress in Prepayment: A Summary of the Pilot Project Designed to Deliver Quality Medical Care to the Poor, at 4, June 1969. Criteria are organized based on diagnosis. For example, diagnosis and treatment of hypertension without mention of heart disease based upon
criteria, approximately 20 percent, were sent to a reviewing physician.\footnote{68}

The reviewing physician examined the claim against the framework of the provider and patient profiles. Further information might have been requested from the provider. If the reviewing physician felt the extra services were justified, the payment was approved. If the physician did not approve payment in full, the claim was referred to the Quality and Cost Review Committee.\footnote{69} Approximately 2 percent of all claims ended up in the Quality and Cost Review Committee. The Review Committee reviewed the claim and could request the provider to appear before it. If the claim was disallowed in whole or in part by the committee, further review was available by appeal to the California Medical Association. No appeals were ever made.\footnote{70}

Extensive peer review should discourage excess provision of services,\footnote{71} and therefore act as a cost control device.\footnote{72} Unfortunately, however, such review may not be nearly as successful in uncovering the more serious problem of underutilization. This factor would become crucial when the San Joaquin model was used outside the pilot project setting in widespread Medi-Cal programs.

The second pilot project was instituted on September 1, 1969,
with the Family Health Program of Southern California, a medical

The objective of this project was to test the cost control potential as well as recipient acceptance of a prepaid group practice. The Family Health Program Pilot Project varied significantly from the San Joaquin Foundation in that Medi-Cal recipients were not automatically enrolled in the plan. The Family Health Program thus had the burden of persuading eligible Medi-Cal recipients within its geographical area to join.

Participants were limited to those receiving aid to families with dependent children and old age security. By November 1, 1970, nearly 5,000 individuals, 90 percent of whom were recipients of aid to families with dependent children, had enrolled in the plan. These recipients lived in the Long Beach area of Los Angeles.

Services available to Medi-Cal enrollees in the Family Health Program were comparable to those available under fee-for-service Medi-Cal. There were certain exclusions, however. As a means of attracting Medi-Cal eligibles to join the Family Health Program, two types of services that were not generally provided under Medi-Cal fee-for-service were promised to recipients. Transportation was available without charge by Family Health Program bus to all Medi-Cal enrollees for the purpose of keeping medical appointments at Family Health Program clinics. Child care also was furnished.

73. 1969 PILOT PROJECT REPORT, supra note 52, Attachment 1, at 1.
74. Id.
75. Under the San Joaquin Foundation Pilot Project, the Foundation received a set amount each month based on the number of Medi-Cal eligibles in the four counties served. From this amount the Foundation had to pay for all covered services received by the Medi-Cal recipients whether through a Foundation doctor or not. Id.
76. Id. Under the San Joaquin Project a Medi-Cal recipient maintained freedom of choice in selecting providers as required by state and federal law. See text accompanying notes 52-72 supra. Under the Family Health Program, however, a recipient could only be treated by providers who were members of the Family Health Program. See 1970 PILOT PROJECT REPORT, supra note 58, at 32. Limitation of the recipient's freedom of choice therefore required some affirmative act by the recipient. That affirmative act was enrollment in the plan.
77. 1970 PILOT PROJECT REPORT, supra note 58, at 31.
78. Id.
79. The most significant limitation was the denial of payment to unauthorized nonplan providers. See id. at 32. The plan could thereby control the number and type of services that would be provided to enrollees. This was a significant cost control measure and would be included in nonpilot PHP contracts of the department. Failure by enrollees to explain this limitation to potential recipients would be cited as one of the most common types of misrepresentation.
80. Id.
81. Id.
Under the Family Health Program, member physicians were salaried; as a result, there was no financial incentive for overutilization of services by the provider. However, since the plan physician would receive the same amount of money regardless of the number and type of services provided, there was a temptation for those physicians to promote minimal utilization of plan services.

The 1971 Special Hearings of the Assembly Health Committee on Prepaid Health Plans addressed the potential problem of underutilization. Dr. Robert Gumbiner, Executive Director of the Family Health Program, testified that “enemies of group practice prepayment” say that “if you have a direct service prepayment the provider may take the money and not deliver the care, or deliver care of poor quality.” Dr. Gumbiner contended, however, that if the plan does not provide good care in the early stages of disease, it will be forced to provide more expensive services when the patient becomes seriously ill. In addition, the dissatisfied patient would complain to the Department of Health Care Services.

At least in theory, Dr. Gumbiner seemed correct. A prepaid health plan would profit by substituting less costly preventive medicine and ambulatory care for the expensive inpatient hospital services. Moreover, if the Department of Health Care Services received numerous complaints from enrollees about limited and poor quality services, the contract between the state and the plan would surely not be renewed.

Unfortunately Dr. Gumbiner’s comments failed to take several factors into account. First, a large number of the dissatisfied recipients might well disenroll from the plan soon after experiencing difficulties in obtaining services. Thus the plan, no longer responsible for the care of these patients, would never have to provide the hospital services that would later be needed. The costs of correcting the failure of the plan to treat the patient during the early stages of disease would

85. Id. at 38.
86. Id. The department also put forward several mechanisms for control of the potential problem of underutilization. These included disenrollment by the Medi-Cal beneficiary, peer review, comparison by the state of the number of services given to Medi-Cal patients to services provided private patients by the same group practice and comparison with other prepaid plans, comparison of prepaid services to fee-for-service recipient averages, and medical audits by the state. Id. at 12-15.
then be borne not by the prepaid health plan but by the Medi-Cal fee-for-service program. In addition, plan accountability would rest in large part on the watchful monitoring and vigorous enforcement of contractual, regulatory, and statutory requirements by the Department of Health Care Services. The failure of the department to fulfill these responsibilities would become all too apparent in the years ahead.

Numerous other pilot projects in prepayment were tested. Generally the pilot projects were established with existing entities in the health field. The usefulness of these pilot projects was often greatly diminished by the lack of standards for review by the department, but by 1971 the department had concluded that “prepaid comprehensive health care represents a feasible alternative to the Medi-Cal program.” However valid this conclusion may have been, the department did not begin to foresee the problems that would arise in translating the results of the pilot projects to the operational stages of the PHP program.

Fiscal Crisis in the Medi-Cal Program

In fiscal year 1964-65, the last year before implementation of the Medi-Cal program, federal, state, and county expenditures for medical

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87. The pilot projects included one to test the potential of cost control and improvement of utilization practices through preventive dentistry on a prepayment basis, as well as several other projects to demonstrate the cost savings of providing medical care for beneficiaries under a prepayment program. 1970 PILOT PROJECT REPORT, supra note 58, at 36. See also CALIFORNIA DEP’T OF HEALTH, ANNUAL REPORT TO THE GOVERNOR AND LEGISLATURE ON PILOT PROGRAMS 2 (1974) [hereinafter cited as 1974 PILOT PROJECT REPORT]; CALIFORNIA DEP’T OF HEALTH CARE SERVICES, 1972 ANNUAL REPORT TO THE GOVERNOR AND TO THE LEGISLATURE 2 (1973) [hereinafter cited as 1972 PILOT PROJECT REPORT]; CALIFORNIA DEP’T OF HEALTH CARE SERVICES, ANNUAL REPORT TO THE LEGISLATURE ON MEDI-CAL PILOT PROJECTS 17 (1972) [hereinafter cited as 1971 PILOT PROJECT REPORT]; 1971 Health Comm. Hearings, supra note 60.

88. Criteria to evaluate pilot projects were not even developed until late in 1970. Moreover, the standards that emerged were so general as to be of little use in evaluating the success or failure of the projects. Six criteria were put forward. (1) There must be some basis for cost comparison either with a control group or with statewide trends. (2) Quality of care must be measured. The department cautioned that this was especially important in the small prepaid group practice where services might be improperly limited in order to avoid costs. (3) The pilot project should demonstrate increasing acceptance by providers as measured by increased participation. (4) The pilot project should demonstrate increasing acceptance by beneficiaries. This could be demonstrated through consultation with consumer advisory committees within the project. (5) The project should have a positive effect on the delivery of services. This might be indicated by an increase in drug usage as a result of reduced injections in physicians’ offices. (6) The project should also have a beneficial effect on the delivery of services to non-Medi-Cal recipients through, for example, the extension of peer review from Medi-Cal enrollees to private patients. 1970 PILOT PROJECT REPORT, supra note 58, at 5-12.

care under the PAMC and MAA programs were $186,394,000.\textsuperscript{90} In fiscal year 1965-66,\textsuperscript{91} these costs increased to $408,953,000.\textsuperscript{92} By fiscal year 1966-67, the first full year under the Medi-Cal program, total medical care expenditures under the program increased to $709,700,000.\textsuperscript{93}

In November 1966, the administrator of the Health and Welfare Agency, Paul Ward, told Governor-elect Ronald Reagan that the Medi-Cal program would run a deficit of $81.6 million by the end of the fiscal year unless benefits were reduced or appropriations were increased.\textsuperscript{94} By December 4, 1966, the Office of Health Care Services had revised its estimated expenditures downward significantly from $709 million to $614 million.\textsuperscript{95} This new estimate reduced the likelihood of a deficit for fiscal year 1966-67. Although some of the urgency for a solution to spiralling Medi-Cal costs had passed, the problem still remained.

On January 19, 1967, the new administrator of the Health and Welfare Agency, Spencer Williams, announced steps by which the administration would save $30 million of federal and state monies in the Medi-Cal program.\textsuperscript{96} These steps included deferring all elective procedures until the following fiscal year and controlling the amount of hospitalization.\textsuperscript{97}

The governor’s budget, submitted to the legislature on January 31, 1967, projected Medi-Cal program expenditures of $619.4 million for the 1967-68 fiscal year.\textsuperscript{98} More problems soon arose, however, with projected costs for the 1966-67 fiscal year.\textsuperscript{99}


\textsuperscript{92} See 1969 Senate Study, supra note 90, at 132.

\textsuperscript{93} Id. at 131. Between fiscal years 1964-65 and 1966-67, the state share alone of administrative and medical expenditures increased from $55,767,000 to $225,200,000. Id. at 132.

\textsuperscript{94} Greenfield, supra note 9, at 53. The 1966-67 appropriation for the Medi-Cal program had been set at approximately $620 million for health services and administrative costs.

\textsuperscript{95} Id.


\textsuperscript{97} Id.

\textsuperscript{98} Cal. Support and Local Assistance Budget for the Fiscal Year July 1, 1967 to June 30, 1968, at 956.

\textsuperscript{99} The first problem was whether the state costs of the county option were to be included in the per capita ceiling on expenditures. The county option allowed
On July 19, 1967, Administrator Williams announced to the Health Review and Program Council that the deficit for the 1966-67 fiscal year might be as high as $150 million.\(^\text{100}\) Williams explained that an emergency session of the council might be necessary to develop plans for reducing this deficit.\(^\text{101}\) On July 25, 1967, new estimates were released by the Health and Welfare Agency which projected that Medi-Cal expenditures for the 1966-67 fiscal year would exceed allocations by almost $130 million.\(^\text{102}\) This deficit would have to be carried over into the 1967-68 fiscal year.\(^\text{103}\) In addition, revenues had been overestimated for the 1967-68 fiscal year.\(^\text{104}\) As a result, the total Medi-Cal deficit for 1967-68 was now estimated at $210 million.\(^\text{105}\)

On August 16, 1967, the Health and Welfare Agency announced a series of program changes designed to bring the Medi-Cal program into fiscal balance.\(^\text{106}\) These changes reduced the scope of services available and eliminated many services altogether.\(^\text{107}\) The cuts in serv-

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\(^\text{101}\) Id.  
\(^\text{102}\) GREENFIELD, supra note 9, at 55.  
\(^\text{103}\) Since this estimate was made prior to the passage of S.B. 1065, the Health and Welfare Agency administrator had anticipated satisfying the 1965-66 deficit out of the 1967-68 appropriation. Regarding S.B. 1065, see note 99 supra.  
\(^\text{104}\) GREENFIELD, supra note 9, at 55.  
\(^\text{105}\) Id.  
\(^\text{106}\) Health and Welfare Agency Press Release, Aug. 16, 1967. See also GREENFIELD, supra note 9, at 56.  
\(^\text{107}\) Surgical procedures for nonemergency or non-life-threatening conditions were
ices were widely condemned by professional organizations, community
groups, and Democratic legislators. On August 28, 1967, a tempo-
rary restraining order was issued by Judge Irving Perluss in a lawsuit
filed by California Rural Legal Assistance, a legal services program
funded by the Office of Economic Opportunity, on behalf of affected
Medi-Cal recipients throughout the state. The order in Morris v. Williams
enjoined the Reagan administration from implementing the
proposed cutbacks in services.

After further briefing and oral argument, Judge Perluss ruled that
the curtailment in the scope of services violated state law which re-
quired proportionate reductions in all services rather than elimination
of any services entirely. Only the limitation on private hospitaliza-
tion to eight days was upheld.

On September 12, 1967, Williams announced that an appeal
would be filed and that “pending a final determination by the Appellate
Courts, bills for services beyond those authorized by the regulations
may not be paid.” On November 20, 1967, the California Supreme
Court affirmed the decision of the trial court. The court concluded
that the service cutbacks violated “the mandatory requirements of
[Welfare and Institutions Code] sections 14006.5 and 14105 by re-
stricting physicians’ services for recipients of public assistance without
eliminating the medically indigent from the Medi-Cal program.”

Outpatient psychiatric services in physicians' offices were no longer provided. Routine
foot care, hearing examinations, restorative dentistry and several other services previ-
ously provided were also eliminated. In addition, physicians' fees were rolled back
to the January 1, 1967, “usual and customary” level. Id. at 2-3.

108. GREENFIELD, supra note 9, at 57.
28, 1967). Medical, dental, and pharmaceutical groups joined in the action as amicus
curiae in support of the California Rural Legal Assistance position.
110. Id.
111. At the August 11, 1967 meeting of the Health Review and Program Council,
Administrator Williams had stated to the council members that the staff of the Office
of Health Care Services had found unfeasible the legislative mandate that services
be curtailed proportionately. GREENFIELD, supra note 9, at 56.
27, 1967).
The appeal had been filed with the California Court of Appeal for the Third District.
Upon the request of the parties, and in view of the importance and urgency of the
matters involved, the case was transferred to the California Supreme Court. Id. at
738, n.3, 433 P.2d at 700, 63 Cal. Rptr. at 692.
115. Id. at 761, 433 P.2d at 716, 63 Cal. Rptr. at 708. Welfare and Institutions
Code section 14006.5 provided: “. . . If sufficient funds are not available to provide
The court also concluded that the service cutbacks violated section 14103.7 (of the Welfare and Institutions Code) "by eliminating certain services entirely in the absence of a showing that proportionate reductions were not 'feasible' to some extent."¹¹⁶

Governor Reagan was severely critical of the Morris decision.¹¹⁷ On November 21, 1967, the governor placed the question of Medi-Cal reform before the legislature during the Second Extraordinary Session of 1967.¹¹⁸ During that session two important measures were passed. The first measure, S.B. 7, introduced by Assemblyman Burgener, shortened the allowable period for submission of bills from six to two months after service was rendered.¹¹⁹ The second measure, introduced by Assemblyman Veneman, called for a moratorium on Medi-Cal cutbacks and appropriated funds for an audit to ascertain the extent of purported deficits in the program.¹²⁰

On December 14, 1967, the Health and Welfare Agency announced that the estimated deficit for the 1967-68 fiscal year had been revised downward from $210 million to $35.5 million.¹²¹ On January 1977
4, 1968, state Director of Finance, Gordon P. Smith, announced that
enough money was available to operate the Medi-Cal program at the
present level without any major cutbacks in services or in recipient
rolls. Smith further announced that the overexpenditure for services
rendered prior to July 1, 1967, had been paid out of 1966-67 appro-
priations.

A report by the bipartisan Joint Legislative Committee on Medi-
Cal Administration confirmed Smith's conclusions. The committee
found that instead of a fiscal shortage, the Medi-Cal account would
show a surplus for the 1967-68 fiscal year. The committee con-
cluded that "[t]here are no financial reasons to reduce Medi-Cal bene-

Actual total expenditures for Medi-Cal decreased from the previ-
ous year's $805 million to $706 million for the 1967-68 fiscal year. During the 1968-69 fiscal year, however, actual expenditures turned
upward again to $940 million. Expenditures during the 1969-70 fis-
cal year increased to $1.119 billion. Projected expenditures for the
1970-71 fiscal year were set at $1.25 billion.

In August, 1970, eligibility levels for medically needy individuals
were raised to include more people within the program. In Sep-
by an additiona $27 million. Another $27 million was saved by eliminating certain
funds that were originally projected to meet new nursing home standards. Tighter
nursing home utilization controls saved $7 million. The eight day limitation on private
hospitalization reduced the projection by $15 million. Finally, a rollback of physicians'
fees was expected to save $10 million. Id. at 1-2. $35.5 million of the remaining
$71 million deficit would be paid by the federal government under the 50% matching
formula, leaving a net deficit for the state of $35.5 million. See note 4 supra. Regard-
ing S.B. 1065, see note 99 supra.

123. Id.
124. JOINT COMMITTEE ON MEDI-CAL ADMINISTRATION, 1968 REG. SESS., REPORT
(1968).
125. Id. at 19.
126. Id. at 20. For a further description of the events during this period, see
R. STEVENS & R. STEVENS, WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDI-
CAID (1974).
127. CALIFORNIA LEGISLATIVE ANALYST, CALIFORNIA MEDICAL ASSISTANCE PRO-
GRAM, BACKGROUND INFORMATION, Table 3, at 4 (1971). Part of this reduction was
due to the uncertainty engendered by the warning of Administrator Williams after
the trial court decision in Morris v. Williams that bills would not be paid by the
state if the appeal to the supreme court was successful. See text accompanying note
90 supra. Thus, many procedures were deferred until the following fiscal year by wary
providers.
128. Id.
129. Id.
130. Id.
131. Id. at 13.
tember, 1970, the scope of benefits for the medically needy was expanded to be commensurate with the benefits provided to public assistance recipients. These changes added to the spiralling increase in costs for the Medi-Cal program. By December 1970, a $200 million deficit was projected for the Medi-Cal program.

On December 11, 1970, with a certain sense of déjà vu, Dr. Earl Brian, Director of the Department of Health Care Services, announced the promulgation of emergency regulations to deal with a projected $140 million deficit in the Medi-Cal program for the 1970-71 fiscal year. These emergency regulations, effective December 15, 1970, provided for a cut of 10 percent in physicians' fees and in fees to most other providers. Prior authorization was required for some drugs and price ceilings were placed on others. Certification was required for all hospitalization, even in emergencies.

On January 13, 1971, a lawsuit was filed by the California Medical Association against the state seeking to prevent enforcement of the emergency regulations. On June 1, 1971, after a lengthy trial, Judge William M. Gallagher of the Sacramento County Superior Court ruled that Director Brian had failed to establish that an emergency existed. These latest cutbacks had therefore been implemented without statutory authorization and were invalid.

Although an "emergency" had been judged not to exist, costs continued to increase dramatically. Both the legislative and executive branches searched for a solution. In early 1971, the Reagan administration announced its answer.

132. Id. at 14.
135. Id.
136. Id. “Prior authorization” required a provider to receive approval by a department consultant before providing specified services. If prior authorization was not granted, reimbursement would not be provided for the service by the state.
137. Id.
139. Id.
140. Id. The decision of the trial court was affirmed by the court of appeal in California Medical Ass'n v. Brian, 30 Cal. App. 3d 637, 106 Cal. Rptr. 555 (1973).
141. Increasingly, the solutions proposed relied on the concept of prepaid health care. In 1968, the Assembly Committee on Public Health issued a report on the Medi-Cal program with several recommendations for change. One of the recommendations was for the development of prepaid contracts for comprehensive health care serv-
The Medi-Cal Reform Act

Governor Reagan outlined his proposal for reform of the Medi-Cal program in his state of the state message to a joint session of the California State Legislature.\[^{142}\]

[Dr]astic reform is demanded in Medi-Cal.

In its first year of operation, Medi-Cal began exceeding estimated costs when only a third of those eligible had discovered its magic basket of goodies. Five years ago one out of fifteen Californians was on Medi-Cal—today one out of nine is enjoying with few inhibitions on use a program of unlimited coverage providing two to three times the services of health programs the working man can afford for himself and his family. . . .

. . . Hastily enacted under a federal whip, five years of operation have made it plain that Medi-Cal cannot meet California's needs.

During this session we will present for your consideration a plan to limit our health care services to the poor so they will be comparable with the health benefits provided by the various pre-paid health insurance plans covering most of our citizens.\[^{143}\]

This proposal was expanded in the Message from the Governor transmitted to the legislature on March 3, 1971. The Governor's message described the basic operation of PHPs and proposed to stimulate the development of qualified PHPs and to finance the enrollment of eligible welfare recipients through capitation payments.\[^{144}\] In addition to.

ices. Assembly Comm. on Public Health, A Preliminary Report on Medi-Cal, 1968 Reg. Sess. 24 (1968). The committee pointed out that "if there is validity to the premise that having responsibility for providing health care services within a fixed monthly amount per person will significantly reduce costs, especially through reduced hospital utilization, then the cost per recipient should be less for the same amount of protection." Id. at 26 (citations omitted).

Support for the prepayment concept as a means of controlling Medicaid costs was also building on a national level. In 1970 an HEW task force endorsed the development of health maintenance organizations as an option for Medicare and Medicaid beneficiaries. U.S. Dep't of Health, Education, & Welfare, Report of the Task Force on Medicare and Related Programs 33 (1970). The report concluded. "The Health Maintenance Organization proposal constitutes an important step toward possible long-range improvements in the organization and delivery of health services. It would encourage the Nation's physicians, hospitals, and other health institutions to seek out optimum ways of providing adequate services while striving to control unnecessary utilization." Id. at 33-34.

143. Id. at 144-45.
prepayment, Governor Reagan also proposed institution of copayment by Medi-Cal recipients and authorization controls for those services requested by recipients beyond a specified basic schedule of benefits.

On March 15, 1971, A.B. 949 was introduced by Assemblyman William Campbell. This bill embodied the proposals outlined by Governor Reagan. After lengthy negotiations between the administration representatives and legislators, A.B. 949 was passed by both houses of the Legislature. On August 13, 1971, it was signed into

145. ASSEMBLY DAILY JOURNAL, 1971 Reg. Sess., Mar. 3, 1971, at 822. Under the copayment plan, Medi-Cal recipients would be required to contribute to the cost of health services as a means of discouraging utilization. Copayment was analogized to the deductible required in most health insurance plans. Id. at 822-24.

146. Id. at 820. The basic schedule of benefits would include, for example, two outpatient visits per month and two prescriptions per month. Under the governor's proposal, recipients who required more than two outpatient visits or more than two prescriptions in a particular month would receive such services through supplemental care organizations at the county level under state supervision. Id. at 820-22.


Numerous other measures to revise the Medi-Cal program and reduce costs had been proposed during the same period. S.B. 1271 was introduced at the request of the California Medical Association. SENATE DAILY JOURNAL, 1971 Reg. Sess., Apr. 14, 1971, at 1016. See also CMA Bill Seeks to Divorce Medi-Cal From Politics, CMA NEWS, May 25, 1971, at 3; 1971 Health Comm. Hearings, supra note 60, at 87-98 (testimony of Dr. Marvin Shapiro). This legislation would have replaced the Department of Health Care Services with a public corporation which would contract annually with the legislature for the provision of health services to Medi-Cal beneficiaries.

The following day, Assemblyman Henry Waxman introduced A.B. 2719. ASSEMBLY DAILY JOURNAL, 1971 Reg. Sess., Apr. 15, 1971, at 1831. This legislation would have established minimum physician-patient staffing ratios for prepaid health plans serving Medi-Cal recipients. The legislation would also have required all facilities and personnel used by plans to be licensed. All but emergency surgery would have had to be performed by qualified specialists, and health plans would have been required to assign one managing physician to each enrollee to supervise and coordinate the enrollee's health care. A.B. 2719, as submitted, Apr. 15, 1971, at 3-4.

Centralized recordkeeping, internal medical audits, and continuing education for plan medical personnel, would have been required. Standards would also have been established for enrollment, and for consumer participation in plan decisionmaking. Id. at 3-7.

The Reagan administration, however, opposed the passage of the Waxman bill. Provisions requiring a public hearing before the execution of a PHP contract, for exam-
law as an urgency measure.\textsuperscript{150}

As enacted, A.B. 949 maintained the Governor's strong emphasis on PHPs as a means of reducing Medi-Cal costs. Studies were to be undertaken to determine the most cost-effective system for delivering health care, and this system was to be implemented throughout the state.\textsuperscript{151} Plans were required to insure that health care services were readily available to beneficiaries\textsuperscript{162} and to pay for emergency services rendered outside of the plan's contract area.\textsuperscript{163} In addition, A.B. 949 established data reporting responsibilities for PHP contractors and directed contractors to allow state access to plan records for the purpose of verifying these reports.\textsuperscript{154} Capitation rates were to be reasonably consistent with, and potentially less than, the cost of providing such services to comparable beneficiaries in the same area under the Medi-Cal fee-for-service program.\textsuperscript{155} A.B. 949 authorized the Department of Health Care Services to provide information to Medi-Cal beneficiaries on the availability and coverage of PHPs.\textsuperscript{156} The Health Care Commission\textsuperscript{157} was to study the quality of care under Medi-Cal, including the provision of services by PHPs.\textsuperscript{158}

The Medi-Cal Reform Act (A.B. 949) made several other changes that affected the development of the prepaid health program. The director of the Department of Health Care Services was given discretion to require prior authorization before particular services could be provided

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\textsuperscript{151} Cal. Welf. & Inst'ns Code § 14000(f) (West 1972).
\textsuperscript{153} Id.
\textsuperscript{154} Id.
\textsuperscript{155} Id. 1120.
\textsuperscript{156} Id., § 34.4, at 1124.
\textsuperscript{158} Cal. Stat. 1971, ch. 577, § 34.4, at 1124 (repealed 1972).
to recipients. Copayment was established for many recipients with charges of $1.00 for each outpatient visit and $.50 for each prescribed drug. In contrast to the many restrictions on services imposed by the Medi-Cal Reform Act, coverage was extended for the first time to non-categorically related medically indigent adults.

Since Medi-Cal recipients maintained their freedom of choice in selecting health care providers under the new legislation, some method had to be used to encourage providers and recipients to participate in the PHP program. This method was characterized by the Reagan administration as "the carrot and the stick." The administration acknowledged that while "the State has eschewed coercion, it has implemented a definite philosophy." The "stick" in this system was represented by the additional requirements of prior authorization and copayment. As well as being restrictive and bothersome to patients, these new procedures would increase the red tape and bureaucratic annoyances for physicians seeking rapid reimbursement. Recipients would be encouraged to enroll in PHPs by the promise of unlimited services (theoretically not subject to prior authorization) and by the fact that PHP clinics did not require copayment by recipients. Providers would be encouraged to participate through the promise of assured and prompt capitation payments.

The "carrot and the stick" approach to encouraging provider and recipient participation was linked to a theory of "minimal regulation" for encouraging the formation of plans. As described by the department:

The program operates without undue governmental interference in the practice of medicine and other healing arts. The State's role

162. Id. § 14005 (West 1972).
163. Cal. Dep't of Health, Prepaid Health Plans: The California Experience, June 9, 1974, contained as Exhibit No. 30 in Hearings on Prepaid Health Plans Before the Permanent Subcomm. on Investigations of the Senate Comm. on Gov't Operations, 94th Cong., 1st Sess. 236 (1975) [hereinafter cited as Jackson Committee Hearings].
164. Id.
165. Id.
166. Id. See also Fairbanks, Medi-Cal: Seeking a Cure for Unbearable Costs, 6 CAL. J. 40, 41 (1975).
is limited to safeguarding its interests and those of its beneficiaries, without the constriction of unnecessary anticipatory regulations.\textsuperscript{168} This \textit{laissez faire} philosophy was expressed in the first set of regulations adopted by the department in the fall of 1971.\textsuperscript{169} Generally, these regulations simply incorporated the provisions of the Medi-Cal Reform Act. Several additional requirements were imposed by the regulations, however. PHPs were required to have the financial resources and the administrative and organizational capabilities sufficient to carry out their contractual obligations.\textsuperscript{170} Plans were also required to demonstrate the availability and accessibility of an adequate number of facilities and personnel.\textsuperscript{171} Proposals for PHP contracts were to include information regarding the proposed health care delivery system,\textsuperscript{172} plan finances,\textsuperscript{173} the administrative organization of the plan,\textsuperscript{174} the plan's system for internal performance monitoring,\textsuperscript{175} and such additional information as the department might require.\textsuperscript{176} No standards were established, however, to guide the department in considering these proposals.\textsuperscript{177}

The regulations also provided that enrollments must be voluntary,\textsuperscript{178} and that enrollment contracts would be for a minimum period of one year,\textsuperscript{179} with each plan restricted to enrolling Medi-Cal beneficiaries residing within its geographical boundaries.\textsuperscript{180} The minimum enrollment period was to be clearly stated on the enrollment form signed by the recipient.\textsuperscript{181}

The regulations required that beneficiaries be provided with written information about the plans available to them.\textsuperscript{182} All written information prepared by the PUP was subject to prior approval by the department.\textsuperscript{183} Disenrollment was deemed mandatory when the en-

\begin{itemize}
\item \textsuperscript{168} Cal. Dep't of Health, Prepaid Health Plans: The California Experience, June 9, 1974, in \textit{Jackson Committee Hearings}, supra note 163, at 234.
\item \textsuperscript{169} \textit{Cal. Admin. Reg.} 71, No. 40 (repealed 1973).
\item \textsuperscript{171} \textit{Id.} § 51600(a)(3).
\item \textsuperscript{172} \textit{Id.} § 51602(a)(3).
\item \textsuperscript{173} \textit{Id.} § 51602(b).
\item \textsuperscript{174} \textit{Id.} § 51602(i).
\item \textsuperscript{175} \textit{Id.} § 51602(g).
\item \textsuperscript{176} \textit{Id.} § 51602(k).
\item \textsuperscript{177} \textit{See id.} § 51604.
\item \textsuperscript{178} \textit{Id.} § 51606(a).
\item \textsuperscript{179} \textit{Id.} § 51606(b).
\item \textsuperscript{180} \textit{Id.} § 51606(c).
\item \textsuperscript{181} \textit{Id.} § 51606(e).
\item \textsuperscript{182} \textit{Id.} § 51606(d).
\item \textsuperscript{183} \textit{Id.}
\end{itemize}
rollee moved outside the geographical area covered by the PHP or became ineligible for Medi-Cal benefits.\textsuperscript{184} The enrollee could also terminate at any time after having been enrolled in the plan for the minimum period.\textsuperscript{185} Disenrollment in other circumstances would only be approved when the director of the Department of Health Care Services determined that reasonable cause was present.\textsuperscript{186} The regulations provided that contracts could be terminated or capitation payments withheld whenever the plan failed to comply with all the appropriate laws, regulations, or terms of the contract or for other good cause.\textsuperscript{187}

The first nonpilot PHP contract, with Innovative Health Systems, became effective on April 1, 1972.\textsuperscript{188} A contract, effective May 1, 1972, was signed with the Central Los Angeles Health Project.\textsuperscript{189} By December 1972, twenty-two PHP contracts were in effect.\textsuperscript{190} The

\begin{itemize}
\item \textsuperscript{184} Id. § 51608(a).
\item \textsuperscript{185} Id. § 51608(b).
\item \textsuperscript{186} Id. § 51608(c).
\item \textsuperscript{187} Id. § 51612.
\item \textsuperscript{188} 1972 PILOT PROJECT REPORT, supra note 87, at Table I. Other materials published by the Department of Health Care Services do not list this contract. See CAL. DEPT. OF HEALTH, ANNUAL REPORT TO THE LEGISLATURE ON PREPAID HEALTH PLANS (PHPs) 2 (June 1974). The Innovative Health Systems contract, which lapsed on January 1, 1973, was the conversion of a preexisting pilot project contract. 1972 PILOT PROJECT REPORT, supra note 87, at 7.
\item \textsuperscript{189} 1972 PILOT PROJECT REPORT, supra note 87, at Table I.
\item \textsuperscript{190} Id.
\end{itemize}

During 1972, standards were established for evaluating proposals for PHP contracts. Cal. Dept. of Health Care Services, Evaluation and Monitoring of Prepaid Health Plans (1972). Prospective PHPs were expected to cover ten areas in their initial proposals to the state: the general purpose of the proposal, the legal capacity under which the carrier intended to contract, the service area to be covered, the number of proposed enrollees for the first contract year, proposed premiums, design of health delivery capabilities, a certified statement of existing assets and liabilities, a proposed budget, the proposed system of internal performance monitoring, and information regarding the proposed providers. Id. at 3-4.

Plans were to include a roster of all key administrative and professional medical personnel involved in the plan and brief resumes. Copies of all subcontracts and administrative or management agreements were also to be provided, and upon receipt of this information, the department was to conduct an "extensive and thorough background check" on the providers. The investigation was to cover "potential criminal background, current status with the appropriate state licensing board, Medi-Cal provider status, and a provider status check with the appropriate fiscal intermediaries." The investigation was also to determine that all proposed plan facilities were appropriately licensed or certified. \textit{Id.} at 4.

After completion of the investigation, the facilities to be used by the PHP were to be subjected to an on-site inspection by departmental staff prior to contract approval. There was, however, no routine inspection by medical personnel. \textit{Id. See also CALIFORNIA LEGISLATIVE ANALYST, A REVIEW OF THE REGULATION OF PREPAID HEALTH PLANS 16 (1973) [hereinafter cited as 1973 LEGISLATIVE ANALYST REPORT]. The main purpose of the precontract visit was to evaluate the adequacy of the physical plant in light of the
overwhelming majority of these plans were in the Los Angeles area. As of December 1, 1972, 132,668 Medi-Cal beneficiaries were enrolled in the plans.

Capitation rates paid by the state varied significantly from plan to plan. No capitation rate was to exceed the 90 percent level of costs for the same services provided in the same locale on a Medi-Cal fee-for-service basis. Within that limitation, however, the department represented that variation in capitation rates was based only on the geographical location of the plan, the services provided, and the plan's organizational structure. Capitation rates in the Los Angeles area ranged from $21.86 to $34.75 per month for an Old Age Security recipient, and from $19.30 to $23.75 per month for an AFDC recipient.

Once a contract was signed between the Department of Health Care Services and a PHP, the plan could begin to seek enrollments from Medi-Cal recipients. Since no capitation monies would be received from the state until recipients were enrolled, the first few months of any plan's existence would be spent securing these enrollments. Because the names and addresses of Medi-Cal recipients are confidential and were therefore theoretically unavailable to PHP contractors, methods of enrollment became a serious concern for plans. Information prepared by the plans could be mailed out by the state at plan expense to prospective enrollees without breaching confidential-

number of enrollees the plan expected to serve. Cal. Dep't of Health Care Services, Evaluation and Monitoring of Prepaid Health Plans at 5.

191. 1972 PILOT PROJECT REPORT, supra note 87, at Table I.

192. Id. Each contract entered into by the department with a prepaid health plan provided for a maximum enrollment within a specified service area.

193. Id.

194. Id. at 7.

195. Not all plans were required to provide all covered services under Medi-Cal. Cal. Stat. 1971, ch. 577, § 38, at 1131 (repealed 1972). Medi-Cal recipients enrolled in such plans would receive specified services from the plan, and other services from other providers with fee-for-service reimbursement. The most common type of covered service which was excluded from plan contracts was dental service.


197. Id. at Table I.


199. The standard procedures developed for marketing prepaid group practices were designed for enrollment of organizational memberships. They had minimal usefulness for the PHP seeking to enroll a Medi-Cal recipient population. See HEALTH SERVICES & MENTAL HEALTH ADMIN., U.S. DEP'T OF HEALTH, EDUCATION & WELFARE, MARKETING PRE-PAID HEALTH PLANS (1972).
ity.\textsuperscript{200} This, however, proved to be a relatively ineffective method of securing enrollments.\textsuperscript{201} Most plans decided to rely instead on door-to-door solicitation in low income neighborhoods.\textsuperscript{202}

**The Problems Begin**

The problems that were to arise in the PHP program in the next few months should not have come as a great surprise to the Reagan administration. As early as September 21, 1971, when the Department of Health Care Services began consideration of non-pilot PHP contracts, Chester Jones, then in charge of the Los Angeles, San Bernardino, and San Diego offices of the department's investigation section, sent a memorandum to his superiors outlining potential problems in the new PHP program.\textsuperscript{203}

Jones warned that several applicants for PHP contracts were under investigation by the department for alleged fraudulent activities in the Medi-Cal fee-for-service program. Jones also warned of potential abuses which might arise in the PHP program. For example, contractors might deliberately fail to provide proper and adequate medical care or might discourage recipients from securing necessary medical attention. By thus minimizing utilization, plans would maximize profits since capitation payments would not have to be expended for medical services. Inadequate staffing might be employed to further minimize patient utilization. Jones also cautioned that PHP contractors could enroll thousands of recipients during an initial period, receive capitation payments from the state without providing care, and then declare bankruptcy.\textsuperscript{204}

Despite this warning, a directive was issued less than two weeks later which instructed investigators to conduct only limited background investigations of PHP contract applicants.\textsuperscript{205} Even the presence of unfavorable background investigations, however, did not always deter the department from contracting with questionable providers.\textsuperscript{206}

\textsuperscript{200} Cal. Stat. 1971, ch. 577, § 34.4, at 1124 (repealed 1972).
\textsuperscript{201} Special Meeting on Prepaid Health Plans: Enrollment and Marketing Procedures, Before Assembly Comm. on Health, 1973 Reg. Sess. 75 (1973) [hereinafter cited as 1973 Enrollment and Marketing Hearings].
\textsuperscript{202} Id.
\textsuperscript{203} Cal. Dep't of Health Care Services, Potential Problems with Some PHP Contractors, September 21, 1971, contained as Exhibit No. 9, Jackson Committee Hearings, supra note 163, at 37 (internal memorandum by Chester Jones).
\textsuperscript{204} Id.
\textsuperscript{205} P. Newlin, Memorandum to Investigation Staff of the Cal. Dep't of Health Care Services, September 27, 1971, contained as Exhibit No. 10 in Jackson Committee Hearings, supra note 163, at 38.
\textsuperscript{206} See, e.g., Cal. Dep't of Health Care Services, Agent Report on Edward Rubin,
On October 5, 1972, the *Los Angeles Times* reported the picketing of the offices of the DePaulo Health Plan. The demonstrators complained about misrepresentation by DePaulo enrolers, failures to provide quality medical services, and failures to provide promised transportation to plan clinics. Picketers reported being approached by women in nurses’ uniforms who told them that if they did not enroll their Medi-Cal benefits would be terminated. Others reported receiving prescriptions for sick children without any observation of the patient by a physician. On November 10, 1972, the *Los Angeles Times* reported that PHP contractors were minimizing their costs by providing inappropriate and substandard care to the poor.

In spite of these early warnings, the role of the department’s Investigation Bureau was limited even further. Responsibility for investigation of complaints regarding prepaid health plans was taken out of its hands, and investigators were instructed to limit their involvement to cases in which the Monitoring Unit of the Prepaid Health Plan Bureau or other bureau employees discovered violations of law requiring a criminal investigation.

Responsibility for field investigations was assigned instead to John Blaul, a former Navy medical corpsman, whose only investigative experience had been six weeks training at the Riverside, California, Sheriff’s Academy. Despite his lack of experience, Blaul substantiated numerous allegations of forged enrollments by PHPs, misrepresentations by enrolers, and substandard care. The Los Angeles Times played an especially important role in the early months of the PHP program by investigating and reporting on violations within the program. Part of the following chronology is contained in *Jackson Committee Hearings*, supra note 163, at 8-13. The chronology should be viewed as descriptive rather than inclusive. The actual number of reports and incidents relating to prepaid health plans far exceed the number contained here.

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207. *L.A. Times*, Oct. 5, 1972, Westside section, at 1, col. 5, *reprinted in Los Angeles County Health Rights Organization, Health Rights Handbook* 43 (1974) [hereinafter cited as *Health Rights Handbook*]. The *Los Angeles Times* played an especially important role in the early months of the PHP program by investigating and reporting on violations within the program. Part of the following chronology is contained in *Jackson Committee Hearings*, supra note 163, at 8-13. The chronology should be viewed as descriptive rather than inclusive. The actual number of reports and incidents relating to prepaid health plans far exceed the number contained here.


210. *Id.*, col. 2.

211. *See L.A. Times*, Nov. 10, 1972, at 1, col. 4.

212. E. Chamberlin, Memorandum to All Investigative Offices of the Cal. Dept of Health Care Services, Nov. 14, 1972, contained as Exhibit 11 in *Jackson Committee Hearings*, supra note 163, at 38-39.

213. *Jackson Committee Hearings*, supra note 163, at 38 (testimony of Jonathan Cottin, Investigator for the Minority). The affidavit of John Blaul was retained in the files of the subcommittee as confidential.
tions by plan enrollees claiming to be state and local welfare department employees, enrollees wearing nurses’ or doctors’ white coats, and poor or non-existent medical care. Blaul later reported to United States Senate investigators that although his superiors told him that contract managers would correct these violations, the same violations arose week after week against the same plans. Blaul further reported that he was consistently discouraged by his supervisor from conducting in-depth investigations of these recurring complaints.

For approximately one year, Blaul was the only person assigned to PHP field investigations despite the tremendous growth within the program. All of Blaul's investigative files were later lost within the Sacramento office of the Department of Health Care Services.

On December 10, 1972, the Los Angeles Times disclosed that 500 complaints against PHP contractors had been received by the Los Angeles County Medical Association during the preceding eight weeks. PHP enrollees reported clinic closures during evening hours and non-availability of physicians during daytime hours. The article revealed that some PHP investors anticipated a 2500 to 3000 percent return on their investments. On January 10, 1973, the San Pedro News Pilot reported a warning from the Los Angeles County Health Rights Organization (LACHRO) to Medi-Cal beneficiaries that they should “investigate before giving up Medi-Cal [fee-for-service] benefits.”

214. Id. at 39.
215. Contract managers were employees of the Department of Health Care Services within the Prepaid Health Plan Bureau who were assigned to monitor the operations of specific prepaid health plans.
217. Id. at 40.
218. J. Cottin, Memorandum to PHP Case File on C. Blake, Mar. 10, 1975, contained in Jackson Committee Hearings, supra note 163, at 40.
219. Id.
220. L.A. Times, Dec. 10, 1972, § 2, at 1, col. 1. On January 23, 1973, the Times reported the rejection by the state of a PHP contract proposed by the Whittacker Corporation of Los Angeles. The proposed contract was refused on the grounds that the prepaid health plan was to be run for profit. Ironically, the proposed profit was to be 5%. L.A. Times, Jan. 23, 1973, § 1, at 3, col. 5.
LACHRO described the plight of one enrollee who had called her PHP requesting emergency medical transportation. She had received it two days later.\(^{222}\) In another incident, an enrollee with an ulcer had had to turn to a Free Clinic for care after being unable to get an appointment with her plan.\(^{223}\) LACHRO also warned of high pressure door-to-door salesmen dressed in doctors' uniforms or representing themselves as county social workers or state employees.\(^{224}\) Since an enrollee in a prepaid health plan could only visit providers who participated in the plan, LACHRO cautioned recipients not to rely on enroller promises that they could continue to see their own physicians.\(^{226}\)

On January 29, 1973, the *Los Angeles Times* published an editorial in response to an announcement by the Reagan administration that coverage of all Medi-Cal recipients under prepaid health plans would save California taxpayers $150 million to $300 million per year.\(^{226}\) The *Times* argued that while “[a]ny such savings would be welcome . . . it must not come about by shortchanging the state’s 2.4 million medically indigent.” The editorial noted the failure of the Department of Health Care Services to establish any standards for prepaid health plans, and urged that no new contracts be negotiated until standards were established. It also pointed to the 34 percent rate of disenrollment from plans, and the repeated reports of failures by the plans to provide required services, especially 24 hour a day emergency services. The editorial concluded that “as quality controls are improved, costs will rise and the expected tax saving will diminish. But substandard care for the medically indigent must not be tolerated.”\(^{227}\)

On February 15, 1973, the *Times* reported that the state contract with Innovative Health Systems had been cancelled because one of the plan’s hospitals lacked accreditation and because of poor quality pharmacy services.\(^{228}\)

On February 24, 1973, the *Times* reported that the Comprehensive Health Planning Council of Los Angeles County had asked the Los

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\(^{223}\) Id.

\(^{224}\) Id. Because of such abuses, the Department of Health on September 5, 1973, banned door-to-door solicitation in Los Angeles and Orange Counties. *L.A. Times*, Sept. 6, 1973, § 1, at 23, col. 3.

\(^{225}\) Id.


\(^{227}\) Id.

\(^{228}\) *L.A. Times*, Feb. 15, 1973, § 1, at 27, col. 1.
Angeles District Attorney, the California Attorney General, and the Department of Consumer Affairs to investigate fraudulent enrollment practices by prepaid health plans. A statement issued by Dr. Joseph F. Boyle, council president, declared that "[t]he enrollment practices appear to have been designed to prey upon the naivete, language difficulties, state of social dependence, and fears of poor people, particularly members of minority groups." Dr. Boyle went on to charge that the Department of Health Care Services "has either been the witting accomplice in deceitful enrollment practices or has been grossly negligent in carrying out its responsibility." The statement described many PHPs as a serious threat to the mental and physical well-being of Medi-Cal enrollees.

On February 27, 1973, the Times published another editorial regarding PHPs. This editorial noted the report of the Comprehensive Health Planning Council and stated that while the concept of prepaid health care was a good one, "the program is now clearly deficient and widely distrusted by the public, with good reason." On April 5, 1973, the Department of Health Care Services ordered Marvin Health Services to cease enrollment and improve plan operations. The department noted numerous patient complaints and high disenrollment rates, and also pointed out that Marvin enrollment had been previously terminated during the period November 15, 1972, through December 15, 1972, because the plan had enrolled Medi-Cal recipients in areas of Los Angeles which lacked accredited plan facilities. One week later the department announced the opening of a Los Angeles office to investigate complaints concerning PHPs.

On April 29, 1973, the New York Times reported that Teamster consultant Allan Dorfman and Teamster president Frank Fitzsimmons had allegedly arranged with three reputed California Mafia figures to enroll Teamster Union members in Marvin Health Services in exchange for a split in kick-backed funds.

In May 1973, Chester Jones, who had repeatedly requested authority to investigate the large number of PHP complaints that he had received, was relieved of his command of the San Diego and San Ber-

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229. L.A. Times, Feb. 24, 1973, § 2, at 1, col. 5. The Comprehensive Health Planning Council of Los Angeles is one of a number of agencies that plan and coordinate the delivery of health services in specified areas.

230. Id. at 10, col. 4.


nardino investigations field offices of the Department of Health Care Services.\textsuperscript{234}

On June 15, 1973, \textit{Medical World News} reviewed the recent developments within the California prepaid health plan program.\textsuperscript{235} The article asserted that the lessons learned in California would affect the delivery of health care nationally by helping to shape attitudes and legislation.\textsuperscript{236} The report also discussed one particularly unfavorable evaluation of the quality of care offered by the California Medical Group,\textsuperscript{237} the provider of medical services for the largest PHP contractor in the state.\textsuperscript{238}

\textsuperscript{234} Testimony of J. Cottin, \textit{Jackson Committee Hearings, supra} note 163, at 41. The frustration experienced by Mr. Jones was apparently shared by other investigators. Gerald B. Rohlfes, who became chief of the Investigations Section in March 1973, later testified that the decision to reduce the role of the investigations section "was viewed by some of our staff as an effort by our Executive Staff to cover up or at least take the heat off the PHP Program which our Management was anxious to sell from a political standpoint." \textit{Jackson Committee Hearings, supra} note 163, at 131.

\textsuperscript{235} \textit{HMOs' Stormy Tryout in Los Angeles Area}, \textit{MEDICAL WORLD NEWS}, June 15, 1973, at 17.

\textsuperscript{236} \textit{Id}.

\textsuperscript{237} The unfavorable evaluation discussed in this article was reached in a report prepared for the Teamsters Union by a group of investigators under the direction of Dr. Lester Breslow, dean of the UCLA School of Public Health. California Council for Health Plan Alternatives, California Medical Group (CMG) Evaluation Report, Dec. 6, 1972, contained as Exhibit No. 21 in \textit{Jackson Committee Hearings, supra} note 163, at 311. The report listed several major deficiencies in the staffing and hospitalization practices of CMG, including a ratio of full-time physicians to patients in the plan of 1:1,375. This compared unfavorably with the physician-patient ratios of 1:1,000 and 1:1,200 at two separate Kaiser facilities. The ratios of pediatricians, internists, and obstetrician-gynecologists to plan enrollees were also far below those in effect in other health maintenance organizations. Although CMG had a total patient population of over 100,000, for instance, it did not have a single obstetrician on its staff. The ratio of pediatricians to patients was 1:55,000, which compared unfavorably with the range of 1:4,545 to 1:10,357 in the other prepaid plans used as study comparisons. \textit{Jackson Committee Hearings, supra} note 163, at 313-14.

The report was equally critical of CMG hospitalization practices. First, it noted that although the Los Angeles area had many excellent hospitals from which to choose, CMG sent most of its patients to several small proprietary hospitals, one of which was not even accredited by the Joint Commission on Accreditation of Hospitals. Second, the number of hospital admissions per 1,000 enrollees per year and number of hospital days per 1,000 enrollees per year were significantly lower in CMG than in other health care plans in California. Finally, the research team was critical of CMG's peer review system. Under this system the work of plan physicians was rated according to the norm of other doctors within the group rather than according to the norm of the entire medical community or to a standard of acceptable care developed by experts in the various medical specialties. \textit{Id} at 314-17.

\textsuperscript{238} California Medical Group is one of the complex of companies that provides medical services to Consolidated Medical Systems. See \textit{Joint Legislative Audit Comm., Report of the Office of the Auditor General, Department of Health:}
The Legislative Response

The lessons of the first few months of the prepaid health plan program were not lost on the state legislature. Complaints about misrepresentation, profiteering, conflict of interest, and lack of standards for assuring quality of care were translated into legislation by the end of 1972.

On March 15, 1972, several weeks before the first nonpilot contract became effective, Assemblyman Waxman reintroduced his standard-setting legislation as A.B. 1496 with the cosponsorship of Republican Assemblyman Gordon Duffy. A.B. 1496 was to establish, for the first time, specific standards for the administration of the prepaid health plan program in California. As it had done the year before, the Reagan administration initially opposed the new legislation. The administration position later changed, however, and the Waxman-Duffy Prepaid Health Plan Act was passed by the legislature, and was approved by the governor on December 22, 1972. It became effective as an urgency measure on July 1, 1973, although provisions of the act also applied to existing PHP contracts that were renewed prior to that date.

A.B. 1496 required that all enrollments be voluntary and prohibited the use of false advertising to induce enrollment. The granting of monetary or other consideration for enrollment was also prohibited. Written materials provided to Medi-Cal beneficiaries by plan enrollers were to be approved by the department prior to distribution. As a further protection against enrollment fraud and other violations, the administrative hearing process was specifically made applicable to prepaid health plan complaints, giving dissatisfied recipi-
ents some recourse, should the department fail to act on their complaints.

A.B. 1496 established basic quality standards as well. The legislation set minimum patient-physician ratios. The act also specified that a PHP must provide at least five physicians representing pediatrics, internal medicine, general surgery, and obstetrics-gynecology. PHPs were directed to assign a primary care physician to every enrollee to manage the enrollee’s medical care. PHP facilities and providers were required to be appropriately licensed and accredited. The Department of Health Care Services was mandated to “conduct periodically an onsite review of the level and quality of care, the necessity of the services rendered, and the appropriateness of the services provided” by the PHPs. Each PHP was also required to conduct internal medical audits and to make “all reasonable efforts to achieve, by the third contract year, an enrollment of not more than 50 percent Medi-Cal beneficiaries.”

The Waxman-Duffy Act (A.B. 1496) also contained expanded provisions relating to conflict of interest. The act prohibited the approval or renewal of any contract if any officer or employee of the state or any member of the legislature had any direct or indirect financial interest in any plan or in any contract with the plan, or if the prepaid health plan had offered or given anything of value to the officer, employee, or member of the legislature for the purpose of influencing or attempting to influence the approval or renewal of any contract with the department.

Although this legislation did not become effective until July 1, 1973, on January 30, 1973, the Department of Health Care Services
promulgated regulations which contained many of the provisions of the Act. The regulations also established several new standards. Plans were required to have one acute hospital bed per 500 enrollees and at least one licensed pharmacist per 2500 enrollees. The regulations also expanded the information that plans were required to provide to recipients.

The Problems Continue To Mount

Although the legislature had enacted specific standards and procedures for administration of the PHP program, problems continued and multiplied in the months that followed. The new rules proved to be only as effective as the departmental personnel that administered them. Unfortunately, the department continued the policies of minimal enforcement and accommodation that had characterized the program from its inception. The written rules had changed; the unwritten rules had not.

On July 5, 1973, the Los Angeles Grand Jury indicted an enroller for the Harbor Health Services plan for forging the names of Medi-Cal recipients on enrollment forms after those persons had refused to enroll. On July 17, 1973, the San Diego County District Attorney’s office filed a suit against Consolidated Medical Systems, Inc., for false and misleading representations by its salesmen. On August 6, 1973, the Los Angeles County District Attorney’s office began a comprehensive investigation into enrollment violations by prepaid health plans.

On the same day, hearings on PHP enrollment practices were conducted by the Assembly Committee on Health. In opening the hearings, Chairman Henry Waxman noted that the “charges of misrepresentation and fraud continue to mount in such numbers that they cannot be ignored.” Assemblyman Waxman cited the case of a Medi-

261. 1973 Enrollment and Marketing Hearings, supra note 201.
262. Id. at 1.
Cal recipient who had been told by an enroller that President Nixon wanted to cut off her medical assistance. The recipient was told to sign a form provided by the enroller if she wanted to maintain her Medi-Cal eligibility. The form turned out to be an enrollment application for a PHP. Enrollers in this plan were paid base salaries of nearly $8000 per year plus $3 per enrollment contract. The plan representative acknowledged that the state did not review the background of enrollers, nor did the state ask the plans to terminate solicitors against whom complaints had been filed.

Plan representatives also testified that even where a recipient had been fraudulently enrolled and decided to disenroll immediately, delays in the disenrollment process could deprive the recipient of Medi-Cal benefits for as long as six weeks. During that interim period, the plan would continue to receive capitation payments for the enrollee. It was also admitted that Spanish speaking recipients were approached by Spanish speaking enrollers, but were required to sign English language contracts.

During the hearings, an official from the Department of Health acknowledged that although contracts between the state and PHPs required the submission of background information regarding plan enrollers prior to commencement of solicitation, the state had not received any such reports. The department representative also testified that without door-to-door solicitation, plans would be unable to attract sufficient numbers of Medi-Cal recipients to establish fiscal stability. He also noted that only four investigators were available across the entire state to follow up on enrollment complaints. Assemblyman Duffy then inquired about the requirement of the Waxman-Duffy Act that the director "terminate contracts with any carrier if he finds that the standards are not being complied with." Department officials

263. Id. at 2.
264. Id. at 25.
265. Id. at 27.
266. Id. at 31.
267. Id. at 35-36.
268. Id. at 50.
269. Id. at 64-65.
270. Id. at 75-76.
271. Id. at 79.
272. Id. at 81. Assemblyman Duffy was referring to provisions of the 1972 Wax-
were forced to acknowledge that despite the large number of complaints, no plan had yet been terminated for enrollment violations.\textsuperscript{273}

On August 8, 1973, the \textit{Los Angeles Times} reported that the dental director of Consolidated Medical Systems had resigned because of the repeated refusals by the plan to authorize needed dental services. The director also charged that Consolidated Medical Systems would authorize extractions rather than the more costly restorations.\textsuperscript{274}

On August 10, 1973, the state auditor general's office issued a preliminary report on its investigation of the PHP program.\textsuperscript{275} The report began by pointing out that the investigation had been frustrated by Department of Health officials who had limited the investigators' access to personnel and records.\textsuperscript{276} Despite these restrictions, the report went on, the staff had documented numerous failures by the department and violations of law by prepaid health plans.\textsuperscript{277} The Auditor General found that the state was often paying more than once for services: health care covered under the capitation payment was also billed on a fee-for-service basis.\textsuperscript{278} The report also emphasized that PHPs were actually profit-making entities that functioned through a system of interlocking officers and directors and subsidiary relationships.\textsuperscript{279}

Numerous cases of PHP representatives using fraudulent practices to enroll Medi-Cal recipients were also documented in the report.\textsuperscript{280} In addition, the report criticized the department for failing to coordinate implementation of the PHP program with county welfare departments.\textsuperscript{281} Finally, the report charged the department with failing to establish requirements for effective monitoring of PHPs including uniform accounting and medical auditing procedures.\textsuperscript{282}

276. \textit{Id.} at 1, 12-13.
277. \textit{Id.} passim.
278. \textit{Id.} at 5.
279. \textit{Id.} at 6.
280. \textit{Id.} at 7.
281. \textit{Id.} at 8.
282. \textit{Id.} at 9-10. Dr. Stubblebine, then state health director, disputed the findings of the auditor general regarding double payment, administrative incompetence, and non-cooperation by departmental staff with the investigation. In a news conference called to respond to the auditor general's report, Stubblebine declared, "We claim, and I will shout it from the rooftops, we have competent, adequate, skilled management." \textit{L.A. Times}, Aug. 29, 1973, § 1, at 22, col. 1.}
On November 15, 1973, the California Legislative Analyst issued a report reviewing the administration of the PHP program. This study concluded that the Department of Health had failed to adequately monitor PHPs and recommended that the department conduct more comprehensive background checks of applicants for contracts, including checks of both principals and providers. It was also recommended that the department review the quality of care in facilities to be utilized by the plan before an initial contract was let.

The legislative analyst noted that at least two PHPs received capitation rates in excess of local fee-for-service rates. The report also noted the tremendous variance in capitation rates within a particular locale. It was therefore recommended that the department establish an actuarial basis for establishing capitation rates based on the actual costs of the health care services provided. The report criticized significant turnover of staff within the department and urged that contract managers be assigned specific contracts to supervise for substantial periods of time. New legislation was recommended to penalize plans whose enrollers were found to be guilty of misrepresentation. The report urged revision of the form of contracts so that a recipient would have to read and initial those sections governing limitations on the types of care provided.

The remainder of the study was concerned with insuring that monies expended by the state were used to provide services to Medi-Cal recipients. The report pointed out that many PHPs, although non-profit corporations, actually acted as financial conduits for profit-making organizations owned by the same individuals who operated the PHP.

The following chart prepared by the legislative analyst, describes the basic structure:

283. 1973 LEGISLATIVE ANALYST REPORT, supra note 190.
284. Id. at 16.
285. Id. at 17.
286. Id. at 21-22.
287. Id. at 19-20.
288. Id. at 23.
289. Id. at 28-29.
290. Id. at 33.
291. Id.
292. Id. at 47.
The report recommended that prior to the execution of initial contracts the state investigate the interrelationships between the PHP and those organizations which provide services to PHP enrollees. The department was urged to insure that these organizations actually did provide services to plan enrollees. While the legislative analyst did not discuss the theoretical worth of the PHP program, the report amounted to a scathing indictment of the administration of the program in California.

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293. Id. at 8.
294. See id. at 47-48.
295. The Department of Health responded to the legislative analyst's recommendations in a document prepared for the Assembly Health Committee. Cal. Dep't of Health,
On December 13, 1973, the Assembly Health Committee conducted a hearing in Los Angeles to receive testimony on the quality of care received by Medi-Cal recipients in PHPs. In opening the session, committee chairman Henry Waxman reiterated his "strong commitment" to the PHP concept, but expressed his concern as well:

[W]e have learned that many of the prepaid plans under contract did not exist prior to the Medi-Cal Reform Act of 1971 which spawned the PHP program. Only 11 of the 48 plans provide prepaid health services to non-Medi-Cal recipients. Of this total, 85% are enrolled in but 2 plans. We are concerned that the State is fostering "Medi-Cal mills" which will give recipients less than the quality of care available to other citizens. Given the inexperienced and untested number of medical groups under contract, we have not received adequate evidence that the Department is requiring the achievement of high standards which should be indicative of the program . . . .

In the course of the hearing, the Health Committee reviewed reports of PHP medical audits conducted by state personnel in 1973. Of the twelve plans described in the audit reports, seven were found to have inadequate peer review or quality control. Seven of the

Response to the Legislative Analyst's Recommendations Regarding the State Department's Regulation of Prepaid Health Plans, Dec. 13, 1973 (undated document on file at San Francisco Neighborhood Legal Assistance Foundation). This statement accepted many of the legislative analyst's criticisms.

296. Special Meeting on Prepaid Health Plans: Quality of Care, Before the Assembly Health Comm. (1973) [hereinafter cited as 1973 Quality of Care Hearings].
297. Id. at 3.
298. Id. at 1-2.
299. Id. at 4.

Although the first PHP contract became effective in April 1972 and ten others were in operation by July 1, medical audits did not commence until October 1972. Id. at 5-6.
300. Id., Appendix B, Summary of Medical Audits, at 4. Such a finding appeared to contradict the substance of earlier department pronouncements concerning PHP peer review. Earlier, the department had represented that "[e]ffectiveness, or the quality of care provided, is assured through different mechanisms in the PHPs. All PHPs have peer review mechanisms in operation." 1972 PILOT PROJECT REPORT, supra note 87, at 8.

Part of the reason for this disparity between department pronouncements and actual PHP performance was the department's philosophy of "minimal regulation." In a document prepared by the department one month prior to the Health Committee hearings, the policy regarding regulation of PHP peer review mechanisms was explained: "Each prepaid health plan is required, by Department regulations, to operate its own internal peer review program. Although the Department has specified the areas of service which the peer review program is to cover (inpatient hospitalization, certain outpatient services, and the plan's drug services) the Department has not specified the exact form or review procedures for a peer review program. The reason is that the wide variety of PHP organizations facilitates the development of many different forms of effective peer review programs." Summary of Current Program for Monitoring Quality
PHPs described in the reports were also rated as having "unsatisfactory medical work-up or physical examination." Five plans were noted for the "unavailability of simple lab work at each clinic." In addition, six plans had inadequate or incomplete medical records systems and five had illegible medical records. In all, the PHPs were rated in fourteen quality related areas of performance. While two plans had no deficiencies, the number of deficiencies in the other plans ranged as high as eleven. One PHP in which deficiencies were noted in ten of the fourteen quality areas had had its contract renewed by the state several months after the negative audit.

Committee criticism was also leveled at the form of the medical audits. Chairman Waxman commented:

[In far too many audits the stress is on the manner of operation, not the performance of the operation. While the procedures for auditing pharmaceutical and dental services appear excellent, too little time is devoted to the appropriateness and quality of the delivery of professional medical practice and the overall quality of organizational performance and responsiveness.]

The chief of the medical audits section of the Department of Health seemed to be in agreement. He expressed an intention to involve medical professionals and consultants in developing specific "process" and "outcome" criteria for use in future evaluations.

The committee also heard testimony from several PHP enrollees. One enrollee told of telephoning the "twenty-four hour emergency service" of a Southern California PHP for over twelve hours before finally

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of Care in Prepaid Health Plans (1973), contained as Appendix D in 1973 Quality of Care Hearings, supra note 296.

301. 1973 Quality of Care Hearings, supra note 296, Appendix B, Summary of Medical Audits, at 4.

302. Id.

303. Id.

304. Id.

305. 1973 Quality of Care Hearings, supra note 296, at 50-57.

306. Id. at 2.

307. Id. at 15 (testimony of Tom Heerhartz, Chief, Medical Audits Section). Mr. Heerhartz stated, "We have been using the term 'medical audit' but medical audit really applies to something other than what we are doing."

308. Id. at 15-19. During a "process" review, auditors evaluate the method by which the physician arrived at a diagnosis and the method by which the physician treated the condition once diagnosed. The physician's approach is ordinarily measured against objective standards established for the diagnosis and treatment of specified disorders. Under an "outcome" measurement system, the degree to which patients survive and are restored to health is measured. If the treatment program for these patients has been correct, this should be reflected in lower mortality and morbidity rates. For a detailed discussion of quality of care measurement, see Donabedian, Evaluating the Quality of Medical Care, 44 Milbank Mem. Fund Q. 166 (July 1966).
securing medical attention for her mother, who had gone into convulsions.\textsuperscript{309} Another told of spending a similarly long time attempting to obtain emergency care from her PHP for an acute tubal infection.\textsuperscript{310}

On April 16, 1974, a consent judgment was entered into in San Diego between the county district attorney and Consolidated Medical Systems to settle the pending case.\textsuperscript{311} Without admitting liability, the plan agreed to pay \$30,000 in damages and agreed to the issuance of an injunction requiring enrollers to accurately represent the terms and conditions of enrollment.

On April 22, 1974, the Joint Legislative Audit Committee issued a second report by the state auditor general on the PHP program.\textsuperscript{312} The auditor general had investigated fifteen plans, fourteen of which provided services in Los Angeles County.\textsuperscript{313} The report concluded that of the \$56.5 million paid to these fifteen plans by the Department of Health between January 1, 1971, and December 31, 1973, only 48 percent had actually been expended for health care services to Medi-Cal recipients. The balance had been used for administrative costs or had resulted in net profits to contractors or subcontractors.\textsuperscript{314} Although thirteen of the PHPs reviewed were technically nonprofit corporations, the officers or directors of eight of the plans had formed profitmaking entities which supplied various services to the nonprofit PHP.\textsuperscript{315} The report therefore recommended legislation that would require that at least 75 percent of capitation payments be actually expended for health care services.\textsuperscript{316}

\begin{itemize}
  \item 309. 1973 \textit{Quality of Care Hearings}, \textit{supra} note 296, at 117-18.
  \item 310. \textit{Id.} at 131-33.
  \item 312. April 1973 \textit{Auditor General Report}, \textit{supra} note 238.
  \item 313. \textit{Id.} at 3-4. These plans included some of the largest in the state including Consolidated Medical Systems, Marvin Health Services, and Omni-Rx Health Care. At the time of the report, the fifteen selected plans represented 60\% of the total number of Medi-Cal recipients enrolled in all of the PHPs statewide. \textit{Id.} at 5.
  \item 314. \textit{Id.}
  \item 315. \textit{Id.} at 13. The report repeated the conclusion of the legislative analyst: "Through these affiliated profitmaking subcontractors, the officers and directors of the nonprofit PHP contractors are able to obtain profits from what is ostensibly a nonprofit operation. Also . . . the use of these interlocking firms makes it more difficult to determine how much of the Department of Health's payments to the PHP contractors actually is expended for health care services for Medi-Cal recipients and how much results in net profits or is expended on executive salaries and other costs of administration." \textit{Id.} See text accompanying notes 292-93 \textit{supra}.
  \item 316. \textit{Id.} at 9.
\end{itemize}
The report also concluded that the Department of Health had failed to fulfill its statutory mandate to insure uniform accounting procedures, complete financial reporting, and routine fiscal auditing of PHP contractors and their affiliated subcontractors. The report recommended that in light of the failure of the Department of Health to fulfill this mandate, responsibility should be transferred by legislation to the Department of Finance.

On May 23, 1974, the Los Angeles Times published an article alleging that the Department of Health had demonstrated favoritism in dealing with PHPs represented by a former Health Department official. The article reported that two of these plans had received unprecedented $70,000 interest-free loans from the state. Also named were three legislators who had assisted individual PHPs. The article concluded by alleging that a deputy director of the Department of Health had prevented cooperation between the Health Department and the Los Angeles district attorney in the investigation of prepaid health plans.

On June 5, 1974, the United States Department of Health, Education, and Welfare, published proposed regulations relating to health maintenance organizations (HMOs) serving Medicaid recipients. As finally approved on May 2, 1975, these regulations established several new requirements. Health maintenance organizations were required to safeguard the confidentiality of eligible recipients. All subcontracts between IMOs and providers were now to be in writing. Within two years after the effective date of an initial contract with the state, but not sooner than two years after the effective date of the regulations, at least 50 percent of the plan enrollees were to be neither Medicare nor Medicaid beneficiaries. This provision could only be waived by the secretary of HEW. Other provisions restated many pro-

317. Id. at 11. Carriers and providers of Medi-Cal benefits were required to institute uniform accounting and cost reporting systems. CAL. WELF. & INST'NS CODE § 14161 (West 1972), as amended, CAL. WELF. & INST'NS CODE § 14161 (West Supp. 1976).
318. April 1974 AUDITOR GENERAL REPORT, supra note 238, at 12.
320. Id. at 3, col. 1.
321. Id. at 6, col. 3-4.
322. Id. at 28, col. 3-4, 29, col. 1.
325. 45 C.F.R. § 249.82(c)(1)(viii) (1975).
326. 45 C.F.R. § 249.82(c)(1)(x) (1975).
327. 45 C.F.R. § 259.82(c)(5)(ii) (1975).
ections already present under California law. These regulations became effective on August 9, 1975.328 On July 10, 1974, the office of the auditor general issued a third report on the administration of the PHP program in California.329 The report found that the Department of Health had inadequate controls to prevent duplicate billings and payments by the state for health services rendered to PHP enrollees.330 These duplicate payments were estimated at $4.2 million through December 31, 1973.331 The auditor general also found that the Department of Health had paid approximately $960,000 on a fee-for-service basis for dental services rendered to enrollees in the Foundation Community Health Plan. These services should have been provided at no cost under the PHP contract.332 The report reiterated earlier findings that the department had failed to establish capitation rates on an actuarial basis as required by state law.333 The report noted that several PHPs were paid different rates although they were operating in the same geographical area and were providing the same scope of services.334 Some of the rates charged were found to exceed the fee-for-service costs and thus were in violation of state law.335 Finally, despite the requirements of the Waxman-Duffy Act and applicable Health Department regulations,336 numerous plans had failed to reimburse Los Angeles County for emergency services rendered to PHP enrollees and the state had failed to review these claims to insure payment.337 Many of the conclusions of the au-

330. Id. at 8.
331. Id. at 10.
332. Id. at 12.
333. Id. at 16. See text accompanying notes 286-88 supra.
334. July 1974 AUDITOR GENERAL REPORT, supra note 329, at 17. The disparity within counties was eliminated effective July 1, 1974, when the Department of Health established uniform rates within a county. D. Burkett, Uniform Prepaid Health Plan Capitation Rates, June 28, 1974 (Dep't of Health internal memorandum to Jerry Green).
336. PHPs were required to pay for emergency services rendered to plan enrollees by non-plan providers. Cal. Stat. 1972, ch. 1366, § 9, at 2725; CAL. ADMIN. REG. 73, No. 5 (1973), adopting 22 CAL. ADMIN. CODE § 51841 (1973), as amended, CAL. ADMIN. REG. 74, No. 3 (1974).
337. July 1974 AUDITOR GENERAL REPORT, supra note 329, at 19-23. The correspondence between the county and the Department of Health regarding this problem has been reprinted in Jackson Committee Hearings, supra note 163, at 17-21.
ditor general were disputed by the Department of Health.338

On August 30, 1974, the Los Angeles Times reported that after the Orange County Foundation Health Plan had closed down with a $500,000 to $700,000 debt, its physicians had attempted to recoup losses by billing Medi-Cal recipients for services compensated already through the capitation payments.339 A later study of the closing, conducted by the office of the auditor general, concluded that the Department of Health had failed to require the plan to comply with a number of statutory, regulatory, and contractual obligations.340 The violation of these requirements by the plan included inadequate accounting procedures, inadequate capitalization, and inadequate peer review.341 The study also criticized the department for failing to conduct required medical audits,342 for negotiating too many contracts in Orange County, thereby creating undue competition,343 and for loaning $70,000 interest free to the plan in violation of Health and Safety Code section 1178.344

On September 10, 1974, the comptroller general of the United States issued a report to the United States Senate which reviewed the operation of the PHP program in California.345 The report evaluated three areas of the state's program: (1) capitation rates; (2) enrollment, disenrollment, and grievance procedures; and (3) quality of services.346

In the area of capitation rates for PHPs, the comptroller general found that in some cases per capita payments exceeded fee-for-service estimates, and that rates were not established on a sufficient actuarial basis.347 The report recommended that the secretary of HEW assist in the development of an actuarial basis for establishing health mainte-

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341. Id.
342. Id. at 11.
343. Id. at 14-16.
344. Id. at 18.
346. Id. at i.
347. Id. at 11-14.
nance organization capitation rates for Medicaid recipients and that a federal surveillance mechanism be established to insure that HMO cost would not exceed the cost of providing similar services under the fee-for-service mode.\textsuperscript{348}

The comptroller general also found that enrollment irregularities continued to be a problem in the PHP program, and that this contributed to a 6.2 percent average monthly turnover of enrollees.\textsuperscript{349} The study concluded that the basis for disenrollment listed on disenrollment forms was often different than the actual reason expressed by the enrollee. The most common reasons for disenrollment not reflected on disenrollment forms forwarded by the plans to the Department of Health were misrepresentation in enrollment and dissatisfaction with plan services.\textsuperscript{350} The report therefore recommended that procedures for controlling enrollment misrepresentation be established by the state, that disenrollment forms be promptly processed by plans, that all HMOs be required to establish effective enrollee grievance procedures, and that HEW develop monitoring systems for use in other states that would avoid the types of problems which arose in California.\textsuperscript{351}

Finally, the comptroller general reported that neither HEW nor California had developed standards with which to evaluate the quality of PHP health care.\textsuperscript{352} This failure was compounded by the failure of the Department of Health to conduct medical audits in sufficient depth to determine whether the PHP program had provided quality medical services to enrollees.\textsuperscript{353} Moreover, the report found, medical audits had not been conducted in the past as often as required by state regulations due to the lack of medical audit staff.\textsuperscript{354} The comptroller general therefore recommended that HEW develop procedures for evaluating the quality of health maintenance organization care under Medicaid, including requirements for standardized data reporting by plans.\textsuperscript{355}

On October 2, 1974, a lawsuit was filed by twenty-three San Francisco Medi-Cal recipients against the American Health Care Plan and
against the director of the Department of Health. The complaint charged widespread enrollment violations as well as failures by the plan to provide needed medical services. Damages and injunctive relief were demanded. The lawsuit also sought a writ of mandamus to compel the director of the Department of Health to fulfill his obligation to lawfully administer the PHP program.

On November 15, 1974, the Department of Health announced the cancellation of the UMEDCO PHP contract because the plan was $800,000 in debt and therefore did not have sufficient financial reserves. On November 23, 1974, the Times reported that because of the failure of UMEDCO, an emergency plan had been established to serve UMEDCO enrollees in county hospitals.

On December 27, 1974, Chester Jones, who had continued to press for thorough investigations into PHP wrongdoing, charged that the Reagan administration was attempting to punish him before its term expired for his efforts to expose corruption in the PHP program. Jones alleged that staff investigations had discovered widespread enrollment violations, illegal referral of sick patients by plans to county hospitals so that costs would be borne by county taxpayers, and derogatory background information on applicants who were ultimately awarded PHP contracts.

On December 31, 1974, just prior to leaving office, Governor Reagan, conceding that his previous reforms had failed to curb soaring

357. The complaint alleged that in one instance a child with a fever of 105 degrees had been repeatedly denied emergency treatment and was forced to wait more than thirteen hours before services were finally rendered. Exhibit A, Declaration of Jackie Ortiz, id.
358. L.A. Times, Nov. 16, 1974, § 2, at 1, col. 3.
360. L.A. Times, Dec. 28, 1974, § 2, at 1, col. 1. In response to the inquiry of the chief counsel of the Permanent Senate Subcommittee on Investigations (the Jackson Committee), a California Department of Health representative characterized Jones as a disgruntled employee and denied that there was anything more than coincidence in his transfer from Los Angeles to Sacramento three hours after the service of a committee subpoena on the health director. Letter from Merle L. Shields to Howard J. Feldman, Jan. 8, 1975, contained as Exhibit No. 12 in Jackson Committee Hearings, supra note 163, at 43.

Shortly thereafter, Robert Gnaizda, acting director of the Department of Health for the Brown administration, praised the efforts of Jones and two other department investigators for bringing the problems of PHPs to the public's attention. Gnaizda stated, "Under extraordinarily difficult circumstances you have remained true to your beliefs and commitment to protect the public." Jackson Committee Hearings, supra note 163, at 44-45.
costs, called for another reform of Medi-Cal. Reagan proposed the creation of PHPs which would serve all Medi-Cal recipients living in a particular geographic area. This proposal, it was acknowledged, would necessitate changes in state and federal law which required that recipients have freedom of choice in selecting providers.

Waxman-Duffy Is Amended

On March 5, 1973, even before the Waxman-Duffy Prepaid Health Plan Act of 1972 had become effective, its authors introduced legislation to strengthen the state's ability to supervise the operation of PHPs and to further protect prospective enrollees. This legislation was passed by both houses and signed into law by the governor on September 23, 1974. The provisions of the amended Waxman-Duffy Prepaid Health Plan Act became effective on January 1, 1975.

Under these amendments, plans were required to provide prospective enrollees with specific information on the affiliated medical personnel, the services and benefits offered, the transportation arrangements available, and the hours and days when plan facilities were open. The amendments also expanded the information that plans were required to provide to recipients once enrolled, including the procedures for obtaining services.

PHPs were required to obtain prior written approval by the department before engaging in any marketing activities and all marketing materials were to be cleared by the department before being used by a plan or an affiliated marketing organization. Plans were expressly prohibited from claiming that marketing representatives were employees of the state or county, that the plan was endorsed by the state or county, or that Medi-Cal benefits would be terminated if the beneficiary did not enroll. Penalties for misrepresentation included revocation of particular methods of marketing, termination of new en-

361. L.A. Times, Jan. 1, 1975, § 1, at 1, col. 1.
367. Id. § 14406.
368. Id. § 14408.
369. Id.
370. Id. § 14409.
rollments, forfeiture of all or part of the capitation payment for fraudulently enrolled recipients, or termination of the contract. Beneficiaries were also expressly given the right to disenroll under specified circumstances and were required to be disenrolled within forty-five days of filing the application for disenrollment. In addition, plans were prohibited from enrolling Medi-Cal beneficiaries who resided outside of the contract service area. The department was directed to prescribe a standard contract that would be readily understandable to enrollees.

Improvements were also made in other areas relating to the provision of medical services. PHPs were required to provide the services of an optometrist and an ophthalmologist whenever the contract included vision care services, and dental services were to be made available to enrollees without prior screening or authorization.

All subcontracts entered into by a plan were required to be in writing, and to be submitted to the department for approval. Medical audits, which the department previously had been required to conduct "periodically," were now required to be performed at least every six months.

The 1974 amendments also strengthened the provisions of the 1972 Waxman-Duffy Act relating to public hearings. Any findings that the prepaid health plan had complied with its contractual obligations were required to be based on the evidence presented at the public hearing. Under the 1972 act the department could contract for a minimum of one year with a plan; the 1974 amendments limited initial contracts to a period of one year, and renewal contracts to a maximum of two years.

The 1974 amendments also strengthened and broadened the conflict of interest provisions relating to PHPs. At the same time, the department was required to file reports with the legislature on the in-

371. Id.
372. Id. § 14412. These circumstances now included cases where the beneficiary had been fraudulently enrolled.
373. Id. § 14413.
374. Id. § 14402.
375. Id.
376. Id. § 14452.3.
377. Id. § 14452.4.
378. Id. § 14452.
379. Id. § 14456.
380. Id. § 14300.
381. Id. § 14302.
382. Id. §§ 14475-81.
cidence of enrollment violations and the actions taken by the department against violators.\textsuperscript{383}

**The Brown Administration Attempts Reform**

When the Brown administration assumed office in January 1975, the problems besetting the PHP program were well known. The individual plans had failed to provide adequate health care for enrollees; there had been widespread enrollment fraud; and there was growing evidence of inadequate fiscal resources within many plans. The government's inability to cope with those problems was also apparent. Health Department administrators had failed to enforce existing regulations. Serious allegations of conflict of interest and possible corruption within the department had been made. It had also become clear that prophylactic legislation and regulations alone were inadequate to curb provider abuses or to insure quality health care.

After frankly acknowledging the nature and scope of the problems within the program, the Brown administration made several highly visible attempts to solve those problems. Whether these attempts were meant to succeed is problematical; as will be shown, these attempts were largely unsuccessful. Perhaps, as some have suggested, this lack of success was due in part to the administration's desire to avoid alienating the health plan lobby as a source of campaign contributions and political support. In addition, the new administration lacked the expertise necessary to understand and direct bureaucracies such as the Department of Health.\textsuperscript{384} The Department of Health can be viewed as an entrenched bureaucracy, with a tenured staff, largely able to survive any particular administration. As such, it will tend to resist (and develop successful ways to resist) any outside threats to its internal workings or to its relationships with health care providers. This section will chronicle the present administration's difficulties in reforming the program.

On January 16, 1975, a program white paper was prepared within the Department of Health.\textsuperscript{385} This internal memorandum outlined major

\textsuperscript{383} Id. § 14313.

\textsuperscript{384} See, e.g., Liebert, *The State's Sick Health Department*, S.F. Chronicle, Sept. 20, 1976, at 1, col. 1; *He Says He's Not an Administrator*, id., at 6, col. 1.

\textsuperscript{385} R. Lohmeyer, Program White Paper, Jan. 16, 1975 (internal Health Plans Administration memorandum), contained as Exhibit No. 31 in *Jackson Committee Hearings, supra* note 163, at 248. Although authored by Richard H. Lohmeyer, chief of the Health Plans Administration, this memorandum apparently summarized the perceptions shared by the state officials responsible for the operation of the PHP program.
problems within the program and suggested solutions for those problems.

The memorandum acknowledged that the PHP program had been administered with the attitude that the program was to be expeditiously developed. This attitude led the department to disregard inadequate financial resources when evaluating PHP contract proposals, and resulted in restricted delivery of health services and occasional fiscal collapse. Because the requirements for data reporting by the plans were similarly limited, the department was deprived of a means to evaluate the quality of care provided. The memorandum also emphasized that financial audits were so narrow in scope that they did not reveal the actual distribution of state funds. The auditing procedure seemed entirely incapable of exposing the affiliated profitmaking entities that received the substantial portion of the capitation funds paid to the plans. The memorandum therefore recommended expansion of the audits to affiliated entities, and also urged the imposition of higher tangible net equity requirements.

In the area of quality assurance, the memorandum pointed out that medical audits by the department were inadequate due to the lack of objective standards and clearly defined health quality objectives. It recommended the establishment of auditing criteria which would “stand independent of subjective evaluations on the part of reviewers,” and promulgation by the department of standards for PHP peer review.

In the area of marketing, the memorandum conceded that there were documented cases of selective enrollment, but emphasized the department's difficulties in detecting such practices within a plan. Lohmeyer concluded that, despite the problems of misrepresentation by door-to-door solicitors, “[a]t present there is no truly successful alternative to knocking on doors in hopes of finding an eligible Medi-

386. Jackson Committee Hearings, supra note 163, at 249.
387. Id.
388. Id. at 250.
389. Id.
390. Id.
392. Jackson Committee Hearings, supra note 163, at 251.
393. Id.
394. Id. at 252.
395. Id. at 252-53.
Alternative solutions to these marketing problems suggested in the memo included transferring all enrollment functions to the state or the counties, establishing mandatory enrollment with an option to disenroll, waiving confidentiality and thus allowing the PHPs access to eligibility lists of Medi-Cal recipients, and granting area-wide exclusive franchises.

On January 22, 1975, Governor Brown asked the acting director of the Department of Health, Robert Gnaizda, to investigate charges of mismanagement within the department. Gnaizda assembled a team of lawyers and health professionals and commenced a study of the department and its administration of the PHP program.

On January 28, 1975, poverty lawyers from all over California called for an immediate termination of all PHP contracts. Those plans wishing to challenge these terminations would have the burden of showing that they were providing quality care. The attorneys charged that the program was "rife with abuses" and that the legislation governing the PHP program should be revised to eliminate the economic incentives for providing minimal care.

On February 9, 1975, the San Francisco Sunday Examiner and Chronicle reported on the possibility of more scandal within the Department of Health. The article noted Lieutenant Governor Mervyn Dymally's admission that while a state senator he had pushed through legislation which had assisted a PHP in which he was a substantial shareholder. The article also noted the pending investigation by the Gnaizda team and revealed that in order to facilitate the investigation Gnaizda had ordered all important files in the department sealed.

On February 11, 1975, Governor Brown announced that the state would not approve any new PHP contracts and would only renew current plans until June 30, pending a review of the entire PHP program. Brown also announced the appointment of Steven Passin, a former employee of the American Medical Association, as head of the Alternative Health Systems Division, charged with the responsibility of administering the PHP program.

On February 12, 1975, Acting Health Director Gnaizda disclosed that his investigators had presented the attorney general's office with
extensive documentation of illegal acts committed by employees of a number of prepaid health plans. Gnaizda insisted, however, that there were no ongoing scandals and indicated that the state did not intend to abandon the concept of prepayment for Medi-Cal recipients.

On March 13, 1975, Senator Henry Jackson convened two days of hearings on the California PHP program by the Permanent Senate Subcommittee on Investigations. In opening these hearings, Senator Jackson explained that testimony would demonstrate “the absolute moral and ethical bankruptcy of elements of the health care industry.” Senator Jackson went on to emphasize that “[prepaid health care for the poor] is a good idea, that should not be abandoned because men without consciences, profiteers, and scam artists took the initiative in California from those with good intentions.”

In testimony before the Jackson Committee, Steven Passin, Alternative Health Systems Division chief, reported that the investigators appointed by Acting Health Director Gnaizda had confirmed many of the charges contained in earlier reports critical of PHP administration. The Gnaizda team documented high level state mismanagement of the program. It also found a complete lack of emphasis by the department on preventive health services, no objective method

404. Jackson Committee Hearings, supra note 163, at 1.
405. Id. at 2.
406. Id.
407. Id. at 111.
408. Id. Some of the mismanagement problems were discussed in an internal memorandum prepared for Robert Gnaizda by three attorneys of the investigative team. F. Hiestand, P. Coppelman & D. Epstein, Investigation of Department of Health's Policy Toward Prepaid Health Plans, Apr. 1975 (on file at San Francisco Neighborhood Legal Assistance Foundation) [hereinafter cited as Hiestand Memorandum].

The memorandum discussed a group of PHP contract proposals which had been approved despite the fact that members of the departmental staff who had reviewed them agreed that they were inadequate. Impetus for the granting of state funds appeared to have come from the director of Health Care Services, who allegedly expressed a desire to secure approval prior to July 1, 1973. After that date public hearings were required before individual contracts could be let. Cal. Stat. 1972, ch. 1366, § 2726, as amended, CAL. WELF. & INSTR’NS CODE § 14300 (West Supp. 1976). Hiestand Memorandum, supra, at 9. The memorandum also noted that “[t]he Department had no set procedures for passing on proposals and no systematic or extensive requirements which proposals had to meet.” Id. at 10.

One month after the funding of the last of this group of proposals, the state contract analyst in charge of working them up accepted employment with the consulting firm which had prepared them. Id. at 10. Also documented in the memorandum was the case of a southern California PHP whose contract was renewed despite evidence of a systematic practice of selective enrollment by the plan. Id. at 23-26.
of measuring quality of care, and no consistent direction in any aspect of the PHP program.\textsuperscript{409}

Passin testified further regarding the Brown administration's plans to remedy these problems. He said that a PHP advisory committee would be established through which the Health Department would form "a partnership with the private sector."\textsuperscript{410} This committee would recommend ways to implement quality assurance and regulation in the areas of enrollment and marketing, data retrieval, and financial and management disclosure.\textsuperscript{411}

Other testimony presented to the Jackson Committee indicated that quality of care was indeed still a problem under the new administration. Dr. Joseph Mells, a physician member of a department medical audit team, reported to the committee that "[h]aving reviewed, first hand, the quality of care at these [PHP] clinics, I can say that it is as unacceptable today as it was when I started in October 1974."\textsuperscript{412} Mells

\begin{footnotes}
\footnote{409. \textit{Jackson Committee Hearings, supra} note 163, at 111 (testimony of Steven Passin). With regard to the level of quality monitoring under the previous administration, the Gnaizda team noted in particular a memorandum to the chief of the medical audits section, in which twenty-nine medical audit reports were analyzed. Memorandum from Mel Saferstein to Tom Heerhartz, Analysis of Prepaid Health Plan Audit Reports, Oct. 16, 1973. The investigators summarized: "[O]f the twenty-nine (29) reports reviewed more than 55\% of the medical charts lacked clarity, were poorly organized, and not legible; 41.3\% showed a low rate of dental utilization by enrollees . . . more than 34\% were in agreement that there was an inadequate follow-up system for missed appointments; 34\% showed no dental peer review system; more than 37\% indicated an absence of licensed support staff working in the clinic or physician's office; almost 7\% found that unlicensed physicians were treating people in the plans; and more than 34\% identified outdated medications being used in the plans." Hiestand Memorandum, \textit{supra} note 408, at 3-4 (punctuation added).}

\footnote{410. \textit{Jackson Committee Hearings, supra} note 163, at 112 (testimony of Steven Passin).}

\footnote{411. \textit{Id.}}

\footnote{412. \textit{Jackson Committee Hearings, supra} note 163, at 205 (statement of Dr. Joseph H. Mells). Dr. Mells gave examples of what he considered unacceptable medical treatment and inadequate medical recordkeeping. One PHP enrollee had received no treatment for more than two months after having been diagnosed as having gonorrhea.

In another case, the chart of a five-year old male patient indicated that the boy had surgery for an ovarian cyst in 1968.

The doctor testified regarding inadequate diagnostic procedures as well. At one PHP, he disclosed, physicians diagnosed vaginal infections "purely by odor"—without the use of laboratory procedures. Mells said he had once reported to his departmental superior that several PHP clinics had medical deficiencies so severe that they should be reevaluated within thirty days. He had not been allowed, however, to reaudit these facilities.

When questioned regarding this incident by Senate investigators, Robert Ledbetter, chief of the Quality Evaluation Section, said that the thirty day reaudit would have been a logistical nightmare for the PHPs. \textit{Jackson Committee Hearings, supra} note 163, at 212.}

reported that in December 1974, the chief of the PHP Quality Evaluation Section had led him to believe that the department was prepared to act against PHPs which rendered substandard care.413 More recently, however, he had been informed by the same official that “[o]ur mission was not to discipline these clinics but to educate them to write up the charts properly.”414

Dr. Mell's conclusions regarding the state’s unwillingness to discipline poorly performing PHPs were shared by another member of the medical evaluation staff, Refugio Garcia. When asked whether a clinic or provider had ever been asked to leave the PHP program after a negative medical audit, Mr. Garcia testified, “There have been instances where the State has taken appropriate action; but I would say that these instances are far too few. . . . In the medical audit findings, we are finding the same deficiencies continually. . . .”415

On April 1, 1975, the Los Angeles Times disclosed that the Brown administration had decided to continue the PHP program and that three officials from the Department of Health had testified on behalf of one of the plans in a law suit filed by the attorney general.416 Department officials were quoted as acknowledging that the challenged plan had failed to meet net equity requirements,417 but that the department had decided to waive this obligation.

On April 6, 1975, the San Francisco Sunday Examiner and Chronicle reported on the contract renewal hearing for the American Health Care Plan, a San Francisco-based PHP. The plan had been assailed in bitter testimony by employees of the San Francisco Department of Social Services, by the director of a medical center in Chinatown, by a plan physician, and by several enrollees. The Department of Health

413. Jackson Committee Hearings, supra note 163, at 206 (statement of Dr. Joseph Mells).
414. Id.
415. Jackson Committee Hearings, supra note 163, at 233 (testimony of Refugio Garcia). Garcia also noted that “economics, not good professional judgment, decides the level of care at . . . PHPs.” Id. at 211. Garcia went on to describe incidents that had occurred during medical audits of plans: “One device employed by a medical plan clinics [sic] is to use a holding room for observation of critically ill persons, rather than refer such enrollees to hospital emergency rooms. In October, 1974 I was a member of a medical audit team evaluating that medical plan. We observed a patient lying semicomatose in a holding room. Nurses told us he had low blood pressure, had consumed a pint of gin and an unknown quantity of mellaril, a tranquilizing drug. Two hours after we first saw him, we heard a nurse cry out that the man was ‘stiffening’ and it was an emergency. An ob-gyn, the only doctor then in the clinic, ordered the patient sent to the hospital.” Id.
417. See note 391 & accompanying text supra.
contract manager for the plan testified that after conducting a survey of only 15 of the 8,000 plan enrollees, she had concluded that the PHP was well accepted by its patients.\textsuperscript{418}

On April 24, 1975, the auditor general issued a report reviewing administrative functions within the Foundation Community Health Plan in Sacramento and the American Health Care Plan in San Francisco.\textsuperscript{419} The report concluded that the Department of Health had paid an estimated $1.6 million more for health services provided by the Foundation Plan during 1974 than such services would have cost on a fee-for-service basis.\textsuperscript{420} The extra costs had been generated by the high capitation rates charged by the Foundation Plan. The study emphasized that the departmental rationalization for this discrepancy, that the Foundation Plan had enrolled a disproportionate number of sick people, had never been documented.\textsuperscript{421} The report also concluded that the Foundation Plan had failed to satisfy the tangible net equity requirements of the Knox-Mills Health Plan Act.\textsuperscript{422}

On May 5, 1975, after the department announced that it would extend the contract with the American Health Care Plan for a period of ninety days, a lawsuit was filed against it seeking to set aside the contract renewal.\textsuperscript{423}

One month later the \textit{San Francisco Chronicle} reported a stormy contract renewal hearing on the American Health Care Plan.\textsuperscript{424} The hearing, which started at approximately 4 p.m., was not completed un-

\textsuperscript{418}. S.F. Sunday Examiner & Chronicle, Apr. 6, 1975, § 1, at 23, col. 1; Dept' of Health, Transcript of Pub. Hearing, Am. Health Care Plan, Prepaid Health Plan Contract Continuation, Apr. 4, 1975 at 7-8, 11. A reading of the testimony discloses that the newspaper inaccurately described the size of the survey sample. The text of this article reflects the sample size specified in the testimony, not the newspaper.

\textsuperscript{419}. \textsc{Joint Legislative Audit Committee, Office of the Auditor General, A Review of the Administration by the Dept' of Health of Contracted Prepaid Health Plans with the Foundation Community Health Plan and the American Health Care Plan, Doc. No. 172.5, 1975 Reg. Sess.}

\textsuperscript{420}. \textit{Id.} at 8.

\textsuperscript{421}. \textit{Id.} at 7.

\textsuperscript{422}. \textit{Id.} at 10, 14.

\textsuperscript{423}. Ortiz v. Lackner, No. 254434 (Sacramento, Cal. Super. Ct., filed May 5, 1975). On September 3, 1976, a judgment was entered requiring major revisions in the conduct of contract renewal hearings. The department was barred from relying on evidence not presented at the renewal hearing, was required to conduct hearings as quasi-judicial procedures subject to review under \textsc{Cal. Code Civ. Proc.} § 1094.5 (West 1955), \textit{as amended} (West Supp. 1976). Hearings would now provide for cross-examination of department representatives, and for public access to department records relating to the plan prior to the contract renewal hearing.

\textsuperscript{424}. S.F. Chronicle, June 6, 1975, at 27, col. 6.
til 4 A.M. the following morning amidst claims of intimidation of adverse witnesses by plan representatives. 425

On June 9, 1975, the Prepaid Health Plan Advisory Committee, appointed by Governor Brown, issued a progress report. 426 The report recommended that the PHP program be continued only if measures were taken to stabilize enrollment and improve department supervision. 427 The committee advised that, except in medically underserved areas, only two types of plans be allowed PHP contracts—the foundation model and the multi-specialty prepaid group practice. 428 The committee also recommended that all plans be required to conform to federal health maintenance organization standards. 429 In light of the failure of most plans to enroll a substantial non-Medi-Cal population,

425. Almost a year later the Sacramento Union also reported that threats had been made by plan representatives. Sacramento Union, May 30, 1976, at A1. The report also noted that the state had treated the American Health Care Plan “gently” despite documentation of widespread misrepresentation by the plan. Id.


428. Id. If adopted, this recommendation would eliminate the most common type of plan, the so-called brokerage plan in which the contractor subcontracts for the provision of medical services to enrollees. In that setting the contractor acts simply as a fiscal intermediary or insurer. The committee noted that brokerage plans had “clearly shown their inability to meet reasonable performance standards.” Id. at 2.


These standards were modified by the Health Maintenance Organization Amendments of 1976, an act which enjoyed the support of an active lobbying effort by the health insurance industry. Pub. L. No. 94-460; see HMO Bill Signed by Ford, THE NATIONAL UNDERWRITER: LIFE AND HEALTH INSURANCE EDITION, Oct. 16, 1976.

The 1976 amendments weakened the original health maintenance organization standards in several important respects. The 1973 legislation, for instance, required health maintenance organizations to have a thirty day “open enrollment” period each year during which they would accept individuals in the order in which they applied. Act of Dec. 29, 1973, Pub. L. No. 93-222, § 2, 87 Stat. 914. This provision allowed for the enrollment of high-risk persons who might otherwise have had difficulty in obtaining health care on a prepaid basis. Under the 1976 amendments, these open enrollment requirements were considerably weakened. In addition, the 1973 legislation provided that health maintenance organizations must fix capitation rates on the basis of community rating—that is, rates must be uniform within the community, rather than variable according to the projected health care needs of the enrollee. This provision, which allowed high-risk individuals to purchase prepaid health care at a price which was not prohibitive, was also weakened by the 1976 amendments. For discussion of these and other modifications of the standards, see 122 CONG. RC. H9780, H9785 (daily ed. Sept. 13, 1976).
the committee recommended mandating that all plans be composed of at least 50 percent non-Medi-Cal beneficiaries by the end of the second year of operation. This requirement could only be waived by the department under specific standards. In order to ensure a greater consumer voice in the operation of the plans, the committee recommended requiring that one-third of each PHP's policymaking board be plan enrollees. Plans would also be prohibited from using hospitals not approved by the California Medical Association Medical Staff Survey.

The report recommended an end to the department policy of "minimal regulation," and urged the department to encourage the creation of plans owned and operated by counties, communities, and consumers. The report also suggested development of new cost and quality monitoring mechanisms which would provide an economic incentive for plans to actually practice preventive medicine. Interestingly, these recommendations were approved by a committee which included prepaid health plan administrators as well as Medi-Cal recipients and health professionals.

On June 26, 1975, the secretary of the Health and Welfare Agency, Mario Obledo, announced the "termination" of the PHP program. PHPs were to be replaced by Institutes for Medical Service (IMS). Secretary Obledo stressed the importance of this new program:

Medi-Cal costs have soared while service has declined. In the last eight years, Medi-Cal costs have risen more than two-fold. The Institutes, which will receive at least 10% less than is paid to physicians under fee-for-service, may assist in controlling costs, and are specifically designed to guarantee an adequate level of care.

If the rhetoric was familiar, several of the specific proposals were not.

430. Progress Report, supra note 426, Summary, Findings and Recommendations, at 1. This proposal was already contained in the regulations proposed by HEW. See text accompanying notes 323-28 supra. The performance of most plans in this area was dismal. The overwhelming majority of PHPs had little or no non-Medi-Cal enrollment. 1973 Quality of Care Hearings, supra note 296, Appendix C.

431. Progress Report, supra note 426, Summary, Findings and Recommendations, at 1. These enrollees could be from both the private and Medi-Cal populations enrolled in the plan.

432. Id. For a discussion of the nature of the CMA Medical Staff Survey, see Jackson Committee Hearings, supra note 163, at 144-98 (testimony of Dr. Bert Halter & Dr. Robert Schlens).


434. Id.

435. Health and Welfare Agency Press Release, June 26, 1975. As will be seen, the basic PHP structure remained intact under the new IMS proposal.

436. Id.

437. Secretary Obledo's announcement had been delivered in remarkably similar
Nine points, drawn from the PHP Advisory Committee recommendations, were outlined as the cornerstones of the IMS program. Boards of directors of institutes were to include at least one-third plan enrollees. Preventive medicine was to be a mandatory component in every institute and incentives were to be included to encourage such care. Emergency care was to be assured through requirements of on-duty, available physicians around the clock. Administrative costs were to be limited to 12 percent of revenues for ongoing plans and 25 percent for beginning plans. Medical audits by department teams would be conducted every six months and would place greater emphasis on outcome-oriented measures and verification of data reported by the institutes.

Conflict of interest provisions were to be strengthened and enforced. "Only stable, multi-specialty group practices or community-wide foundations for medical care" were to be permitted to contract with the state. Pilot projects were to be conducted to determine methods of assuring stable enrollments in plans. By the third contract year, institutes were to be encouraged to have membership mixes of not more than 50 percent Medi-Cal beneficiaries.

Originally, the Brown administration had decided to implement the IMS program without public hearings or the promulgation of regulations. After lengthy meetings with consumer representatives, however, the department was finally convinced that the IMS program could not be legally implemented in such a fashion, and it therefore

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language three years earlier by Governor Reagan in his message to the legislature. See text accompanying note 144 supra.

Most of these points were explained and developed in a document accompanying the press release. Division of Alternative Health Systems, Dep't of Health, California Health & Welfare Agency, Institutes for Medical Services, June 26, 1975 (on file at San Francisco Neighborhood Legal Assistance Foundation).

439. Id.
440. Id. at 2. This requirement already existed, but would now be assured, according to the press release, through vigilant enforcement by the department.
441. Id.
442. Id. at 3.
443. Id.
444. Id. at 4.
445. Id.
446. Id.
448. Internal Memorandum from Pat Butler to the San Francisco Neighborhood Legal Assistance Foundation Staff, Aug. 12, 1975 (on file at San Francisco Neighborhood Legal Assistance Foundation).
agreed to promulgate regulations on an emergency basis. Significantly, the department was later forced to reject even this compromise and to agree to promulgate regulations through the regular hearing process. This final capitulation was the product of industry pressure, spearheaded by the Health Maintenance Organization Association of America, a trade association of PHP administrators.

In the meantime, several pieces of relevant legislation were enacted. On September 22, 1975, the Knox-Keene Health Care Service Plan Act of 1975 was signed into law. This act delegated the responsibility for the regulation of health care service plans, including PHPs, to the commissioner of corporations. PHPs were therefore required to comply with the provisions of both the Knox-Keene Act, supervised by the commissioner of corporations, and with the provisions of the Waxman-Duffy Act, supervised by the director of the Department of Health. Plans were required to register with the commission...
sioner of corporations and to meet specified financial and informational requirements.\textsuperscript{466} Enrollment solicitors for plans were also required to register, and were prohibited from using or permitting the use of any advertising or method of solicitation which was untrue or misleading.\textsuperscript{467} General standards were also established for the medical services to be provided by plans to enrollees.\textsuperscript{468} Regulations to carry out these registration functions were filed with the secretary of state on June 1, 1976.\textsuperscript{469}

On September 30, 1975, S.B. 385 was signed into law.\textsuperscript{460} This measure widened departmental and public access to information regarding PHP subcontractors and financial records.

In November 1975, Steven Passin was removed as manager of the Alternative Health Systems Division.\textsuperscript{461} Thomas G. Moore, Jr., formerly executive secretary to the PHP Advisory Committee, was named to take his place on an acting basis.

On November 19 and 20, 1975, the Department of Health conducted public hearings in Los Angeles on proposed regulations to implement the IMS program.\textsuperscript{462} On November 24, a hearing was conducted in San Francisco. A week later a final hearing was conducted in Fresno. No IMS regulations have yet been promulgated as a result of those hearings.\textsuperscript{463}

On January 19, 1976, the Los Angeles Times reported that the Brown administration's first attempt at a major governmental reform, the IMS program, had "quietly fallen on its face."\textsuperscript{464} The Times noted that these proposed health plan reforms had never been implemented because of opposition by plan representatives and threats of litigation.\textsuperscript{465}
In April, six months after his appointment as acting manager of the Division of Alternative Health Systems, Thomas Moore was discharged.\textsuperscript{466} In announcing the firing, Jerome Lackner, director of the Department of Health, explained that Moore was imposing excessively rigid and uncompromising standards on the PHP program,\textsuperscript{467} noting in particular that the number of PHP contracts had been reduced from fifty-four to thirty in less than six months.\textsuperscript{468} A few days later Moore responded to his ouster by charging that he had been fired for trying to end favoritism and profiteering in the PHP program.\textsuperscript{469}

The PHP program received national attention on April 17, 1976, when the ABC television network aired an hour-long news close-up \textit{Medicine and Money}.\textsuperscript{470} Included in this special report was a segment on several Southern California plans, including the DePaulo Health Plan and the Central Los Angeles Health Project.\textsuperscript{471} Enrollees of the two health plans were interviewed regarding their desperate attempts to obtain emergency care from plan physicians. In one case, a patient's family had tried for four days to secure emergency hospitalization; the patient died soon after finally being admitted.\textsuperscript{472}

The president of a "trade association" of PHPs described medicine as "inherently a profitable business."\textsuperscript{473} In response, Thomas Moore, the reform-minded health department official who had been fired in the interim between the filming and airing of the television report, said that the PHP program had attracted "organizations motivated by the opportunity to take off the top," managed by people "who had never been in prepaid medical care before, but who could do a little figuring with a pencil and a piece of paper."\textsuperscript{474} Moore also described the increased surveillance that would have to be imposed "in the wake of this bad experience."\textsuperscript{475}

\begin{footnotes}
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467. \textit{Id.}
468. \textit{Id.} at 27, col. 2.
469. \textit{L.A. Times}, Apr. 19, 1976, \S\ 1, at 3, col. 4.
472. \textit{Id.} at 32-38.
473. \textit{Id.} at 30.
474. \textit{Id.}
475. \textit{Id.} at 40.
\end{footnotes}
On April 19, 1976, the Department of Health issued administrative subpoenas to open up the books of subcontractors of the Omni-Rx Health Care Plan, after the plan had refused to allow departmental auditors to review financial records.\textsuperscript{476} A \textit{Sacramento Bee} article reporting on the subpoenas noted links between the Omni-Rx plan and political officials in Sacramento and Washington, D.C., through the state Democratic party chairman and through the husband of U.S. Representative Yvonne Braithwaite Burke, a Democrat from Los Angeles.\textsuperscript{477} On May 19, 1976, it was further disclosed that Omni-Rx had refused to allow state auditors access to the financial records of the affiliated companies that provided services through subcontracts with the plan.\textsuperscript{478}

On May 28, 1976, the Sacramento Foundation Community Health Plan announced that it was terminating its PHP contract with the state.\textsuperscript{479} The president of the Foundation criticized the Brown administration for using the poor as "political pawns" and for failing to honor commitments to the Foundation.\textsuperscript{480}

On July 8 and 9, 1976, the California Assembly Subcommittee on Health Care Investigations conducted hearings on the Omni-Rx Health Care Plan. The subcommittee investigated charges that Omni-Rx had misused public funds, failed to provide quality care, and made payments from Medi-Cal monies to the spouse of a congresswoman to lobby for federal funds. Also explored were allegations that the Department of Health had failed to adequately review the operations of Omni-Rx, and had concealed major shortcomings of the health plan.\textsuperscript{481}

The following week, Governor Brown announced that he would conduct a personal inspection of the Health Department.\textsuperscript{482} This examination would focus on claims of departmental incompetence in investigating the possible misuse of public funds by the Omni-Rx Health Care Plan.\textsuperscript{483}

On August 2, 1976, a letter was sent by the members of the Special Assembly Subcommittee on Health Care Investigations to Governor Brown setting forth the preliminary findings of the subcommittee and

\textsuperscript{476} Sacramento Bee, Apr. 20, 1976, § 1, at 1, col. 3.
\textsuperscript{477} Id. at 1, col. 3.
\textsuperscript{478} Id. at 1, col. 3.
\textsuperscript{479} Sacramento Bee, May 19, 1976, § 1, at 16, col. 6.
\textsuperscript{479} Sacramento Bee, May 29, 1976, § 2, at 5, col. 5.
\textsuperscript{480} Id.
\textsuperscript{481} Preliminary Hearings on Prepaid Health Plan Abuses Before the Special Assembly Subcomm. on Health Care Investigations (1976). See text accompanying note \textsuperscript{477} supra.
\textsuperscript{482} S.F. Examiner, July 14, 1976, at 2, col. 5.
\textsuperscript{483} Id.
recommending several changes in PHP administration. The letter criticized the quality of care within the Omni-Rx Health Care Plan on several counts including findings that the plan had employed questionable providers, had seriously underprovided dental services, and had numerous deficiencies in its pharmacy services.

The subcommittee criticized the financial and corporate structure of Omni-Rx: "The relationships between these individuals and companies are so entangled that they obstruct public scrutiny and confuse efforts to trace the passage of public funds from one entity to another." The letter also pointed out that Omni-Rx had been allowed to continue its state PHP contract despite the fact that it had not met tangible net equity requirements of state law. The letter recommended immediate termination of the Omni-Rx contract, prohibition of similar types of brokerage plans, broader reporting responsibilities as to the flow of health care dollars, and stricter standards for plans.

Probably the strongest criticism, however, was reserved for the Department of Health. The subcommittee noted that from the beginning of the PHP program, there had been two main weaknesses: the state's inability to trace taxpayers' funds to insure that they were actually being used for health care, and its failure to monitor the quality

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485. One of the providers, a podiatrist, had previously billed the Medi-Cal program for services rendered to two dead men. This same provider had been involved in at least forty-five malpractice cases in Los Angeles, and had been denied institutional privileges at numerous California hospitals. The subcommittee criticized the use of this podiatrist and another provider used by the plan, in the strongest language: "This cursory review disclosed two providers whose professional histories were so clouded that it strains the limits of imagination to understand their continued presence anywhere in the medical field. That they were permitted to act under the seal of state government approval is astounding." Id. at 2.

486. Id. at 3-4. The four most recent medical audits had revealed the same deficiencies in the plan's dental program. The most recent audit recommended the termination of dental services within the plan for Medi-Cal recipients. Id.

487. Id. at 4.

488. Id. at 5.

489. Id. at 6.

490. See note 428 & accompanying text supra. On September 1, 1976, in a complaint filed in the U.S. District Court in Los Angeles, the Securities and Exchange Commission charged Omni-Rx Health Systems with issuing false financial statements, manipulating stock, and misusing $670,000 from a public stock offering. L.A. Times, Sept. 2, 1976, at 9. Assemblyman Keene commented that the SEC complaint "unburdens us of the charge that we were picking on Omni-Rx." S.F. Examiner, Sept. 2, 1976, at 7, col. 1 (city ed.).

of care provided by PHPs. The letter then pointed out that “[s]ome civil service holdovers from the previous administration continue guiding the prepaid health program with the attitude that their primary purpose is to promote these plans, rather than to regulate the quality of their performance.”

The subcommittee recommended the termination of several staff members and the reprimanding of others “[u]nless their behavior can be justified by them in the course of continued legislative inquiry.” The members also urged commendations for the PHP investigators who had attempted to uncover violations by the Omni-Rx plan despite “foot-dragging and outright hostility by their superiors.”

On August 9, 1976, Governor Brown ordered the commissioner of corporations to investigate all prepaid health plans and to terminate contracts with all plans that did not meet tangible net equity requirements.

The Brown administration received further reprimands regarding the PHP program on October 5, 1976, when the undersecretary of HEW sent a warning letter to the Governor. The letter pointed out that the standard Medi-Cal contract was out of compliance with federal regulations, that the state had failed to secure precontract approval from HEW for expenditures exceeding $100,000 as required by federal regulations, and that the efforts of the State Department of Health to monitor the PHP program “[l]eft much to be desired.”

Citing the state’s “continued failure . . . to correct the serious deficiencies of the PHP program,” the HEW undersecretary ordered Governor Brown to correct these deficiencies by February 15, 1977, in order to insure California’s continued receipt of federal Medicaid matching funds.
Conclusion

As of August 1, 1976, only 192,972 Medi-Cal recipients were enrolled in twenty-seven PHPs in California.\(^503\) This figure represents a substantial drop from the 254,363 Medi-Cal recipients enrolled in fifty-three plans as of May 1, 1974.\(^504\) It is clear that rapid expansion of PHPs has been not only halted, but reversed.

While the PHP program in California is waning, several other states are experimenting with prepayment projects under Medicaid. As of September 1976, thirteen states besides California had contracted with a total of twenty prepaid group practices to provide health services to Medicaid recipients.\(^505\) As in California, however, problems have arisen with several of these plans.

On July 21, 1976, the Illinois state welfare director informed the Cure Health Plan that its contract with the state was being terminated because of fiscal mismanagement and inadequate medical care.\(^506\) Among the complaints leveled against the Cure Health Plan were inadequate facilities for provision of simple laboratory tests, inadequate staffing of physicians, inability to obtain specialty referrals, inadequate transportation of patients, and a general breakdown of morale among Cure physicians.\(^507\) The state reported that although Cure was a non-profit entity, much of the money it received was paid into five affiliated profit-making companies. The lessons from California apparently had not been lost on Cure administrators.

We are, therefore, at a crucial time in the development of health care services for indigents. Many states, concerned about rising costs of health care, have initiated drastic cutbacks in the scope of their Medicaid programs.\(^508\) Other states, apparently more impressed by the theory of the PHP program than by its track record, have begun exploring the delivery of health services through mechanisms other than the fee-for-service system.

\(^503\) CALIFORNIA DEP'T OF HEALTH, PHP CONTRACTS 3 (effective Aug. 1, 1976).
\(^504\) CALIFORNIA DEP'T OF HEALTH, PHP CONTRACTS 5 (effective May 1, 1974).
\(^507\) Id.
As has been shown, each potential weakness in the concept and implementation of the PHP program has created major institutional problems. The program has been plagued by enrollment and billing fraud, poor quality care, and bureaucratic inertia. Before suggesting measures to save the program, however, it must first be determined whether it is worth saving.

Since the inception of the PHP program, the underlying assumptions of the program have gone unquestioned. Even the program’s most severe critics have generally agreed that the concept of prepaid medicine is a good one, and that the problems arose in translating that concept into practice.\(^{509}\) Supporters have contended that PHPs could, if properly administered, alter the delivery of health services so that patients would become reoriented from crisis medicine to preventive care. Plans could thereby meet costs at less than fee-for-service rates by substituting relatively inexpensive programs such as health education for more expensive medical procedures.

These assumptions, however, are now being subjected to critical analysis.\(^{510}\) The greater reported use of preventive services within many health maintenance organizations than within control groups of fee-for-service patients may actually be the result of a self-fulfilling process whereby individuals oriented toward preventive medicine tend to enroll in health maintenance organizations.\(^{511}\) The economies achieved by

\(^{509}\) See, e.g., Jackson Committee Hearings, supra note 163, at 52 (statement of Dr. Lester Breslow).

\(^{510}\) For an examination of the assumptions of the prepaid group practice model, see D. Mechanic, The Growth of Bureaucratic Medicine 83-98 (1976) [hereinafter cited as Mechanic]. Mechanic points out, for instance, that most of what we know regarding the prepaid group practice mode comes from large prototypes such as Kaiser-Permanente, and that these data have probably given a more favorable picture of the generic prepaid group practice “than reality warrants.” Id. at 84-85.


\(^{511}\) For a discussion of factors involved in patient selection of prepaid group practice versus fee-for-service, see Mechanic, supra note 510, at 119-58. Mechanic reviews the existing studies and finds that it is still unclear whether there are systematic differences regarding health attitudes and practices between the people who select prepaid group practice and those who elect to receive care under the fee-for-service mode.

In order properly to test the true effects of the health maintenance organization method of health care delivery on the health status of patients, the patients need to be randomly assigned to health maintenance organization and fee-for-service modes. Such a study is currently being conducted by the Rand Corporation under a grant from HEW. The Rand study is discussed in a symposium in 11 Inquiry 3-60 (1974). (Inquiry is published by the Blue Cross Association.)
many health maintenance organizations may in part be the result of the use of outside medical care by many plan enrollees. The low hospital utilization rates reported in many studies of prepaid group practices may also be more a byproduct of a lack of available hospital beds than a result of altered treatment patterns within the plan.

Whatever the validity of the prepaid group practice concept generally, the application of this concept to a poverty population in California pointed up tremendous shortcomings in the existing models. The economic incentive to undertreat, for example, is inherent in any prepaid program. The temptation may be counteracted by several other factors: for instance, the medical provider's ethical code, the threat of malpractice lawsuits, and the costly complications which could arise if potentially serious medical conditions are not treated.

Those constraints, however, probably provide more protection for the middle class patient than for the disadvantaged Medi-Cal recipient. The low-income patient may have neither the sophistication nor means to pursue a malpractice claim. Moreover, the cost of delayed treatment may not have to be borne by the plan, since the patient may be disenrolled or no longer a Medi-Cal recipient by the time treatment is necessary.

The threat of undertreatment and the relative inability of indi-

512. Among patients of the Kaiser plan in Portland, approximately 10% had used some nonplan services during the preceding year. Greenlick, The Impact of Prepaid Group Practice on American Medical Care: A Critical Evaluation, 399 ANNALS OF THE AM. ACADEMY OF POL. & SOC. SCI. 100 (1972). A "significant portion" of these services, however, had been reimbursed by the Kaiser system, and thus were included in Kaiser's costs. Id. at 112. Another of the health maintenance organization studies found in one case that 12% of all ambulatory patient contacts during one year occurred with nonplan physicians. In addition, 7.2% of plan members' hospital admissions were to nonplan hospitals. The researchers did not note how many of these outside services were paid for by the plans. M. ROEMER, R. HETHERINGTON, C. HOPKINS, A. GERST, E. PARSONS, & D. LONG, HEALTH INSURANCE EFFECTS: SERVICES, EXPENDITURES, AND ATTITUDES UNDER THREE TYPES OF PLANS (1973).

California's experience has been consistent with the results of the Roemer study. In Los Angeles, for example, many PHP enrollees unwilling or unable to secure services through their plans received services through county facilities. See note 337 supra.


514. For a discussion of the effect of hospital bed availability on hospital utilization see Roemer & Shonick, HMO Performance: The Recent Evidence, 51 MILBANK MEM. FUND Q. 271, 281-88 (1973). After reviewing a number of research reports, Roemer and Shonick concluded that bed supply is "an important explanatory variable" affecting hospital utilization. Id. at 283.

gents to protect their rights under a PHP contract have been underscored by the actual experience of Medi-Cal recipients enrolled in prepaid health plans. Thus, if the California experience is evaluated on an absolute scale, the program is probably not worth saving. The PHP program, however, does not exist in a vacuum, and must be compared to the delivery of health services under the fee-for-service model.

In September 1974, a report was issued by the General Research Corporation of Santa Barbara, California\textsuperscript{516} comparing quality of care under the fee-for-service and prepaid systems. These researchers investigated five Southern California PHPs. By means of process audits of medical records, the care provided by these five health plans was compared to the care given by a sample of fee-for-service Medi-Cal providers in the same locale. The quality scores of both the PHP and fee-for-service physicians were found to be “disappointingly low.”\textsuperscript{517} On the average, the quality of PHP care differed little from that of the fee-for-service practices.\textsuperscript{518}

The fee-for-service and prepaid models have not only both provided poor health service, but have shared other problems as well. Recent reports have documented fiscal mismanagement and provider fraud in the Medicaid program generally.\textsuperscript{519} In many areas, fee-for-service providers have been unwilling to provide services to recipients under the Medicaid program.\textsuperscript{520} It is because the alternative of fee-for-service medicine is so inadequate, that we recommend radical restructuring of the PHP program rather than its termination. But having

\begin{footnotes}
\item[517] Id. at 4.
\item[518] Id. at 3. It should be noted, however, that there were wide differences among the plans. Several tended to score significantly higher than fee-for-service providers on the various quality measures. Other tended to score significantly lower on these same measures. Id. at 32-50.
\end{footnotes}
recognized that the program should be saved, we must also recognize that it is still at a pilot project stage. PHPs will not, in the near future, be the answer to rising costs in the Medi-Cal program. They may never be. Moreover, PHPs have not been and may never be the answer to providing mainstream medicine to the poor.

Numerous measures have been recommended to improve the PHP program and many have been adopted. Unfortunately, most of these measures implicitly depend upon vigorous regulation of the PHPs by the Department of Health. Had the department displayed that vigor, reforms such as the initial Waxman-Duffy legislation might well have

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521. In the recent past, PHPs have probably contributed to the increase in costs in the program. As discussed earlier, some received capitation payments in excess of the fee-for-service costs for providing similar services. See text accompanying note 335 supra. In addition, PHPs were supposed to reduce the high administrative costs incurred by the state in the fee-for-service system. Administrative costs within the plans have been extremely high. See April 1974 AUDITOR GENERAL REPORT, supra note 238. Thus, the PHP program has often merely shifted administrative costs from one entity to another, and perhaps actually increased those costs in the process.

Moreover, although costs were supposed to be reduced by insuring that capitation rates were at least 10% less than fee-for-service averages, this goal may have been realized through selective enrollment by the PHPs. Assume, for example, that the fee-for-service AFDC average monthly cost for medical care was thirty dollars. This cost would contemplate some recipients utilizing services at the rate of twenty dollars per month and others utilizing services at the rate of forty dollars per month. The average of such utilizations costs would be thirty dollars per month. The PHP would receive twenty-seven dollars per month for each AFDC recipient enrolled ($30 - (10% x $30) = $27). If the plan practiced selective enrollment, as many reports indicated, and only enrolled relatively healthy AFDC recipients with utilization rates of twenty dollars per month, costs to the state would actually have increased. The state would now be paying twenty-seven dollars per month to the PHP whereas it had been paying only twenty dollars per month to the fee-for-service providers for that same patient. The plan could deliver exactly the same level of care provided under the fee-for-service system and realize seven dollars per month as profit.

522. One of the goals of the Medi-Cal program which was to be advanced by the PHP program was that poor people would receive care in the same manner as wealthier individuals. As discussed earlier, few PHPs had any significant non-Medi-Cal enrollment. As a result, mainstream medicine as a goal was better realized in the fee-for-service model. As Assemblywoman Leona Egeland pointed out: “I have sat at least for this past year on the Health Committee in the Assembly and listened to all sorts of bills relating to mainstream medicine. I would define mainstream medicine as medical care with profit for someone. I'm not sure that that's the goal that we should continue to look at.” Oversight Hearing on Medi-Cal Before the Senate Comm. on Health and Welfare, 1976 Reg. Sess. 15. Whatever the merits of the goal of mainstream medicine, nearly all observers agree that it has not been realized within the PHP program.

523. Cal. Stat. 1972, ch. 1366, at 2718, as amended, CAL. WELF. & INST'NS CODE §§ 14118-481 (West Supp. 1976). The initial legislation, for example, prohibited enrollment misrepresentations. Id. The Department of Health documented numerous such violations against many plans. Despite that fact, no plan contracts were terminated for such violations.
been adequate to correct abuses within the PHP program. The Department of Health, however, has proven inadequate to the task.

It is unlikely for both fiscal and political reasons that the department will ever have adequate investigative staff to police the program closely. The enforcement problem is compounded by the failure of officials to follow up on the discoveries and recommendations of their investigators. It is therefore necessary that new standards and procedures be developed which will function within a less than aggressive bureaucracy.524

**Increased Record Keeping and Reporting**

The state health department’s audits have proven inadequate for monitoring plan operations. We therefore recommend increased reporting responsibilities for PHPs. The additional information required would allow simplified analysis of the quality of medical care by the Department of Health. Information could be required relating to both process and outcomes measures.526

Plans should be compelled, for example, to report monthly the number of adult women who have *not* received a documented pap test within the past year. Data could be similarly required regarding the non-occurrence of other screening procedures such as blood pressure

524. On October 8, 1976, President Ford signed into law legislation which provides, in part, that Medicaid providers must meet federal health maintenance organization standards in order to qualify for federal funding through capitation payments. Health Maintenance Organization Amendments of 1976, Pub. L. No. 94-460, § 202. See note 429 *supra*. The federal HMO requirement applies where the services under contract include inpatient hospital service and any other Medicaid service, or any three other Medicaid services. *Id.* The determination that a provider has satisfied the federal standards is made by the secretary of Health, Education, and Welfare. *Id.* Certain providers, such as those receiving a specified level of funding as migrant health centers, are exempt from the HMO standards. *Id.* The new amendments also require that the provider draw at least one-half of its enrollees from the private (non-Medicaid or Medicare) sector, although this requirement can be waived by the secretary of HEW for up to three years if the provider demonstrates progress toward meeting the requirement. *Id.*

This new scheme contrasts sharply with California’s present system, under which PHP contracts have tended to go to newly formed plans with neither the financial base nor the organizational structure necessary to provide quality care. Inevitably, money which should be spent on providing health services to recipients is diverted to establish the kind of structure necessary to appeal to enrollees. Both the state and the Medi-Cal enrollees are shortchanged in the process. Thus, to the extent that the new federal restrictions favor the established prepaid group practice with an already diverse patient population, they will serve to greatly lessen financial and administrative problems within the program. Moreover, the legislation has provided an additional level of scrutiny of plan operators which may serve to weed out the “fly-by-night” operators. See note 530 *infra*.

525. See note 308 *supra*. 
readings. Through the requirement of such data reporting, plans would be forced to establish centralized recordkeeping, to maintain charts on all enrollees (not just those who present themselves for medical care), to formulate specific treatment criteria, and conduct outreach among enrollees to ensure program utilization. Some discretion would necessarily be vested in the Department of Health to promulgate regulations regarding what would constitute acceptable utilization levels within plans.

Plans should also be required to report data relating to such outcomes measures as birth weight and incidence of hypertension. This data could then be compared to data collected from other plans and from control groups in the fee-for-service sector. Plans which were actually practicing preventive medicine should have improved outcome measures for these factors.

In light of the increased data reporting responsibilities there may be a tendency for plans to overreport utilization in order to secure favorable evaluations. On-site medical audits, during which utilization data could be verified, should therefore be conducted. Periodic interviews should also be conducted of plan enrollees to verify the accuracy of medical charts and utilization data, and to survey enrollee satisfaction.

Removal of PHPs Power to Solicit Enrollees

As long as door-to-door solicitation is the sole or primary method of securing new plan members, enrollment abuses will be the rule rather than the exception. We therefore recommend that the initial solicitation function be removed from the plans. Instead, county eligibility workers could inform new Medi-Cal recipients during certification of the fee-for-service and prepaid alternatives for health care available locally. This procedure could be repeated during redeterminations of eligibility for continuing recipients. The Medi-Cal recipient could then elect to waive confidentiality and have his or her name forwarded to any plans in the area. The plans could provide the recipient with further information. PHPs should be prohibited from compensating marketing representatives on a commission or partial com-

526. Process audits as presently performed appear to be used primarily as educational devices for plans. See text accompanying notes 412-15 supra. Despite the deficiencies exposed by these audits, offending plans have been renewed again and again. It should therefore be made clear at all levels of the Department of Health that audits have an enforcement function and are not state subsidized, chart writing tutorials for PHP staffs.
mission basis. Such a step would remove much of the incentive for enrollment fraud. Moreover, since the plan would be contacting only recipients who had expressed an interest in prepaid care, much of the inefficiency of door-to-door solicitation would be avoided.

**Enrollment Stabilization**

The Department of Health should take steps to stabilize enrollment within plans to insure continuity of care. As currently established, enrollment in PHPs is limited to certain public assistance recipients. Many recipients lose public assistance eligibility in a single month for various technical reasons but are restored to eligibility the following month. Eligibility for the plan, however, will have been terminated in the interim. We therefore recommend that eligibility for PHPs be expanded to include all Medi-Cal recipients. Interim eligibility for recent Medi-Cal recipients could also be provided by the state for limited periods.

The recent passage of the HMO Amendments of 1976, which require in effect that PHPs meet federal HMO standards if they are to continue to receive Medicaid funding, may well result in the termination of many present PHP contracts. Such a result must surely be applauded. But it would be unfortunate if the amendments had the additional effect of relaxing the pressure on the state of California to improve its own oversight capabilities.

527. Enrollment in PHPs has been limited to Medi-Cal recipients who are either public assistance recipients or categorically related medically needy individuals. This has been due to the lack of sufficient actuarial data to establish capitation rates for medically indigent adults. As we have seen, however, capitation rates for public assistance recipients have been questioned.

528. See notes 429 & 524 supra.

529. See note 4 & accompanying text supra.

530. Two recent developments have renewed hope that California will not abdicate its own oversight responsibilities. On November 10, 1976, the Department of Health announced that the State of California would not grant provisional HMO certification to California PHPs. (Pursuant to Public Law 94-460 (see notes 429 & 524 supra), section 202, states were authorized to provisionally certify HMOs pending action by HEW on applications for certification.) Although the announced basis for this decision was fiscal, the decision will have the effect of terminating, at least temporarily, most PHP contracts in early 1977. Cal. Dept. of Health, PHP Letter No. 60, Nov. 10, 1976; Cal. Dept. of Health, Press Release, Nov. 10, 1976.

On December 15, 1976, a law suit was filed by the California Department of Corporations against Omni-Rx Health Systems seeking to halt the sale of company stock and to place the firm in receivership. In announcing the filing of this lawsuit, Governor Brown, who had previously described Omni-Rx as “a pretzel palace of interlocking entities,” declared that company directors had “not only defrauded the stockholders but also channeled funds through intricate corporate entities to enrich themselves.” San Fran-
As Senator Henry Jackson declared in convening the United States Senate hearings on PHPs, "We do not want other states to repeat California's mistakes."\textsuperscript{531} It would be doubly tragic now for us to repeat our own.

cisco Examiner, Dec. 15, 1976 (city ed.), p. 6, col. 3. This long overdue step by the state was taken amidst mounting pressure by the federal government. See, e.g., text accompanying notes 497-502 supra. On December 12, 1976, the General Accounting Office had released a report reviewing the operations of five PHPs including Omni-Rx. The report concluded that the "nonprofit" PHPs were actually fronts for profitmaking companies. U.S. General Accounting Office, Relationships Between Nonprofit Prepaid Health Plans with California Medicaid Contracts and For Profit Entities Affiliated with Them (Nov. 1, 1976).

\textsuperscript{531} Jackson Committee Hearings, supra note 163, at 2.