Appendix E.—California Prepaid Medi-Cal Health Plans*

The State of California, through the Waxman-Duffy Prepaid Health Plan Act, enacted in 1971 an alternative form of delivering, organizing, and financing health care services to beneficiaries of Medi-Cal, the State's Medicaid program. Program costs in California had risen rapidly and continuously under an existing fee-for-service system. In March 1966, Medi-Cal program operations began spending at the rate of $600 million per year. By 1970, program costs had doubled. Spiraling costs and a suspicion that at least some of the inflation was caused by unnecessary provision of health care services led the California legislature to enable the State Health Department to contract with prepaid health plans (PHPs) for the delivery of health care to Medicaid beneficiaries.

PHPs were comparable to health maintenance organizations (HMOS). Both were private entities—primarily corporations—which agreed to provide a broad range of health care services to groups of individuals for a fixed monthly rate per individual or family.

PHPs were designed to provide comprehensive health services to enrolled Medi-Cal beneficiaries in a specified service area. PHPs were reimbursed ***on*** a prepaid cavitation basis dependent on the number of enrollees in the aid categories: Aid to the Blind (AB), Aid to Old Age Survivors (AOAS), Aid to the Totally Disabled (ATD), and Aid to Families With Dependent Children (AFDC). The vast majority (from 75 percent to over 90 percent depending on the PHP) of PHP enrollees were AFDC beneficiaries.

The first contract for a PHP that was not a pilot project took effect in May 1972. By July of 1973, there were 47 operational projects with a total enrollment of over 178,000 Medi-Cal beneficiaries. The PHP program had resulted in the development of more health systems with cavitation payment in California than in any other State.

From its inception, the PHP program aroused great controversy throughout the State. Charges were made ranging from financial manipulation and fraudulent marketing practices to the delivery of inadequate medical care.

In 1973, the Federal Government enacted the Health Maintenance Organization Act to provide funds for the development of HMOS across the Nation. Senate hearings were held in 1975-76 not only to investigate allegations of fraud and abuse by PHPs, but also to prevent the occurrence of similar errors in other States with the new Federal HMO development program.

The Senate hearings found that almost all of 54 California PHPs were nonprofit, tax-exempt organizations that subcontracted with for-profit corporations and partnerships owned or controlled by officers or directors of the nonprofit organizations. The hearings revealed that this type of corporate structure and contracting practice opened the way for the diversion of Medicaid funds away from the program's purposes.

Independent individuals and groups served as brokers, promoting State contracts for interested entrepreneurs in return for a percentage of Medicaid program payments made under State contracts. No funds were available for startup or fixed costs, so it was imperative that the PHP enroll members as quickly as possible. The money to finance the contracts subsequently came from the poor who were enrolled in PHPs by door-to-door salesmen employed by the plans, some of whom threatened, coerced, and forced the signatures of Medicaid beneficiaries on their plan enrollment forms. Other enrollees, who needed treatment, were involuntarily disenrolled from the plans by the operators when the cost of their care became expensive.

The quality of care provided in some PHPs was below reasonable standards, as judged by the State's own medical auditors. Some of the plans contracted with substandard and nonaccredited hospitals. Nonlicensed physicians were often recruited. Selective enrollment practices were common. Thousands of promised childhood immunization programs were never provided. Other types of care were often "skimped" on. Consulting firms exacted exorbitant fees for providing management and computer services.

Despite awareness of these problems, the State did little from the PHP program's inception in 1972 to 1975 to reform the program. Investigative reports on abuses and fraud were ignored, as were medical quality audit findings. The State failed to scrutinize the role of consultants. Program contract managers were rotated so frequently that none spent enough time working with specific plans to learn enough about each to manage them properly. The State had ***no*** method to objectively monitor quality of patient care, nor did it develop, in violation of its own regulations, an actuarially based reimbursement rate.

Federal response to this situation came late in 1976 through the Health Maintenance Organization Act amendments, which required that all PHPs receiving Medicaid funds be federally qualified HMOS. This forced the California PHPs to include the scope of

● **This appendix is condensed from** *Prepaid Health Plans and Health Maintenance Organizations,* **report of the Committee on Governmental Affairs, United States Senate, Report 95-749, Apr. 20, 1978; and from General Research Corp.,** *Evaluation of California's Prepaid Health Plans,* **submitted to the Department of Health, Education, and Welfare, contract No. HEW-05-73-194, September 1974 (264).**

federally mandated plan benefits and to be approved by the Department of Health, Education, and Welfare (now the Department of Health and Human Services) as a condition for continuing in the California Medicaid program,

Some PHPs did not seek Federal qualification and dropped out of the program. Other plans qualified, or sought qualification. The State concurrently implemented tougher regulations for certification, imposing standards in some areas that were even more stringent than Federal guidelines:

- new regulations, paralleling the Federal HMO legislation and strengthening the State's existing regulations, were promulgated;
- Ž a new standard contract between the State and individual plans was developed, better improved performance standards were adopted, and a State staff team approach to contract management was instituted;
- standards for the evaluation of quality of care were established; and
- the process by which contracts were renewed was totally revamped.

These efforts and the 1976 Health Maintenance Organization Act amendments had the effect of reducing the number of PHPs with State Medicaid contracts from 26 to 12.

In addition, the California legislature passed and the Governor signed in 1977a new law aimed at responding to problems identified by congressional investigators and others. For example, the new law prohibited certain types of marketing practices. Responding to the problem of complicated corporate structures, the law required the prime PHP contractors to manage themselves and prohibited subcontracting for management. The statute prohibited interentity conflicts of interest on the part of plan officials. In addition, broad requirements were established for disclosure by plan officials of ownerships' interest and reimbursement.