Consumer Problems with Prepaid Health Plans in California

Implications for serving Medicaid recipients through health maintenance organizations

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ESCALATING COSTS, UNEVEN ACCESS TO PHYSICIANS, and lack of quality control in Medicaid programs have led policymakers to seek options to the fee-for-service system. In 1971, California led the nation in implementing a promising alternative—a statewide prepaid health program for Medicaid beneficiaries. This action was widely heralded as a solution to the problems of cost containment, guaranteed access, and quality assurance in the provision of health care to the poor.

Under California's program, prepaid health plans (PHPs)—modeled after prototype prepaid group practice organizations—contracted to provide comprehensive health care to Medicaid recipients in return for a predetermined per capita payment by the State for each eligible enrollee. Based on the results of studies of established prepaid group practices *(1–4a)*, it was assumed that this arrangement would provide more benefits than available through fee-for-service coverage. Moreover, built-in provider incentives to keep members healthy presumably would result in a greater emphasis on prevention and improved quality of care, which, in turn, would reduce costs—saving millions of dollars in public funds *(5)*.

California's program, however, has fallen so far short of its promise that many consider it scandalous. Because this situation has received little attention in the public health and medical care literature, our aim here is to alert public health professionals to the many possible pitfalls in applying the health

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maintenance organization (HMO) concept to programs for the poor. This alert is particularly important now that at least 14 other States are contracting with prepaid health plans to provide health care to Medicaid recipients (*6*), and more States are likely to begin such programs soon.

It is ironic that California's most recent experiment with prepaid health care has resulted in such a tempest, since the earlier successful experiences of its "first generation" PHPs—the Ross-Loos Medical Group, the Kaiser Foundation Health Plan, the San Joaquin Foundation for Medical Care, and others—contributed significantly to the development and passage of Federal HMO legislation. Although California's present stormy developments do not concern all HMO-type organizations in the State, they do reveal a complex series of difficulties in providing quality health care to the poor through the HMO mechanism. At issue are not only operational dilemmas as to how publicly supported health care can be effectively planned, organized, financed, delivered, regulated, monitored, and evaluated, but also larger public policy questions fraught with political, economic, and legal ramifications of great import to those whose health is at stake.

Our central emphasis is on consumer problems with PHPs for several interrelated reasons. First, the poor have borne the greatest burden of California's experiment, and their statements of what went wrong are the most poignant of all. Second, consumer reports of difficulties with prepaid health plans, particularly as expressed through disenrollments, were the initial impetus for arousing more widespread concern which eventually led to the disclosure of underlying legislative, organizational, and administrative defects in the program. Third, at least until recently, the majority of consumer complaints were never followed up by the State (*4b*). Although two prior reviews of California's PHP experience (*7, 8*) take a consumer perspective, neither of these was published in a public health journal nor did the authors have access to certain data considered in this report.

Most important, as health educators, we saw the need to search out and analyze consumer problems in greater detail, since the achievement of PHP program goals depends to a large extent upon consumer behavior. Thus, in deciding whether to join a PHP, and if so, for how long to continue membership, consumers as a group will determine the extent to which enrollment targets are met, as well as the economic viability of the various participating plans. Similarly, consumer expectations for, perceptions of, and actual experiences with accessibility and quality of care will affect their satisfaction with the plan, their adaptation to a new system, and what they say about the plan to others. Because these factors affect both the size and stability of the PHP enrollment base, they bear heavily upon the actual quality of care which can be provided and ultimately upon the extent to which broader health goals can be achieved through the PHP mechanism.

In the following discussion, we consider the impact of California's PHP experience on consumers in three sections: (*a*) a brief overview of the program's history, (*b*) limited, but highly suggestive data emphasizing a special form of consumer complaint—disenrollment, and (*c*) program weaknesses revealed by our analysis and the thinking of others concerned with health care for the poor.

Program Overview

California's active restructuring of its Medicaid system began with the Medi-Cal Reform Act of 1971 (*9*). Although prior State legislation to implement Title XIX of the Social Security Act (Medicaid) specified that care for public assistance eligibles "to the extent feasible, be provided through prepaid health care or contracts with carriers" (*10*), only a few pilot contracts were developed under this authorization (*11*). To further encourage this pattern of care, the 1971 legislation authorized minimal constraints on full-scale State contracting with prepaid health plans. At the same time, it placed stringent restrictions on use of fee-for-service benefits, requiring prior authorization for more than two physician office visits and two prescription drugs monthly and for nonemergency hospitalization. Copayment charges on office visits and prescriptions were also imposed on about half of the beneficiaries—a cost-saving strategy conducted as an experiment under a special waiver from the Department of Health, Education, and Welfare (*12–14*).

Called the "carrot and the stick approach" by the State department of health, the law made PHPs relatively more attractive to Medicaid beneficiaries because of freedom from copayments, avoidance of delays caused by prior authorization procedures, and the provision of extra benefits such as transportation. At the same time, physicians were further deterred from accepting Medicaid patients under fee-for-service arrangements by the additional "red tape."

Those portions of the legislation that encourage development of new health services delivery organizations are germane to understanding many of the ensuing problems. The underlying philosophy was

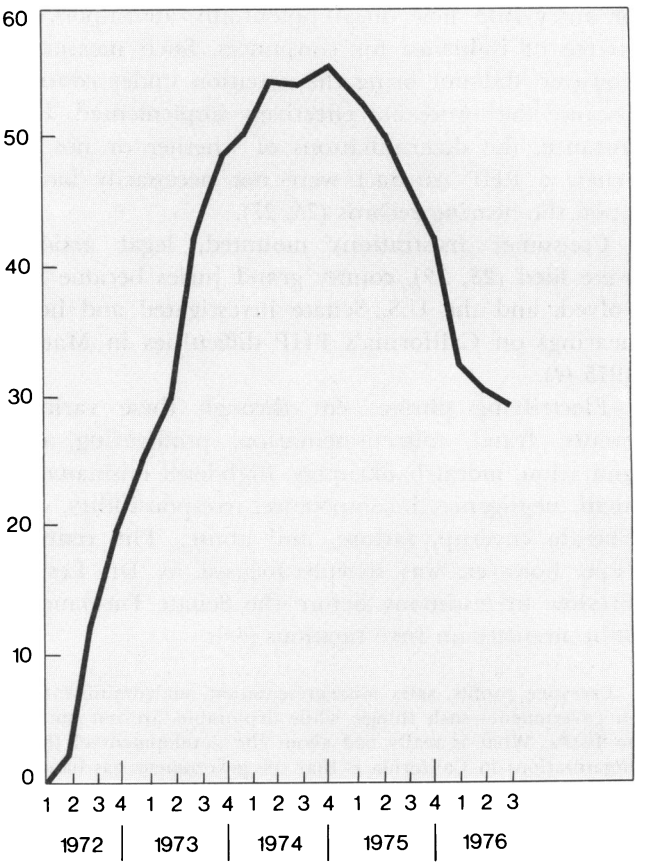
that without government interference, private enterprise would produce a cost-effective system with quality controlled through free competition in the marketplace (*7a, 15*). As in private enterprise, risks were also to be borne by the contracting PHPs. Accordingly, no provision was made for marketing assistance similar to that given to developing HMOs through the "dual option requirement" in the Federal HMO Act of 1973. No planning or startup monies were offered by the State. Additionally, no limits were placed on the number of plans that could be granted contracts in a given area. Nothing prevented PHPs from being composed entirely of Medicaid enrollees; but despite the vicissitudes of eligibility, continuity of membership for specified periods of time was not guaranteed.

Contracts were to cost less than the same services delivered under the fee-for-service system and were to be let on a nonbid basis, but qualifications for applicants were purposefully left vague. Although most PHPs chose to organize as nonprofit corporations because this offered them the least limitation from government regulation, under California law such organizations are permitted to subcontract with for-profit groups, the directorships of which may be overlapping. A final important point is that the law did not require contractors to provide services, only that they arrange for them. This feature, of course, is consistent with one classic model for organizing prepaid health care (*16a*).

The legislature authorized the State department of health to establish requirements governing PHP contracts, but the department followed the lead of the administration in taking a laissez-faire stance toward PHPs, both in the establishment of regulations and in their enforcement. Moreover, to encourage a rapid transition to the cost-saving PHP system, the State executed contracts as quickly as possible—with only cursory screening of applications and without adequate pilot experience.

According to the department of health, from the effective date of the first PHP contract on May 1, 1972, the program grew by the end of the year to include 21 plans with a combined enrollment of 147,569 persons. Only five of these organizations existed before that year. By the end of 1974, just 3 years after the 1971 act, the State was paying 54 contractors $84.6 million per year for the health care of 252,000 Medicaid recipients, roughly 10 percent of the eligible population (*4c*). The speed with which this development took place, as illustrated in figure 1, precluded the careful phased development built into the Federal HMO program, which generated only half as many operational HMOs in a similar timespan (*6*).

Figure 1. Average number of approved prepaid health plans per quarter, 1972-76



As new prepaid health plans sprang up in California, consumer complaints began to mount, flowing from aggrieved persons to the State health department through neighborhood groups, consumer organizations, concerned welfare workers, public health nurses, legal-aid societies, local health departments, medical associations, and comprehensive health planning councils. These complaints resulted in unfavorable newspaper publicity, decreases in PHP enrollments, increases in disenrollments, the development of consumer advocacy organizations, and a rallying of public support against these plans, as for example, through disenrollment campaigns. Reports prepared by the California Legislature (*17, 18*), the State auditor-general (*19, 20*), responsible Federal agencies (*21*), and various other official and private organizations (*4d, 22–24*) pointed to the existence of serious problems.

Some statutory protection was obtained through the Waxman-Duffy Prepaid Health Plan Act, enacted in 1973 (*25*). This legislation set forth stand-

ards governing marketing, established a ceiling on the proportion of Medicaid enrollees, and required public hearings before renewal of existing contracts or entry into new ones—potentially an important source of influence for consumers. Such measures, however, did not bring the situation under control because they were not effectively implemented. For instance, the determinations of whether or not to renew a PHP contract were not necessarily based upon the hearing records (*26, 27*).

Consumer frustrations mounted, legal actions were filed (*28, 29*), county grand juries became involved, and the U.S. Senate investigated and held hearings on California's PHP difficulties in March 1975 (*4*).

Electrifying phrases cut through these various events: fraud, misrepresentation, profiteering, exploitation, moral bankruptcy, high-level mismanagement, negligence, incompetence, irresponsibility, deliberate coverup, failure, and abuse. The central issue, however, was sharply focused by Dr. Lester Breslow in testimony before the Senate Permanent Subcommittee on Investigations (*4e*):

> Excessive profits, sales misrepresentation, maladministration in government—such things, while deplorable, are not unique to PHPs. What is really bad about the development of these organizations in California is that the government has handed over the health care of tens of thousands of poor, and mainly unsophisticated, people to organizations that cannot provide and do not provide good quality care . . . often in situations where permanent damage to health, even death, may occur . . . The fact that people for whose health care government has declared itself responsible are not getting good care—that is the main issue.

Many of the entities with which the State contracted were little more than management shells that had been quickly thrown together by entrepreneurs who saw attractive profitmaking possibilities in the margin between capitation payments and expenses for services rendered. Some of the contractors were basically holding companies purchasing all their laboratory, pharmacy, physician, hospital, and other services from affiliates owned by the directors and their associates (*17a*). The absence of an adequate rate-setting mechanism, combined with loose contracting controls enabled some of the contractors to skim substantial profits from the monthly State payments in the form of excessively high administrative overhead (*18*) and, it is alleged, low enrollee utilization rates (*4f*).

Contrary to the intent of the State legislature in implementing Title XIX (*10*) and despite the potential of prepaid group practice to integrate the poor into one-class medicine (*16b*), a dual-track pattern emerged early on. Thus, many PHPs enrolled Medicaid recipients almost exclusively (*7b*).

> Three years after the passage of the Medi-Cal Reform Act of 1971 there existed two types of HMOs in California: PHPs and non-PHPs. The majority are PHPs; of the 77 HMOs operational as of October 1, 1974, 58 or 75 percent were Medi-Cal contractors . . . The overwhelming majority of the PHPs have enrollee populations in which Medi-Cal beneficiaries are disproportionately represented.

A department of health survey of 46 PHPs in early 1975 found that among those responding (all but 8 percent), the memberships of 74 percent consisted of three-quarters or more Medicaid recipients. Of this 74 percent, 57 percent had Medicaid members only (*30*). The legislature's effort to alter this situation through the Waxman-Duffy Act has largely failed.

California embarked on a fresh chapter in its PHP experience in 1975 when the present Governor assumed office and placed a moratorium on PHP contracting. A broad-based advisory team was formed, and after several months the new PHP director for the State testified that the team's investigation "confirmed much of what was suggested in other reports" (*4g*). The new deputy secretary of the Health and Welfare Agency and, at that time, acting director of health, also acknowledged significant PHP problems in his testimony before the Senate Subcommittee on Investigations (*4g*):

> We . . . recognize our obligation to set the record straight that the California model—without necessary regulatory development and quality assurance mechanisms—in general, does not provide a satisfactory level of quality to patients and encourages an unwholesome and complex network of big business relationships. . .

In June 1975, new and stricter standards were promulgated by the department of health. Other promising actions included the enactment of legislation that involved the California commissioner of corporations in the financial audit of PHPs commencing July 1, 1976 (*31*).

A vigorous PHP program director who was appointed later—the sixth in 5 years and the second in the new administration—began to weed out the marginal plans, and during his tenure the number of contractors was substantially reduced (fig. 1). But, in April 1976, this administrator was dismissed abruptly (*32–34*).

Once again consumers and their advocates were disappointed by what they perceived as a backing off from tough regulation by the department of health. Repercussions quickly developed. The State Assembly Subcommittee on Health Care Investigations

conducted hearings in July 1976 and subsequently issued a blistering report calling for the termination of another Los Angeles PHP and a "systematic housecleaning" among State contract managers (*35*). Further State assembly hearings were scheduled for September. In the meantime, the U.S. Senate Permanent Subcommittee on Investigations again began to probe California's PHPs. Concurrently, the program is being investigated by the U.S. General Accounting Office and the DHEW Audit Agency. Federal concern for Medicaid beneficiaries in prepaid health plans was additionally evidenced in the new HMO amendments signed into law in November 1976. One of these amendments limits Medicaid matching payments to prepaid health plans which are federally certified HMOs. Since at the time of this writing only one of California's first and second generation PHPs meets this requirement, the impact of this legislation on the State's Medicaid program is yet to be determined.

In view of the preceding events, it is certainly not clear that the "good has driven out the bad," as once envisioned by the State administration under its free market-oriented philosophy espoused in 1971. Political ambitions on all sides continue to affect action, and the countervailing forces to meaningful reform are strong (*33*). The serious danger has not been dispelled that inferior plans might succeed financially and become firmly entrenched, making "extremely difficult future efforts to deal with them in the public interest" (*4h*). A second grave danger exists in that negative experiences with some PHPs may jeopardize unfairly the reputations of responsible plans, as well as the entire concept of providing health care to the poor through the prepaid mode. To the extent that this occurs, it may be more appropriate to say that "bad health care tends to drive out the good" (*4h*). One should keep in mind these perils and the existence of multiple problems in the fee-for-service sector when reading our following detailed examination of problems experienced by Medicaid enrollees in California PHPs.

Consumer Problems With PHPs

Assessment of the impact of California's PHP experiment on Medicaid enrollees is both a moral responsibility and a pragmatic imperative. Evaluation therefore is exigent not only to effect program improvements and to determine future program directions but also to judge the extent to which the program has fulfilled the public mandate to provide quality health care to the poor. Within the broad scope of evaluations needed, we have focused on sources of consumer dissatisfaction leading to disenrollments as indicative of underlying problems that need resolution if consumer decision making is to support the development of PHPs as a viable alternative for implementing Medicaid legislation.

Sources of data. To develop a more comprehensive view than previously available of the difficulties experienced by Medicaid consumers in conjunction with the expansion of PHPs in California, we extensively examined certain public records, many of which have been relatively inaccessible. Documents reviewed included all available enrollment and disenrollment data from the State department of health, disenrollment forms collected by consumer groups in Los Angeles during the first 2 years of the program, and affidavits from lawsuits against individual plans. The information thus obtained was supplemented through personal interviews with consumers and those working on their behalf, as well as by newspaper articles, testimony presented before investigative bodies, and the findings of other evaluations and reports (*7, 8*).

Symptomatic of larger difficulties, State PHP records are inadequate and incomplete. These limitations are reflected in this paper and will certainly affect other evaluation attempts. A broader significance of these limitations however, is that the lack of adequate data has obviously affected the State's ability to identify problem areas for responsible monitoring of plans, as well as to manage the program as a whole. In fact, the State's data base is so disappointing that one wonders what combination of mismanagement, personnel turnover, naivete, and deliberate attempts to thwart scrutiny have produced the present system.

Thus, for example, although the monthly reports giving frequencies and rates of enrollment and disenrollment by plan are intact, tabulations of the reasons for voluntary disenrollment exist for only 13 months, 6 of which are from 1976. Much of the available information has not been tabulated for more than 1 month at a time; preparation of statistics to examine trends over time is complicated by periodic changes in the statistics collected, coding systems, and reporting formats. These problems, in turn, have created other data gaps, such as the lack of departmental analyses of program activity relevant to essential administration and policy decisions.

Although we found State health department personnel cooperative in opening their files for the present study, the department previously has been reluctant to make available PHP information that

legally is a matter of public record. This reluctance has also contributed to holes in documentation, as illustrated most notably by the experience of the Los Angeles County Health Rights Organization in attempting to obtain PHP utilization data. A successful lawsuit (*36*) filed under the California Freedom of Information Act was required before the State acknowledged LACRO's right to gain access to monthly utilization reports. Shortly thereafter, the department halted compilation of these records, leaving raw utilization data on the computer where it was effectively inaccessible not only to the plaintiffs, but to the State itself—and we might add, to subsequent investigators.

In light of these problems, an important supplement to State PHP data has been our review of 769 disenrollment forms through which 2,099 persons sought to terminate membership in 28 Los Angeles PHPs. These forms were collected during 1972–73 by two consumer advocacy groups because people reported difficulty in disenrolling through the plans themselves (*4i*). Although lack of access to all disenrollment records listing the reasons for voluntary withdrawal from a plan precluded a representative sampling, other reports (*4*) clearly indicate that the difficulties revealed in these documents did not merely reflect a "reporting" bias, but rather a problem of epidemic proportions. Moreover, the documents available draw from an important Medicaid population, for Los Angeles has been a major PHP center. According to department of health records, more than half of the PHPs operating in the State at any given time have been located in the Los Angeles area, and between two-thirds and three-quarters of all Medicaid PHP members have been enrolled there.

Further data were obtained from affidavits representing some 132 consumers bringing civil suit against 1 Los Angeles PHP (*28*) and 8 additional affidavits involving 23 persons who initiated successful litigation against another plan in the San Francsico Bay area (*29*). Not all lawsuits against California PHPs have been examined, nor is the total number even known, but the civil actions considered here are especially important in that the plaintiffs are seeking not only personal damages but also injunctive relief—that is, basic changes in the organizational situation which led to their complaints.

The more complete data—disenrollment and enrollment reports—provide a backdrop against which to discuss the Los Angeles disenrollment forms and affidavits. Despite their obvious limitations, the latter sources serve to point out and emphasize the paramount issues in providing publicly supported prepaid health care from a consumer perspective.

The data available do not assure the identification of all problems which Medicaid beneficiaries have experienced with PHPs. Neither do they permit an accurate estimate of the frequency with which the problems revealed have occurred. What does surface therefore should be regarded as the "tip of the iceberg." As such, the following discussion should forewarn public health professionals to explore further the hazards involved before steering the Medicaid ship deeper into prepaid waters.

Enrollment and disenrollment trends. Figure 2 charts the actual and potential number of Medicaid enrollees in California prepaid health plans from the first nonpilot contract approval in 1972 through June 1976. As is immediately apparent, enrollments have fallen far short of the Medicaid memberships authorized by the State department of health and the targets that these reflect. Thus, although the department's goal was to enroll half of California's 2 million Medicaid beneficiaries in PHPs during 1973, by the end of 1974 only 10 percent of this population had enrolled (*4c*)—a figure which has remained fairly constant since. While the authorized Medicaid membership capacity has decreased with recent reductions in the number of operating plans, enrollment potential is still more than double the number of actual Medicaid subscribers. Therefore, despite the State's attempts to effect major changes in the health care delivery system, California's poor have not enrolled in PHPs to the extent anticipated.

Figure 2 Actual and potential Medicaid enrollments in California prepaid health plans, January 1973 - June 1976

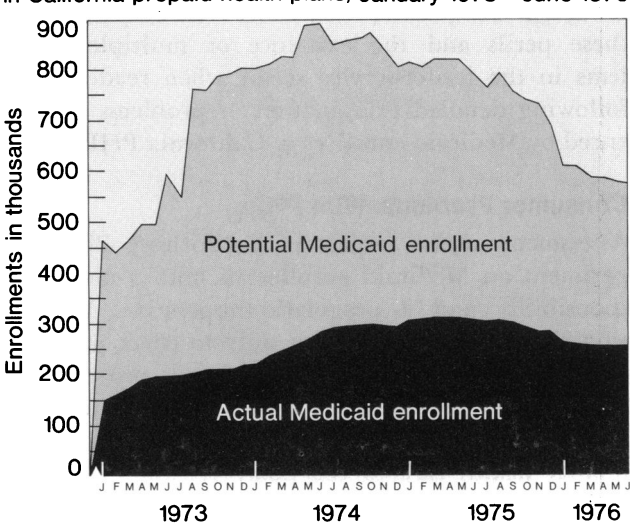
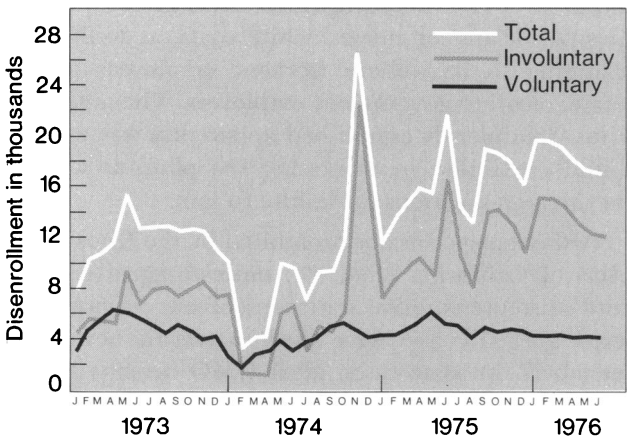


Figure 3 Prepaid health plans disenrollments, January 1973 - June 1976



This situation generally reflects the experiences of prepaid group practices elsewhere (*37a*).

Notwithstanding, the actual PHP membership curve suggests gradual and stable growth. This is deceptive, however, because rapid turnover and fluctuation in membership have been hallmarks of California's "second generation" PHPs. Monthly Medicaid enrollment figures mask this situation in that gains in new subscribers offset losses from disenrollments to produce the illusion of membership stability.

As figure 3 demonstrates, disenrollments have varied erratically, with monthly disenrollment statistics greatly affected by marked variations in involuntary disenrollments—primarily due to members' loss of Medicaid eligibility (*8a*), but also more recently to the reduction in plan contracts. Voluntary disenrollments, too, have been a steady drain on PHP membership; these result from subscribers moving from a plan's service areas or subscriber dissatisfaction.

The impact of enrollment and disenrollment on Medicaid membership in PHPs is exemplified by data for April through August 1973, when new enrollments averaged approximately 8 percent of the total membership per month and disenrollments averaged 5.5 percent. The voluntary disenrollment rate alone was 2.3 percent monthly, ranging from 0 to 21 percent for individual plans. Projected annually, this means that 66 percent of the total PHP Medicaid membership disenrolled per year and that nearly 28 percent of all Medicaid subscribers did so voluntarily.

By 1975, involuntary disenrollments were averaging 4.2 percent monthly. In addition, an average of 1.8 percent of the Medicaid PHP subscribers were still disenrolling voluntarily each month—a trend that persisted through the first 6 months of 1976. Individual plans also continued to vary in voluntary disenrollment rates, ranging from 0 to 8.1 percent during 1975 and from 0 to 6.2 percent in the first half of the following year.

The effects of these patterns on PHPs—and on the Medicaid recipients for whose health they are responsible—have varied, depending not only on each plan's particular enrollment and disenrollment experience, but also on the proportion of the plan's total membership which Medicaid consumers represent. For the substantial number of plans relying mainly or solely on Medicaid enrollees, however, the failure to attract the expected number of subscribers has inevitably affected the range and quality of services. A prepaid membership base of 20,000–50,000 enrollees has been estimated as the minimum essential for economic survival and the delivery of comprehensive health care (*8b, 16c, 38a*), but the average Medicaid enrollment in California PHPs did not exceed 5,000 members until early 1975, and in March of that year only two plans had registered more than 11,000 beneficiaries (*39*).

Coupled with problems of size, membership turnover has resulted in tremendous marketing pressures, not only to achieve plan growth but to replace enrollees who became ineligible, moved, or withdrew PHP membership as a result of dissatisfaction. These factors, as well as the lack of an adequate enrollment "mix" to spread the risk of coverage, have also exacerbated the difficulties of providing quality care to new and continuing subscribers. Herein lie the major sources of consumer complaints against California PHPs as revealed in disenrollment forms and the other documents that we reviewed.

Consumer complaints against PHPs. In contrast to complaints against fee-for-service providers, which in California typically concern billing for services not rendered, consumer complaints against PHPs can be categorized into two broad groups: marketing and enrollment practices and lack of services to meet member needs (*4j*). As previously noted, however, the lack of sufficient data makes it difficult to estimate the proportion of PHP Medicaid members registering such complaints and the frequency of specific alleged abuses.

Although State health department personnel began investigating complaints from Medicaid consumers shortly after the first PHP contracts were written, this activity was the subject of considerable intradepartmental conflict. As a result, systematic records of complaints were not kept and (*4j*):

. . . program staff responsible for contract supervision most often resorted to disenrolling a complaining beneficiary to solve the enrollee's problem rather than impose sanctions against the plan.

The disenrollment forms collected by the two Los Angeles consumer groups during 1972–73 therefore assume a special significance and provide the primary source of data on the dissatisfactions of Medicaid recipients with PHPs during this period.

Content analysis of these latter documents clearly reveals that PHP marketing and the accessibility and acceptability of services are the major problems. Not all reasons for consumer dissatisfaction may have been listed, however, since only one was required for a member to disenroll. The use of a single form to disenroll more than one subscriber and variations in the way documents were completed further complicate tabulations of frequencies, while changes in PHP membership, contracts, and plan service areas result in a denominator much too slippery to estimate the extent to which complaints stated on disenrollment forms represent the Medicaid population then enrolled in PHPs.

The earliest information on the relative frequency of consumer problems with prepaid health plans is provided by an analysis of 860 complaints on file with the State department of health as of September 1973. Working from "typically handwritten telephone messages taken by PHP management staff during the past seven months" which . . . "gave no evidence of follow-up action or indication of referrals having been made," the then newly appointed chief of the investigations section found that 46 percent of these complaints were for poor service, 33 percent concerned marketing misrepresentation, and 17 percent involved transportation difficulties. Less common problems were failing to pay non-PHP providers for health care given enrollees in emergencies or outside the plan service area, as well as selective disenrollments of members who were seriously ill (*4j*).

Because the particulars of alleged abuses are numerous, we cite only a few of the most frequently reported reasons for grievances. Although these suggest related problems, only individual case histories can capture the frustration, bewilderment, and personal tragedy underlying consumer complaints against PHPs.

Marketing and enrollment practices. Repeated consumer protests strongly suggest that Medicaid recipients have been pressured into joining PHPs through a variety of deceptive enrollment practices, many of which were employed in door-to-door solicitations in poverty areas. One common report is that enrollers hired by PHPs misrepresented themselves by wearing physicians' or nurses' white coats, as well as by claiming to be welfare workers, employees of the State, or other government employees. The authority thus fraudulently established apparently was used to build credibility in marketing the plan, as well as to threaten sanctions for failure to join.

Although specifically prohibited by the Knox-Mills Acts of California (*16d, 40*), misleading advertising and misrepresentative statements about services covered allegedly also were used to recruit new PHP members. In some cases, ideal HMO benefits apparently were promised regardless of the plan's ability to deliver, but in other instances, not even a model HMO could fulfill the promises which plaintiffs claim were made. Alternatively, some PHP recruiters allegedly failed to make clear that a choice of health care plans was possible, advised people that they would lose their Medicaid benefits unless they joined the PHP in question, or provided so little information that consumers were enrolled unwittingly or without full understanding of the changes which PHP membership would effect in their health care coverage.

Typical is the statement of a woman who reported that a man claiming to be from the State came to her door and asked to see the family's Medicaid cards. In her words:

He copied our names and numbers from the cards. He filled out a paper and told me to sign it, saying that from now on we will have better care than we had before. He did not give me any printed material, nor did he explain anything about the plan to me. He did not say that we would not receive our regular Medi-Cal cards the following month.

Until she took her father-in-law to their family physician, this woman did not know that his services were no longer covered. When two of her children needed medical care, she did not go to the PHP clinic because it was too far and because she had heard that its services were not good. Instead, she took them to the family physician and paid for the visits and prescriptions herself. Not all PHP enrollees had sufficient money to exercise this option.

Further complaints held that peer pressure in several forms was exerted to obtain PHP enrollments. For example, an elderly Chinese man stated that he joined a plan after being convinced that most others in his senior citizens' group already had done so (*29*). Misstating that one person could enroll others, PHP representatives also allegedly urged new

members to enroll their relatives and friends. In other instances, the enrollment of members through deliberate forgery was reported.

Problems in obtaining services. Although the intent of Medicaid legislation is to remove barriers to health care for the poor, another large category of consumer complaints concerns problems in obtaining PHP services. For those who sought promised care under the strain of illness or injury, the discovery that medical attention was not readily available often compounded personal pain and stress, sometimes in life-threatening situations. For others, the difficulties in obtaining even routine care created a crisis.

Distance and transportation problems represent obvious obstacles to obtaining health care, especially for the poor, and thus numerous consumer grievances related to transportation hardships. These hardships allegedly were compounded by providers' failure to keep scheduled office hours and appointments and by the enrollment of PHP members beyond the prescribed service area. Geographic limitations of PHP services, even when legal, have presented problems for consumers in other ways. For example, since plans are required to provide emergency care at only one of their locations, emergency services have been effectively inaccessible for all but the most extreme conditions to members living far away.

Consumers have criticized the availability of PHP emergency services on other counts also—that enrollees are sometimes required to get a physician's approval before they can use emergency facilities; that physicians are on call only for emergencies rather than being at the clinic on a 24-hour basis as required by PHP contract; that emergency treatment was denied because the appropriate specialist was not available; and that some plans do not even maintain an emergency facility or telephone contact with emergency providers.

Inordinate waiting time is another commonly reported hindrance. An extreme example is that of a 3-year-old with a severely and obviously painful fractured arm who waited with her mother in a PHP clinic from 10 am until 6 pm for an orthopedic specialist to arrive. At 6 pm the pair was sent home to await word about where to go for treatment. Unable to wait any longer by 9 pm, the enrollee took her child to an orthopedic hospital where she received attention immediately. Nevertheless, since the visit was not authorized by the PHP, the mother had to pay for it out of her own pocket (*7b*).

Poor quality of care. The documents reviewed for this study indicate that for the poor, quality is judged first by the availability of services. The more usual definition of quality, however, concerns the evaluation of care actually delivered. The blending of these two dimensions is apparent in specific consumer grievances regarding inferior PHP services. Thus, charges that the clinic atmosphere was unfriendly, that the physician would not prescribe the treatment the patient desired, or that no followup service was provided tend to be associated in individual experience with difficulties of access, such as long waiting times or the unavailability of a specialist.

These consumer indicators of health care quality differ markedly from those used in professional evaluations which, nevertheless, have found PHPs seriously lacking in the quality of care provided (*4k, 22*). If we assume that consumer assessments of quality are related to expectations for health care, our data suggest that extravagant promises made in PHP marketing may well contribute to later disappointments with PHP services. Similarly, previous patterns of health care tend to shape notions of what adequate care should be.

Medicaid recipients accustomed to frequent prescriptions, laboratory tests, and hospitalizations under the fee-for-service system may be likely to complain when PHPs do not provide such services in the same volume, regardless of whether or not they are medically appropriate. Past inequities in services received by the poor as compared to those economically more advantaged may also condition Medicaid members of PHPs to expect "second-class treatment," thereby sensitizing them to perceive even the smallest deviations from usual practice as indicative of inferior care. This was illustrated by one enrollee's complaint that rather than taking a thermometer from a sterile container, a health plan nurse gave her one from a table, which she "of course, refused."

The results of several studies also indicate that the extent to which health workers, and particularly physicians, demonstrate interest in patients and try to communicate effectively with them about their medical problems is extremely important in consumer assessments of the quality of care (*41*). At the same time, there is evidence that the systematic organization of prepaid group practice tends to be associated with a less personalized form of physician care than is provided in fee-for-service medicine (*1, 42*). Consumers disappointed with the quality of the physician-patient relationship therefore may per-

ceive problems in PHP services regardless of their technical adequacy. This situation does not preclude the possibility of overlap in the problems identified by differing consumer and provider criteria. Few providers, for example, would quibble with the complaint of a PHP member that she could not communicate with her physician who spoke only the language of the small Asian country where he was born and trained.

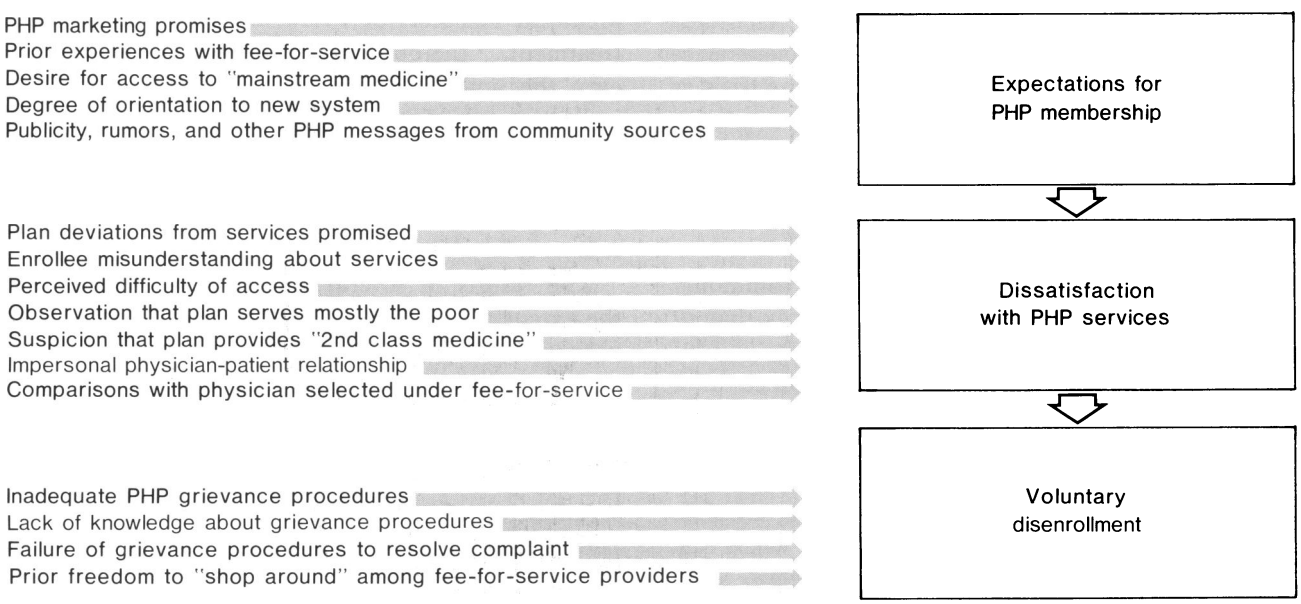
Voluntary disenrollment as an expression of dissatisfaction. Many Medicaid recipients who joined prepaid health plans, whether or not under conditions of informed consent, and subsequently discovered that services were unavailable or of inferior quality quite naturally tried to disenroll and return to the fee-for-service system. In some instances where the PHP had no grievance procedures, or grievance procedures were unknown to the enrollee, or such procedures failed to resolve the problem, consumers may have seen disenrollment as their only recourse. In other cases, Medicaid beneficiaries who had been free to "shop around" under the fee-for-service system may have attempted to disenroll from the PHP before trying to resolve complaints through other channels. Hypothesized relationships among these complex factors are diagramed in figure 4.

Although the specific events preceding attempts of Medicaid recipients to terminate PHP membership obviously vary, the problems encountered in disenrollment were so severe that these form yet another major group of consumer complaints, including some which led to lawsuit (*29*). Dissatisfied PHP members frequently reported that they were not informed of their right to a fair hearing to resolve grievances, and indeed some plans apparently did not even have procedures for handling grievances. In addition, enrollees allegedly were not advised of their right to disenroll under certain circumstances at any time if dissatisfied; rather, they were told that they had to stay in the plan for at least 1 year.

Persons who insisted on exercising their right to disenroll reported numerous difficulties, including harassment in being questioned about reasons for wishing to do so; disenrollment forms which were hard to understand; hostile PHP personnel who gave consumers the run-around about being able to disenroll only at inconvenient locations during certain limited hours; and long waits to complete the necessary paperwork.

After necessary forms were completed despite these obstacles, plans allegedly failed to forward them to the State for several months, thereby continuing to receive capitation payments without pro-

Figure 4. The dynamics of voluntary disenrollment from prepaid health plans (PHPs)



Reasons for State health department disapproval or approval of 20,187 disenrollment forms submitted by 51 California prepaid health plans during 8 months in 1975

Reason	Number of forms	Percent of total forms approved or disapproved [1]	Number of plans for which reason was coded	Number of plans for which reason was most common
Disapproval codes				
Insufficient explanation to determine or support reason	388	26	39	13
Desire to return to fee-for-service	323	22	40	8
Desire to change plan	158	11	21	5
Generally dissatisfied with plan	351	24	37	10
Not in plan 1 year and claims to have been	63	4	15	—
Wants a medical service that can be obtained from plan	64	4	20	1
Invalid lack of transportation claim	34	2	17	1
Other	94	6	25	—
Approval codes				
Enrolled more than 1 year	5,762	31	47	26
Dissatisfied with medical services (after 1 year)	1,639	9	46	—
Plan not explained completely or misunderstood plan representative	1,185	6	45	—
Requires Medi-Cal services not provided by plan	145	1	37	—
Return to prior treatment	2,652	14	49	5
Breakdown in physician-patient relationship	181	1	39	—
Transportation problems	2,102	11	45	2
Moved from service area	1,840	10	50	5
Other	1,424	8	47	2
Blanket approvals	1,782	10	23	7

[1] Percentages do not total 100 because of rounding.

viding services (*33*). In some cases, this was because disenrolling members were so disillusioned that they chose not to return to the PHP for care while waiting to get their Medicaid cards back, but in other instances plans reportedly failed to inform clients that the PHP was still responsible for their health care until the new card arrived or refused to provide needed care to disenrolling members, particularly if the services required were expensive. In any event, the outcome was that consumers failed to receive the medical coverage to which they were entitled during the frequently extended disenrollment period.

Under persistent pressure, the State health department in 1973 set up a PHP Information Center in Los Angeles to handle the heavy number of complaints, to curb marketing abuses through enrollment verification, and to facilitate the disenrollments of dissatisfied subscribers. A subsequent decline in voluntary disenrollments (fig. 3) suggests that these actions had a positive effect.

Later data on reasons for State health department approval and disapproval of PHP disenrollment forms provide additional information of interest. The first available department report, covering December 1974, indicates that the most common approval code for that period was "enrolled over one year" followed by "return to prior treatment program" and "moved from service area." On the other hand, the beneficiary's desire to return to fee-for-service accounted for approximately 33 percent of the disapproved disenrollments, while the next most frequently used disapproval codes were insufficient explanation to determine or support the reason for disenrolling and a desire for a medical service that as one of the standard Medicaid benefits should have been provided by the plan. Similar data available for 8 months in 1975 are summarized in the table.

As apparent from the table, the codes used provide only limited information about sources of consumer dissatisfaction with PHPs. Neither of the codes accounting for the highest proportion of disapproved and approved disenrollments indicate *why* subscribers wished to withdraw from plan membership, and several other codes are equally devoid of explanation which would be helpful in preventing or resolving problems. Nevertheless, it can be assumed that approximately 90 percent of the voluntary disenrollment documents submitted, whether approved or not, were filed as the result of dissatisfaction by PHP members. Some requests for withdrawal can be at-

tributed to specific complaints against a plan, while others may represent an unfavorable comparison of the PHP with the more familiar fee-for-service option. General exceptions include disenrollments approved because members moved from the PHP service area or required Medicaid services not provided by the plan.

During the time period considered in the table, an average of 93 percent of the disenrollment documents received by the State were approved, with approval rates ranging among plans from 69 to 100 percent. The actual number of documents approved per plan ranged from 1 to 3,953, with many documents typically disenrolling more than one Medicaid recipient. Because of the larger number of PHPs in the Los Angeles area, most disenrollment requests originated there, but the percentage approved did not differ significantly either by region or by the number of disenrollment forms which plans submitted.

Enrollment for more than 1 year was the most common reason for approval of disenrollments during each of the 8 months and for all regions, but this was not true for all plans as indicated by the two right-hand columns in the table. Similarly, not all approval and disapproval codes were applied to all plans, and differences in the rank order of reasons for disenrollment were noted. Certain regional differences also emerged. Thus, while transportation problems were the second-ranked reason for approved disenrollments in the Los Angeles area, this was the fifth most common code in San Diego, and eighth in northern California. In contrast, marketing problems accounted for 10 percent of approved disenrollments in the northern region, but 5 percent or less in other areas. Regional variations were also observed in reasons for disapproving disenrollments, for example, general dissatisfaction with the plan accounted for 27 percent of the disenrollments denied in the Los Angeles area, but only 17 percent of the disapprovals in both the San Diego and northern California regions.

Discussion and Implications

The preceding summary of consumer complaints and related allegations against prepaid health plans provides an important public perspective on what went wrong with California's program. If such problems are to be avoided in the future, this perspective cannot be ignored because it reveals the existence of PHP problems as perceived by those whose behavior ultimately will affect the achievement of PHP program goals. Thus, prompt resolution of consumer grievances is necessary not only to overcome dissatisfaction with the program, but also to stem the growth of public rumor and distrust which can jeopardize the viability of particular plans, as well as the prepaid health care concept in general.

Moreover, our analysis indicates that consumer complaints often reflect real problems in the program. Other reports and evaluations taken together acknowledge and corroborate the existence of each type of abuse which forms the basis for consumer protest and PHP disenrollment. Early attention to members' grievances therefore can serve to identify underlying program weaknesses so that these can be corrected before they become compounded into larger difficulties.

The best approach to these problems is, of course, to prevent their occurrence in the first place. Therefore, as new State PHP programs are initiated, public health professionals should scrutinize enabling legislation, accompanying administrative regulations, and procedures for implementing them in order to identify inadequacies that could result in program abuse. Above all, mechanisms must be developed to assure that PHPs have the resources necessary to provide acceptable health care coverage for the people they are contractually obligated to serve.

Many analyses indicate that predominant emphasis on the economic advantages to be realized both by the State and by PHP providers, rather than concern with quality of care for consumers, contributed heavily to the problems with which California's program has been associated. The following are particular danger signals:

- Laissez-faire or poorly developed regulations and monitoring mechanisms for assuring reasonable access of members to PHP services, acceptable quality of care, and effective PHP management—including safeguards against profiteering.
- Rapid program expansion without detailed prior planning and the development of adequate supportive and regulatory mechanisms at the State level.
- Approval of PHP contracts without adequate prior screening for evidence of operational and delivery capability, including sufficient capital to assure service capacity development before enrollment of members.
- Lack of State assistance to PHPs, both financial and technical, during planning, organizational, and early implementation stages.
- Marketing on a per capita commission basis, no mechanisms for assuring consumer rights to an in-

formed choice based on a fair representation of the plan and discussion of the consequences of membership, and no "cooling off" period for new enrollees to reconsider their decision to join.

- No commitment by individual PHPs or the State through a dual-choice requirement to attracting at least 50 percent of the membership from non-Medicaid groups.
- No preparation of the public for acceptance of the PHP concept, including establishment of criteria for judging plans.
- Lack of State guarantee of Medicaid eligibility for at least 1 year to prevent high involuntary turnover rates.
- No provision for orientation of PHP members to insure understanding of the plans' utilization procedures.
- Absence of clearly defined and operational procedures within the PHPs and in the State Medicaid office for reviewing and responding to grievances of members and for assuring members' right to speedy disenrollment if a problem cannot be resolved.
- Lack of mechanisms to assure direct public accountability by PHPs, as well as by the State, to PHP enrollees and to taxpayers, including disclosure of utilization rates, quality of care reviews, identification of financial interests in other organizations, and additional relevant data.
- Lack of a range of sanctions and procedures, in addition to contract cancellation, for disciplining PHPs with confirmed violations.

Even if such deficiencies are discovered, correcting them will not be easy. The stakes are high, the vested interests are strong, and the pressures are enormous. Therefore, in addition to working through administrative channels in the State health department, persons discovering PHP problems may well have to seek other strategies, including conferences with legislators and the mobilization of professional and community groups who together can counterbalance the forces of those attracted by the profit motive.

The importance of forming coalitions to fight the multiple vested interests in PHPs is pointed out succinctly by Singh (*43*): "When the tiger is in the garden, need the cobra fear the mongoose?" Tigers for the PHP garden can be found not only among public health workers and consumer organizations, but also in district attorneys' offices, social welfare associations, organized medicine, and the press corps, as well as among well-motivated PHP providers whose reputations can be tarnished by the unethical practices of other PHPs. Alerting these people to the issues, keeping them informed of program developments, and suggesting possibilities for cooperative efforts to effect needed change constitute a challenge that health educators especially have a responsibility to meet—but doing so promises to test both our commitment to the public and our courage in taking risks.

Health education is also significant in preventing PHP problems and in strengthening PHP programs, as indicated in detailed discussions by other authors (*36, 44*). Unfortunately, however, those who see PHPs primarily as cost-saving ventures or get-rich-quick schemes are likely to resist comprehensive and multifaceted educational efforts with the open communication, consumer involvement, informed decision-making, and public accountability toward which these are aimed. At the same time, there may be enthusiastic support for health education as an euphemism for manipulative tactics to increase PHP enrollments and to restrict the use of services without consideration of either population needs or the appropriateness of current utilization patterns. The employment of untrained or naive "health educators" to serve as blind instruments of the program is one way in which such perversion could be accomplished. Therefore, although PHPs may include health education as a funded benefit, it is critical to ask "benefit for whom?"

There is much to learn, then, from California's PHP experience, which should serve as an early warning system to identify possible points of breakdown in the effective development and expansion of HMOs throughout the nation. Although we have considered only a few of the problems associated with one State's program, we hope that this paper demonstrates that translating the promise of the HMO concept into the reality of improved health care for the poor is no simple task. Nevertheless, the opportunity is here and if we fail to seize it, others will exploit it for their self-interests.

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