

RECENT CASES

ADMINISTRATIVE REGULATIONS—MEDICALLY INDIGENT MUST BE ELIMINATED FROM “MEDI-CAL” BEFORE HEALTH AND WELFARE AGENCY MAY REDUCE MINIMUM SERVICES TO RECIPIENTS OF PUBLIC ASSISTANCE; BEFORE OMITTING ANY MEDICAL SERVICE, REGULATIONS MUST MAKE PROPORTIONATE REDUCTIONS IN ALL SERVICES. *Morris v. Williams* (Cal. 1967).

Spencer Williams,¹ administrator of the Health and Welfare Agency of the State of California, promulgated extensive regulations in regard to the California Medical Assistance Program, popularly known as “Medi-Cal.” The regulations, which were to take effect September 1, 1967, were adopted as an emergency measure in order to avoid a pending financial crisis within the program and thereby maintain the “Medi-Cal” expenditures within their budgetary limitations for that fiscal year. To effect this purpose, certain services to both the medically indigent² and the public assistance recipient³ were eliminated—though as a group the medically indigent were retained. Included in these reductions were services that comprised part of the “minimum coverage” category.⁴

In August, 1967, the plaintiff, Harvey Morris, a recipient of welfare assistance and therefore eligible for “Medi-Cal” benefits, challenged the validity of these regulations in a class action.⁵ Morris argued that the services included in “minimum coverage” could not be reduced as to welfare recipients without first eliminating the medically indigent from the program. The trial court, by construing

¹ Hereinafter referred to as administrator.

² CAL. WELF. & INST'NS CODE § 14051 (West 1966), defines a “medically indigent” person as:

[A]n aged or other person who is not currently receiving public assistance, but whose income and resources as defined by regulations are not sufficient to meet the cost of maintenance and health care or coverage.

³ A recipient of public assistance, also referred to as a welfare recipient, is a person who is already on welfare under a state plan.

⁴ CAL. WELF. & INST'NS CODE § 14056 (West 1966), defines minimum coverage as the “care or coverage specified in paragraphs (1), (2), (3), (4), and (5) of Section 14053.” The coverage delineated in these paragraphs is basically (1) inpatient hospital services, (2) outpatient hospital services, (3) laboratory and x-ray services, (4) skilled nursing home services, and (5) physicians’ services, whether furnished in the office, the patient’s home, a hospital, or a skilled nursing home, or elsewhere.

⁵ Morris claimed that the members of the class were readily ascertainable; that their numbers were so numerous as to make joinder impracticable; and that the issues of law and fact were common to all members of the class.

the administrative action to be beyond the scope of the power conferred on the agency, declared the regulations invalid. On appeal to the Supreme Court of California, *held*, affirmed: (1) In making reductions in "Medi-Cal," the medically indigent must be eliminated before reducing the minimum services to the recipients of public assistance; and (2) before any services are eliminated entirely, proportionate reductions to the extent feasible must be made. *Morris v. Williams*, 67 Adv. Cal. 755, 63 Cal. Rptr. 689 (1967).

In 1965, the California Legislature adopted "Medi-Cal" in order to provide basic and extended health care services to the recipients of public assistance and to the medically indigent.⁶ The services included in the program ranged from diagnostic examinations⁷ and complete dental care⁸ to providing artificial limbs⁹ and drugs.¹⁰ Pursuant to current federal legislation,¹¹ California acquired a grant of matching funds from the federal government for its medical assistance program. The federal law requires that the state program must cover individuals who are already receiving aid under federally aided state programs for the aged, blind, disabled, and needy families with children. In addition, the state plan must provide the "basic five" services: (1) inpatient hospital services; (2) outpatient hospital services; (3) other laboratory and x-ray services; (4) skilled nursing home services; and (5) physicians' services.¹² The

⁶ CAL. WELF. & INST'NS CODE § 14000 (West Supp. 1967) states in part:

The purpose of this chapter is to afford basic health care and related remedial or preventive services to recipients of public assistance and to medically indigent aged, and other persons

The intent of the Legislature is to provide, to the extent practicable, through the provisions of this chapter, for basic health care in 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 persons or family's future minimum self maintenance and security.

⁷ 22 CAL. ADM. CODE § 51055.

⁸ *Id.* § 51307.

⁹ *Id.* § 51315.

¹⁰ *Id.* § 51321.

¹¹ 42 U.S.C. § 1396 (Supp. II 1965-66) provides:

For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or permanently and totally disabled individuals, whose income or resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health, Education, and Welfare, State plans for medical assistance.

¹² 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(13) (Supp. II 1965-66).

program in California was designed to meet these requirements and to garner as much of the available federal funds as possible.¹³

In June, 1967, the "Medi-Cal" budget for the fiscal year 1967-68 was set at 310 million dollars from state sources.¹⁴ With the federal contribution added, approximately 600 million dollars were available in that year. In August of 1967, the administrator realized that if the program continued at its then-existing expenditure rate, the statutory allotment would be exceeded. In an attempt to prevent this, the administrator set forth the challenged regulations; and as a result, several of the services provided under the minimum coverage were eliminated, *e.g.*, certain physicians' services, such as non-emergency surgery, eye refractions except after operations, and out-patient psychiatric care.¹⁵ Moreover, inpatient hospital services were limited to a maximum of eight consecutive days in a non-county hospital.¹⁶

In construing administrative action, courts are generally concerned with arbitrariness and capriciousness rather than validity. The ultimate decision is thus placed on reasonableness. In *Pitts v. Perluss*,¹⁷ where the legislature had ordered the Director of the Department of Employment to formulate certain tests, the California Supreme Court held that in regard to the reasonableness of quasi-legislative acts, judicial review is limited to a determination of whether the action has been arbitrary or capricious.¹⁸

However, as the plaintiff in *Morris* contended, administrative regulations are also subject to California Government Code Sections 11373,¹⁹ and 11374,²⁰ which require such promulgations to be within

¹³ CAL. WELF. & INST'NS CODE § 14010 (West 1966) reflects this intent by providing that if the amount spent in the program is less than what is necessary to secure the maximum amount of federal sharing, the director may increase the level of income to secure the maximum amount of federal participation.

¹⁴ Ch. 1421, § 4, [1967] Cal. Stat. Reg. Sess., Cal. Leg. Service 2496.

¹⁵ 22 CAL. ADM. CODE § 51305.

¹⁶ *Id.* § 51327(a).

¹⁷ 58 Cal. 2d 824, 377 P.2d 83, 27 Cal. Rptr. 19 (1962).

¹⁸ *Accord*, *Ray v. Parker*, 15 Cal. 2d 275, 101 P.2d 665 (1940); *Brock v. Superior Court*, 109 Cal. App. 2d 594, 241 P.2d 283 (1952).

¹⁹ CAL. GOV'T. CODE § 11373 (West 1966) provides:

Except as provided in Section 11409, nothing in this chapter confers authority upon or augments the authority of any state agency to adopt, administer, or enforce any regulation. Each regulation adopted, to be effective, must be within the scope of authority conferred and in accordance with standards prescribed by other provisions of law.

²⁰ CAL. GOV'T. CODE § 11374 (West 1966) says:

Whenever by the express or implied terms of any statute a state agency has authority to adopt regulations to implement, interpret, make specific or other-

the scope of authority conferred and not in conflict with the statute. In *Whitcomb Hotel, Inc. v. California Employment Commission*,²¹ the court enunciated this principle, and invalidated a regulation which interpreted and implemented a statute pertaining to unemployment benefits. Further the court held that an administrator may not make a rule or regulation that alters or enlarges the terms of the legislative enactment.²²

It was this aspect of the regulations with which the court in *Morris* was concerned, since the plaintiff had challenged the statutes' validity and not their reasonableness. It must be noted that only if the regulations are within the scope of the power conferred on the administrator may their reasonableness be considered.

In determining the validity of the regulations, the court first questioned the propriety of reducing minimum coverage for welfare recipients without first eliminating all services to the medically indigent. In this regard it is significant that the "Medi-Cal" program was designed to garner as much of the federal funds as possible,²³ and that nowhere in the federal statute²⁴ is there a requirement that the medically indigent be incorporated into the state plan. Though the medically indigent *may be* included in such a plan, as in California,²⁵ the *Morris* court observed that the state legislature had evinced a clear preference for the welfare recipient vis-à-vis the medically indigent, since Section 14006.5 of the California Welfare and Institutions Code²⁶ grants priority to welfare recipients if sufficient funds are not available for the health care of all. In addition, section 14105,²⁷ which requires at least minimum coverage to be

wise carry out the provisions of the statute, no regulation adopted is valid or effective unless consistent and not in conflict with the statute and reasonably necessary to effectuate the purpose of the statute.

²¹ 24 Cal. 2d 753, 151 P.2d 233 (1944).

²² *Accord*, *Duskin v. State Bd. of Dry Cleaners*, 58 Cal. 2d 155, 373 P.2d 468, 23 Cal. Rptr. 404 (1962).

²³ CAL. WELF. & INST'NS CODE § 14010 (1966).

²⁴ 42 U.S.C. § 1396a(a)(10) (Supp. II 1965-66).

²⁵ CAL. WELF. & INST'NS CODE § 14000 (West Supp. 1967); *id.* § 14005 (West 1966).

²⁶ *Id.* § 14006.5 (West 1966). Hereinafter, unless otherwise indicated, all section references are to the Welfare and Institutions Code.

²⁷ CAL. WELF. & INST'NS CODE § 14105 (West Supp. 1967) reads in part:

In establishing the scope of services to be provided, the director shall provide for recipients at least for a minimum coverage as defined in Section 14056, and insofar as possible shall include other health care and related remedial or preventive services giving priority to those services which are considered to have the greatest value in preventing or reducing the likelihood of future high cost medical services.

provided for welfare recipients, allows the administrator to limit the number of the medically indigent and the scope of their coverage in case of inadequate funds. In reading these two sections together, the inescapable conclusion was that before any reductions are made in minimum services for welfare recipients, the medically indigent must be eliminated from the program. Thus the failure to conform to this conclusion was one of the bases for the court to decide against the regulations' validity.

The court secondly considered the regulations in light of section 14103.7, which provides:

The Administrator of the Health and Welfare Agency, when reducing services . . . in order to maintain the program within the fiscal limits fixed by the legislature, shall to the extent feasible, make proportionate reductions in all services, rather than eliminating any service or services entirely.²⁸

This provision was easily interpreted as a legislative mandate compelling the administrator, when modifications in the program are necessary, to make proportionate reductions in all services to the extent possible rather than eliminate any service. It would only be after all possible reductions are made, the court reasoned, that the director could eliminate any service.

At this juncture, it should be noted that the legislature followed the enactment of section 14103.7 with section 14120,²⁹ which provides that if payments for physicians' services exceed the scheduled amount, the administrator must modify the customary fees paid to physicians. Also in its 1967 amendment to section 14105,³⁰ the legislature allowed the administrator to limit the rates of payment for services. Although not specifically articulated in *Morris*, it was implied that the legislature had anticipated some of the very plans,

²⁸ *Id.* § 14103.7 (West Supp. 1967).

²⁹ CAL. WELF. & INST'NS CODE § 14120 (West Supp. 1967) reads in part:

(c) At any time the total amounts paid for physician services since the beginning of the fiscal year exceed by 10 percent the amounts scheduled to have been paid by that time, the administrator shall so inform the Director of Finance and at that time the administrator shall modify the method of payment of usual and customary fees to physicians to assure that the total amount paid for physicians services in the fiscal year shall not exceed the total amounts scheduled.

³⁰ CAL. WELF. & INST'NS CODE § 14105 (West Supp. 1967) states in part:

The director shall prescribe the policies to be followed in the administration of this chapter and Chapter 8 (commencing with Section 14500) and the scope of the services to be provided, and may limit the rates of payment for such services, and shall adopt such rules and regulations as are necessary for carrying out, not inconsistent with, the provisions thereof.

such as the establishment of a fee schedule for services, that the administrator rejected in favor of eliminating certain services.

Section 14105 also grants to the "Medi-Cal" recipient a free choice of arrangements under which he may receive health care. The program, therefore, included private as well as public or county hospitals.³¹ However, this free choice is dependent upon an economical administration of the program.³² Thus, it would seem that in a financial crisis, the legislature had expected patients' discretion to be suspended in the interest of economical administration. Nevertheless, the administrator had disregarded recommendations to use public in lieu of private hospitals.³³ In light of these factors and the clear mandate of section 14103.7, the court held that proportionate reductions required by that section were not made, again necessitating a determination that the regulations were invalid.³⁴

Although *Morris* is definite in its holding, there remain unanswered questions in regard to reductions in the "Medi-Cal" program. For example, what is "minimum coverage?" Section 14056³⁵ defines this term as inpatient hospital services, outpatient hospital services, laboratory and x-ray services, skilled nursing home services, and physicians' services; yet this is scarcely helpful. Even though the administrator is required to maintain minimum coverage for welfare recipients, such broad categories as physicians' services, inpatient and outpatient hospital services are in no way defined. There is no limitation to the services, either basic or supplemental, which could be covered under these broad headings. A strict redefinition of what is contained in these categories could eliminate some of the unnecessary

³¹ *Id.* § 14000.2 (West 1966).

³² CAL. WELF. & INST'NS CODE § 14105 (West Supp. 1967) reads in part:

Insofar as practical, consistent with the efficient and economical administration of this part, the department shall afford recipients of public assistance free choice of arrangements under which they shall receive basic health care.

³³ The administrator argued that he had rejected the utilization of county hospitals because of a fear of a break in the continuity of care by physicians having no staff privileges at county hospitals and a reluctance to assign recipients to facilities traditionally reserved for the poor.

³⁴ The court placed the burden of proving that the proportionate reductions were not feasible on the defendants. Ordinarily, the burden of proving every element of a claim is on the one who asserts it. However, the plaintiff was relieved of that burden because evidence necessary to establish this fact was peculiarly within the knowledge and competence of the defendant. 67 Adv. Cal. 755, 783, 63 Cal. Rptr. 689, 707 (1967). *Accord*, *Garcia v. Industrial Accident Comm'n*, 41 Cal. 2d 689, 263 P.2d 8 (1953).

It is also interesting to note that subsequent to the decision in *Morris*, funds became available for "Medi-Cal" and need for major reductions in the program was eliminated. *Los Angeles Times*, Feb. 22, 1968, at 3, col. 8.

³⁵ CAL. WELF. & INST'NS CODE § 14056 (West 1966).

services that ought to be excluded by the very term "minimum coverage." Pursuant to this redefinition, the medically indigent would be afforded greater coverage, because reductions could be made in more services prior to any reduction in minimum coverage. The effect of this would be to prolong the coverage of the medically indigent before reaching the point in *Morris* where they must be eliminated. This result is in accord with the "Medi-Cal" program's general purpose of affording comprehensive medical services to recipients of public assistance *and* medically needy.

Another ambiguity inherent in any reduction lies in the elimination of the medically indigent. *Morris* specifies that the medically indigent must be eliminated from the program before minimum services are reduced for welfare recipients. Must the medically indigent be eliminated, however, before reducing services other than those required for minimum coverage? Though the *Morris* court did not directly decide the question, by limiting its holding to minimum services, it implied that reductions may be made in other categories without eliminating the medically indigent.

Unfortunately the statutes are of limited value in this area, and in fact seem to be contradictory. Section 14000³⁶ reflects a general intent to benefit both the recipients of public assistance and the medically indigent—an atmosphere which permeates the "Medi-Cal" statutes. Section 14105³⁷ manifests an intent to reduce services to the medically indigent only in regard to preserving minimum coverage for welfare recipients. Furthermore, it should be noted that federal law, though also devoid of a minimum coverage definition, requires only that minimum coverage, and not other services that may constitute a state's program, be guaranteed the welfare recipient.³⁸ Thus, there does not seem to be any valid reason for eliminating the medically indigent before reducing services other than those included in minimum coverage. Indeed, such an elimination would tend to defeat rather than give effect to the evident purpose of the statute.³⁹

However, section 14006.5⁴⁰ would appear to require the opposite

³⁶ *Id.* § 14000 (West Supp. 1967).

³⁷ *Id.* § 14105 (West Supp. 1967).

³⁸ 42 U.S.C. §§ 1396a(a)(10), 1396a(a)(13) (Supp. II 1965-66).

³⁹ *East Bay Garbage Co. v. Washington Township Sanitation Co.*, 52 Cal. 2d 708, 713, 344 P.2d 289 (1959).

⁴⁰ CAL. WELF. & INST'NS CODE § 14006.5 (West 1966) states in part:

If sufficient funds are not available to provide health care for all of the

result. The language in that section indicates that in the event of insufficient funds to provide health care for *all*, services should be reduced in accord with the listed priorities. As previously mentioned, the priorities in this section dictate reducing the services for the medically indigent before the public assistance recipients. It should be noted that reference is made to "health care" and not to minimum coverage. The clear implication is that services should be reduced for the medically indigent prior to any reduction affecting welfare recipients. The result is an apparent conflict among the sections of the "Medi-Cal" statutes.

Doubtless, the "Medi-Cal" statutes are vague and extremely difficult to construe in regard to reductions. Outside of *Morris*, there are no clear guidelines for making reductions in the program. With an ever-increasing population, the demands on "Medi-Cal" are likely to increase, and continuing financial crises are a distinct possibility. It would therefore seem incumbent upon the legislature to redefine terms such as "minimum coverage" and set forth more definitive standards in the event reductions in the program become necessary.

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persons enumerated in this section, the director shall reduce services in accordance with the priorities set forth in this section and in accordance with the provisions of Section 1902(a)(14) of the Federal Social Security Act.