Overview of Arbitration in California Managed Health Care Plans

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DIGEST

This report discusses the significance of the recent California Supreme Court decision, *Nida Engalla et al. vs. Permanente Medical Group, Inc. et al* and the role of arbitration in California's health maintenance organizations (HMOs). The issues raised by this case are a concern to all consumers in managed care health plans which use binding arbitration to settle health care-related problems. The research was requested by Assembly Member Martha Escutia, Chair of the Assembly Judiciary Committee.

The following discussion examines the concept of arbitration, explores how arbitration is used in a wide variety of business disputes and analyzes its role in helping to resolve health care-related disputes. Topics include the application of arbitration in managed care health plans and its interaction with ongoing grievance and complaint procedures; the various responsibilities of state regulatory and oversight agencies; and actions that other states are considering to protect consumers and providers of health care.

The Engalla Decision

On June 30, 1997, the California Supreme Court, in a 6-1 decision, for the first time decided the propriety of a court taking a case out of mandatory arbitration in the area of patient's rights. In that case, called *Engalla et. al. v. Kaiser Permanente Medical Group, Inc. et. al.* (1997) 15 Cal. 4th 951, 64 Cal.Rptr.2d 843, 938 P.2d 903, the Supreme Court held that a court may deny a request by an HMO to compel a patient to undergo arbitration when it finds the HMO engaged in fraud when forcing the patient to agree to mandatory arbitration at the time of enrollment and then delaying the arbitration for its own benefit.

In *Engalla*, the Court described in unusually strong detail how it found that Kaiser misleadingly portrayed its arbitration system as fair and efficient, when in fact it manipulated the arbitration process for its own benefit. The Court stated that the case arose when Wilfredo Engalla complained that Kaiser misdiagnosed his lung cancer for five years, telling him that his shortness of breath and constant coughing were due to colds and allergies. By the time X-rays were performed revealing Mr. Engalla's malignant tumor, his cancer had become inoperable. After Mr. Engalla and his family filed for arbitration as required under Kaiser's service agreement, his lawyer reminded the HMO that his client was terminally ill, and specifically asked that it comply with the commitment in its service agreement to appoint a three-member panel of arbitrators within 60 days.

Despite repeated requests by Mr. Engalla's counsel to expedite the arbitration process due to the terminal nature of Mr. Engalla's condition, the Court noted that Kaiser continued to delay the process. One hundred and forty four days elapsed before Kaiser signed off on the neutral arbitrator. Tragically, Mr. Engalla died the very next day -- almost three months past the 60 days for selection of arbitrators required in the agreement.

The Engalla family thereafter sued Kaiser for its alleged malpractice, and for allegedly delaying arbitration until Mr. Engalla's death to eliminate the family's ability to receive the full amount of damages available due to Kaiser's alleged misconduct. (The Court noted that Mr. Engalla's death reduced Kaiser's potential liability for noneconomic damages to $250,000 from the $500,000 potential liability it would have faced had the claims been arbitrated during Engalla's life.) At trial, Kaiser moved to force the Engalla family into arbitration even after Mr. Engalla's death, but the trial court refused. On appeal, the court of appeal reversed, and held that under California law the question of fraud and all other claims had to be decided by the arbitrator rather than a court.

In its landmark opinion, the Supreme Court concluded, "There is evidence to support the Engallas' claims that Kaiser fraudulently induced Engalla to enter the arbitration agreement in that it misrepresented the speed of its arbitration program, a misrepresentation on which Engalla's employer relied by selecting Kaiser's health plan for its employees, and that the Engallas suffered delay in the resolution of its malpractice dispute as a result of that reliance, despite Engalla's own reasonable diligence." The Court also held that there was sufficient evidence to suggest that Kaiser, as a matter of law, had waived its right to arbitrate the Engallas' claim. The Court therefore overturned the court of appeal decision and remanded the case to the trial court, which must now determine whether Kaiser's conduct was in fact fraudulent, and whether Kaiser purposely delayed the arbitration for its own benefit.

Nature of Kaiser's Mandatory Arbitration Program Before *Engalla*

In the Court's decision, the Court noted that Mr. Engalla's health coverage was provided through his employer; his application merely stated that the agreement *may* provide for binding arbitration of any disputes with insurer. The arbitration program in question was designed, written, mandated and administered by Kaiser. The fact that Kaiser administers its arbitration program from an adversarial perspective was NOT disclosed to Kaiser members or subscribers. The timelines specified that each side under the Kaiser arbitration program selects a party arbitrator within 30 days of the claim, and that the two party arbitrators selected shall then designate a third, neutral arbitrator within 30 days thereafter. Kaiser represented in various promotional materials that hearings under its arbitration programs occur "within several months time," and that its members "would find the arbitration process to be a fair approach to protecting their rights."

Statistical data noted by the Court showed that delays occurred in 99% of all Kaiser medical malpractice arbitrations. In only 1% of the cases was a neutral arbitrator selected within the 60 days. Prior to the court case, only 3% of cases saw a neutral arbitrator appointed within 180 days. On average, it took 674 days for the appointment of a neutral arbitrator. And, on average, it took 863 days - almost 2 and ½ years - to reach a hearing in a Kaiser arbitration. Finally, the Court noted, depositions of former Kaiser in-house counsel revealed that Kaiser had long been aware of these widespread delays prior to the Court's decision in *Engalla*.

What Is Arbitration?

Arbitration is an alternative dispute resolution mechanism to the civil justice system. It allows the adjudication of a dispute by one or more arbitrators without recourse to the courts. The arbitrator "issues an award" (or makes a decision) after each party to a dispute has had an opportunity to present evidence and arguments in its favor. Developed in 1872, and initially used by the securities industry, arbitration is now widely recognized as a fair, expedient, and relatively inexpensive mechanism to resolve disagreements about personal contracts, brokerage agreements, partnership agreements, franchise agreements, and many other forms of business disputes.[1] While there are other forms of alternative dispute resolution, including mediation, conciliation, and neutral evaluation, arbitration is the most commonly used alternative to judicial review for these types of disputes.[2]

Literally thousands of companies across America use some form of arbitration as an alternative to civil litigation. From the brokerage houses on Wall Street, to the computer assembly-lines of Silicon Valley and the movie lots of Hollywood, binding arbitration agreements are the standard practice for resolving contractual and, more recently, workplace related disputes. The following are typical arbitration cases filed each year:

- Business to business (commercial);
- Consumer;
- Health Care (medical malpractice);
- Employment;
- Personal Injury (insurance).

There are generally three types of pre-dispute arbitration agreements:

- *Arbitration for collective bargaining* agreements. This widely employed form of arbitration has generated most of the federal law relative to arbitration.
- *Voluntary arbitration* (or private contractual) is negotiated between parties of similar bargaining strength and with similar goals, as generally defined in the Federal Arbitration Act of 1925.
- *Imposed Arbitration*, in which a weaker party is forced by a stronger party to accept arbitration as a condition for doing business. For example, the stock and commodity exchanges require clients and employees to sign arbitration agreements. More recently, some health maintenance organizations have imposed similar contract provisions on prospective members. This is the type of arbitration at issue in *Nida Engalla et al. vs. Permanente Medical Group, Inc. et al*.

Most commonly the agreement to arbitrate is formed prior to any dispute. It is this type of "pre-dispute" arbitration agreement that is at issue in the *Engalla* decision and more generally in the managed health care industry.

A party may also be forced to arbitrate without a pre-dispute resolution agreement. Sometimes the parties involved agree to arbitrate a dispute that has already arisen. In judicial arbitration, a court requires litigants to arbitrate their dispute. However, awards granted in these disputes are not binding. The loser can still have a trial at which the dispute is decided in court.[3]

Approaches To Arbitration

One approach to arbitration is typified by the American Arbitration Association (AAA), which has set the standard for the responsible development of neutral alternative dispute resolution programs since the mid-1920s. This nonprofit public service organization has established a reputation as a neutral entity for resolving disputes through the use of mediation, arbitration, negotiation and other dispute settlement techniques. The AAA has several regional offices throughout the country, including one in Los Angeles.

In California, the California Dispute Resolution Council (CDRC) was formed in 1994 to promote accessible conflict resolution in the state. CDRC is a nonprofit corporation made up of professional arbitrators and volunteers who are also members of other national conflict resolution organizations. CDRC believes that no person should be denied access to dispute resolution services because of an inability to pay, and that government and community organizations should make mediation and other dispute resolution services widely available.

Self-administered arbitration organizations offer a second approach to resolving disputes. For example, employees on Wall Street in arbitration face a panel of arbitrators who work for the securities industry. Under a system referred to as "self-regulation," employees who want to make a complaint about their employers must go to arbitration panels operated and paid for by the New York Stock Exchange or the National Association of Security Dealers. Most corporate alternative dispute resolution programs involve several steps whereby the dispute is first considered by an ombudsperson, then a mediator and finally the dispute goes to arbitration. In these corporate programs, 80 to 85 percent of the cases are settled before they go to arbitration.

The Permanente Medical Group's arbitration process is self-administered. In the case of *Nida Engalla et al. vs. Permanente Medical Group, Inc. et al.*, the California Supreme Court found that, "[t]he arbitration program is designed, written, mandated and administered by Kaiser."

How Long Does Arbitration Take?

AAA reports summarize time and cost data for two categories of cases, those involving awards under $50,000 and those with awards over $100,000. On average, it took two hearings and 209 days (seven months) to resolve cases involving awards under $50,000. For cases that involved awards over $100,000, the average time to resolution was 297 days (ten months) with three hearings. While exact figures are unavailable, according to an AAA spokesperson most of the 70,000 arbitration cases filed in 1996 involved awards under $50,000 and shorter resolution periods. In contrast, the average amount of time to resolve disputes in self-administered arbitration is 24 months.

Appointment of a neutral arbitrator is a critical first step in resolving a dispute in self-administered arbitration.[4] A statistical survey of 196 self-administered health care arbitrations in Northern California, completed between 1984 and 1988, found that in only one percent of the cases was a neutral arbitrator appointed within 60 days. On average, that step took 677 days or more than 22 months, according to the survey.[5] The *Engalla* case involves Kaiser Permanente's self-administered process, which took 144 days past the plan's 60 day time limit to select a neutral arbitrator. Mr. Engalla died the next day.

How Common Is Arbitration?

According to a RAND study of arbitration presented during a 1995 California State Senate Judiciary Committee hearing, a growing number of civil disputants are turning to alternative dispute resolutions such as private arbitration instead of relying on the courts. In the three large urban counties of Los Angeles, San Francisco, and San Diego, the use of alternative dispute resolution mechanisms grew at a rate of 15 percent per year over the last five years.[6] While the majority of these cases involved automobile personal injury, a growing number of cases also involved health care and medical malpractice.

In 1996, 70,000 arbitration cases nationwide were filed with the AAA, including consumer, employment and health care disputes. Most of these cases proceeded from contract or agreement stipulations which specified the AAA as the final arbitration source. Other cases were received after disputants failed to reach an agreement or were referred to the AAA by the courts. Only one quarter of one percent, or 175 of these claims were health-related, of which 95 were filed in California.[7]

Fairness

The inherent fairness of self-administered dispute resolution processes is a concern. In the case of *Nida Engalla et al. vs. Permanente Medical Group, Inc. et al.*, California Supreme Court Justice Kennard's concurring opinion states that,

> Private arbitration may resolve disputes faster and cheaper than judicial proceedings. Private arbitration, however, may also become an instrument of injustice imposed on a 'take it or leave' basis. The courts must distinguish the former from the latter, to ensure that private arbitration systems resolve disputes not only with speed and economy, but also with fairness.

The fairness of private arbitration was a major focus at a 1995 Senate Judiciary Committee hearing, one key issue being whether there is a "selection bias" in choosing a neutral arbitrator. Arbitrators may have an incentive to make decisions that recommend them to the corporate or business clients who regularly use their services, as opposed to individual plaintiffs.[8] Businesses may keep records of favorable arbitrators. In the case of the Kaiser Permanente arbitration process described in the *Engalla* decision, each party chooses an arbitrator and jointly agrees to a third "neutral arbitrator." With regards to the selection of the neutral arbitrator, the California Supreme Court found,

> Although the arbitration provision specifies that the two party arbitrators "shall" select a neutral arbitrator, in reality the selection is made by defense counsel after consultation with the Kaiser medical-legal department. Kaiser has never relinquished control over this selection decision.

Some analysts believe that self-administered arbitration systems are at risk of bias, in contrast to non-profit organizations like the AAA. A recent survey by the California Association of Health Plans (CAHP), formerly known as the California Association of Health Maintenance Organizations found that the Kaiser Permanente and CIGNA self-administered managed health care plans had the highest number of arbitration requests that were later abandoned by claimants without settlement (Kaiser 50 percent, CIGNA 49 percent). Whether these figures indicate resolution of the cases or claimant frustration with the arbitration process cannot be determined. Kaiser and CIGNA arbitrations averaged 24 to 26 months.

There are other potential fairness issues which arise from the use of imposed arbitration to resolve medical malpractice claims. Imposed medical malpractice arbitration hearings are private and transcripts are not required. Therefore, the chances of prosecution for perjury committed during an arbitration are slim. Moreover, the ability to discover false testimony by an expert may be compromised because only the principals and arbitrator (s) are present.[9]

California Civil Code of Procedures, Section 1295 (e) declares: "Such a contract [one which provides certain statutory notices] is not a contract of adhesion, nor unconscionable nor otherwise improper..." In essence, members of managed health care plans which impose arbitration have been precluded from seeking civil litigation for malpractice. *Engalla* raises questions about whether this is still the case.

Who Pays For Arbitration?

Arbitration, unlike litigation, is not subsidized by the taxpayers. Parties to arbitration must pay the administrative costs of arbitration, including fees for the arbitrator(s). Some arbitration clauses specify that the arbitrator will be paid by the plaintiff.[10] To use the AAA system, plaintiffs must pay a filing fee ranging from $500 to $5,000. In addition, arbitrators from the AAA can charge up to $3,000 per day for a typical three to five day hearing. Other nationally recognized arbitration organizations, such as the Commission for Conciliation, Mediation and Arbitration (CCMA) and the Chartered Institute of Arbitrators, charge from $750 to $2,000 per day, depending on the size of the claim.[11] Arbitrators are not paid from the award offered to the prevailing party.

Kaiser Permanente requires claimants to deposit $150 in order to commence its arbitration process. The fund is maintained in a special trust and savings account to help select the neutral arbitrator. Both the claimant and the defendant are required to pay the daily fees of their respective arbitrators and pay for the neutral arbitrator.

Use of Pre-Dispute Arbitration Agreements In Health Care

Information from the ten largest full-service managed health care plans on file with the Department of Corporations shows that about 80 percent of the plans use some form of arbitration, often in conjunction with either a grievance or appeals process, or as a last resort to resolve patient disputes.[1] According to a survey conducted by the California Association of Health Plans in 1995, 90 percent of all full service plans in California reported using binding arbitration with either their enrollees, providers, vendors or employees.[12]

Binding arbitration is most commonly used to resolve contractual disputes about coverage and benefits between the plan and its enrollees. Only two of the ten largest plans report using binding arbitration to resolve medical malpractice claims. These plans (including Kaiser Permanente) indemnify their physicians for any malpractice claims filed by members.

Managed care plans that exclude medical malpractice complaints from arbitration typically employ a highly structured grievance and appeals process, including peer review (appropriateness of medical decisions) and appeal to the medical director (executive re-determination). In these plans, if a member

[1] California Research Bureau survey, July 28, 1997.

exhausts the appeals process and does not get a favorable outcome, they are then free to seek civil redress in court.[13]

Four of the plans examined require members to exhaust the prescribed grievance or appeals process before filing for arbitration. This process could take from 30 to 60 days, and includes a formal filing of complaint with the plan's corporate office and/or the Department of Corporations.

Once a member files for arbitration, most plans specify options as to how arbitration is to be used. For example, if a claimant is seeking damages of $50,000 or less, a single neutral arbitrator agreed upon by both parties may be used to resolve the case. For claimants seeking damages over $50,000, three arbitrators are typically used; one representing the managed care plan, one for the claimant, and a neutral arbitrator agreed upon by both parties. Many of the managed care plans specify that the neutral arbitrator will be selected from the American Arbitrators Association (AAA). However, according to *Health and Safety Code Section 1379.19* which became law on January 1, 1997, claimants seeking damages under $200,000 shall use a single neutral arbitrator to resolve the dispute. The health plans examined by the California Research Bureau did not reflect this change in the law.

The Kaiser Permanente and CIGNA managed care health plans are among the very few California plans which administer their own arbitration processes. The HMO and the claimant each select their own arbitrator and a neutral arbitrator from a pool specified by the plan.

State Regulation of Managed Health Care Grievance Procedures

All managed care health plans are required by *Health and Safety Code Section 1368* to have a grievance procedure. The Department of Corporations is responsible for approving grievance procedures and for responding to consumer grievances. The Department of Corporations is one of three state government agencies with jurisdiction over health care-related complaints. The other two agencies are the Departments of Insurance and Health Services.

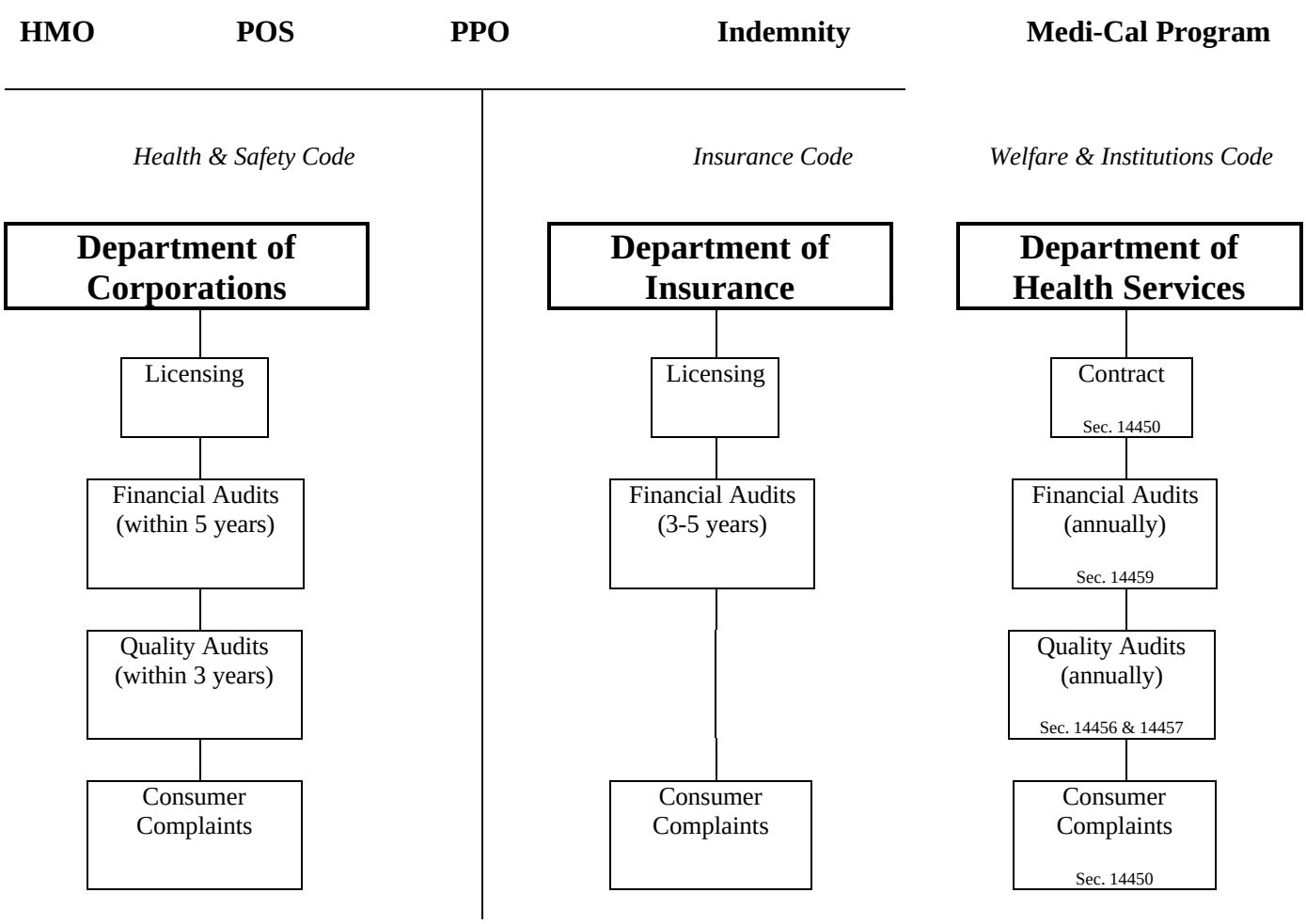
Charts 1 and 2 detail the consumer grievance systems at the three state agencies regulating health care coverage.

Chart 1
The Consumer Grievance Systems of Three State Agencies Regulating Health Coverage
(Non-Emergency Situations)

Department of Insurance	Department of Corporations	Department of Health Services Medi-Cal
Health Insurer (First, consumer attempts to resolve issue with insurer	**Health Plan Grievance Process** (Section 1368.01 encourages health plans to resolve complaints within 30 days)	**Health Plan Grievance Process**
Go to Department of Insurance If 1. Not satisfied with response--no set time frame.	**Go to Department of Corps. Either** 1. After Completing Grievance Process, or 2. After 60 days	**Go to DHS Either** 1. After Completing Grievance Process, or 2. After 30 days
Department of Insurance 1. Call 1-800-927-4357 2. Dept. mails out request of assistance form 3. Enrollee mails form back to the Department 4. Dept. Reviews Complaint	**Department of Corporations** 1. Call 1-800-400-0815 2. Dept. mails out request of assistance form 3. Enrollee mails form back to Department 4. Dept. Reviews	**Department of Health Services** 1. Call 1-888-452-8609 2. Dept. takes both Voice & Written Complaint
The Department of Insurance must notify consumer of the final action take within 30 days of the final action.	Final Disposition must be within 60 days of Request for Assistance	If Recipient is still unsatisfied, then go to **Fair Hearing Process of Department of Health Services or Social services**
Department's Final Action	**Department's Final Disposition**	
Reference: Insurance Code, Sections 510,12921.1, 12921.3, 2921.4	Reference: Health & Safety Code, Sections 1368 to 1368.1	Reference: Welfare & Institutions Code, Secs. 10950, 14450 Regulations, Title 22, Secs. 51014.1, 53858, 53893, 53914

Chart 2
Health Care Regulatory Overview: California

The Managed Care/Indemnity Spectrum

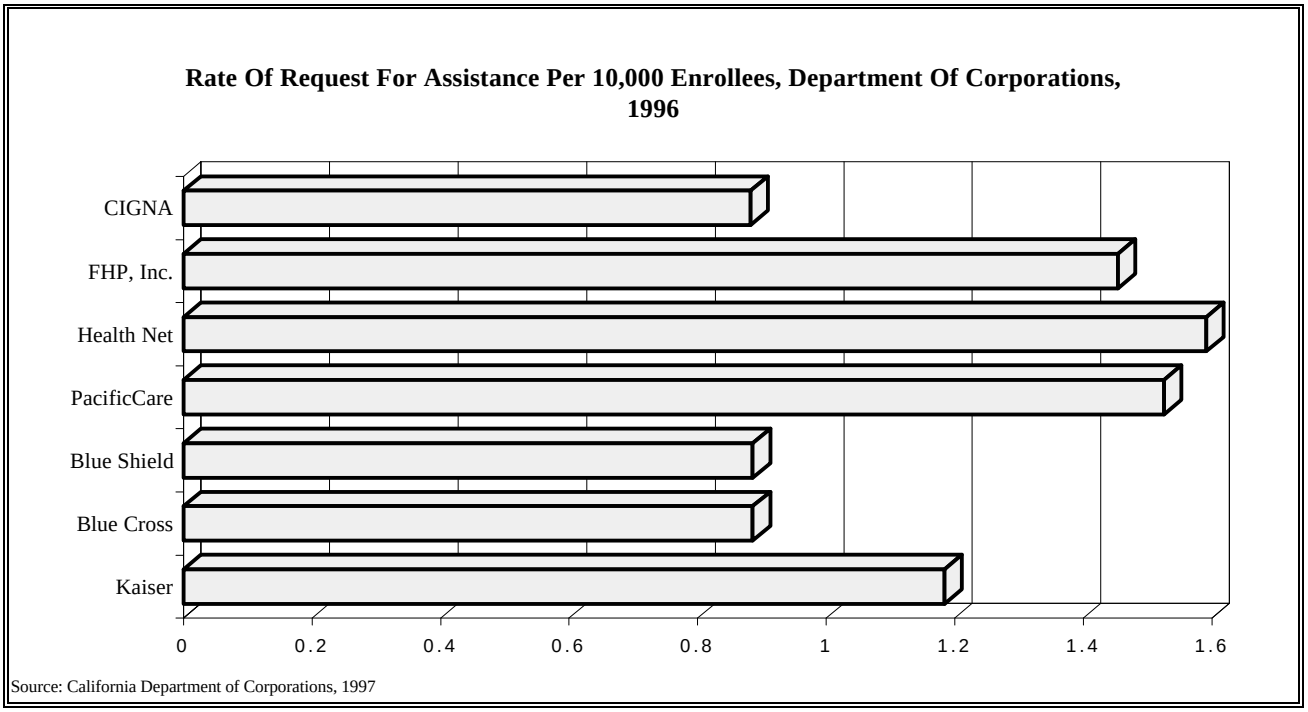


HMO = Health Maintenance Organizations
POS = Point of Service
PPO = Preferred Provider Organizations

The Department of Corporations operates a toll-free number (800 400-0815) for members of the public to call if they have general questions about their managed care plan needs, seek evidence of plan coverage, or need to file one of 32 specific complaints about accessibility, benefits/coverage, claims, or quality of care. The Department Ombudsperson, who is responsible for the Consumer Services unit which operates the program, has a 16 person staff to monitor the toll-free hotlines. (The Governor's 1997-98 budget proposal calls for 27 staff.) According to the Ombudsperson, a consumer can establish a complaint (Request For Assistance) through the hotline if the matter is imminent and a serious threat to health, or if the consumer has utilized the individual plan grievance system for at least 60 days. In either case, the Department of Corporations is obligated to begin and complete its involvement within 60 days (See Charts 1 and 2).

According to the Department of Corporations' *1997 Health Care Service Plan Complaint Report*, 2,126 consumer Requests For Assistance (RFAs) were received, out of 19,186,997 members enrolled in full service health plans in California. This was an increase of 324 RFAs, or 15.3 percent from the previous year. However, 593 or 28 percent of the RFA/complaints were referred back to the health plans for further action. According to the Department Ombudsperson, these RFAs were referred back to the plan because the enrollee did not use the plan's grievance system properly or the complaint fell under the responsibility of the plan. Chart 3 shows the rate of consumer complaints\RFAs to the Department of Corporations per 10,000 enrollees of seven of the largest full service health care plans in California.

Chart 3



Health plan grievance processes vary. The Department of Corporations does not have information about how consumer complaints registered through each health plan grievance process are handled or processed. The Department of Corporations does not keep statistical information about how many grievances are filed, the decisions made by managed care organizations (such as how often the plans decide for or against members), or how many cases go to arbitration.

What Other States Are Doing

Fifteen states have enacted or are considering taking a comprehensive approach to the regulation of managed care by establishing "Managed Care Consumer Protection Acts." A primary impetus for legislation is increasing public concern about the role of the fiscal intermediary (insurer) in managed health care plans, and the potential conflict between cost and the basic physician/patient relationship. The legislation generally seeks to offset the authority of insurers by creating a closer patient-physician relationship.

Common components of the "Managed Care Consumer Protection Acts" include the following:

- *Forbidding the "gag rule"* that prohibits a physician from honestly discussing and recommending all treatments, regardless of the cost, to the patient.

- *Peer review and referral* which allows for physician peer review panels to decide what is appropriate and not appropriate in terms of patient treatment, without intervention by insurers.

- *Quality care measurements* that provide consumers with the information they need to understand and compare the components of different plans.

- *Better data collection* which allows consumers and providers to assess the likelihood of successful outcomes of various treatments and at different providers.

- *Guarantee* of a member's right to formal appeal of health care decisions.

Many health care consumer advocates believe that managed health care plans with these features offer superior protection for consumers and allow medical personnel to make decisions based on patient need, not cost, thereby substantially reducing the need for arbitration. They argue that patients are finding it difficult to assert their rights in the managed health care arena, and that a comprehensive approach is necessary to protect patients and ensure access and quality.[14]

Conversely, managed care advocates argue that it is necessary for a medical group to oversee the utilization practices of its physicians to ensure that appropriate systems are in place, that quality assurance is conducted, and that utilization is appropriate. Without such controls, the managed care system would have to increase fees. A managed care advocate stated recently at a California State Senate Committee on Insurance hearing that,

> "We've come to a time now where plans are more and more delegating decisions to the doctors. They're captivating physicians, as you know, giving them a set per-member, per-month fee and saying, 'Okay, you guys have told us all along to get out of the way. Well, here are the resources, go do it as you know how.' They're doing it and now what's happening is we're

being asked to second-guess them and basically monitor every decision. There is no way a health plan can make sure that every prescription written is correct, that every test that's ordered is correct."[15]

A matrix of the major state Comprehensive Consumer Rights Laws is displayed below (see Attachment A, B, and C for the full text of selected state laws).

Table 1 Recently Enacted Laws

State	Major Features of Comprehensive Consumer Rights Laws
Arkansas	(H 1843) Direct access to physicians, no gag clause, continuity of care, provider incentives, grievance procedure, disclosure, and utilization review.
Colorado	(H 1122) Consumer grievance procedures, continuity of care, ER network adequacy, prescription mandate, provider grievance procedure, no forced arbitration.
Connecticut	(H 6883) Grievance procedure for consumer and provider, continuity of care, no gag clause, liability, medical records, data collection, parity, and utilization review.
Florida	(H 297) No gag clause, grievance procedure, continuity of care, data collection, direct access, disclosure, and network adequacy.
New Hampshire	(S 178) No gag clause, consumer and provider grievance procedures, insurer liability, medical records network, adequacy review of services, and utilization review.
Oregon	(S 21) Consumer grievance procedure, data collection disclosure of inpatient care after child birth, data collection network, adequacy review of services, insurer liability, and utilization review.
Texas	(S 383) No gag clause, consumer and provider grievance procedure, insurer liability, network adequacy, quality assurance, continuity of care, direct access, and utilization review.

[1] Bruce H. Mann, *The Normalization of Informal Law: Arbitration Before the American Revolution*, 59 N.B. L. Rev. 443 (1984).

[2] Deborah Masucci, "*Securities Arbitration--A Success Story: What Does The Future Hold*," Wake Forest Law Review. 183 Spring 1996.

[3] California Legislature, Senate Committee on Judiciary, Senator Charles Calderon, Chairman, Testimony by Ken Sigelman, Consumer Attorneys of California, "*Issues In Arbitration*," October 24, 1995.

[4] Toni L. Griffin, Director of Public Relations, American Arbitrators Association, News Release, "*Leading Consumer Affairs Experts Gather in Washington D.C. To address Arbitration and Mediation To Resolve Consumer Disputes*," July 22, 1997.

[5] Michael Hiltzik and David Olmos, "*Kaiser Justice System's Fairness Is Questioned*," Los Angeles Times, August 30, 1995.

[6] RAND Cooperation Study, "*Escaping the Courthouse: Private Alternative Dispute Resolution in Los Angeles*," Presented Before The California Senate Committee on Judiciary, Issues In Arbitration, October 24, 1995, Sacramento, CA.

[7] Toni L. Griffin, Director of Public Relations, American Arbitrators Association, Internal Data Report, July 29, 1997.

[8] Budnitz, supra note 3, at 294 (quoting Richard Reuben, *The Dark Side of ADR*, Cal. Law., Feb. 1994, at 53 and 54. The neutrality of arbitrators is an important issue in those cases or situations where the institution or defendant imposing arbitration on a weaker party specifies a for-profit company as the source of the arbitrator. "For-profit arbitrations generate inherent conflicts of interest, including the ADR provider's pursuit of repeat business from high volume customers."

[9] Norman Brand, The Practitioner, "*Are Unique Rules Required for Imposed Malpractice Arbitration*?," San Francisco Daily Journal, April 1, 1994.

[10] Sarah R. Cole, "*Incentives and Arbitration: The Case Against Enforcement of Executory Arbitration Agreements Between Employers and Employees*," 64 UMKC L. Rev. 449, 478 (1996).

[11] American Arbitration Association, Internet Home Page, Cost information on mediation and arbitration, August 1, 1997.

[12] California State Senate Committee on Insurance, Oversight Hearing, Testimony by Maureen O'Haren, Director of Legislation, California Association of Health Maintenance Organization, December, 5, 1995.

[13] Review of full service managed care plan statements of inclusion, Department of Corporation, Sacramento, CA, July 28, 1997.

[14] Molly Stauffer, Health Policy Tracking Service, "*Comprehensive Consumer Rights Legislation*," June 26, 1997.

[15] California State Senate Committee on Insurance, Oversight Hearing, Testimony by Maureen O'Haren, Director of Legislation, California Association of Health Maintenance Organization, December, 5, 1995.