

Arbitration in California Managed Health Care Systems

*By Marcus Nieto
and
Margaret Hosel*

DECEMBER 2000

CRB-00-009

Arbitration in California Managed Health Care Systems

*By Marcus Nieto
and
Margaret Hosel*

ISBN: 1-58703-130-2

*This report is not copyrighted and
may be reproduced with attribution.*

Table of Contents

EXECUTIVE SUMMARY	1
ARBITRATION AS AN ALTERNATIVE DISPUTE RESOLUTION PROCESS.....	4
A Brief History.....	4
Contemporary Arbitration	5
Recent Arbitration Case Law.....	6
HEALTH CARE ALTERNATIVE DISPUTE RESOLUTION IN CALIFORNIA	8
Provision of Health Care Services: Capitation and Utilization Review.....	9
Which Health Care Plans Arbitrate?	11
Denial of Coverage Claims.....	13
Reporting Denial of Coverage Arbitration	13
Malpractice Claims.....	14
Total Health Care-Related Arbitrations in California	14
The Grievance and Appeals Process	15
Health Care Arbitration Outcomes.....	17
Comparing Successful Plaintiff Rates in Arbitration and in Court.....	20
Length of the Arbitration Process	20
How Much Money do Patients Usually Win in Arbitration?	21
Choosing a Neutral Arbitrator	22
Public Records	23
Arbitrator Qualifications and Rules of Ethics.....	23
Arbitration Costs to Consumers.....	24
Indigent Patients.....	25
ARBITRATION IN OTHER STATES	26
Malpractice	26
Contracts of Adhesion-Binding Arbitration	26
Insurance.....	27
Mediation as a Mutually Accepted Alternative	27
Federal Preemption	29

LEGISLATIVE AND ADMINISTRATIVE OPTIONS	30
Framing the Debate.....	30
Improvements to the Arbitration Process	30
Independence of Arbitrators	30
Information for Patients.....	30
Fees for Arbitration	31
Professional Standards and Training for Arbitrators in Health Care Disputes.....	31
Due Process.....	32
Department of Managed Health Care Oversight Process	32
Judicial Review	33
Prohibit Pre-Dispute Arbitration Agreements	34
Alternatives to Arbitration	34
Mediation	34
Integrated and Targeted Arbitration	35
ENDNOTES	36
APPENDIX A	

EXECUTIVE SUMMARY

Nearly 24 million Californians receive their medical care from a managed health care plan. These plans range from tightly structured health maintenance organizations (HMOs), such as Kaiser Permanente, to preferred provider organizations and physician group medical providers. Their goal of keeping health care costs low allows many families to afford the health care they need. Managed care has also inspired some controversy, particularly about health plan arbitration requirements. This report describes the landscape of health care plan arbitration in California. The research was undertaken in response to a request by the Chair of the Assembly Judiciary Committee, Assemblymember Sheila Kuehl (who has now been elected Senator Sheila Kuehl).

Conflicts arise every day between health care plans and patients. They are often over what services are covered, or whether adequate care is being provided. Most of these conflicts are resolved through ordinary human interaction. Some escalate to more formal processes. California managed care health plans generally rely on internal grievance and appeal procedures to allow patients an initial opportunity to contest adverse actions or benefit decisions. If these procedures fail to resolve the matter, most California health care plans require the patient to use arbitration as a final means to resolve disputes. Both the patient and the health plan are then bound by contract to accept the decision of neutral arbitrators.

Arbitration is an alternative to going to court. It is not a new invention of the health care industry. It has roots going back to the 15th century, and has long been used in the securities industry and in labor relations, among other places. Its attractions are both ancient and clear; when used well, it is held to resolve disputes fairly, quickly, and comparatively inexpensively.

Large scale use of arbitration in health care is still new, and serious questions have been raised about whether arbitration in practice is fair to patients. California's Supreme Court found in 1997 that certain aspects of Kaiser Permanente's arbitration system appeared fraudulent. Kaiser completely overhauled its arbitration arrangements following the decision. A more recent Supreme Court decision on labor law arbitration suggests that, while the court supports arbitration as a method for resolving disputes, it may be increasingly willing to insist that the reality of the arbitration process be fair to all parties.

This report collects what is publicly known about the practice of health care arbitration in California. Given the importance of medical care disputes to those citizens who are involved, and to the health plans, the available information is pretty sketchy. Among the more enlightening findings are these:

- Arbitration requirements are common. Thirty of California's main 50 health plans, which cover 80 percent of Californians enrolled in a health plan, require that coverage disputes be decided in arbitration. Five of the plans, with 27 percent of the enrollees, require that malpractice claims be decided in arbitration. A table showing the arbitration requirements of each plan is included in the report.*

* Our review of Department of Managed Health Care records covered the time period of April 1999-March 2000.

- We estimate that about 300 medical arbitration cases are decided in California each year. It is a rough estimate. It should be possible to give a precise number, because health care plans are required by state law to report arbitration cases to the Department of Managed Health Care (DMHC). However, DMHC records show only 171 arbitrations from March 1999 to April 2000; 168 with Kaiser Permanente and three with other plans. Private arbitration providers, such as the American Arbitration Association (which reported 87 health care-related arbitrations in 1999), account for the remainder of our estimate. Private arbitration providers are not required to report to the state. Since 30 health care plans require binding arbitration, it seems likely that many health plans are not complying with the statutory reporting requirement.
- Many arbitration cases are dismissed through summary judgments, meaning that the patient has presented little or no evidence, so that a hearing would be a waste of time. Most of what information is available about this phenomenon is from Kaiser, to its credit. Under the Kaiser OIA, Kaiser's summary judgment rate was 12 percent (from March 1999 to January 5, 2001). For comparison, only 0.6 percent of all civil complaints in courts (in calendar year 2000) were dismissed through summary judgments.
- Arbitration is expensive, at least for patients on normal budgets. California arbitrators typically charge \$250 to \$400 per hour, and a typical arbitration case takes one to two days to resolve. In addition, hearing room rental and administrative expenses must be paid. A typical California health care arbitration costs around \$4,500. Most health plans require that all these costs be split by the patient and the plan, unless the arbitrator decides that, due to hardship, part of the patient's share should be paid by the plan. If the patient elects to hire a lawyer, that is an additional expense. Lawyers seldom take arbitration cases on a contingency basis, because the potential earnings, relative to the costs of preparing a case, are too limited.
- Arbitrators are human, with all the subtle opinions and biases that make us all human. Some are more likely to decide a case one way, some another. Health plans, which are likely to have repeated experiences with individual arbitrators, are in a reasonably good position to make informed decisions when choosing an arbitrator for a case. For example, only a few of the arbitrators in cases reported to DMHC decided to award the patient more than \$1 million, and none of those arbitrators has a second reported case. Patients may not be as well informed about arbitrator behavior, especially if they are proceeding without the aid of a lawyer. State law requires that arbitrators provide patients some information about their arbitral history, but only after they are selected.
- California, like most states, does not have established professional standards or licensing requirements for arbitrators. Michigan does, and Minnesota and Texas are considering doing so. The American Bar Association, the American Arbitration Association, and the American Medical Association attempted together to draft model procedures and standards for arbitrations, including in health care, but failed to reach agreement.

- Several other states prohibit or restrict the use of arbitration in health care disputes. These findings are summarized in Table 3.

The report includes a number of options for changing California's health care arbitration laws, should the Legislature wish to do so.

ARBITRATION AS AN ALTERNATIVE DISPUTE RESOLUTION PROCESS

A Brief History

Alternative dispute resolution (ADR) processes such as arbitration and mediation, in which conflicts are settled outside formal judicial processes, have a long history.¹ Contemporary issues raised by the use of ADR are similar to those raised by the emergence of alternative courts in 15th century England, when lengthy complex procedures in the law courts caused individuals who needed legal remedies to cast about for alternatives. The Court of Chancery, which allowed direct petitions to the King, evolved as an alternative to the expensive and time-consuming court system. English alternative courts were controversial because functions originally performed by juries were performed instead by judges, and because procedural safeguards were eliminated to promote efficiency. Both English alternative courts and modern ADR were designed to be more flexible than traditional law courts.

In the United States, arbitration was initially used by the securities industry in 1872 as a fair, expedient, and relatively inexpensive mechanism to resolve disagreements over personal contracts, brokerage agreements, partnership agreements, franchise agreements, and other forms of business disputes.² In 1925, the U.S. Congress passed the Federal Arbitration Act (FAA).^{*} Since that time, arbitration has proved particularly useful as a tool for unions and employers engaged in collective bargaining.[†] The U.S. Supreme Court, in the *Steelworkers' Trilogy*, strongly endorsed the use of arbitration in this context.³

In 1975, the California *Code of Civil Procedure* was amended to permit the contractual use of binding arbitration to resolve disputes of medical malpractice (*CCC section 1295*). Current law provides that health care plans must give notice in the contract clarifying that when both parties enter into a contract, they give up their constitutional right to have the dispute decided in a court of law before a jury, and instead accept the use of arbitration. Consumers enrolled in California health maintenance organizations (HMO) are also required under state law (*Health and Safety Code section 1363 (a) (10) and 1373*) to be notified by their health care plans of the types of disputes that are subject to arbitration, and how to initiate the process.

^{*} For a discussion of the politics leading up to the passage of the FAA of 1925, see Ian R. MacNeil, *American Arbitration Law: Reformation, Nationalization, Internationalization*, Oxford University Press, 1992.

[†] See, for example, *Gilmer v. Interstate/Johnson Lane Corp.*, 500 U.S. 2d. Appellate Courts have generally interpreted *Gilmer* to “require enforcement of pre-dispute arbitration agreements, so long as they are fair and provide the employees a forum to vindicate their rights,” Alexandra McDonald, “Escape from Arbitration,” *American Bar Association Journal*, August 1999, page 33.

Contemporary Arbitration

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 areas in which arbitration cases are filed each year:

- Business-to-business
- Consumer
- Health Care (medical malpractice and service coverage)
- Employment
- Personal Injury (insurance)

There are four main 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 generally require clients and employees to sign arbitration agreements. As a result of a recent employment-related discrimination lawsuit, some brokers have eliminated arbitration requirements, but many still impose arbitration agreements on their employees. More recently, many health maintenance organizations have imposed binding arbitration contract provisions on prospective members. When binding arbitration is part of a contract, it means that the arbitrator's decision is final and cannot be appealed to a judicial authority. When the parties agree to arbitrate through a contract clause (either pre-dispute or post-dispute), a court will not review the award unless there is an exceptionally obvious error or a severe problem with the contract. Even if the binding arbitration contract contains a clause calling for judicial review, that clause would be considered invalid.⁴
- *Judicial arbitration* occurs when a court requires the parties to arbitrate. These awards are not binding and the loser can still have a trial in which the dispute is decided in court.⁵ The participating parties may also agree to a binding arbitration without a pre-dispute agreement, after a dispute has already arisen.

California's Arbitration Act (*Code of Civil Procedure, section 1295*) generally reflects a policy encouraging the use of arbitration. The Knox-Keene Act creates a framework for health care plans in California, including the notification and use of arbitration. Beginning with *Health and Safety Code section 1363.1*, health care plans are required to disclose to enrollees that binding arbitration is required to resolve all health care-related disputes. *Health and Safety Code section 1373.20* requires that health care plans bear the burden of arbitration fees and expenses in cases of extreme hardship.

California *Code of Civil Procedure* section 1286.2 provides grounds on which a judge can vacate an arbitrator's decision. However, the standard for vacating an award is very high and includes the following grounds:

- The award was procured by corruption, fraud, or other undue means.
- There was corruption in any of the arbitrators.
- The rights of a party were substantially prejudiced by misconduct of a neutral arbitrator.
- The arbitrators exceeded their powers and the award cannot be corrected without affecting the merits of the decision.
- The rights of a party were substantially prejudiced by the refusal of the arbitrators to postpone the hearing upon sufficient cause, or by their refusal to hear evidence material to the controversy, or by other conduct contrary to the provisions of this statute.

Even if an error of law seems to have occurred and causes a substantial injustice, it generally is not subject to judicial review unless the plaintiff can find grounds in the statute.⁶ The practical effect of this standard has been that arbitrators' decisions are unlikely to be overturned.

Recent Arbitration Case Law

When a court is faced with an illegal or unconscionable contract for arbitration, it must choose between severing the illegal part and allowing the contract to stand, or finding the entire contract illegal and therefore unenforceable. The first option (severance of the illegal part) allows arbitration to proceed. The second option (illegality of entire contract) allows the plaintiff to proceed in court.

A recent key decision by the California Supreme Court, *Armendariz v. Foundation Health Psychcare* (24 Cal. 4th 83; P.3d 669, 2000), established a neutral position: arbitration agreements are neither favored nor disfavored. Employment discrimination claims may be subject to arbitration if "the arbitration permits an employee to vindicate his or her statutory rights." To provide guidance on the meaning of "to vindicate his or her statutory rights," the court found that an arbitration agreement is lawful if it:

1. provides for neutral arbitrators,
2. provides for more than minimal discovery,
3. requires a written award,
4. provides for all types of relief that would otherwise be available in court, and
5. does not require employees to pay either unreasonable costs or any arbitrators' fees or expenses as a condition of access to the arbitration forum.⁷

In a more recent case (*Shubin v. William Lyon Homes*, (2000 Cal. App. LEXIS 871), the California First District Court of Appeals found that an unconscionable provision in an employment contract must be severed. The court noted that while the *Armendariz* contract had several unconscionable provisions, the *Shubin* contract only had one

unconscionable provision and the “illegality is collateral to the main purpose of the contract.”

These decisions taken together show a strong focus by the courts on the arbitration process as well as the arbitration contract. The *Armendariz* decision in particular points to ways in which an arbitration process may be deficient, and provides grounds for challenging that process.

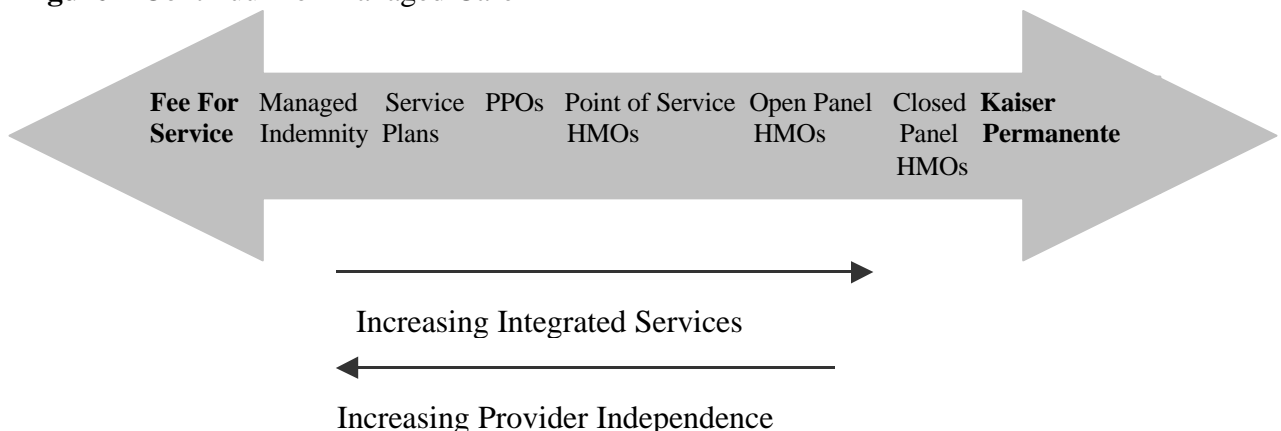
HEALTH CARE ALTERNATIVE DISPUTE RESOLUTION IN CALIFORNIA

Health care plans in California typically include a grievance procedure in their contracts for resolving consumer complaints, followed by some type of arbitration. Several health care plans also include mediation as part of their grievance procedure. Most of the larger health plans require binding arbitration. However, several smaller plans and Blue Shield allow patients to litigate when disputes are not resolved during the grievance process. The major components of the health care dispute resolution process include:

- *Grievance Procedures:* These range from a customer complaint line to hearings for denial of coverage. The health plan is the decision-maker and the goal is to resolve disputes in their initial stages.
- *Mediation:* An impartial neutral mediator facilitates negotiations between disputing parties.⁸ Parties who fail to reach a settlement can proceed to litigation or another adversarial process such as arbitration.
- *Arbitration:* A plaintiff and a defendant, both of whom may be represented by party arbitrators (or by lawyers), have their case heard by a neutral arbitrator who issues a decision. The decision is binding on all parties. To require a patient to arbitrate, a health plan must include a binding arbitration clause in its contract for health care services.

The structure of California health care plans and their health care dispute resolution processes are changing. According to industry experts, health plans are “morphing” rapidly and becoming harder to describe and define.⁹ When viewed as a continuum, at one end structured managed care health plans include large integrated health maintenance organizations (HMO) such as Kaiser Permanente, which has an enrollment of 5,987,559 members. The other end of the continuum has smaller, less integrated plans that use contract providers such as hospitals, physicians, and other diagnostic facilities. Less integrated plans also include preferred provider organizations (PPOs), such as Cedars-Sinai or On Lok, that generally have enrollments of less than 1,000 patients (See Table 1, page 12, for a complete list of California health plans on file with the state).

Figure 1 Continuum of Managed Care¹⁰



Provision of Health Care Services: Capitation and Utilization Review

Managed health care creates incentives both to treat (especially preventive care) and not to treat. “Under managed care, health care providers make medical decisions within a cost containment perspective.”¹¹ Utilization review is one tool health plan operators use to control costs and make rational decisions about providing care to patients. Utilization review occurs when a health care plan requires a doctor to receive permission from a reviewer before providing treatments. An alternative method for limiting costly services is called “capitation.” Instead of directly reviewing doctors’ decisions and denying care, a health care plan may specify a certain percentage of insurance premiums for use in providing care. If the group of medical providers spends more, the provider group must bear the excess costs. If the group spends a lesser amount of money, the provider group reaps the rewards.

Currently, many health care plans use a combination of utilization review and capitation. Utilization review requires that health care plans hire utilization reviewers who process requests for patient care from providers and either approve or deny treatment. Capitation does not require this added layer of bureaucracy. Larger more tightly integrated health care plans may be able to realize cost savings from utilization review, while smaller health care plans may not wish to invest in the necessary bureaucracy and therefore may prefer capitation.¹² When doctors are paid through capitation arrangements, it can be difficult for a patient to determine who denied treatment and the reasons for the denial. Unlike utilization review, there is no paper trail. Thus integrated, tightly structured health plans bear more risk from liability because they directly influence provider behavior and provisions of health services through utilization review.

Managed health care plans attempt to contain costs and improve quality through a variety of means. Examples of cost-containment techniques include improving early screening for diseases or reducing the amount of time doctors spend doing paper work. On the other hand, contract clauses which make it easier for health plans to deny coverage of certain medical services are controversial cost-containment techniques, and can cause conflicts with doctors and patients. A recent survey found that 40 percent of doctors operating under managed care contracts have admitted to deceiving health insurers to obtain treatment coverage they deem necessary for their patients.¹³ People with diseases requiring regular and expensive care report more problems receiving health care services from managed health plans than do average healthy patients. A recent survey by the Health Rights Hotline in four California counties found that persons with diabetes were “nearly two-thirds more likely to report denials of care [and] over four times more likely to report access to coverage problems.” Persons with cancer were nearly 40 percent more likely to report inappropriate care problems, than individuals with other serious medical conditions experiencing similar problems.¹⁴

Conflict in the complex doctor/patient/insurance plan relationship has created a need for fair and efficient dispute resolution. Unlike traditional litigation, health care disputes often involve more than one interested party. They also raise relatively novel issues of law, because in the pre-managed health care world, a physician’s incentives to treat were not in conflict with incentives such as cost containment. A key legal issue revolves around who establishes the community’s “standard of care,” the health care plan or the

physician. If the health care plan's standard of care prevails in a legal dispute, it may differ from that of a physician.

Health care disputes are also unique because the relative bargaining power weighs heavily in favor of the provider and plan operator over the consumer. A health care provider usually has more medical knowledge than a patient does. Managed care plan operators have more power than the physician or the patient to make a final determination of medical care or eligibility. Managed health care operators and providers must also deliver services at a previously negotiated price, requiring a close accounting of expenses.¹⁵ On the other hand, health care plan operators and providers are responsible for the welfare of their patients. Imbalances of power, money, and information, combined with the unique relationship between the three parties, makes resolution of health care disputes particularly complex and difficult.

The structure of California health care plans influences the kinds of claims that can be brought against a plan and the likelihood of whether the plan will arbitrate. For example, Kaiser patients are seen at Kaiser hospitals by Kaiser doctors. Kaiser self-insures against malpractice and has a doctors' group that also self-insures. Although Kaiser and the doctors' group are technically separate, they cooperate very closely. Prior to *Engalla v. Kaiser Permanente*, any patient dispute involving Kaiser medical services, malpractice, or plan eligibility required resolution through the Kaiser arbitration system.* Kaiser controlled the flow of management information, including utilization review and collection and management of data. It could also dictate how and when its internally managed arbitration process would resolve a dispute, a process substantially changed after the *Engalla* decision. Following the *Engalla* decision, Kaiser established an Office of Independent Administrator (OIA), independent from its integrated operations, to operate its arbitration system. Experts contend that putting an independent administrator in charge of an arbitration system is an important safeguard to ensure fairness.¹⁶

Smaller and less integrated health plans do not have as much control over hospitals, providers, or patient information. Typically, if this type of plan relies on arbitration to resolve patient disputes, it contracts with an outside arbitrator such as the American Arbitration Association (AAA) or the Judicial Arbitration Mediation Services (JAMS) to provide the service. However, there are variations to the general pattern, and it is possible for a small plan to control its own arbitration system or for a large plan to hire an outside arbitration provider.

* In *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 California Supreme Court held that a court may deny a request by an HMO to compel a patient to undergo arbitration when it finds that the HMO engaged in fraud when forcing the patient to agree to mandatory arbitration at the time of enrollment and then delayed the arbitration for its own benefit. The Court described in unusually strong detail how it found that Kaiser misleadingly described its arbitration system as fair and efficient, but manipulated the arbitration process for its own benefit.

Which Health Care Plans Arbitrate?

Table 1 on page 12 shows which California Knox-Keene plans* arbitrate some health care claims, such as denial of coverage, and which plans arbitrate malpractice claims. Since most plans offer multiple contracts, this information is a general guide only.

The DMHC is required to maintain records of arbitration cases submitted by health plans in accordance with state law (§1373.21 of the Knox-Keene Act).† It is not possible to determine from DMHC files the number of plaintiffs acting in their own behalf (pro-per), how many cases were malpractice cases, or the basis for the arbitrators' decisions. Our review found that the arbitration cases in the state's files provide minimal information, generally the dollar amount awarded to the patient or denial of the claim, perhaps some background medical information, and the name of the arbitrator and the arbitration provider. (see Appendix 1 for examples of January 2000 arbitration decisions).‡

Our review of health care plan contracts indicates that the arbitration clauses are not uniform. Some plans (such as Kaiser) require that malpractice claims be arbitrated. Other plans (such as PacifiCare) only arbitrate claims arising out of the contract such as denial of coverage claims.§ Still others (such as Health Net and PacifiCare) have a clause that requires the arbitration of everything except medical malpractice.

- *PacifiCare's* arbitration clause states that any claim, dispute or disagreement which is related to coverage or service and is not resolved by the plan's appeals and dispute resolution process is to be resolved through binding arbitration by a single arbitrator using Judicial Arbitration Mediation Services (JAMS) rules.
- *Health Net's* arbitration clause states that a dispute or disagreement (not including claims of medical malpractice) must be submitted to the American Arbitration Association (AAA) for arbitration.
- *Kaiser's* arbitration clause states that binding arbitration will be used to resolve all disputes. This includes contract, medical or hospital malpractice, and premises liability claims.

* Knox-Keene plans include both Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs).

† This 1998 amendment to the Knox-Keene Act requires that health care plans file "modified written decisions" regarding the outcomes of arbitration cases with the Department of Managed Health Care. The names of the parties are removed and the records are publicly available. This is the first year that health care plans have been required to file. The Department sent letters to the health care plans explaining the new law. Twenty-six (26) health plans met the filing requirement or did not have to file because they do not use arbitration. Many small health care plans and one major health care plan (Health Net) that do use arbitration did not file.

‡ The Department of Managed Health Care is publishing arbitration decisions (with identifying names removed) on its website at www.dmhc.ca.gov/

§ After the passage of Senate Bill 21 in 1999, denial of coverage claims will be part of a tort cause of action beginning January 1, 2001. Some health care plans may change contract clauses such as this one to include the new tort.

Table 1
Health Care Plan Arbitration Files at the
California Department of Managed Care (April 1999-March 2000)

Health Care Plans	Required to Arbitrate Some Claims	Required to Arbitrate Malpractice	Arbitration Claims Reported to the State	Year 2000 Enrollees
Aetna	Yes	No	0	679,101
Alameda	No	No	0	80,079
Blue Cross	Yes	No	2 (AAA)	3,927,309
Blue Shield	No	No	0	2,124,041
Care 1 st	No	No	0	214,178
Cedars-Sinai	No	No	0	1,837
Chinese Community	Yes	No	0	5,576
Cigna	Yes	No	0	694,697
Cohen	Yes	No	0	119,893
Community Health	Yes	Yes	0	75,323
Concentrated Care	No	No	0	16,483
Contra Costa	No	No	0	52,960
County of LA	No	No	0	102,395
County of Ventura	Yes	Yes	0	9,162
Health Net	Yes	No	0	2,132,363
HP the Redwoods	Yes	No	0	83,331
Heritage	No	No	0	140,854
Inland Empire	No	No	0	186,779
Inter Valley Health	Yes	No	0	69,109
Kaiser	Yes	Yes	168	5,987,559
Kern	Yes**	No	0	48,550
Lifeguard	Yes	No	0	239,615
Local Initiative	No	No	0	578,246
Maxicare	Yes	No	0	258,440
Molina	No	No	0	231,388
National Med.	Yes	No	0	47,185
Omni	Yes	No	0	94,578
On Lok*	No	No	0	848
One Health Plan	Yes	No	0	81,147
PacifiCare	Yes	No	1	2,301,066
Primecare	No	No	0	129,793
Priority Plus	Yes	No	0	97,222
ProMed*	No	No	0	0
Prudential	Yes	No	0	818,207
Regents of the UC	Yes	No	0	18,538
SF Health Plan	Yes	No	0	28,742
San Joaquin	Yes	No	0	54,320
San Mateo	No	No	0	38,495
Santa Clara Co	No	No	0	42,388
Santa Clara Family	No	No	0	31,847
SCAN	Yes	Yes	0	43,577
Scripps*	No	No	0	154,213
Sharp	Yes**	Yes	0	83,739
SIMNSA	No	No	0	7,746
St. Joseph's	No	No	0	5,339
United	Yes**	No	0	94,252
Universal	Yes	No	0	270,342
Vivahealth	Yes	No	0	3,621
Watts	No	No	0	98,302
Western	Yes	No	0	47,146
Totals (50 Plans)	30 (60 percent)	5 (10 percent)	171	22,632,815
% of Enrollees	80%	27%	N/A	100%

Source: California Research Bureau, State Library, September 2000.

* These plans received their Knox-Keene licenses in 1999 and may have experienced significant enrollment changes since their initial filing. For example, ProMed now has 69,594 enrollees (December 13, 2000 phone call).

** Operate arbitration systems independently.

Our review of California health care plan contracts, as detailed in Table 1, found that 60 percent of health care plans arbitrate some disputes with members. These health plans represent nearly 80 percent of all Knox-Keene (HMO) enrollees in California. A smaller number plans, 10 percent, arbitrate malpractice disputes in addition to denial of care and other disputes. These plans represent 27 percent of the total number of enrollees covered by Knox-Keene plans, primarily due to Kaiser. These figures are generally consistent with a 1999 RAND health care arbitration survey of California physicians, hospitals, and health maintenance organizations. The RAND survey found that over 70 percent of all HMOs required new enrollees to sign arbitration agreements. Thirty percent of the enrollees belonged to a health care plan requiring that the arbitration agreement cover both denials of service and medical malpractice disputes.

Binding arbitration agreements are a distinctive feature of HMO plans. The RAND survey found that 90 percent of the responding physicians and hospitals did not ask patients to sign agreements requiring arbitration of medical malpractice claims prior to providing service, or as a condition of admission to the hospital, although they could have done so.¹⁷

Denial of Coverage Claims

Most California health care plans require arbitration of some denial of coverage claims. Five also require arbitration of malpractice claims (see Table 1, page 12). When a health care plan denies coverage, it may do so because the contract for services specifically excludes a certain procedure, or because the treatment falls within the general phrase “not medically necessary.” If a patient believes that the treatment is medically necessary or should be included in the contract for services, the patient may appeal the denial of service decision through the grievance process. If not satisfied, the patient can elect to go to arbitration or, if the patient belongs to a health plan without an arbitration contract, to civil court.

Traditionally denial of coverage lawsuits involved a contract cause of action. With the passage of legislation in 1999 (*California Code of Civil Procedures section 3428*), patients have the option of bringing a tort action, beginning January 1, 2001. The significance of this change in the law is that patients now have an additional cause of action when seeking redress for denial of coverage. While contract law is concerned with justice between two private parties, tort law aims to both compensate the victim and deter other potential wrongdoers from behaving in the same way. Torts are typically tried before juries, while contract disputes are often tried before a judge or arbitrated.

Reporting Denial of Coverage Arbitration

In our review, we examined health care plan contracts on file with the Department of Managed Health Care (DMHC) to determine which California health care plans use arbitration, and what kind of claims they arbitrate. We encountered problems in

reviewing the Department's files; many of the plan contracts are not accessible for public viewing, some are located in different cities and they are not uniformly organized.*

We found that some plans may not be reporting arbitration decisions to DMHC. Under the Knox-Keene law, managed health care plans are required to maintain arbitration records and report arbitration cases to DMHC. However, only Kaiser and two other health care plans (out of 30 plans that require arbitration) have submitted records of arbitration decisions to the state.

Malpractice Claims

Medical malpractice is "a doctor's failure to exercise the degree of care and skill that a physician or surgeon of the same medical specialty would use under similar circumstances."¹⁸ The California Medical Board reported a total of 1,356 medical malpractice awards against physicians in 1999, including jury verdicts, arbitration awards, and financial settlements.

Five California health care plans, including Kaiser, arbitrate medical malpractice claims (see Table 1, page 12).¹⁹ Our review found that only Kaiser reported medical malpractice claims to the DMHC in 1999. No medical malpractice claims were reported to DMHC by the other health care plans.

The Kaiser Office of Independent Administrator reported 944 new demands for arbitration from March 1999 to March 2000, of which 681 were administered by the new OIA. Of these, 641 were medical malpractice cases.²⁰

Total Health Care-Related Arbitrations in California

The number of health care-related arbitration cases in California is relatively small, based on our review of state records. We conservatively estimate that about 300 cases are arbitrated annually by all health care plans and private arbitration providers.[†] There are several possible explanations for the relatively small number of arbitration claims that appear to have come to hearing.

* Health care plan contracts are located at either the Los Angeles or the Sacramento office of the Department of Managed Health Care, but not both. Although there is a mechanism for requesting health plan contracts from the Los Angeles office, the files must be sent in an archive box. When we began our investigation, health plans from the Sacramento office had been sent to Los Angeles and were not available for viewing. A consumer in Los Angeles who wanted to view exhibits from Kaiser's health care plan, for example, would probably encounter some difficulties because that health plan information is physically located in Sacramento. According to Robin Freed of the Department of Managed Health Care, the new Department intends to improve this system.

[†] This number was arrived at using the data we collected from the Department of Managed Health Care, the report from Kaiser's Office of the Independent Administrator and information from major arbitration providers such as AAA. All of these sources overlap to some extent. For example, a health plan may use an AAA arbitrator and report the information to the Department of Managed Health Care. On the other hand, arbitration cases are part of an independent contract between doctors and patients rather than the health plan and the patient, do not have to be reported.

- Health care plan grievance processes may have resolved many claims before they reached arbitration. For example, several health plans emphasize resolution through mediation in their grievance process, prior to arbitration.
- Consumers may be confused about how to pursue a grievance. Many consumers do not even reach the grievance process that eventually leads to arbitration. A Henry J. Kaiser Family Foundation study of HMO consumers found that only six percent of patients with a dispute filed a formal claim either with their health care plan or outside of the plan.²¹
- Settlements are a common occurrence in malpractice disputes that are litigated in the courts. They may also be fairly common in denial of coverage disputes resolved through arbitration. Cases involving denial of coverage disputes are relatively rare in the courts, primarily due to arbitration clauses in health care contracts. Therefore, it is difficult to know if these cases are also likely to settle.
- Arbitration has historically been a confidential process. The 1999 Knox-Keene law requiring health care plans to report all arbitration cases to DMHC is recent and, as we note above, health care plans appear to be underreporting arbitration decisions.
- The cost of pursuing arbitration may prevent consumers from utilizing the system. (See page 23 for discussion)

The Grievance and Appeals Process

Health care plans' internal grievance processes may resolve most health care disputes, prior to any arbitration. When consumers have disputes with their health care plan, they usually begin by filing a claim or making an appeal to the plan's internal grievance process. Most managed health care plans in California have both normal and expedited grievance procedures. Many plans have a multi-step appeals process. A typical managed health care plan lists an address and a phone number for patients to contact in the event that they have a grievance or want to challenge a medical decision. The plan must confirm receipt of the grievance within five days and arrange to hear the patient's appeal. Plans generally agree to expedite the appeal in cases that involve severe pain, serious threat to health, or potential loss of life. Whether the plan has one or two levels of appeal, the patient is usually informed of the decision in writing within 30 days.*

A consumer who challenges a health care plan or provider decision in a grievance process must follow the steps outlined in the health plan's grievance procedure. If the consumer has difficulty with a managed health care organization, he or she can request assistance from DMHC. The Department must respond to the complaint within 30 days. Some managed health care plans have an independent external review process for patients who have been denied treatment on the basis that it is not medically necessary. Our review found that all plans on file with DMHC have clauses that state that DMHC is the place to register complaints.

* These provisions are from Health Net's grievance and appeals procedures. Other health care plans include a multi-step appeals process. Most health care plans include at least as much as Health Net.

In 1999, DMHC received 2,623 requests for assistance from health care consumers (about resolving complaints with the health plan or denial of service issues), of which 1,334 were referred back to 33 individual health plans (see Table 2). The Department did not receive requests for assistance for 26 health care plans. The majority of requests for help, according to the Department, involved “quality of care” issues, as detailed in Table 2.

Table 2
REQUESTS FOR HEALTH CARE PLAN ENROLLEE ASSISTANCE
California Department of Corporations, 1999

Plan	Requests for Assistance	Referrals to Plans	Rate per 10,000 Enrollees	Issue: Accessibility	Issue: Benefits/Coverage	Issue: Claims	Issue: Quality of Care
Aetna	87	69	1.5	8	20	35	52
Blue Cross	390	245	1.05	18	168	147	155
Blue Shield	223	147	1.08	8	62	90	103
Cal Pacific	1	2	0.05	0	0	0	2
Care First	2	0	0	0	0	0	3
Cigna	149	54	2.16	8	36	50	102
Cohen	3	1	0.3	0	0	0	5
Community	1	0	0	0	0	0	1
Contra Costa	1	0	0.2	0	1	0	0
Greater Pacific	6	1	21.	2	0	4	2
Health Net	386	179	1.8	32	84	131	221
Redwoods	19	4	2.2	0	3	3	15
Healthmax	1	0	0	0	0	0	0
Inland Empire	1	2	0.6	0	1	0	0
Inter Valley	10	5	1.5	0	2	1	10
Kaiser	657	313	1.1	63	152	170	492
Key	3	1	2.8	0	1	0	2
Lifeguard	21	7	0.8	2	4	7	15
LA Care	1	0	0.1	1	0	0	2
Maxicare	27	26	1.0	0	9	17	9
Medpartners	2	2	0.03	0	0	1	1
National Med	14	7	2.9	2	4	3	6
Omni Healthcare	23	12	2.43	0	5	11	12
One Health Plan	2	2	0.31	0	0	1	1
PacifiCare	445	167	1.93	29	83	142	283
Prudential Health	86	57	0.92	4	11	46	40
Regents of UC	1	0	0.69	0	0	0	1
Santa Clara Co.	1	0	0.32	0	1	0	0
SCAN	22	7	5.82	2	3	6	16
Sharp	5	1	0.67	0	2	2	2
Universal	10	2	0.40	0	3	1	7
Watts	11	6	1.06	2	2	3	7
Western	3	0	0.77	0	0	3	0

Source: Department of Managed Care, 1999 Department of Corporations data (www.dmhc.ca.gov)

Although DMHC does not currently track outcomes of grievances or requests for assistance, they are setting up a system that will.²² The new grievance review system, mandated in *Health and Safety Code section 1374.30*, takes effect on January 1, 2001. The new law calls for the creation of an independent third party review for consumers whose grievances are not resolved through their health plan procedures.

Given the lack of public records at this time, it is difficult to determine how well the health care plan grievance/complaint processes are working. An independent survey conducted recently in the Sacramento region involving consumer complaints with health plans found that most complainants reported denial of coverage disputes, inappropriate care, and customer service problems. The most frequent complaint involved cancer patients being unable to see a specialist.²³

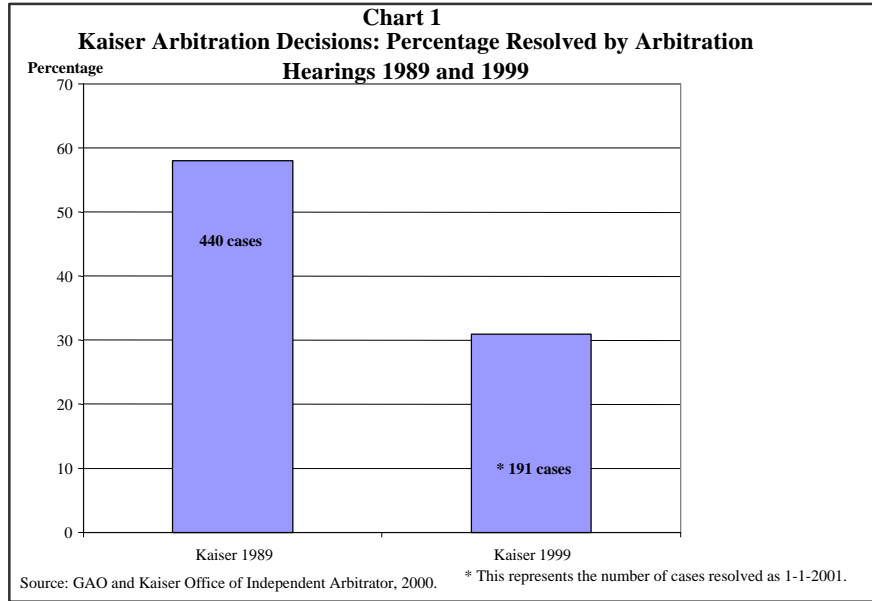
One state that does track health care plan complaints is Connecticut. In 1998, Connecticut reported that 5,246 denials of coverage claims were filed with health care plans for internal review. Of that number, 1,840 of the denials were reversed by the plans. Only 39 of those cases that continued to be denied were appealed to the state's external review process.²⁴

Health Care Arbitration Outcomes

Before arbitration begins, or at some point during the arbitration process, the parties may withdraw or reach a settlement. Settlements are very common in malpractice disputes.

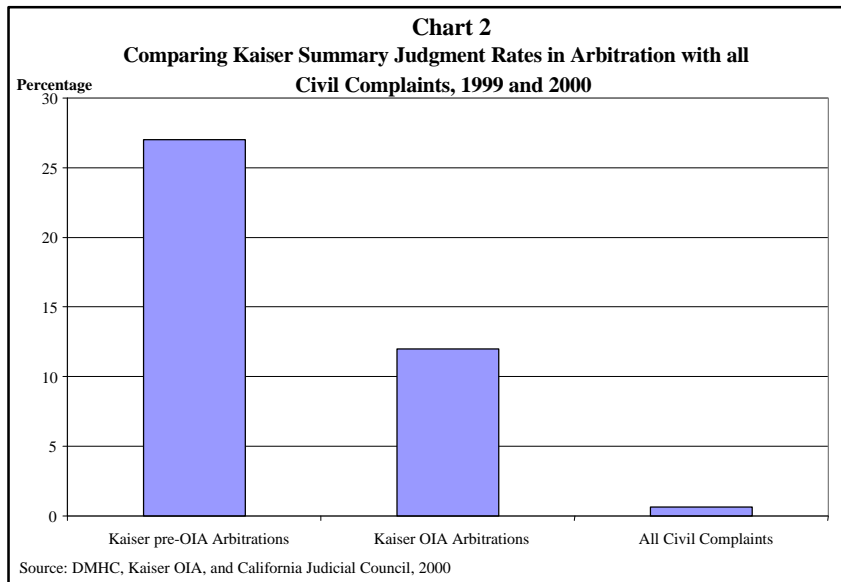
In 1989, Kaiser had about the same number of enrollees as in 1999, and it required binding arbitration in both years. According to an U.S. General Accounting Office (GAO) study, in 1989, 58 percent of Kaiser's arbitration claims were resolved by arbitration hearings.²⁵

According to the Kaiser OIA, between March 1999 and January 2001, 1,950 Kaiser decisions were appealed by consumers to the Kaiser OIA for arbitration. One third of those cases (618) have reached resolution. Of these, 128 were withdrawn, 273 were settled, 73 were summarily dismissed (12 percent), and 118 were awarded a final award in arbitration. Cases resolved by arbitration (summary judgment or a final award) represent 31 percent of the total resolved cases.²⁶ This may indicate that Kaiser is more amenable under its OIA to settling arbitration claims.



Summary Judgment

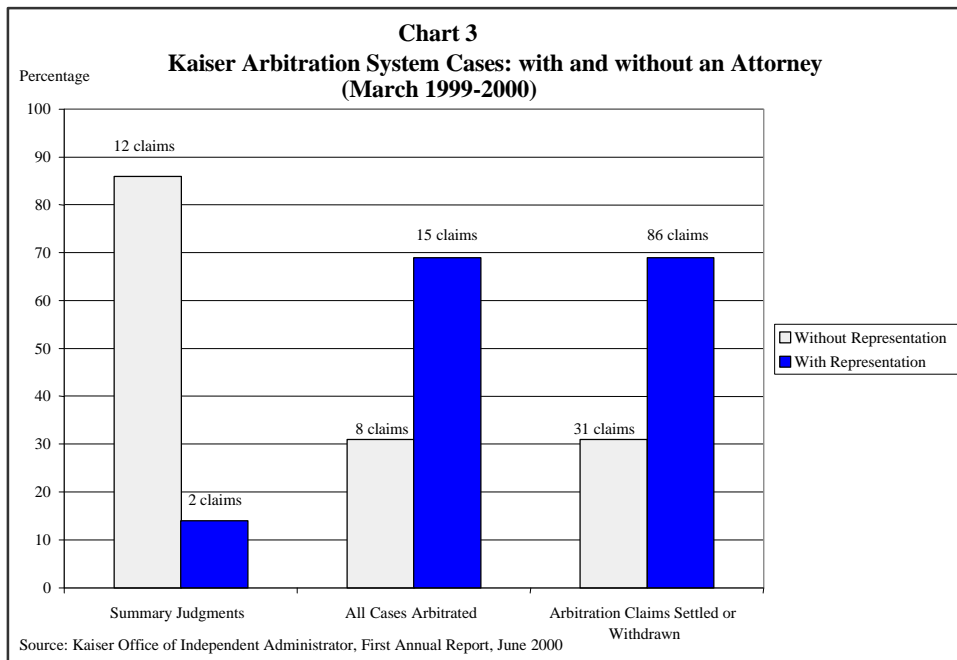
A summary judgment is a verdict (usually for the defense) that occurs before a full arbitration hearing takes place. This type of judgment usually occurs when the plaintiff has not presented any evidence and arbitration would essentially be a waste of time. Of the cases that we reviewed at the DMHC, the summary judgment rate for Kaiser was 27 percent (including “nonsuits” which were dismissed for lack of evidence). Most of these cases were filed under the pre-OIA system. According to the Kaiser OIA, their summary judgment rate is 12 percent (March 1999-January 5, 2001). In contrast, the rate for summary judgments in all civil complaints reported by the Judicial Council in 1998-1999 was 0.6 percent (see Chart 2 below).²⁷



Why do summary judgment rates differ between arbitration cases and court cases? There may be several explanations. In general, it is easier to file an arbitration claim than a court claim. Therefore arbitrators see more plaintiffs who probably would never make it to court. In addition, in the health care arena, many of the patients who are mandated to use arbitration do so without the assistance of an attorney or legal advocate (in legal terms, they are *pro per* plaintiffs). As a result, they may be unable to present evidence correctly or even understand what evidence needs to be presented. Arbitration can also be costly, even without an attorney. For example, an arbitration decision included in Appendix 1 lists “costs and fees of the American Arbitration Association amounting to \$1,000,” exclusive of compensation for the neutral arbitrator. Plaintiffs are generally required to share costs.²⁸

Several factors make comparison of arbitration and litigation data problematic, especially in the health care area. Statistics about litigation rely on self-reporting by participants, and cases may span several years.²⁹ In both arbitration and litigation, confidential settlements account for the majority of cases.³⁰ Cases arbitrated or litigated therefore represent only the tip of the iceberg of those that reach judgment.

In California, only Kaiser, through its OIA, publishes information about health care plan arbitration decisions. Data provided by the Kaiser’s OIA in its 1999-2000 first year report indicate that in 12 of the 14 summary judgments reported, the plaintiffs proceeded without an attorney. In 29 of the “withdrawn” cases reported, the claimants did not have an attorney. Only eight plaintiffs in the Kaiser OIA arbitration system acting without the benefit of an attorney had their cases arbitrated. Only one of these plaintiffs actually won in arbitration (see Chart 3 for details).³¹



None of the pro per (self-represented) plaintiffs listed in the DMHC records won their arbitration case against Kaiser. According to Kaiser's OIA, one pro per plaintiff recently won a case against Kaiser. In complex medical malpractice cases, or any health care-related case where arbitration is required, a patient's attorney may be necessary to fully pursue a case.

Comparing Successful Plaintiff Rates in Arbitration and in Court

A General Accounting Office (GAO) study found that patients won more often in arbitration than in court in 1989.³² Our review of records at DMHC found that patients won in medical malpractice arbitration proceedings about 37 percent of the time, excluding summary judgments.* According to Kaiser's OIA, from March 1999 to January 5, 2001, patients won 35 percent of the time and Kaiser won 65 percent of the time, excluding summary judgments. According to *California Jury Reports*, the patient win rate is about 23 percent for malpractice claims in court.³³ These comparisons are difficult to make. One reason is that summary judgments are much more common in arbitration than in court, and are generally not included when measuring plaintiff win rates in court.

Length of the Arbitration Process

Some consumer advocates contend that speed in arbitration is not necessarily a virtue. If plaintiffs are not adequately prepared to go to arbitration, especially if they are representing themselves, then there may not be enough time for them to discover relevant information. Incomplete discovery is a major problem for pro per arbitration plaintiffs and can lead to summary judgments. According to the *American Bar Association (ABA) Journal*, "Claimants must be able to vindicate themselves as fully as if they were before a judge and jury."³⁴

The time period for discovery is short and occurs before an arbitration hearing, in order to allow both sides to request evidence in the possession of the other party. Kaiser's OIA process, for example, allows up to 30 days for discovery of medical records. Some pieces of evidence are automatically discoverable, while others must be requested before provided. Some evidence is protected by a kind of immunity or privilege, such as communications between lawyers and clients.

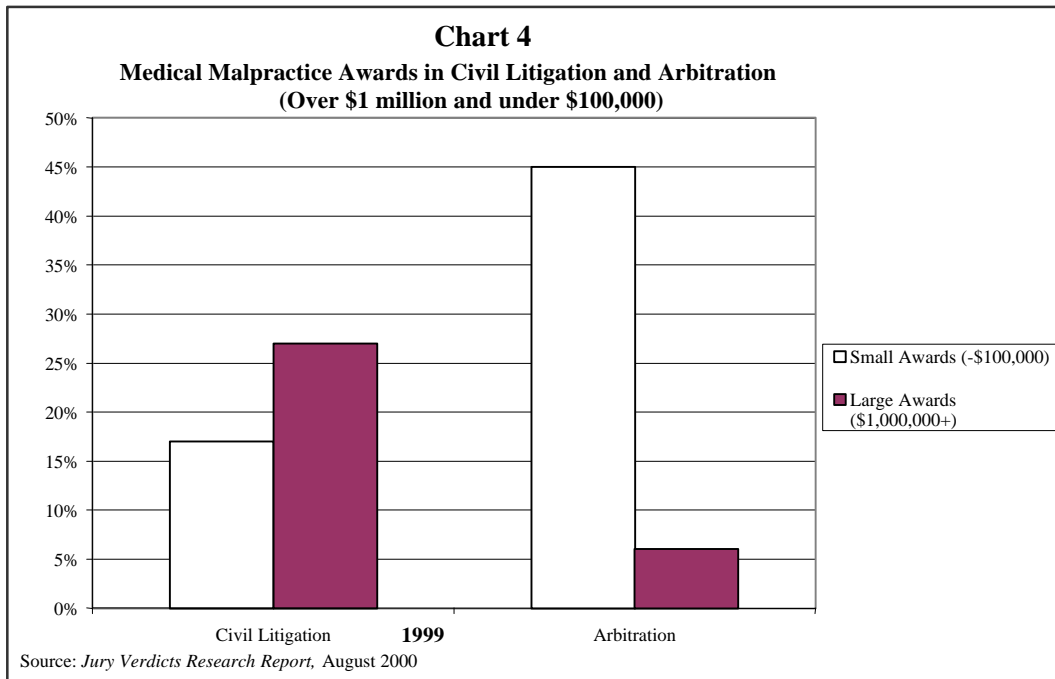
The process of discovery is essential for any lawyer hoping to build a good case and it can be both tedious and time consuming. According to the American Arbitration Association, "It is understood that alternative dispute resolution processes such as arbitration sometimes represent a trade-off between the concept of full discovery associated with court procedures and the efficiencies associated with minimal pretrial process."³⁵

* We chose malpractice cases as the most appropriate kind of case for purposes of comparison. The 37 percent plaintiff win rate in arbitration excludes summary judgments so it can be compared with the civil court win rate. Our review found that summary judgments are much more common in arbitration cases, resulting in a lower overall plaintiff win rate (see page 22).

Although arbitration generally takes less time to complete than litigation in court, it can be very time consuming. For example, when Kaiser administered its own arbitration system prior to 1998, it took 674 days before a neutral arbitrator was even appointed in the *Engalla* case. According to Kaiser's OIA, today the average time to appointment of a neutral arbitrator is under 43 days. Other health care arbitration organizations do not publish data or information about the timing of their systems.

How Much Money do Patients Usually Win in Arbitration?

Large medical malpractice awards are less common in arbitration than in jury trials. In 1999, medical malpractice awards under \$100,000 were 17 percent of the total awards in the court system and 45 percent of the awards in arbitration cases. Nationally, 27 percent of the cases litigated in courts received awards over \$1 million, while only 6 percent of patients in arbitration cases received more than \$1 million (see Chart 4).³⁶



If a medical malpractice error is because of negligence, a patient not bound to arbitration may sue in civil court to recover damages for economic and non-economic losses. Non-economic losses are capped at \$250,000.³⁷ Economic loss can result in substantially higher verdicts; many are paid-out over a ten to 15 year period. According to *California Jury Verdict Weekly*, there were 53 favorable jury awards for medical malpractice plaintiffs in California reported in 1999 out of 203 verdicts (a plaintiff win rate of 26 percent). The gross medium average jury award for those verdicts was \$407,000, including one award of over \$16 million. The 1999 national median jury award for medical malpractice was \$755,530.³⁸

Many attorneys charge contingency fees (a specified percentage of a winning award), not an hourly fee, in medical malpractice cases. According to one law firm specializing in medical malpractice, the firm only accepts about five percent of the medical malpractice clients that seek their counsel. The reason is that only those clients who have the potential for recovering large economic losses as a result of a medical error (generally \$1 million or more) are attractive enough to represent on a contingency basis, in which the firm funds the litigation in anticipation of a final award.³⁹ A lawyer representing a malpractice client is entitled to receive 15 percent of any recovery exceeding \$600,000.⁴⁰ Since arbitration awards are generally smaller than awards in civil litigation, arbitration cases are less attractive to plaintiff's attorneys.

Choosing a Neutral Arbitrator

A neutral arbitrator's role is somewhat akin to that of a judge—to hear a dispute and render an impartial decision. Case law is clear that companies cannot compel or control the choice of an arbitrator. Both parties select from a common pool of arbitrators, striking arbitrators unacceptable to each party to arrive at a final neutral arbitrator. This process places responsibility on the patient-plaintiff to make an informed decision when selecting a neutral arbitrator.⁴¹ However, plaintiffs in California health care claims generally do not have information about arbitrators' decision records before selecting a neutral arbitrator.* In contrast, health care plans do have information about the win-lose decisions of arbitrators. This information gap may favor health care plans.[†]

A repeat arbitrator frequently hears cases involving a particular health care plan. According to one theory, these arbitrators are more likely to be employed again by a health care plan if they have ruled in the plan's favor in the past. Consumer representatives contend that some repeat arbitrators are inclined by their own self-interest to side with health care plans, or temper awards in favor of plaintiffs.⁴² Several studies show that repeat arbitrators in employment arbitration do follow a pattern of favoring employers.⁴³

In a review of 1999 arbitration claims[‡] on file with DMHC, we found that 30 percent of the Kaiser arbitration claims were decided by eight repeat arbitrators (five or more arbitrations each). Six of these eight repeat arbitrators ruled in favor of the defense (Kaiser) in four-fifths of the cases. Overall, however, plaintiffs had a 26 percent chance of winning with a repeat arbitrator, compared to a 30 percent chance of winning with a non-repeat arbitrator.[§] If we define a repeat arbitrator more broadly as someone who arbitrates more than three claims in a given year, 46 percent of the Kaiser cases were decided by repeat arbitrators. In those cases, plaintiffs won 24 percent of the time. In

* In a court case, information about a trial judge's record is available and may be very important.

† State law (*Code of Civil Procedures section 1281.9*) requires some disclosure *after* selection of the neutral arbitrator, but plaintiffs do not have formal access to arbitrators' decision records *before* the selection.

‡ Our review was of DMHC records from April 1999 to March 2000. Most were administered under the Kaiser pre-OIA system.

§ These repeat arbitrator "win rates" include summary judgments.

the three cases in which the plaintiffs were awarded over \$1,000,000, the arbitrator was only employed in that case.

Public Records

Arbitration proceedings in health care plan disputes are closed hearings. Members of the public may not attend. Testimony is not recorded for public review. Awards issued by the arbitrator are presented to the plaintiff and defendant in writing, but all identifying information is removed before the records are sent to the DMHC (some health care plans are not filing any decision information). Kaiser's OIA annually collects information about how its arbitration system functions in terms of adjudicating claims. That information is generally available in the public reports available for review at DMHC.

The lack of an arbitration information record has consequences for judicial review should a plaintiff desire to pursue a civil case after arbitration (as noted above, most health care plans in California require binding arbitration, foreclosing judicial appeal). Our review of arbitration case records at DMHC found a paucity of information, usually just a finding for or against, and no grounds for the decision (see Appendix A).

An arbitrator's authority is derived from the contract binding the parties to arbitrate, and therefore the most likely way that an arbitration decision may be vacated is if the contract is in some way defective. The 1997 *Engalla v. Kaiser Permanente* decision by the California Supreme Court established the principle that an arbitration system that involves too much delay and unfairness can be found to depart so far from the expectations of the contracting parties as to be "fraud in the inducement."⁴⁴ However, "fraud in the inducement" is difficult to prove. The significance of the *Engalla v. Kaiser Permanente* decision is primarily that courts may in the future show increasing willingness to examine cases involving unfairness in arbitration processes. The more recent *Armendariz v. Foundation Health Psychcare, Services Inc.*, in which the California Supreme Court upheld the use of binding arbitration in resolving employment disputes, also upheld the plaintiff's claim that the imposition of fees and certain other provisions of the arbitration contract were invalid. Those provisions included a "lack of mutuality" by the employer in imposing arbitration only on the plaintiffs, and a lack of recovery of full damages by the plaintiff. Similarly, an April 8, 2000 decision by the 4th U.S. Circuit Court of Appeals found that the binding arbitration program of Hooters restaurants was not enforceable because the arbitration rules were "so one-sided as to undermine the neutrality of the proceeding." (*Hooters of America v. Phillips*, No. 98-1459.)

Arbitrator Qualifications and Rules of Ethics

California, like most states, does not have established professional standards or licensing requirements for arbitrators. In contrast, Michigan has adopted professional standards in conjunction with the national American Arbitration Association (AAA) model. The AAA maintains a roster of neutral arbitrators for the state. Minnesota and Texas are considering adopting similar standards.

Most of the California arbitrators examined in our review were highly compensated retired judges or experienced lawyers. They are not a diverse group either by gender or ethnicity. Arbitrators selected in California by the AAA include health care professionals, attorneys, and public members, including business people and non-health care professionals. According to the California State Bar Association, standards and ethical requirements for membership as lawyers do not apply to arbitrators.

Professional organizations are considering whether the complexities of arbitration proceedings require new professional rules. The American Bar Association (ABA), American Arbitration Association (AAA), and American Medical Association (AMA) formed a joint commission in 1997 to develop dispute resolution models, due process safeguards, neutral arbitrator disclosure information, and guidelines for resolving health care disputes. However, a draft final report failed to gain the approval of the governing bodies and was withdrawn. The commission draft report did advocate the use of binding arbitration only when both parties agree after a dispute arises, not prior as in California.⁴⁵ The American Arbitration Association has published health care claims settlement procedures for use in states where there are no clear standards or guidelines in statute. They were considered as part of the final draft report of the joint commission. The American Bar Association is proposing a new rule of professional conduct for lawyers serving as neutral arbitrators in alternative dispute resolution (ADR) proceedings.⁴⁶

Arbitration Costs to Consumers

There are two major private arbitration organizations in California, American Arbitration Association (AAA) and Judicial Arbitration and Mediation Services (JAMS), that charge users a variety of fees for their services. JAMS services include professional fees (hearing, reading/research, and award preparation, \$250-\$600 per hour) and case management fees (scheduling, document handling, and facility rental per day from \$125-\$250 per party). In addition to case management and professional fees, AAA charges a filing fee of from \$500 to \$7,000, depending on the amount of the claim, an administrative fee of \$150 a day, and rental fees for arbitration rooms.⁴⁷

California arbitrators typically charge between \$250 and \$400 per hour.⁴⁸ Most cases that result in an arbitration hearing, on average, take 1-2 days to resolve, according to AAA. While there are no formal records kept on the amount of time it takes to arbitrate a health care dispute, based on the AAA estimate, it would cost about \$4,800 to arbitrate a case. In most cases arbitration fees are shared by the health plan and the plaintiff/patient unless, the arbitrator decides that due to hardship, part or all of the plaintiff's fees should be paid by the plan. In Kaiser's new OIA system, there is a process for plaintiffs to request that the arbitrator's fees be paid by Kaiser based on income or financial hardship.⁴⁹

In addition to paying a neutral arbitrator and other fees, a plaintiff must also consider hiring an attorney to enhance the likelihood of winning. Hourly lawyer fees or per day costs are at least as expensive as the arbitrator's fees. The relatively high rate of pro per

plaintiffs (without an attorney) in the Kaiser arbitration system (29 percent in 1999) may indicate that plaintiffs are unwilling or unable to pay for both a neutral arbitrator and an attorney.⁵⁰ Kaiser's OIA does not disclose whether there is any correlation between pro per plaintiffs and application for fee waiver.

Consumer groups contend that requiring consumers to pay arbitration fees as a condition for filing claims puts them at a significant disadvantage. The cost may discourage consumers from filing claims and may lead to summary judgments due to inadequate representation. The California State Supreme Court, in its recent ruling in the *Armendariz v. Foundation Health Psychcare, Inc.*, case, concluded that when mandatory arbitration is imposed as a condition of employment, the agreement obliges the employer to pay all types of costs that are unique to arbitration.⁵¹ Federal employment case law specifies that it is unlawful to require an employee who is the subject of a mandatory employment arbitration agreement to pay the costs of arbitration.⁵² While no specific ruling or case has come before the court challenging this requirement in health care plans, these employment cases could provide a precedent.

Indigent Patients

The Knox-Keene Act section 1373.20 states that health care plans must contain a provision for the assumption of all or a portion of an enrollee or subscriber's share of arbitration fees and expenses in cases of extreme hardship. The plans are required to disclose this provision to patients. Our review of plans suggests that some plans do not clearly disclose this provision, or disclose it in a section separate from other arbitration provisions. The practical meaning of "extreme hardship" and "all or a portion of enrollee's or subscriber's share of the fees and expenses" may be unclear to consumers and the plans.

ARBITRATION IN OTHER STATES

Some states regulate, or do not allow, the use of binding arbitration clauses in health care contracts. Table 3 presents a comparative analysis of arbitration-related state statutes. The last category includes state statutes that seriously limit and regulate the use of arbitration. Statutes limiting arbitration in many states are exceptions to the *Uniform Arbitration Act* (UAA), which strongly encourages the use of arbitration.

State Statute Requirements	States
Prohibits the use of binding arbitration for medical malpractice	South Dakota and South Carolina
Excludes personal injury and malpractice actions from general arbitration statutes	Arkansas, Iowa, Kansas, Montana, Nebraska, South Carolina, and Texas
Excludes contracts of adhesion from general arbitration statutes	Iowa, Missouri, and Nebraska
Excludes contracts of insurance from general arbitration	Arkansas, Iowa, Kansas, Kentucky, Missouri, Montana, Nebraska, Oklahoma, South Carolina, Texas, and Vermont
Seriously regulates the use of binding arbitration	Illinois and Michigan
Source: California Research Bureau/ State Library, August 2000	

Malpractice

Malpractice is a difficult and technical civil tort action. The legal grounds for a civil tort action are when one party is accused of committing either a negligent or intentional action against another party. The states prohibiting the use of binding arbitration for medical malpractice may be motivated in part by the discovery problems inherent in arbitrating a difficult tort. In addition, the secrecy of arbitration proceedings may prevent publicity that could reveal poor doctors. A tort action involving medical malpractice, in addition to, financially compensating a successful plaintiff theoretically deters “bad behavior” in the future.

Contracts of Adhesion-Binding Arbitration

Some states (such as Iowa and Missouri) will not enforce contracts for binding arbitration if they are “contracts of adhesion.” A contract of adhesion is a standardized contract offered to all or most consumers or employees on a “take it or leave it” basis.⁵³ For example, if all health care plans required binding arbitration, these contracts would be considered a contract of adhesion because consumers would have no choice. Given that 80 percent of California health care plan consumers are covered by contracts requiring arbitration, health care plans may be approaching adhesion “territory.” However, even if a contract is adhesive, the courts must find an additional element of unfairness or fraud before the contract will be invalidated. According to the chair of the American Bar Association, Dispute Resolution Section’s Arbitration Committee, “...with increasing

frequency, the courts are beginning to look at the guts of arbitration agreements in standardized adhesion contracts...⁵⁴

Illinois law requires binding arbitration agreements to be signed when a patient enters the hospital for treatment. However either party has the right to rescind the arbitration agreement within 60 days.⁵⁵

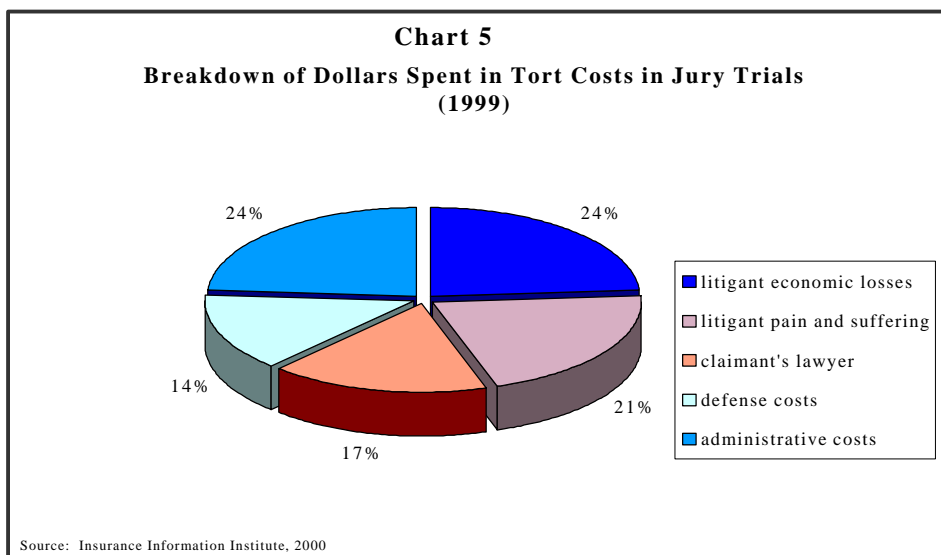
Insurance

Eleven states exclude contracts of insurance from general arbitration statutes. Insurance companies are usually heavily regulated by the states for several reasons. One reason is that insurance companies have strong financial incentives to pay as few claims as possible. When a person's claim is denied, an adjudication process closely tied to the company that denied the claim can be problematic. In addition, a secret adjudication process may benefit companies that deny claims unfairly.

Regulation and regulatory fines are methods for ensuring that insurance companies pay legitimate claims. Legal actions can cause companies a great deal of unwanted publicity and also serve as a deterrent to egregious behavior. However, regulatory agencies are often unable to monitor arbitration. The secrecy of the process may allow "bad actor" insurance companies to not pay valid claims, to the detriment of ethical insurance companies that could suffer financial losses.

Mediation as a Mutually Accepted Alternative

The popularity of mediation as a dispute resolution method is fueled in large part by the simple fact that both parties are likely to begin the mediation wanting to settle. While settlements are also common in adversarial systems, litigation or arbitration systems both encourage parties to adopt an "attack and defend" posture that makes settlements more costly and less amicable. The Insurance Information Institute estimates that for the average dollar spent in tort costs, 24 cents compensates litigants for economic losses, 22 cents covers their pain and suffering, 16 cents are spent for the litigant's lawyers, 14 cents are spent for defense costs, and 24 cents are spent on administrative costs (see Chart 5).⁵⁶



Both arbitration and mediation are used unevenly nationwide. Texas requires mediation of some cases before they may go to court, but does not permit arbitration prior to court hearing. Texas law prohibits managed health care plans from requiring their members to enter into pre-dispute binding arbitration agreements.⁵⁷ As an alternative, Texas law allows managed health care plans to use alternative dispute resolution (ADR) programs, including mediation, to resolve consumer health care disputes. Texas law allows the State Bar Association to be an active participant in the ADR process. The Texas non-binding pre-dispute resolution process is designed to eliminate minor medical claims. There is no data available to measure or evaluate program success. However, consumer demand for arbitration is exceeding the supply of qualified neutral arbitrators.

In health care dispute resolutions, California may use more binding arbitration and less mediation than other states. In contrast, California is noteworthy for the use of mediation among small business owners.⁵⁸

The primary issue in some states is no longer whether or not to encourage mediation, but how to certify mediators. In Illinois, both judicial circuits and private organizations train and certify mediators.⁵⁹ Massachusetts is currently experimenting with a system that would require mediation before malpractice claims can be brought to court.⁶⁰ This policy is designed both to encourage the reporting of medical errors and to settle cases with less acrimony. Rush Medical Center, a large hospital in Illinois, initiated a mediation program in 1995. According to Max Douglas Brown, Vice-President and general counsel for Rush, the Medical Center selected mediation rather than arbitration because:

- They were unwilling to enter into a binding arrangement that was arbitrary and brought no finality.
- Arbitration was viewed to be potentially as costly and unpredictable as a jury trial.⁶¹

During the first two years of its mediation program, Rush Medical Center maintained constant settlement costs, and experienced a dramatic decrease in their defense costs and a decline in the number of suits brought against them. According to Brown, one of the intangible benefits of the program was that the process brought an opportunity for individual plaintiffs and defendants to amicably resolve the matter. The program has been warmly applauded by the plaintiffs' bar and the defense firms representing the hospital who were initially reluctant to participate in the program.⁶²

The Veterans Affairs (VA) Medical Center in Lexington, Kentucky, initiated a mediation program in 1987. While VA hospitals do not have the liability exposure of private hospitals, the potential for malpractice law suits is still large. The unique aspect of this program is that when a medical error occurs, the hospital tells the patient about the error and encourages the patient to get a lawyer.⁶³ Ginny Ham, the hospital lawyer, explained the policy: "We have an ultimate responsibility for the veterans and their families."⁶⁴ Before the program began, Lexington VA paid out more than most VA hospitals for malpractice settlements and verdicts. It now has one of the lowest payout rates in the VA 178 hospital system.⁶⁵ More importantly, medical errors are more likely to be reported and addressed systemically.

Federal Preemption

Under the Supremacy clause of the United States Constitution, federal laws “can supersede or supplant any inconsistent state law or regulation.”^{*} In response to a series of Supreme Court decisions that found state insurance laws preempted by federal laws, the U.S. Congress passed the *McCarran-Ferguson Act*. This act explicitly states that “no act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purposes of regulating the business of insurance” (15 U.S.C. 1012).⁶⁶ Insurance laws are the traditional domain of the states and this language can be construed to create a “reverse preemption” effect.

The Federal Arbitration Act, which favors the use of arbitration, was designed to have a preemptive effect. Thus there is an unresolved conflict in federal law as to the role of the states in health insurance arbitration. Furthermore, common law grounds for revoking a binding contract such as lack of consideration or unconscionably, does not violate the Federal Arbitration Act.[†] Thus one way States might avoid being pre-empted by federal law is to rely on traditional contract law in regulating health care insurance issues relative to the state’s regulation of health care plan arbitration.

^{*} In preemption cases, the key issue is the scope of the federal law. The Supreme Court has not addressed this issue with regard to the Federal Arbitration Act.

[†] *Patterson v. Tenet Healthcare Inc.* (8th Cir. 113 F. 3d 832, 838, 1997), plaintiff was unaware that he knowingly waived the right to jury trial after signing an arbitration agreement. Also see p. 8, *Armendariz v. Psychcare*, for discussion.

LEGISLATIVE AND ADMINISTRATIVE OPTIONS

While not necessarily the recommendations of the California Research Bureau, the authors, or the Legislative members requesting this report, the following options reflect some of the possible applications of our research.

Framing the Debate

Both health care services and legal disputes are costly. Managed care and arbitration can reduce costs to consumers and therefore help to achieve important policy goals such as access to health care insurance and fair dispute resolution. However, economic efficiency is not the primary goal of either medicine or the law. The tricky question is how to balance efficiency and cost control with high quality legal and medical care. We examine three broad categories of options.

- Improvements to the health care plan arbitration process
- Judicial or administrative oversight
- Limiting pre-dispute binding arbitration

Improvements to the Arbitration Process

Independence of Arbitrators

Health care plans that operate their own arbitration system may influence the process to their advantage. Most health care plans now use an independent arbitration provider, such as American Arbitration Association (AAA), Judicial Arbitration and Mediation Services (JAMS) or Kaiser's Office of Independent Administrator (OIA). Nonetheless several health care plans (see Table 1, page 12) are still operating their own arbitration systems. This process is fraught with potential difficulties, as the courts have established.

- To ensure fairness, the Legislature could require health care plans to use an independent arbitration provider, by prohibiting in-house administration of arbitration dispute resolution.

Information for Patients

Although arbitrators are mandated by state law to disclose any previous decisions for or against a particular health care plan *after* they are selected in a case, patients do not have access to this information *before* they select an arbitrator. In contrast, most health care plans do have access to this information *prior* to selection and are able to compile information about an arbitrator's record. Patients are at a serious disadvantage during the selection process.

- The Legislature could require that when health care plans file information about arbitration decisions with the Department of Managed Care (DMHC), they also

- provide a quarterly summary of awards by each arbitrator. These summaries could be made available to the public on the DMHC website.
- DMHC may need authority to levy fines on health care plans for non-compliance with filing requirements, given the paucity of records already legally required.

Fees for Arbitration

Current law is rather vague about when health care plans are required to pay expenses for indigent patients.

- *Section 1373.20* of the Knox-Keene Act might be amended to provide more specificity, both about the standards for “indigent” and consumer disclosure.
- The Legislature could require health care plans to highlight information about waiver of arbitration fees for indigent patients in the arbitration clauses in the contract.

While some of the costs a patient must pay during arbitration are similar to the costs he or she would incur by going to court, other costs are unique to arbitration. For example, a patient would not have to rent a courtroom. Patient litigants do have to pay half of the rent for a room to conduct the arbitration hearing.

- The Legislature could require health care plans to pay into a central claims pool to cover facility costs. A central pool could also serve as a trust account to pay the expenses of low-income patients.
- Alternatively, DMHC could set up an advisory committee comprised of managed health care plan representatives, consumers, and health care providers to develop and recommend to the Legislature an equitable system of payment of arbitration costs.

Professional Standards and Training for Arbitrators in Health Care Disputes

An important issue in several states is how to implement professional standards for arbitrators and mediators. Lack of professional standards is becoming more of an issue as the demand for arbitrators and mediators expands. The American Bar Association (ABA) is currently considering new standards of professional ethics.

- The Legislature could investigate the issue and develop broad professional guidelines for ADR professionals and charge a state agency to develop more detailed standards and qualifications.

California may need to expand its limited pool of knowledgeable and qualified alternative dispute resolution professionals to meet demand. This might also lower fees through competition (arbitration is currently a highly compensated, lucrative career for retired judges and attorneys).⁶⁷

- The Legislature could charge a state agency with creating a licensing and professional certification and training program for ADR professionals. The purpose would be to increase the pool of arbitrators so that there might be some competition for the business of patients as well as health plans. This might improve the fairness of the process. A corollary benefit might be to increase the diversity of this important group of dispute-resolution professionals.

Due Process

Procedural safeguards in the civil justice system, such as adequate time for discovery, juries, court reporters, records, and an appeals process, are expensive. Arbitration realizes cost savings by eliminating or curtailing procedural safeguards. Procedural due process influences public perceptions about the fairness, or lack thereof, of a justice system. Perceived fairness affects the willingness of people to accept a justice system's decisions, even when the decisions are adverse to their interests: "Procedural justice strongly influences institutional legitimacy and through it, acceptance of institutional decisions."⁶⁸

- Currently, the time for discovery in an arbitration case is limited and varies by arbitrator. The Legislature could specify a minimum time for discovery in arbitration proceedings or an opportunity to compel discovery after proceeding begins. Patients need time and access to gather the complex medical information they need to pursue a fair claim.
- The Legislature could impose some form of oversight on managed health care plans that use pre-dispute arbitration agreements. The five factors cited in the *Armendariz* decision could provide guidance for arbitration agreements. These factors are:
 1. provides for neutral arbitrators,
 2. provides for more than minimal discovery,
 3. requires a written award,
 4. provides for all types of relief that would otherwise be available in court, and
 5. does not require employees to pay either unreasonable costs or any arbitrators' fees or expenses as a condition of access to the arbitration forum.⁶⁹

Department of Managed Health Care Oversight Process

The Knox-Keene Act (as amended in 1998) requires that health care plans submit reports on arbitration decisions and consumer complaints to DMHC. Health care plans are also required to annually submit detailed statements explaining the procedures that consumers must follow in submitting complaints about the plan or claims against the plan.

Of the 50 health plans on record with DMHC, only three have filed arbitration decisions with the department. A majority of health care plans did not even file a statement as to whether there were any decisions. Health plans such as Kaiser that do make arbitration

decisions available, are effectively penalized by the inaction of other health plans care because they receive more public scrutiny.

- As part of the DMHC oversight process, the Legislature could require the Department to more systematically monitor the status of all health care grievances, appeals, and arbitrations from inception to final resolution. A similar oversight process has been established in the state of Connecticut.
- The Legislature could require the DMHC to establish and enforce a more systematic and accessible reporting system for health plans.
- The law currently does not authorize penalties for ignoring the filing requirement. The Department could be given authority to levy fines to make the law more effective.
- DMHC could publicize which health plans have or have not filed required documents pertaining to complaints, grievances, and arbitration claims. The Legislature could require that DMHC provide this information in a consumer friendly format on the Internet.
- DMHC could publish an annual report giving general information about the number of health care arbitration decisions by plans and by arbitrator.

Judicial Review

Following *Moncharsh vs. Heily & Blasé* (3 Cal 4th 1; 832 P.2d 899, 1992), California courts review arbitration awards on extremely narrow grounds. Even an award that is unjust and erroneous on its face cannot be overturned by an appeal to the courts. The majority reasoned in *Moncharsh* that arbitration is a private means for resolving disputes. The reasoning may become more tenuous as large numbers of Californians are required by contract to use binding arbitration in health care disputes.

Arbitration records are, in general, not extensive enough to support judicial review. Normally an appeals court will accept all findings of fact as established by the trial court records, and review records only for an error in the law. The arbitration awards that we viewed did not set forth either the facts of the case or the arbitrators' legal reasoning. This effectively makes arbitration decisions unreviewable by the courts for errors of law.

If arbitrators were required to write legal opinions or to keep a court record, it would be possible for an Appeals Court to review decisions for errors in law, while not disturbing findings of fact.

- The Legislature could require health care arbitrators to write legal opinions providing a detailed record of the grounds for the decision, so that it would be possible for an Appeals Court to review decisions for errors in law. In addition, written opinions might develop a system of arbitration precedents that would build a measure of consistency and predictability into the arbitration system.

Prohibit Pre-Dispute Arbitration Agreements

At common law, the parties to an arbitration were able to rescind their agreement to arbitrate up until the moment of award.⁷⁰ Some states, such as Illinois, allow parties to rescind an arbitration agreement for a specified period of time after a dispute arises. California's arbitration statutes make arbitration agreements binding as soon as the contract for arbitration is signed, which is at the time of enrollment in a health care plan.

The American Bar Association (ABA), American Arbitration Association (AAA), and American Medical Association (AMA) formed a joint commission in 1998 to develop consistent policies and guidelines for health care dispute resolution.⁷¹ The draft report (not issued in final) advocated allowing consumers to choose arbitration post-dispute.

- The Legislature could find a middle ground between current California law and the common law rule by allowing a contract to arbitrate a specific dispute, signed after the dispute arises, to bind the parties from the moment of signature. Thus consumers would not be bound to arbitration as a condition of receiving medical care.
- The Legislature could support a market-based approach to this issue. Health plans could offer a discount in rates to individuals who agree to sign a binding arbitration contract. Patients who refuse to sign a binding arbitration contract could be charged larger premiums to cover reasonable anticipated costs. DMHC could be given the authority to review the additional premium costs for "reasonableness," much as other insurance premiums are regulated.

Alternatives to Arbitration

Mediation

Mediation is a form of negotiation that is appropriate in cases where a settlement is in the best interests of both parties. In most mediation cases, if a consumer fails to reach a settlement during mediation, the case can still go to court. In this sense, mediation is not binding until the parties arrive at a final number. Mediation is being used successfully to deal with health care disputes in other states.

Studies show that physicians are most often sued when they do not have a good rapport with patients.⁷² The adversarial relationship inherent in litigation begins even before the suit is filed. Providers are generally unwilling or unable to apologize for errors and may attempt to cover up occurrences. Mediation can help parties address errors in medical practice and communications.

- The Legislature could provide local health care plans with fiscal or regulatory incentives to set up experimental mediation programs for targeted types of disputes or claims by consumers. DMHC could set up a reporting and monitoring system for those plans that participate in the pilot project.

Integrated and Targeted Arbitration

National research into “medical mistakes” finds that there are safety issues that need to be systematically addressed by medical professionals and health care plans.⁷³ Dispute resolution could move beyond punishing bad actors and compensating injured parties to take an active role in encouraging constructive solutions to medical safety problems. Many theorists see mediation as a more promising approach than arbitration to achieve this goal.

- The Legislature could require health care plans with binding arbitration to keep specific records on the medical and administrative problems uncovered in the proceedings. These could be forwarded to DMHC for compilation, analysis, and publication.
- The Legislature could require health care plans to develop a standardized internal system to integrate arbitration results into error prevention plans.
- Arbitrators could be required to target their awards towards three goals: error prevention, compensation of victims, and deterrence/punishment of bad actors.

ENDNOTES

- ¹ Frances Kellor, *American Arbitration: Its History, Functions and Achievements*, (New York: Harper, 1948).
- ² Bruce H. Mann, "The Normalization of Informal Law: Arbitration Before the American Revolution," 59 *N.B. L. Rev.* 443 (1984).
- ³ Michele L. Giovagnoli. "To Be or Not to Be?: Recent Resistance to Mandatory Arbitration Agreements in the Employment Arena," *UMKC Law Review*, 64:547 (1996) p. 557 *United Steelworkers v. Enterprise Wheel & Car Corp.*, 363 U.S. 593, 597 (1960), *United Steelworkers v. Warrior & Gulf Navigation Co.*, 363 U.S. 574 (1960); *United Steelworkers v. American Mfg. Co.*, 363 U.S. 564 (1960)
- ⁴ *Moncharsh v. Heily & Blasé* 3 Cal 4th 1; 832 P.2d 899, 1992.
- ⁵ California Legislature, Senate Committee on Judiciary, Senator Charles Calderon, Chairman, Testimony by Ken Sigelman, Consumer Attorneys of California, *Issues In Arbitration*, October 24, 1995.
- ⁶ *Moncharsh v. Heily and Blasé* (3 Cal 4th 1; 832 P. 2d 899, 1992).
- ⁷ *Armendariz, supra*, at p. 102, citing *Cole*, 105 F. 3d at p. 1482.
- ⁸ American Arbitration Association, Principal 10, Consumer protocol and reporter's comment. <http://www.adr.org/education/consumer/protocol.html> .
- ⁹ Peter R. Kongstvedt. "The Managed Health Care Handbook, 3rd Ed." (Aspen Publishing, 1996).
- ¹⁰ *Ibid.* at 35.
- ¹¹ Amy E> Elliot. "Arbitration and Managed Care, Will Consumers Suffer if the Two are Combined?" *Ohio State Journal of Dispute Resolution*, v.10, (1995) 417.
- ¹² Peter R. Kongstvedt, "The Managed Health Care Handbook, 3rd Ed.", (Aspen Publishing 1996), p. 125.
- ¹³ Elizabeth Thompson, "Gaming the System: Survey Shows Many Doctors are Willing to Deceive Insurers to Obtain Treatment Coverage They've Deemed Necessary for Their Patients," *Modern Healthcare*, April 17, 2000
- ¹⁴ J. Bridget Sheehan-Watanabe, "When What's Ailing You Isn't Only Your Health," *Health Rights Hotline*, August 2000.
- ¹⁵ John E. Schneider, "Four Managed Care Myths," *California Association of Health Plans Research*, April 20, 2000.
- ¹⁶ Alexandra V. McDonald, "Escape From Arbitration," *American Bar Association Journal*, v. 85, (August 1999), p. 33.
- ¹⁷ RAND, "Binding Arbitration is Not Frequently Used to Resolve Health Care Disputes," *Research Brief*, 1999.
- ¹⁸ Black's Law Dictionary, 7th Ed., 1999, medical malpractice (definition), p. 971.
- ¹⁹ Medical Injury Compensation Reform Act of 1975 (MICRA) Implementation Manual, prepared for the California Medical Association by Horvitz and Levy, 1998.
- ²⁰ First Annual Report of the Office of the Independent Administrator of the Kaiser Foundation Health Plan, Inc. Mandatory Arbitration System for Disputes with Health Plan Members, March 29, 1999 – March 28, 2000, Los Angeles, August 2000.
- ²¹ *Kaiser Family Foundation Consumer Survey*, Most consumers generally positive about their health plan, but 51% report having some problem in the past year, June 2000, Kaiser Family Foundation web site, www.kff.org .
- ²² Barbara Dalton, former Kaiser Office of the Independent Administrator, conversation regarding a consumer complaint involving pro per plaintiff resulting in a loss for Kaiser, September 2000.
- ²³ Dorsey Griffith, "Survey Finds Biggest Beefs with Health Plans," *Sacramento Bee*, September 8, 2000, B-1.
- ²⁴ Consumer Reports Online, A Closer Look, www.consumerreports.org , "When Your HMO Says No," July 2000.
- ²⁵ U.S. General Accounting Office, *Report to Congressional Committees, Medical Malpractice Alternatives to Litigation*, (Washington DC: the Office, January 1992).
- ²⁶ First Annual Report of the Office of the Independent Administrator of the Kaiser Foundation Health Plan, Inc. Mandatory Arbitration System for Disputes with Health Plan Members, March 29, 1999 – March 28, 2000, Los Angeles, August 2000.

-
- ²⁶ *Kaiser Family Foundation Consumer Survey*, Most consumers generally positive about their health plan, but 51% report having some problem in the past year, June 2000, Kaiser Family Foundation web site, www.kff.org.
- ²⁷ Arbitrations on file with the DMHC, examined in August 2000.
- ²⁸ Barbara Dalton, former head of the Kaiser Office of the Independent Administrator, interview regarding reason for filing arbitration claims with no results, September 2000.
- ²⁹ "California Jury Verdicts 1999," *Jury Verdicts Research Series*, LRP Publishing, 1999.
- ³⁰ Margaret C. Jasper, "The Law of Medical Malpractice," *Ocean's Law for the Layperson* (1996) p. 33, 1996.
- ³¹ First Annual Report of the Office of the Independent Administrator of the Kaiser Foundation Health Plan, Inc. Mandatory Arbitration System for Disputes with Health Plan Members, March 29, 1999 – March 28, 2000, Los Angeles, August 2000.
- ³² U.S. General Accounting Office, *Report to Congressional Committees, Medical Malpractice Alternatives to Litigation*, (Washington DC: the Office, January 1992).
- ³³ California State Judicial Council, Information Resource Management Unit, "Total Summary Judgment Fiscal Years 1995-1999," August 8, 2000.
- ³⁴ Alexandra V. McDonald, "Escape From Arbitration," *American Bar Association Journal*, v.. 85 (August 1999), p. 33.
- ³⁵ Consumer Due Process Protocol, Reporter's comments, p. 28, August 8, 2000, www.adr.org/education/education/consumer/protocol.html.
- ³⁶ Jury Verdict Research, "Current Award Trends in Personal Injury-1999 Ed.," :Labor Relations Publications, 2000.
- ³⁷ *California Civil Code Section 3333.2*, Medical Injury Compensation Reform Act of 1975 (MICRA).
- ³⁸ Jury Verdict Research, "Current Award Trends in Personal Injury-1999 Edition," Labor Relations Publications, 2000.
- ³⁹ Conversation with Paul Kiesel, of Kiesel, Boucher, and Larson, a noted consumer-oriented law firm, regarding medical malpractice and arbitration, January, 5, 2001.
- ⁴⁰ *California Business and Professions Code Section, 6146*.
- ⁴¹ Alexandra V. McDonald, "Escape From Arbitration." *American Bar Association Journal*, v. 85, (August 1999), p. 33.
- ⁴² Nancy Peverini, Consumer Attorneys of California, interview regarding the selection of repeat arbitrators in health care disputes, October 3, 2000.
- ⁴³ Bingham, *Employment Arbitration: The Repeat Arbitrator Effect*, (1997), "Employee Rights And Employment Policy," J. 189; Schwartz, *supra*, 1997 *Wisconsin Law Review*, pp. 60-61.
- ⁴⁴ *Engalla v. Kaiser Permanente Medical Group, Inc.* 14 Cal. 4th 951, 64 Cal. Rptr.2d 843, 938 P.2d 903, 1997.
- ⁴⁵ Commission on Health Care Dispute Resolution. *Health Care Due Process Protocol: A Due Process Protocol for Mediation and Arbitration of Health Care Disputes* (Joint Commission: American Bar Association, American Medical Association, and American Arbitration Association), 1998.
- ⁴⁶ James Podgers, "Ethics in 2000 and Beyond." *American Bar Association Journal*, v.. 85, (August 1999), p. 96.
- ⁴⁷ National Conference of State Legislatures, American Arbitration Association Price List, August 2000.
- ⁴⁸ Barbara E. Dalton, Office of the Independent Administrator Report on Kaiser Arbitrations, June 11, 2000.
- ⁴⁹ First Annual Report of the Office of the Independent Administrator of the Kaiser Foundation Health Plan, Inc. Mandatory Arbitration System for Disputes with Health Plan Members, March 29, 1999 – March 28, 2000, Los Angeles, August 2000, pg. 23.
- ⁵⁰ Kaiser Office of Independent Administrator, *supra* note 4. The rate for pro per plaintiffs is 29%, August 2000.
- ⁵¹ *Marybeth Armendariz v. Foundation Health Psychcare Services, Inc.*, Ct. App. 1/1 A080224, p. 32, August 2000.
- ⁵² *Cole versus Burns Intern. Security Services, supra*, 105 F. 3d 1465.
- ⁵³ Patricia I. Carter, "Binding Arbitration in Malpractice Disputes: The Right Prescription for HMO Patients?" *Hamline Journal of Public Law & Policy* 18, (1997), p. 423.
- ⁵⁴ Alexandra V. McDonald, "Escape From Arbitration." *American Bar Association Journal*, v. 85,

(August 1999), p. 32.

⁵⁵ 710 ILCS 15/ (2000)

⁵⁶ Barbara Bowers, "Give and Take; Mediation" *Best's Review*, July 1, 2000.

⁵⁷ Texas Insurance Code Article 21.21 §§16,17,18; Article 21.21-2 §§2,3; Article 21.58(a), §6a(c); Business Code §17.41; Civil Practices and Remedies §§ 88.002 (a), (b).

⁵⁸ Brian Cox, "Out-Of-Court Settlements: Mediation Closes Spats Cheaper, Faster Than Lawsuits," *Crain's Chicago Business*, April 12, 1999.

⁵⁹ *Ibid.* at 427.

⁶⁰ Leonard J. Marcus, "Mediation Before Malpractice Suits?" *Newsweek*, March 27, 2000.

⁶¹ Douglas M. Brown, "Rush Hospital's Medical Malpractice Mediation Program: An ADR Success Story," *Illinois Bar Journal* v. 86, (August 1998), pp. 432-433.

⁶² *Ibid.* p. 440.

⁶³ Jonathan R. Cohen, "Apology and Organizations: Exploring an Example from Medical Practice," *Fordham Urban Journal*, v. 27, (June 2000), p. 1448.

⁶⁴ *Ibid.*, page 1449.

⁶⁵ *Ibid.*, page 1449.

⁶⁶ AB 1751 Legislative Analysis, Assembly Judiciary Committee, August 2000.

⁶⁷ Benjamin Howell and Jeanne Steele, "Going Private: Where Have All the Judges Gone?" *California Lawyer*, (May 2000), p. 39.

⁶⁸ *Ibid.* at 334, (quoting Tom Tyler and Kenneth Rasinski, *Procedural Justice*)

⁶⁹ *Armendariz, supra*, at p. 102, citing *Cole*, 105 F. 3d at p. 1482.

⁷⁰ Sam Kegel, Law Revision Commission, *A Study Relating to Arbitration*, 1960, G-25.

⁷¹ Commission on Health Care Dispute Resolution. *Health Care Due Process Protocol: A Due Process Protocol for Mediation and Arbitration of Health Care Disputes* (Joint Commission: American Bar Association, American Medical Association, and American Arbitration Association), 1998.

⁷² Warren Greenberg, *The Health Care Marketplace*, (Spring 2000), p. 20.

⁷³ Linda Kohn; Janet Corrigan; and Molla Donaldson, "To Err is Human: Building a Safer Health System," (Washington, D.C.: National Academy Press), 2000, p. 125.