

**JOINT INFORMATIONAL HEARING
ASSEMBLY HEALTH AND JUDICIARY COMMITTEES**

Tuesday, March 12, 2002

9:00 a.m. to 12:00 p.m.

State Capitol, Room 4202

BACKGROUND

AGENDA – Part I

ARBITRATION IN HEALTH CARE: WHERE ARE WE AND WHAT DO WE KNOW?

WHAT IS ALTERNATIVE DISPUTE RESOLUTION (ADR)?

The term "ADR" was once understood to mean "Alternative Dispute Resolution." More recently, many of the leading commentators in the field now suggest that the preferable term is "Appropriate Dispute Resolution." Whichever formulation one uses, the notion is the same – a range of tools for resolving disputes and helping parties deal constructively with their differences outside of traditional civil litigation. Mediation and arbitration are the two most common, but the term "ADR" also includes: neutral evaluation, mini-trials, facilitation, policy dialogues, summary jury trials, neutral fact-finding, and ombuds practice.¹

ADR is intended to be less formal than court proceedings. It may have a variety of objectives or expected outcomes, is intended to be applied flexibly, and, according to the American Bar Association, should be voluntary. These qualities permit ADR to be adapted to the needs of particular settings, cases, and parties in order, ideally, to save both time and cost and to produce results that may not be able to be realized in the more formal court setting. Well-informed participants in voluntary ADR have a number of choices not available to those in litigation. Such participants can negotiate about, or consider options regarding, the kind of resolution techniques for their case, the person or persons who will provide ADR services, significant aspects of how ADR will operate for them, or in fact may reject ADR as an alternative to court.²

Voluntary ADR techniques have been used in a wide range of settings, including family matters, community conflicts, business-to-business disputes, consumer complaints, construction matters, environmental cases, public policy issues, and even criminal cases.

WHAT ARE MEDIATION AND ARBITRATION?

Arbitration Defined

Reduced to its essence, arbitration means the use of a *private third party to issue a binding decision regarding a dispute*. Arbitration has been an alternative to litigation for hundreds of years. It was used, for example, in the thirteenth century by English merchants who preferred to have their disputes resolved according to their own customs (the law merchant) rather than in law courts. In modern times, it has been used extensively to resolve disputes arising under collective bargaining agreements and under a wide variety of commercial agreements and contracts.³

By "third party," the definition of arbitration implies that the decision-maker is not one of the parties in the dispute, but rather is someone expected to be neutral and disinterested. The third party may be one or more persons. Any person may serve as a private arbitrator; there are as yet no credentials, qualifications or licensing requirements in California.

The "binding decision," element of the definition contains three important components. Unless the parties agree otherwise⁴: (i) the decision is binding on the parties in the sense that it can be enforced against them; (ii) a court will generally not consider whether the arbitrator was right or wrong; and (iii) the award, to be legally appropriate, must decide the dispute which the parties have submitted to arbitration, and nothing else. In fact, the California Supreme Court has held that "an arbitrator's decision is not generally reviewable for errors of fact or law, whether or not such error appears on the face of the award and causes substantial injustice to the parties."⁵ Because the arbitrator is not required to follow the law, and because the courts effectively do not review arbitrators' awards, no body of law or precedent is developed in arbitration. In essence, each issue and controversy arises and must be decided as if for the first time – without regard to the laws enacted by the Legislature or the interpretation of those laws by public judges or the received common law developed over the centuries by the public courts.

Contractual arbitration, described above, is distinct from "judicial arbitration" or "court annexed arbitration," as it is sometimes called. This ADR technique may be imposed by the court in certain cases, and proceeds like traditional arbitration, except that the parties have the option as to whether the award becomes binding. The arbitrator renders an award, which provides a benchmark for both sides to consider as they review possible settlement options, if it does not dispose of the case.⁶ Either of the parties may subsequently request the court to hold a hearing to decide the matter on both the facts of the case and the governing rule of law.⁷ Even if a binding arbitration contract called for judicial review of the arbitrator's decision, that clause would be invalid.⁸

California Code of Civil Procedure section 1286.2 provides the grounds on which a judge can vacate an arbitrator's decision. However, the standard for vacating an award is very difficult to meet. Even if an error of law has occurred and causes a substantial injustice, it generally is not subject to judicial review unless the plaintiff can find grounds in the statute. The practical effect of this standard has been that arbitrators' decisions are unlikely to be overturned, and they rarely are. Nor are there any statistics available, unlike public court cases, regarding such basic data.

How Contractual Arbitration Arises

Voluntary, Post-Dispute Agreements

Contractual obligations to arbitrate may arise before or after a dispute. Post-dispute voluntary arbitration is the traditional arbitration model. In these cases, both parties agree, after knowing the nature and extent of their conflict, to use arbitration as their dispute resolution mechanism. Historically, the parties had relatively equal bargaining power and desired to provide for an expedited process for resolving commercial disputes which arose out of or related to the implementation of their contractual agreement.

Pre-dispute Arbitration Imposed as a Condition of Receiving Goods, Services or Employment

However, in the past decade, businesses, employers, and parties of superior bargaining power have increasingly imposed pre-dispute binding arbitration provisions on consumers as a condition of providing goods, services or employment.⁹ The contract containing the mandatory pre-dispute arbitration clause usually has something other than arbitration as its main subject matter (*e.g.*, health care services). Such pre-dispute clauses are called "adhesion contracts" because the bargaining power of the contracting parties is highly unequal, and the party with lesser bargaining power is required to accept the entire contract on a take it or leave it basis (*i.e.*, he or she is not able or permitted to accept the majority of the contract but reject the required arbitration provision). Much more litigation about such contracts results, and courts scrutinize such contracts more closely. Involuntary arbitration in such contexts is generally referred to as "mandatory arbitration" or "imposed arbitration" in order to convey that one party did not have the degree of choice normally present.

The degree to which such an arbitration is "voluntarily selected," and the processes and procedures that govern whether the arbitration is "agreed to" by the parties is the subject of much debate. Parties may lack knowledge, or make mistakes, about the neutrality or expertise of the arbitrator, and consumers often have significantly less access to information about arbitrators and their decision records than the employer, health plan, or business they face in arbitration.

Mediation Defined

In contrast to arbitration, mediation is a voluntary process in which a neutral person facilitates communication and negotiations between the disputants to assist them in reaching a mutually acceptable agreement, or a better understanding of each participant's interests, needs, values, and options. Mediation is similar to voluntary forms of arbitration in that a neutral third party is involved and also in that an agreement between the parties may specify the circumstances under which mediation will occur.¹⁰

However, mediation is distinguishable from arbitration in several significant respects. Most important, in mediation the neutral third party has no authority to decide the dispute. The mediator's task, instead, is to assist the parties in reaching agreement on a negotiated resolution.

Second, participation in mediation is almost always voluntary. Mediation agreements are generally not specifically enforceable; even when made a part of a larger contract, agreements to mediate typically provide that mediation is a pre-condition to arbitration or litigation, as the case may be. Parties are generally not compelled by statute or a court to participate in mediation.¹¹

Third, while parties to arbitration are committed to the process until its conclusion in a decision, parties to mediation are not obligated to reach any agreement; any party generally may withdraw from the process at any time.

As mediation has developed as a more recognized and accepted way of resolving disputes, the field has become more diverse in the types of disputes addressed. Mediation is now commonly used for business and civil cases of all sorts, construction, employment, environmental, commercial, education, community, health care, family (including dependency, divorce, and custody disputes), as well as some criminal matters (in the form of victim-offender mediation).

THE CONTROVERSIAL USE OF MANDATORY ARBITRATION AGREEMENTS IN HEALTH CARE AND OTHER CONSUMER TRANSACTIONS

Voluntary arbitration, particularly where the parties have relatively equal bargaining power, has a long and distinguished history of success and is universally recognized as an appropriate and highly effective form of dispute resolution. However, the imposition of mandatory arbitration in consumer agreements is highly controversial. One reason for the controversy is that these arbitration clauses are typically imposed by the stronger corporate party as a condition of doing business before a dispute has even arisen, and therefore before the consumer is in a position to decide whether arbitration is in fact the best means of resolving the dispute.

Another important reason for the controversy rests with the fact that in arbitration, unlike civil litigation, there are no fixed rules governing the proceedings. As one court put it, "The American Arbitration Association [a large arbitration provider company] is in competition not only with other private arbitration services but with the courts in providing – in the case of the private services, selling – an attractive form of dispute settlement. It may set its standards as high or as low as it thinks its customers want."¹² Of course, this is fundamentally different than litigation where the rules are not for sale; all parties are subject to the same set of rules in every case. Not surprisingly, giving the stronger party in an adversarial proceeding the power to dictate that arbitration will be required, and which rules apply, allows for the potential that the party may seek to gain an advantage in the arbitration.

The arbitration rules affect every aspect of the proceeding. They determine the fees the parties must pay to the arbitrator and any arbitration provider organization that may administer the arbitration. The rules likewise determine how the fees will be allocated between the parties, when the fees must be paid, and whether the arbitration will go forward or whether a decision will be issued if any party has not paid the allocated fees. Perhaps more importantly, the rules dictate every other aspect of the proceeding, including, fundamentally:

- what types and how much discovery any party will be permitted
- whether there will be an in-person hearing
- whether the proceeding is subject to confidentiality
- whether summary disposition is allowed
- the scheduling and location of any hearing
- whether the arbitrator may sanction the parties
- whether the arbitrator will issue a written decision, and if so whether that decision will be admissible in evidence for the purpose of challenging the arbitrator's conduct/fairness

The *San Francisco Chronicle* recently ran a series entitled "Private Justice" that focuses on the private arbitration system and the growing arbitration industry in California. The series consisted of three articles. The first, entitled "Millions are losing their legal rights," focused on the inclusion of mandatory arbitration clauses in many consumer and employment contracts. The article raised concerns regarding the use of mandatory arbitration including, among other things, potentially high filing fees, limitations on class actions, and the lack of written opinions by arbitrators. The second article, titled "Can public count on fair arbitration?," discussed the nature of the relationship, particularly the financial relationship, between arbitration firms and their clients with a focus on the potential appearance of conflicts created by these relationships. Entitled "Judges' action cast shadow on court's integrity," the third article focused on concerns that the attraction of potentially lucrative jobs as private arbitrators once judges leave the bench may compromise the integrity of the courts.

HEALTH CARE DUE PROCESS PROTOCOL

In August 1997, leaders of the American Arbitration Association (AAA), American Bar Association (ABA), and American Medical Association (AMA) met in Chicago and determined to form a commission to study and make recommendations on the appropriate use of ADR in the private health plan/managed care environment. This first-time joint effort by the AAA, ABA and AMA underscored the need of providing the public with a fast, just and efficient means of having their healthcare disputes resolved outside of court litigation. The Commission "unanimously recommended that ADR can and should be used to resolve disputes over health care coverage and access arising out of the relationship between patients and private health plans and managed care organizations."¹³

In summary, the Commission established the following principles for the appropriate use of ADR:

- All parties are entitled to a fundamentally fair ADR process.
- Full and accurate information regarding the program should be provided in writing by the plan to patients and providers in plain, easily understood language. Disputes over exchanges of information should be resolved by an ADR professional.
- The agreement to use ADR should be voluntary and knowing. Consent to use an ADR process should not be requirement for receiving emergency care or treatment. In all disputes

involving patients, binding forms of dispute resolution [such as arbitration] should be used only where the parties agree to do so only after a dispute arises.

- All parties are entitled to a neutral dispute resolution professional who is independent and impartial. Administration of the ADR program should be neutral, and independent of the parties. In no event should the ADR program be administered by the health plan. The rules of administration should guarantee impartiality in selecting neutrals and require conformity with ethical standards of conduct. All parties should have an equal voice in the selection of neutrals in connection with a specific dispute. Neutrals should be required to disclose any circumstance likely to affect impartiality and be subject to disqualification if a party objects after this disclosure. This disclosure obligation and right to disqualification should continue throughout the period.
- All parties are entitled to competent, qualified neutrals. ADR administrators are responsible for establishing and maintaining standards for neutrals in ADR programs they administer. Neutrals serving in health care disputes should have knowledge and experience in health care matters. The creation of such a roster dictates the development of training program for the mediators and arbitrators involved.
- All parties participating in the process have the right at their own expense to be represented by an attorney or other spokesperson of their choosing. The ADR procedures should direct the parties to referral services for representation.
- Hearings and pre-hearings should be conducted with adequate notice and a fair opportunity to be heard. The place of the proceedings should be reasonably accessible to the parties. In cases involving a patient, the place should be in close proximity to the patient's residence. In arbitration, the arbitrator should carefully consider claims of privilege and confidentiality in addressing evidentiary issues.
- ADR proceedings should occur within a reasonable time and without undue delay.
- Arbitration awards should be in writing and should be accompanied by an opinion where requested by any party. The arbitrator should be empowered to grant whatever relief would be available in court. There should be limited judicial review.

CURRENT LAW RELATING TO ARBITRATION FOUND IN THE KNOX-KEENE ACT

In 1975, the California Code of Civil Procedure was amended to permit the contractual use of binding arbitration to resolve disputes of medical malpractice. (*CCP section 1295*). Currently there are several provisions of law relating to the use of arbitration in the health care setting. The bulk of these provisions is found in the Knox-Keene Act and relate to the use of arbitration by health care service plans (health plans) to settle disputes.

Disclosure Of Pre-Dispute Binding Arbitration Provisions

Health plans that use pre-dispute binding arbitration provisions in their contracts with enrollees are required to include a disclosure that satisfies specified requirements.¹⁴ The disclosure is required to clearly state whether the plan uses binding arbitration to settle disputes, and specifically whether the health plan uses binding arbitration to settle claims of medical malpractice. The disclosure is required to clearly state whether the subscriber or enrollee is waiving his or her right to a jury trial for medical malpractice, other disputes relating to the delivery of service under the plan, or both. The disclosure is also required to appear as a separate article in the agreement issued to the employer group or individual subscriber and to be prominently displayed on the enrollment form signed by each subscriber or enrollee. Finally, the disclosure is required to be displayed immediately before both the signature line provided for the representative of the group contracting with a health plan, and the signature line provided for the enrollee.

Providing For The Use Of A Single Neutral Arbitrator For Claims Under \$200,000

Any number of arbitrators may be used during an arbitration proceeding. Where more than one arbitrator is used, it is generally an odd number of arbitrators so that a decision can be made by a majority. In some cases a three-member (tripartite) arbitration panel is used. When a tripartite arbitration panel is used, each party picks its own party-appointed arbitrator, and the two party-appointed arbitrators choose a neutral third arbitrator.

Health plans that require parties to submit to binding arbitration are required to provide for selection by the parties of a single neutral arbitrator for those cases or disputes for which the total amount of damages claimed is \$200,000 or less.¹⁵ In these situations, the single neutral arbitrator is prohibited from awarding more than \$200,000. Parties to an arbitration agreement may agree in writing, after a case or dispute has arisen and a request for arbitration has been submitted, to use a tripartite arbitration panel, or another multiple arbitrator system agreeable to the parties. If the parties agree to waive the requirement to use a single neutral arbitrator, the enrollee or subscriber is required to have three business days to rescind the agreement .

If the parties are unable to agree on the selection of a neutral arbitrator, and the health plan does not use a professional dispute resolution organization independent of the plan that has a procedure for a rapid selection or default appointment of a neutral arbitrator, then the parties may use a method prescribed in current law that permits parties to petition a court to select the arbitrator.¹⁶

Provisions of Law Relating to Preventing Undue Delays In The Arbitration Process

Health plans that use arbitration to settle disputes with enrollees or subscribers, and who do not use a professional dispute resolution organization independent of the plan that has a procedure for a rapid selection, or default appointment of neutral arbitrators are subject to specified requirements.¹⁷ These requirements are intended to prevent undue delays in the arbitration process and are not subject to waiver.

In situations where either the use of a single neutral arbitrator or a tripartite arbitration panel is required, and the parties are unable to select a neutral arbitrator within 30 days after service of a written demand requesting the designation, then there is a conclusive presumption that the agreed method of selection has failed. If the method of selection has failed the parties are then permitted to use a method of selection prescribed in current law that permits parties to petition a court to select the arbitrator.¹⁸

In that method, the court is required to nominate five persons from a list of individuals supplied jointly by the parties or obtained from a governmental agency concerned with arbitration or private disinterested association concerned with arbitration. The parties may within five days of receipt of notice of the nominees from the court jointly select the arbitrator whether or not the arbitrator is among the nominees. If the parties fail to select an arbitrator within five days, then the court is required to appoint the arbitrator from the pool of nominees.

When the parties petition the court to select the arbitrator, the court may award reasonable costs, including attorney fees incurred in connection with the filing of the petition, if the court finds that a party has engaged in dilatory conduct intended to cause delay in the arbitration process.

Provisions Relating To Extreme Hardship Cases

A health plan that uses arbitration to settle disputes with enrollees or subscribers is subject to specified requirements with respect to extreme hardship cases.¹⁹ The health plan contract is required to contain a provision for the assumption of all or a portion of an enrollee's or subscriber's share of the fees and expenses of the neutral arbitrator in cases of extreme hardship. The health plan is required to disclose this requirement to subscribers in its evidence of coverage.

The health plan is also required to provide enrollees with an application for relief due to extreme hardship, or information on how to obtain an application from the professional dispute resolution organization that will administer the arbitration process, upon the request of an enrollee. If the health plan uses a professional dispute resolution organization independent of the plan, then that dispute resolution organization is required to provide for the assumption of the arbitration fees in cases of extreme hardship.

Approval or denial of the application for relief due to extreme hardship is required to be determined by either a professional dispute resolution organization independent of the plan if the plan uses a professional dispute resolution organization, or a neutral arbitrator who is not assigned to hear the underlying dispute and whose fees and expenses are paid for by the plan.

Provisions Requiring A Written Decision To Be Sent To The Parties And The Department Of Managed Health Care

Health plans that use arbitration to settle disputes with enrollees or subscribers, are required to have the arbitration award be accompanied by a written decision to the parties that indicates the prevailing party, the amount of any award and other relevant terms of the award, and the reasons for the award rendered.²⁰

A copy of the written decision is required to be provided to DMHC on a quarterly basis. The copy of the decision includes information relating to the amount of the award and other relevant terms of the award, the reasons for the award rendered, and the name of the arbitrator or arbitrators. The copies provided to DMHC exclude the names of the enrollee, the health plan, witnesses, attorneys, providers, health plan employees, and health facilities. DMHC is required to make these modified copies of the written decision available to the public upon request. DMHC is prohibited, however, from releasing information identifying a person or entity whose name has been or should have been removed from the arbitration decision.

CURRENT LAW RELATING TO ARBITRATION AND LONG-TERM HEALTH CARE FACILITIES

There are also provisions of law relating to the use of binding arbitration clauses and long-term health care facilities.

Provisions Of Law Relating To Admission Contracts For Long-Term Health Care Facilities

There are specified requirements for arbitration clauses found in admission contracts for long-term health care facilities.²¹ All contracts of admission for long-term health care facilities that contain an arbitration clause are required to clearly indicate that agreement to arbitration is not a precondition for medical treatment or for admission to the facility.

The arbitration clauses are also required to be included on a form separate from the rest of the admission contract. This attachment is required to contain space for the signature of any applicant who agrees to arbitrate their disputes. On these attachments, clauses referring to arbitration of medical malpractice claims, are required to be clearly separated from other arbitration clauses, and separate signatures are required for each clause. The contract attachment pertaining to arbitration is also required to contain a notice that the patient may not waive his or her ability to sue for violation of the Patient's Bill of Rights.

Provisions Relating To The Use Of Arbitration By Licensees Of Long-Term Health Care Facilities In Contesting Citations

Licensees of long-term health care facilities (licensees) are subject to specified citations by the Department of Health Services (DHS).²² The citations are classified as "AA", "A", and "B". Class "AA" violations are violations that DHS determines to have been a direct proximate cause of death of a patient or resident of a long-term health care facility. Class "AA" citations may range from \$5,000 to \$25,000. Class "A" violations are violations which DHS determines presents either imminent danger or substantial probability that death or serious harm to the patients or residents of the long-term health care facility would result therefrom. Class "A" citations range from \$1,000 to \$10,000. Class "B" violations are violations that DHS determines have a direct or immediate relationship to the health, safety, or security of long-term health care facility patients or residents, other than class "AA" or "A" violations. Class "B" citations range from \$100 to \$1,000.

A licensee is permitted to contest a class "B" citation by submitting the matter through binding arbitration.²³ A licensee may choose to have his or her appeal heard by an administrative law judge or submit the matter to binding arbitration without having first appealed the decision to a citation review conference. A licensee may also request that the citation be reviewed by an administrative law judge through a citation review conference. If the administrative law judge upholds the class "B" citation and the licensee wishes to appeal the decision, the licensee has the option of submitting the matter to binding arbitration.

PROPOSED REGULATIONS BY THE DEPARTMENT OF MANAGED HEALTH CARE RELATING TO THE REPORTING OF ARBITRATION DECISIONS BY HEALTH PLANS

The Department of Managed Health Care (DMHC) has proposed Title 28, section 1300.73.21, relating to the reporting of arbitration decisions by health plans. The public comment period for these regulations ended on February 11, 2002, and the regulations and comments relating to the regulations are currently under review by DMHC. Generally the regulations: 1) require health plans to submit a copy of a complete arbitration decision to DMHC within 30 days of receiving a written arbitration decision; 2) require health plans to provide DMHC with redacted copies of all written arbitration decisions on a quarterly basis for public disclosure purposes; and 3) require written arbitration decisions and written settlement agreements resolving disputes between a plan and an enrollee to contain a disclosure stating that nothing in the arbitration decision or settlement agreement restricts the enrollee from discussing the underlying facts or results of the case with DMHC.

DMHC Has Proposed The Following Language For Title 28 Section 1300.73.21:

- (a) "All health care service plans (plans) shall ensure that all arbitrations involving the plan and a current or former enrollee shall be provided to the Department as follows:
 - (1) Within thirty (30) days of receiving a written arbitration decision, the plan shall provide a copy of the complete arbitration decision to the Department. The complete arbitration decision shall have no part of the decision altered or redacted. The complete arbitration decision shall indicate the prevailing party, the amount and other relevant terms of any award, and the reasons for the decision.
 - (2) On a quarterly basis, plans shall provide the Department with redacted copies of all written arbitration decisions. The plan shall be responsible for redacting the written arbitration decisions ensuring that the names of the enrollee, the plan, witnesses, attorneys, providers, plan employees and health facilities have been removed from the decision. The redacted arbitration decisions will be

available for public inspection on the Department's web page (www.dmhc.ca.gov).

- (b) Every written arbitration decision, and every written settlement agreement resolving any dispute between a plan and a current or former enrollee shall contain the following language in bold, twelve (12) point type: Nothing in this arbitration decision (or settlement agreement) prohibits or restricts the enrollee from discussing or reporting the underlying facts, results, terms and conditions of this decision (or settlement agreement) to the Department of Managed Health Care.
- (c) All health care service contracts containing an arbitration clause; all arbitration agreements and decisions; and all settlement agreements resolving any dispute between a plan and a current or former enrollee, shall contain no language that expressly or impliedly prohibits the enrollee from discussing or reporting the underlying facts, outcome, results or decision with the Department.
- (d) For purposes of this section, a "settlement agreement" shall be broadly construed to include any writing resolving a dispute, including but not limited to, a grievance, mediation, arbitration, or other alternative dispute resolution process, or any civil lawsuit between a plan and a current or former enrollee.

DMHC's Description and Rationale for Proposed Regulations

According to DMHC, in early 2001, consumer groups petitioned the director calling for full public reporting and disclosure of all documents and discovery in health plan arbitrations. The director agreed, in part, that the failure of health plans to report even basic information about their arbitrations demonstrates the need to promulgate a regulation in this area. According to the director, quality-of-care violations are hidden from public view because no public records exist of health plan arbitrations. Alternatively, the privacy right of a party to a health care dispute resolution as codified in the confidentiality of medical information act, and the information practices act of 1977, is an equal consideration. Confidentiality provisions routinely included in settlement documents preclude parties from discussing the facts of the dispute with DMHC impeding DMHC's statutory responsibilities.

DMHC argues that the proposed Title 28, section 1300.73.21 effectuates a simple and specific procedure plans must use to comply with current law which requires health plans to submit to DMHC modified written arbitration decisions (where identifying information is removed) to the DMHC. The regulation provides that plans must submit to DMHC all complete, unredacted arbitration decisions within 30 days after receipt by the plan. Moreover, every quarter, the plans must submit to DMHC redacted copies of all written arbitration decisions. These redacted copies ensure that no identifying information – of the enrollee, subscriber, plan, witnesses, attorney, providers, or health plan employees – is disclosed. The regulation alerts plans that

these quarterly, redacted arbitration decisions will be published on DMHC's website (www.dmhc.ca.gov).

According to DMHC, the proposed regulations will preclude all writings resolving disputes from containing language expressly or impliedly prohibiting the enrollee from disclosing the facts, outcome, results or decision with DMHC. The proposed regulation also mandates a broad definition of "settlement agreement," which includes any writing resolving a dispute including, but not limited to, a grievance, mediation, arbitration, civil lawsuit or other alternative dispute resolution process.

Public Comments Regarding DMHC's Proposed Regulation

California Pan-Ethnic Health Network, the Center for Health Care Rights, Consumers Union, Health Access, the Latino Issues Forum, and the Western Center on Law and Poverty all state that they support the proposed regulation, but argue that DMHC should collect demographic information such as race, gender, age, primary language spoken, and zip code of all enrollees with disputes resolved by arbitration. By analyzing this demographic information, and allowing public scrutiny of it, DMHC and advocates will be able to determine whether plans have a pattern or practice of disparate treatment of certain groups, such as seniors, women, low-income people, people of color, or residents of certain communities.

Eyexam of California, Inc. (Eyexam) states that it is primarily concerned with the proposed definition of the term "settlement agreement" which includes grievances. Generally health plans are required to maintain an internal grievance system where enrollees are permitted to submit grievances to the plan. Eyexam states that the word grievance is a term of art under the Knox-Keene Act, and the grievance system is already extensively regulated. Inclusion of the term grievance within the definition of settlement agreement appears contrary to DMHC's expressed intent of providing public access to the outcome of arbitrations, mediations, or other formal proceedings between a plan and an enrollee since the internal grievance process is generally not considered a formal proceeding. Eyexam therefore has requested that the term grievance be removed from the definition of settlement agreement.

SCAN Health Plan (SCAN) argues that the proposed language requiring health plans to submit to DMHC all complete, unredacted arbitration decisions within 30 days is an unwarranted invasion of privacy, breach of confidentiality, and is burdensome and oppressive to the health plans. SCAN adds that the quarterly reporting requirement of the proposed regulation is also unnecessarily burdensome and oppressive since sufficient reporting to DMHC is already required.

The California Association of Health Plans (CAHP) states that of paramount concern to the health plans is the issue of whether the proposed regulations go beyond the statutory authority of the DMHC granted pursuant to Health and Safety Code section 1373.21, by including settlement agreements within the proposed regulations. Subdivision (a) of the proposed regulations require that plans ensure that "all arbitrations" are provided to DMHC. CAHP argues that the phrase "all arbitrations" is vague and inconsistent with Health and Safety Code Section 1373.21 which refers to "written decisions" that accompany arbitration awards. The proposed regulation should

apply only to *final* written decisions that accompany an award disposing of an arbitration proceeding, and not to intermediate decisions such as rulings or preliminary determinations that may occur throughout the course of an arbitration.

CAHP also argues that the requirement that an unedited copy of each and every arbitration decision be routinely sent to DMHC within 30 days of receipt raises privacy concerns that do not exist with the current occasional case-specific reviews by DMHC of a complete arbitration decision. Health plan enrollees may not want to have routinely disclosed to state employees complete arbitration decisions, which include their identities and personal information, including medical information, even with a promise of confidential treatment.

CAHP adds that the proposed requirements that settlement agreements include language prohibiting their confidential treatment would undo longstanding policy respecting the privacy of such documents and would unnecessarily infringe on the public interest in encouraging settlement of legal disputes. While DMHC has the authority to investigate and take action with regard to disputes between plans and their enrollees, in the context of private settlement documents, any request for disclosure must be supported by a compelling interest, and the request must seek the minimum disclosure necessary to achieve the requestor's objective. By requiring that no settlement agreement be held confidential from DMHC, the proposed regulations permit *carte blanche* disclosure of settlement agreements and terms without requiring a demonstration of a compelling interest in disclosure, or that the disclosure sought is the minimum necessary to achieve DMHC's objective.

HISTORY OF KAISER'S MANDATORY ARBITRATION SYSTEM

The Engalla Decision

In *Engalla et al. v. Kaiser Permanente Medical Group, Inc.*, 15 Cal. 4th 951 (1997) the Supreme Court held that a court may deny a request by an HMO to compel a patient to undergo arbitration when it finds the HMO engaged in fraud when forcing the patient to agree to mandatory arbitration at the time of enrollment and then delaying the arbitration for its own benefit.

In *Engalla*, the Court found that Kaiser misleadingly portrayed its arbitration system as fair and efficient, when in fact it manipulated the arbitration process for its own benefit. Prior to *Engalla*, the arbitration program in question was designed, written, mandated and administered by Kaiser. The fact that Kaiser administered its arbitration program from an adversarial perspective was not disclosed to Kaiser members or subscribers. The timelines specified that each side under the Kaiser arbitration program selects a party arbitrator within 30 days of the claim, and that the two party arbitrators selected shall then designate a third, neutral arbitrator within 30 days thereafter. Kaiser represented in various promotional materials that hearings under its arbitration programs occur “within several months time,” and that its members “would find the arbitration process to be a fair approach to protecting their rights.”

Statistical data noted by the Court showed that delays occurred in 99 percent of all Kaiser medical malpractice arbitrations. In only 1 percent of the cases was a neutral arbitrator selected within the 60 days. Prior to the court case, only 3 percent of cases saw a neutral arbitrator

appointed within 180 days. On average, it took 674 days for the appointment of a neutral arbitrator. And, on average, it took almost 2 and ½ years to reach a hearing in a Kaiser arbitration. Finally, the Court noted, depositions of former Kaiser in-house counsel revealed that Kaiser had long been aware of these widespread delays prior to the Court's decision in *Engalla*.

Kaiser's Mandatory Arbitration System Post-Engalla

After the *Engalla* decision, Kaiser convened a "Blue Ribbon Panel" to study its arbitration system and recommend improvements. Kaiser continues to require that its patients submit all disputes to arbitration. However, in response to the court's criticism in *Engalla*, regarding Kaiser's self-administration of the system, Kaiser now pays the law firm of Sharon Lybeck Hartmann to operate its system under the name "Office of the Independent Administrator." Indeed, during 2000 Kaiser altered all of its contracts with members to make the use of its own arbitration system mandatory. Thus, Kaiser enrollees who do not wish to participate in Kaiser's self-funded arbitration system may no longer receive Kaiser services. As of December 31, 2001, Kaiser had forwarded 2968 demands for arbitration, approximately 90 demands per month. In the past the Kaiser arbitration administrator has reported that virtually all of these cases involved medical malpractice disputes.

Kaiser mandatory arbitration system has been substantially revised since *Engalla*. As result, Kaiser's system now averages just 44 days to selection of a neutral arbitrator in all cases, and just 24 days when the parties do not seek postponement or disqualify a proposed arbitrator, according to a draft copy of the administrator's third annual report. Ironically, critics have begun to ask whether the system is now emphasizing speed above all else.

Which Health Care Plans Arbitrate?

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, under the Kaiser plan, all components are controlled by the plan. 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.

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 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.

Committee staff has been unable to obtain reliable current data regarding which plans require arbitration. It is believed that many plans required arbitration of some types of claims, although few require arbitration of medical malpractice disputes. It appears that, other than Kaiser, only a handful of plans covering a relatively miniscule number of enrollees (approximately 200,000 non-Kaiser enrollees compared to approximately 6,000,000 Kaiser enrollees) required arbitration

of medical practice claims. Because most Kaiser arbitrations involved medical malpractice disputes, it is reasonable to suppose that the same is true for other plans. Therefore, there may be relatively few non-Kaiser arbitrations involving managed care patients.

DISCUSSION QUESTIONS

What is arbitration?

How does it differ from litigation?

How does arbitration differ from other forms of ADR?

Which health plans require arbitration and which types of disputes are subject to mandatory arbitration?

What has been the mandatory arbitration experience of the participants? Does it vary by plans or type of claim? Does it vary by arbitrator or the private arbitration company that administers the arbitration?

Other than arbitration, are there other ways in which health plans have dealt with patient disputes? If so, how are these alternatives working?

What data have been collected regarding health care arbitrations?

Who oversees the operation of health care arbitrations?

What is the role of the DMHC in health plan arbitration?

Does the available data satisfy us that health care arbitrations are working satisfactorily? If not, what additional information would be needed to reach a conclusion?

¹Helpful descriptions of these processes may be found in *Dispute Resolution: Negotiation, Mediation, and Other Processes*, by Stephen B. Goldberg, Frank E.A. Sander, and Nancy H. Rogers (3rd ed. 1999).

²Much has been written about ADR in general and as applied in particular settings. Perhaps the most comprehensive description of the range of ADR techniques and their application in California was prepared by the Judicial Council's ADR Task Force in 1999, which will be an excellent source of information for the Committee.

³For additional background, see chapters specifically relating to arbitration contained in the following references, which are updated annually: *California ADR Practice Guide*, edited by Yaroslav Sochynsky, J. Lani Bader, and Francis O. Spalding (Lexis Law Publishing 2000); and *Alternative Dispute Resolution Practice Guide*, edited by Bette J. Roth, Randall W. Wulff, and Charles A. Cooper (West Group 2000).

⁴The degree to which decisions to arbitrate, and the procedures under which the arbitration shall be conducted, are "voluntary," and the subject of "agreement" by parties has been the subject of much controversy.

⁵*Moncharsh v. Heily & Blasé et al*, 3 Cal.4th 1 (1992).

⁶See California Code of Civil Procedure, §§ 1141.10 et seq.

⁷Code of Civil Procedure § 1141.20.

⁸*Crowell v. Downey Community Hospital Foundation*, 95 Cal.App.4th 730 (2001).

⁹As used in this paper, "consumer" includes both individuals who seek to purchase goods or services for personal purposes, as well as employees.

¹⁰For additional background on mediation, see Nancy H. Rogers, Craig A. McEwen, & Sarah R. Cole, *Mediation: Law, Policy, and Practice* (West Group 2000); Christopher W. Moore, *The Mediation Process: Practical Strategies for Resolving Conflict* (Jossey-Bass, 2nd ed. 1996); Deborah M. Kolb and associates, *When Talk Works: Profiles of*

Mediators (Jossey-Bass 1994); and Jay Folberg & Alison Taylor, *Mediation: A Comprehensive Guide to Resolving Conflicts Without Litigation* (Jossey-Bass 1984).

¹¹ For an exception, see the Civil Action Mediation Act (California Code of Civil Procedure, §§ 1775 et seq), which established a five-year experiment with mandatory mediation as an optional alternative to judicial arbitration for Los Angeles County and other counties which opt to join the program. California currently has a pilot program operating in five counties, to test different mediation program approaches. See California Code of Civil Procedure § 1730 (Chap 61 of Statutes of 1999, AB 1105, as amended by Chap 127 of Statutes of 2000, AB 2866).

¹² *Merit Ins. Co. v. Leatherby Ins. Co.*, 714 F.2d 673, 681 (7th Cir.), *cert. denied*, 464 U.S. 1009, 78 L. Ed. 2d 711, 104 S. Ct. 529 (1983).

¹³ *A Due Process Protocol for Mediation and Arbitration of Health Care Disputes*, Final Report of the Commission on Health Care Dispute Resolution, July 27 1998. The Commission did not study or endorse the use of ADR for medical malpractice disputes.

¹⁴ Health and Safety Code Section 1363.1

¹⁵ Health and Safety Code Section 1373.19

¹⁶ See Code of Civil Procedure Section 1281.6

¹⁷ Health and Safety Code Section 1373.20

¹⁸ See Code of Civil Procedure Section 1281.6

¹⁹ Health and Safety Code Section 1373.20 (c)

²⁰ Health and Safety Code Section 1373.21

²¹ Health and Safety Code Section 1599.81

²² Health and Safety Code Section 1424

²³ Health and Safety Code Section 1428