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Emerging Issues in the
Use of Binding Arbitration
to Resolve Disputes between
Individuals and Health Plans

Overview—After briefly describing the federal legal framework that has fostered the growth of binding arbitration, this paper identifies controversies that have developed over arbitration as well as arguments supporting and opposing its use. In attempting to gauge the prevalence of the use of arbitration to resolve disputes between health plans and individuals, the paper then describes its use among certain types of collectively bargained employee health plans regulated under the Employee Retirement Income Security Act of 1974 (ERISA), by health maintenance organizations (HMOs) in California, and by a large employer operating a self-insured ERISA health plan. Next, the paper examines evidence cited by the California Supreme Court that the largest HMO in California operated its mandatory arbitration program in an unfair way. The HMO's subsequent efforts to identify problems with its arbitration program and correct them are presented. Proposals introduced in the California legislature to further regulate arbitration or to ban predispute arbitration agreements with health plans are described as well as their possible preemption by federal law. The paper presents a protocol developed by leading associations involved in alternative dispute resolution, law, and medicine recommending that binding forms of arbitration involving disputes between individuals and private health plans should be used only after disputes arise. After describing the treatment of arbitration by proposed laws and regulations currently under consideration by Congress and the U.S. Department of Labor (DOL) for employee health plans, the paper concludes by raising some of the issues that arbitration presents for federal policymakers.

As Congress considers bolstering the administrative and legal remedies available to private-sector employee health plan participants for resolving coverage disputes, the attractiveness of alternatives to litigation may grow. Employers and unions sponsoring health plans as well as managed care organizations (MCOs) already use alternative dispute resolution (ADR) methods such as mediation and binding arbitration in a variety of contexts. These methods of resolving disputes might take on new gloss if health plan sponsors, administrators, and medical providers faced increased risk of lawsuits and damage awards. Although ADR methods are often touted as a more efficient means of coming to settlement than going to court, they raise several policy issues, particularly concerning the use of binding arbitration to resolve disputes between patients and group health plans, insurance companies, and managed care organizations. The issues are perhaps thorniest in

instances where employers and/or unions arranging group health coverage sign binding arbitration agreements waiving an individual's right to statutory remedies that otherwise would be available should a dispute arise. Binding arbitration is currently used to resolve disputes, including those over coverage issues involving participants in health plans governed by ERISA,¹ the plans themselves, and MCOs contracting with them. Some critics question whether pre-dispute binding arbitration agreements should ever be allowed between individuals and health plans while others argue that, where arbitration is allowed, it should be more heavily regulated and monitored.

Generally speaking, federal law allows parties to waive their rights to go to court to resolve disputes arising from a contract and instead to use alternative means, including binding arbitration, which in essence is a privately administered justice system whose rulings are enforceable in the courts. Arbitration is an adversarial process that can take many forms. It can be binding or nonbinding. Arbitration agreements can be made either before or after a dispute arises. As noted above, arbitration is one of several types of ADR methods that in some instances may be a more efficient way of resolving disputes than going to court. Another prominent form of ADR is mediation. Mediation is fundamentally different from arbitration. It is a voluntary process in which a neutral party facilitates the negotiation of an agreement by the disputing parties themselves. Arbitrators, in contrast, make rulings, often without a written rationale.

THE REACH OF THE FEDERAL ARBITRATION ACT

Federal law has created an increasingly friendly environment for arbitration agreements and, in recent years, has helped to fuel controversy over misuses of arbitration. In a 1991 ruling, Supreme Court Justice Byron R. White declared that the Federal Arbitration Act (FAA), originally enacted by Congress in 1925, was intended "to reverse the longstanding judicial hostility to arbitration agreements that had existed at English common law and had been adopted by American courts, and to place arbitration agreements upon the same footing as other contracts."² Furthermore, he said, the FAA's provisions manifest a "liberal federal policy favoring arbitration agreements." When the FAA was enacted, arbitration was used primarily in commercial settings to resolve disputes between businesspeople with similar bargaining power. Over the years, the use of arbitration has expanded dramatically, in part because of

the Supreme Court's expansive interpretation of both the FAA's scope and its preemption of state law. According to one legal analyst:

Arbitration today . . . is not limited to the commercial context. Indeed, provisions providing for the arbitration of disputes can be found in a variety of contracts, many of which are adhesion contracts.³ Predispute arbitration clauses can be found in contracts between investors and broker-dealers, employment contracts, franchise agreements, health care contracts, and in a whole array of other consumer contracts. . . . Arbitration provisions have been upheld in cases involving breach of contract claims to cases involving violation of statutory rights, including rights based on federal securities laws, antitrust laws, and antidiscrimination laws.⁴

The growth of arbitration agreements and their deployment in contracts formed by parties with unequal bargaining power or information have arguably increased suspicion and resistance to the use of arbitration.

The broad scope of the FAA, combined with the Supreme Court's interpretation of its preemption of state law, has greatly restricted the ability of states to regulate arbitration agreements and has led to increasing frustration among state courts and legislatures seeking to protect citizens from uses of arbitration they perceive to be unfair or abusive.⁵ In *Doctor's Associates, Inc., v. Casarotto*,⁶ the Supreme Court in 1996 ruled that state laws that singled out arbitration agreements in order to limit their validity were preempted by federal law and that, in order to avoid preemption, a state law would have to limit or regulate contracts generally and not specify arbitration agreements. Reversing a decision by the Montana Supreme Court, the Court held that a Montana law mandating conspicuous notice of a predispute arbitration clause in a contract was preempted by the FAA. State contract law governs the question of whether a particular arbitration provision is valid and state courts may apply generally applicable contract laws to find an arbitration agreement to be invalid, such as on the grounds on unconscionability.⁷ To determine whether a contract is unconscionable, courts examine whether contract provisions favor the drafter and whether a weaker party has any meaningful choice in accepting the terms, as well as factors such as unequal bargaining power, oppression, exploitation, or lack of sophistication.

Almost all states have enacted laws that are generally favorable to arbitration and many of these are modeled after the Uniform Arbitration Act, which was developed in the 1950s.⁸ Notwithstanding the Supreme Court's 1996 dictum on preemption of statutes limiting arbitration, many states also have laws on the books that limit the use

of arbitration and at least two regulate binding arbitration through statute⁹ (see Table 1 on page 4).

While the FAA has facilitated the use of arbitration in a wide variety of settings and for many types of issues, in recent years the reach of the law has been challenged on several fronts. One area of contention is whether the FAA can be used to compel arbitration of claims brought under other federal statutes, such as antidiscrimination laws. Some have argued that the FAA was intended to apply primarily to arbitration agreements made in commercial contracts and that arbitration should not be used to substitute for statutory procedural rights. In 1991, however, the U.S. Supreme Court ruled that claims brought under a federal statute (in this instance a claim under the Age Discrimination in Employment Act of 1967) may be the subject of an arbitration agreement and enforceable pursuant to the FAA.¹⁰ In this case (*Gilmer v. Interstate/Johnson Lane Corp.*), as a condition of employment, Robert Gilmer had to register as a securities representative with several stock exchanges, including the New York Stock Exchange. In order to get the job, Gilmer had to sign an agreement that any dispute arising between him and his employer would be required to be arbitrated under the "rules, constitutions, or by-laws" of the organizations with which he had to register. After Interstate terminated his employment when he reached 62 years of age, Gilmer sought to pursue an age discrimination claim in court. Interstate filed a motion to compel arbitration of the discrimination claim.

Four federal circuit courts have held that Congress did not intend to prohibit arbitration of statutory claims arising under ERISA.¹¹ Earlier this year, for example, the U.S. Court of Appeals for the Tenth Circuit upheld the arbitrability of claims that trustees of a corporate profit-sharing plan had breached their fiduciary duties under ERISA by purposefully undervaluing the price at which plan participants' stock was sold.¹²

Another important area of controversy is whether the FAA applies to employment or labor contracts at all. The Supreme Court has agreed to review a decision by U.S. Court of Appeals for the Ninth Circuit (*Circuit City Stores v. Adams*)¹³ that the FAA does not apply to labor or employment contracts. If it agrees with the ninth circuit court decision, the Supreme Court could dramatically constrict the use of arbitration in the employment and labor field. In *Circuit City*, the ninth circuit court, which covers the far western states, reiterated its recent conclusion in *Craft v. Campbell Soup Co.*¹⁴ In that case, a Campbell Soup employee named Anthony Craft was a member of the Food Process Workers and Warehousemen and Helpers Union. The collective bargaining

Table 1
State Statutes Limiting Use of Arbitration

Statutory Provisions	States
Prohibit use of binding arbitration for malpractice	South Dakota, South Carolina
Exclude personal injury and tort actions from general arbitration statutes	Arkansas, Iowa, Kansas, Montana, Nebraska, South Carolina, Texas
Exclude contracts of adhesion from general arbitration statutes	Iowa, Missouri, Nebraska
Exclude contracts of insurance from general arbitration statutes	Arkansas, Iowa, Kansas, Kentucky, Missouri, Montana, Nebraska, Oklahoma, South Carolina, Texas, Vermont
Regulate binding arbitration through statute	Illinois, Michigan

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

agreement (CBA) between the company and the union included a nondiscrimination clause providing that “disputes under this provision shall be subject to the grievance and arbitration procedure” provided in the CBA. Craft filed a grievance alleging racial discrimination, harassment, health and safety concerns, and other claims. The grievance was not resolved in the initial stages and the union referred it to arbitration. While the grievance was still pending, Craft took his case to court. The ninth circuit court reexamined the employment exclusion clause in FAA, which other courts have found to allow the arbitration of employment contracts, along with the act’s legislative history, and concurred with the dissenting opinion in *Gilmer* that the FAA does not apply to labor and employment contracts. According to the ninth circuit court, the legislative history of the act indicates that

the FAA was part of an effort to gain uniformity in the application of agreements to arbitrate sales and commercial transactions. The FAA was never intended to apply to labor contracts of any sort. Labor contracts were seen as having the potential to elicit the forced agreement to arbitrate that the enactors of the FAA so disliked.

The Supreme Court also has agreed to review a ruling by the U.S. Court of Appeals for the 11th Circuit that steep filing fees, arbitrators’ costs, and other arbitration expenses may render an arbitration agreement unenforceable if they curtail a person’s access to an arbitral forum serving as an alternative to a judicial forum available to vindicate statutory rights.¹⁵ In this case, *Randolph v. Green Tree*, a woman who had bought a mobile home sought to sue the financing company on grounds that it had violated the federal Truth in Lending Act by failing to disclose that she had to pay for an insurance policy to cover any repossession expenses.¹⁶ She wanted to sue the

company as part of a class-action suit but the mandatory arbitration clause prevented her from doing so. The 11th circuit court concluded that the arbitration clause was unenforceable because it failed to provide minimum guarantees that she could access her rights under the act.

GENERAL CONCERN ABOUT ARBITRATION

In recent years, the use of binding arbitration has come under fire in several fields, including health care, employment, and financial services. On March 1, 2000, for example, the U.S. Senate Committee on the Judiciary’s Subcommittee on Administrative Oversight and the Courts held a hearing that probed the fairness of the growing number of contracts requiring employees, businesses, and consumers to give up their rights to sue and submit all future claims to arbitration. While subcommittee chairman Charles E. Grassley (R-Iowa) has said that he supports arbitration as a way of unclogging an overburdened court system, he also wants to make sure consumer interests are protected and that arbitration hearings are being conducted in a fair way.¹⁷ Legislation has been introduced in the House that would ban mandatory arbitration provisions in consumer contracts.

While many financial services providers argue that arbitration helps consumers by giving them speedy resolution and greater access to dispute resolution than going to court, critics charge that many arbitration programs are tilted in one direction. For example, data disclosed recently in a class-action lawsuit against First USA N.A., the nation’s second-largest issuer of credit cards, show that the company won 99.6 percent of the cases that went all the way to the arbitrator.

Merits Debated

In general, supporters of arbitration argue that a properly administered program may give consumers greater access and speedier results than the often-overburdened court system. Others dispute this and point out that in many instances arbitration programs are unfairly tilted toward the party with the most power—for example, the employer in some employment cases or the employer, union, or MCO in health coverage or medical malpractice disputes. Opponents of arbitration note that firms that supply neutral arbitrators and the arbitrators themselves are more likely to develop ties to large organizations that use and pay for their services on a regular basis than to individuals who will use their services rarely, if ever. There is evidence that some arbitration programs have been patently unfair to consumers and—through fraud, procedural impediments, or high costs—may bar their access to resolving disputes. Other criticisms of arbitration include that individuals lose appeal rights and, therefore, the ability to correct mistaken decisions¹⁸ and that there is typically no public record or precedential value of an arbitrator's ruling. Supporters of arbitration might argue that the confidentiality of the arbitration process is an asset. According to one commentator, ADR for managed health care is particularly appropriate in situations requiring unique, confidential, and non-precedential decisions.¹⁹

In part because there generally is no record of arbitrators' decisions, little systematic research has been conducted on the effects of arbitration, including whether arbitrators' decisions are skewed in a particular way. Little is known, too, about whether the types of cases that go to arbitration differ in important ways from cases that go to court. In a structural sense, arbitration is dependent on the judicial system; arbitrators must reference court rulings in order to make decisions and set award amounts. Arguably, if arbitration became the norm and not the exception, the ability of the law to evolve through judicial interpretation might become impaired.

USE OF ARBITRATION BY HEALTH PLANS

While there is no definitive research on how widely binding arbitration and other forms of ADR are used to resolve health-care-related disputes involving patients and health plan participants, there is evidence that its use has grown robustly in some areas of the country. For example, it is used by many MCOs in California. Kaiser Permanente, the state's largest HMO, includes binding arbitration agreements in both its individual and group contracts

and uses arbitration primarily to resolve medical malpractice claims. In part because of increasing numbers of disputes over provider payment and health plan coverage issues, providers of ADR services have begun recruiting and training more health professionals. In addition, as described in more detail below, binding arbitration is widely used in resolving disputes over collectively bargained employee benefits. It also is used by some large employers to resolve employment and benefit disputes.

California HMOs

California has been a particularly fertile ground for the use of binding arbitration by managed care organizations. A recent study by researchers at RAND found that most of the state's HMOs incorporated arbitration agreements in contracts with purchasers and enrollees (but preferred provider organizations did not).²⁰ Most of the HMOs designed the agreements to apply only to contract disputes and not to medical liability claims. Despite this, the number of health coverage disputes going to arbitration appears to be extremely small and those disputes that are arbitrated are almost exclusively medical malpractice cases. Of the 20 California HMOs that reported using the agreements with enrollees, 8 (Kaiser Permanente, CIGNA, and 6 very small plans) applied them to both contractual and medical malpractice disputes. The RAND study also found that about 9 percent of hospitals (responsible for about 20 percent of statewide hospital admissions) and 9 percent of physicians surveyed used binding arbitration agreements.

Although most HMO contracts included binding arbitration agreements, they are generally not invoked to resolve coverage disputes because federal laws regulating private-sector employee benefits and overseeing Medicare have eliminated the threat of costly litigation as an alternative. Medicare has established a mandatory appeals process for coverage denials by HMOs. ERISA, which governs most private-sector employee health plans, permits plan participants to seek recovery of denied benefits in a federal court but bars them from suing under state laws for injuries or wrongful death resulting from denials of coverage. Plan participants often find it difficult to appeal coverage denials and very few cases go to court.

MCOs might be more prone to exercise the binding arbitration agreements already in place if they faced an increased threat of costly lawsuits—a scenario that might occur if patient protection legislation passed by the U.S. House of Representatives last year became law or if Congress opted to expand ERISA's court remedies to allow people to sue for damages.²¹ Several states recently have passed laws specifically allowing patients to sue

health plans for injuries caused by coverage denials, but these laws do not apply to ERISA plans and other plans shielded from state law by federal preemption.

Although very few coverage disputes enter a formal appeals process and end up in court, consumer surveys have detected that a significant number of people report problems with treatment delays and coverage denials. A survey by the California Association of HMOs found that health plans responding reported an annual average of only four coverage disputes per one million enrollees (as contrasted with an annual average of 102 claims per one million enrollees for medical malpractice disputes for Kaiser and CIGNA).²² On the other hand, a recent survey by the Kaiser Family Foundation found that, while most people are basically satisfied with their health insurance plans and report positive experiences, a majority of consumers also reported having had a problem with their health plan over the past year.²³ The most common types of problems reported involved delays or denials of coverage or care (reported by 17 percent of all people and 32 percent of people with problems), difficulty seeing a physician (14 percent of all people, 27 percent of people with problems), and billing and payment problems (12 percent of all people, 23 percent of people with problems).

Collectively Bargained Health Benefits

Labor unions and employers usually agree to resolve disputes over interpreting or applying a collective bargaining agreement through binding arbitration. The use of arbitration to resolve health benefit coverage disputes in collectively bargained health plans presents a complex set of issues in part because of the interaction of ERISA with labor law. It is open to question whether employers and/or unions may prevent arbitrated claims from then being appealed to the courts in many instances. One of the reasons for this is that ERISA provides plan participants and beneficiaries with statutory rights to appeal benefit denials and subsequently to go to court to reverse denied appeals. Depending on the case, collectively bargained benefit claims may be characterized as demands for enforcement of a collective bargaining agreement (to be resolved through binding arbitration), as claims for a benefit promised under ERISA's statutory remedial scheme, or as both types of claims. It has been asserted that the uncertainty surrounding how final and "binding" arbitration rulings might be in this context may subject employers to a form of double jeopardy.²⁴ By the same token, from a plan participant's perspective, the use of an arbitration process agreed to in collective bargaining might arguably deprive him or her of statutory appeal

rights available to other types of employees protected under ERISA.

ERISA does not address whether or under what terms arbitration might be used to resolve disputes or to displace legal remedies available to health plan participants.²⁵ Department of Labor regulations, however, explicitly allow the use of binding arbitration under ERISA to resolve disputes over benefit claims in single-employer collectively bargained employee benefit plans, which provide health coverage for millions of Americans.²⁶ Current regulations also prohibit the use of procedures that unduly inhibit or hamper the initiation or processing of plan claims, including requiring claimants to pay a fee or costs in order to make or appeal a claim. As noted below, DOL has published proposed regulations that would preclude plans from requiring claimants to submit to binding arbitration either as part of the claims appeal process or subsequently. As this paper went to press, President Clinton had just ordered Secretary of Labor Alexis Herman to release the new claims appeals regulations. Other than in these regulations (one in force and the other about to be), the Labor Department has not articulated policy on whether and how arbitration might be used to resolve disputes involving ERISA health plan participants. To what degree arbitration might be allowed under other circumstances under ERISA remains an unsettled question. As noted above, four federal circuit courts have held that Congress did not intend to prohibit arbitration of statutory ERISA claims.

ERISA sets out minimum requirements for administrative procedures to resolve disputed employee benefit claims in Section 503 and the legal remedies available to participants once those administrative procedures are exhausted in Section 502. Current DOL regulations generally require that every ERISA-governed employee benefit plan meet these minimum procedural standards but also stipulate that collective bargaining agreements establishing single-employer plans may substitute their own claims appeals process for the Section 503 requirements, including "a grievance and arbitration procedure to which denied claims are subject."²⁷ This exception to ERISA's claims regulations does not apply to multi-employer union plans jointly administered by trustees representing labor and management (these are often called "Taft-Hartley" plans). One reason that the exception to ERISA's claims process may have been granted only to single-employer collectively bargained plans (as opposed to those under the control of multiemployer trusts) is that unions arguably may be better positioned to advocate on behalf of employees with denied claims in this setting. Unions typically do not share responsibility for operating

single-employer collectively bargained plans; however, because they do take joint responsibility for operating multiemployer plans, unions may be more likely to have a conflict of interest (because they not only would be negotiating the terms of the plan along with the methods for resolving disputed claims but also would be responsible for the prudent management of the plan's assets and interpreting plan terms). (In general, collectively bargained health benefits are provided either by an employer or by the jointly trustee funds to which employers contribute. The health benefits may be purchased directly or under contracts with insurers or MCOs.)

Employer-Sponsored Plans

Although the use of binding arbitration does not appear to be widespread among employer-sponsored health plans, instances of its use can be found. At least one large employer, Halliburton, has enthusiastically adopted an ADR program, including binding arbitration, that is designed to resolve most disputes relating to employees, including those over denied health benefit claims.

About ten years ago, the Houston-based energy services company formalized its appeals process for employee benefit disputes and instituted a process ending with binding arbitration.²⁸ The company's self-insured ERISA health plan covers about 75,000 people in the United States. Halliburton has since expanded the conflict resolution program to cover most disputes involving employees, and the vast majority of cases now concern employment issues.

The company's dispute resolution program creates a multilevel process beginning with informal negotiation among disputants, then proceeding to mediation and arbitration. Of the almost 5,000 disputes that have been handled under the program over the past decade, about 125 to 150 have ended up going to arbitration; mediations occur about six times as frequently as arbitrations. Before the arbitration program was adopted, the company faced about half a dozen employee-benefits-related lawsuits a year. Subsequently, the incidence of litigation dropped to almost zero.

After being handled initially by outside contractors administering the health plan, claims for denied health benefits are appealed to the company's vice president of human resources and then to a benefits committee before going to arbitration. According to company officials, disputes over medical necessity rarely go to arbitration. Most of the larger health-related cases that have gone to arbitration are claims by unpaid providers. For example,

one case involved a \$350,000 claim by a hospital for providing services to a plan participant who had died. The plan had denied payment for the services on grounds that they were not covered because the plan participant had a preexisting condition. The company ended up settling the case for about \$150,000. Halliburton draws arbitrators from three organizations that administer conflict resolution programs on a national basis and absorbs the cost of the arbitrations, except for a \$50 fee.

EVIDENCE OF SYSTEMIC UNFAIRNESS: *KAISER V. ENGALLA*

Evidence emerged in a widely cited California medical malpractice lawsuit that Kaiser Permanente, perhaps the largest user of binding arbitration among MCOs, may have misused its arbitration program to defraud consumers for many years. The lawsuit was filed by the estate of Wilfredo Engalla against the Permanente Medical Group and the Kaiser Foundation Health Plan after the HMO engaged in stalling tactics to delay a mandatory arbitration process. In 1997, the California Supreme Court found evidence to support the claim that Kaiser had waived its right to compel arbitration by causing unreasonable or bad faith delays in the choice of arbitrators. The court's majority opinion stated,

We conclude that there is indeed evidence to support the trial court's findings that Kaiser engaged in fraudulent conduct justifying a denial of its petition to compel arbitration, but we further conclude that questions of fact remain to be resolved by the trial court before it can be determined whether Kaiser's conduct was actually fraudulent.²⁹

The court noted, however, that Kaiser's arbitration agreement, per se, was not "unconscionable." In other words, the problem lay with the program's administration, not its contractual nature, according to the court.

Wilfredo Engalla's lung cancer was detected in 1991 after he had manifested symptoms for many years. Engalla and members of his family served on Kaiser a demand for arbitration of their claims that the health plan had been negligent in failing to detect the disease sooner. According to the court, the Engallas' attorney correctly believed that his clients were required to file for arbitration pursuant to the service agreement that Kaiser had signed with Engalla's employer, the Oliver Tire and Rubber Company. Kaiser presented such an arbitration agreement routinely to both individual purchasers and employers purchasing health coverage for employees. Under the agreement, if a claim were filed, three arbitrators were supposed to be selected within a relatively short time frame to deal with it. The

court noted that Engalla and other Kaiser patients were not aware that Kaiser's arbitration program was being administered by attorneys that were also retained to defend the health plan in an adversarial capacity. Engalla's employer's representative had read the provisions of the arbitration agreement and believed that the process would be fair to both employees and Kaiser, according to the court. Kaiser represented that the appointment of a neutral arbitrator would take a few months time and would take a fair approach to protecting participants' rights.

Under the process, each side was supposed to appoint one party arbitrator; these two individuals in turn would jointly appoint a neutral arbitrator to rule on the claim. Instead of acting promptly as promised, the administrators of Kaiser's arbitration program delayed appointing an arbitrator. When Engalla died—145 days after the initial service of his claim—the neutral arbitrator still had not been appointed.

An independent analysis cited by the court showed that, between 1984 and 1986, in only 1 percent of all Kaiser cases was a neutral arbitrator appointed within the 60-day period provided in the arbitration agreement. Furthermore, on average it took 674 days to appoint neutral arbitrators and 863 days to reach a hearing. Delaying the arbitration reduced Kaiser's potential financial exposure in the Engalla case. For one thing, under California malpractice laws, Engalla's death meant that Kaiser faced only a single general damage claim limited to \$250,000 instead of separate claims of the patient (now deceased) and his spouse amounting to a total of \$500,000.

In 1992, the Engallas broke off the arbitration process and filed a complaint in court alleging fraud as a defense to enforcement of the arbitration agreement and pursuing the underlying malpractice claim as well. Kaiser's attorneys then removed the case to federal court, claiming that the action and all issues presented were subject to federal preemption under ERISA and proposed continuing the arbitration process. The Engallas declined the offer and filed a motion to remand the case to state court, which the federal court granted.

According to the California Supreme Court,

the system-wide nature of Kaiser's delay comes into clearer focus when it is contrasted with other arbitration systems. As the Engallas point out, many large institutional users of arbitration, including most health maintenance organizations (HMOs), avoid the potential problems of delay in the selection of arbitrators by contracting with neutral third party organizations, such as the American Arbitration Association (AAA).

To what degree Kaiser was responsible for delays that occurred in its arbitration program on a system-wide basis remains a matter of contention. Some point out that delays in many other cases may just as well have been the result of tactics by plaintiffs' lawyers, who, like defendants' lawyers, often seek to control the speed of a process and may attempt to slow it down to their client's advantage. It has been asserted, too, that lawyers paid on an hourly basis generally may have an incentive to string out disputes in order to increase their billings. However, attorneys representing plaintiffs in medical malpractice cases nearly always are paid on a contingency basis and thus have no financial incentive to delay since the amount they will be paid will be the same whenever a matter is resolved. Attorneys representing defendants, such as HMOs, are more likely to be paid hourly. HMOs can avoid the incentive to delay when they use outside counsel if they pay on a fixed price per claim basis.

The Employer as Agent

The California Supreme Court noted that, as a member of an employee benefit plan, Engalla had little if any cognizance of the arbitration agreement between his employer and Kaiser. Despite this, the court noted that it was reasonable to presume that an employer negotiating or selecting a group health plan on behalf of its employees is acting on their interest. "If that proves not to be the case, then an employee bound by an arbitration agreement of which he was scarcely aware could well raise a claim that such an agreement was unconscionable," the state supreme court said.

KAISER'S EFFORTS TO IMPROVE ITS ARBITRATION SYSTEM

Advisory Panel Recommendations

In the wake of the California Supreme Court decision on the Engalla case, David Lawrence, M.D., Kaiser's chairman and chief executive officer, assembled an independent panel to advise him on how to improve the company's system of medical malpractice arbitration. In 1998, the panel made several recommendations, including the following:³⁰

- An independent administrator should supervise the arbitration system.
- The arbitration process should be expedited, efficient, and fair.
- Methods should be developed to audit and monitor the progress of the independent administrator and to

research and evaluate the fairness and effectiveness of the arbitration system.

- An ombudsperson program should be instituted to assist members in navigating the system.

The Kaiser Permanente arbitration system is used for a variety of disputes between patients, family members, and the Kaiser system, the panel reported. From 1992 to September 1997, a total of 5,313 demands for arbitration were filed. (Note that, although the number of demands for arbitration ran into the thousands over a multiyear period, only a tiny fraction of Kaiser's membership filed such actions in any given year. For example, about two hundredths of a percent of Kaiser members filed such a demand in 1996.) While about 90 percent of Kaiser's arbitration cases concerned malpractice claims, the arbitration system was also used for premises liability and coverage disputes, the panel found. In response to a concern expressed by some that the arbitration system might face an increasing number of cases concerning benefits or coverage issues, the panel said it was unable to address that question for lack of evidence but also suggested that "the unique characteristics of coverage or benefit cases may demand a far more speedy system than one designed for medical malpractice—though all arbitration should be speedy in our view."

The panel noted that before an individual files a demand for arbitration concerning issues of coverage, there is a formal and informal dispute resolution system within the HMO system but found evidence that the system was difficult to navigate for members. In attempting to summarize Kaiser's internal dispute resolution process, the panel noted, "In spite of what would appear to be a good faith attempt to explain the system, and provide printed information to members, we were left with no clear view of the process."

Just as the panel strongly believed that Kaiser must honor its representation that its imposed binding arbitration system is fair, reasonable, and just, employers who contract with the HMO also "have an obligation to see that the medical malpractice arbitration system is fair to their employees," the panel emphasized.

New Independent Administrator and Speedier Process

In October 1998 Kaiser selected the Law Offices of Sharon Lybeck Hartmann to act as independent administrator of Kaiser's mandatory arbitration system for plan members in California. Under the contract, Hartmann's office is to write rules of procedure for Kaiser arbitrations, create a pool of qualified neutral arbitrators

to hear cases, and to independently administer arbitration cases brought by Kaiser members. According to the new independent administrator's first annual report, the process had speeded up dramatically.³¹ During the program's first year, claims averaged 43 days to appointment of a neutral arbitrator (as contrasted to the 674 days cited by the court in the Engalla case) and hearings *ended* in an average of 213 days (as contrasted to the old average of 863 days *to begin* hearings cited by the court). The independent administrator reported that 323 neutrals had been appointed to its panel, 27 percent of whom were retired judges. Of the total, 166 had been named as the neutral arbitrator in at least one case in the program's first year of operation.

Under the new system's operating rules, most cases must be completed within 18 months. So far, 168 of the 681 cases administered under the program have been resolved. A total of 73 (11 percent) of the 681 cases have been settled while 49 people withdrew their claims. Neutral arbitrators have dismissed four cases and five have been deemed abandoned due to a claimant's failure to pay the filing fee. Kaiser resolved one case before a neutral arbitrator was appointed. Summary judgment in Kaiser's favor was granted in 14 cases. A total of 22 cases have proceeded through a full hearing to an award. Judgment was for Kaiser in 17 cases (or 77 percent) while claimants prevailed in five cases (23 percent).

Of the 681 cases received by the independent administrator, 641 (94 percent) were medical malpractice cases, 3 involved benefits disputes, 9 involved premises liability, 2 involved other torts, and 26 were characterized as "unknown." The independent administrator reported that the results of cases in Kaiser's new system appear to be consistent with results in the courts, at least as reported from two sources. For the purposes of comparison, the administrator reviewed the California medical malpractice cases reported to the *Los Angeles Daily Journal's Verdicts and Settlements* over the previous 12 months and found that 75 of the 168 court cases reported to the periodical resulted in defense verdicts, while 27 resulted in plaintiffs' verdicts and 66 cases were settled. Of the 102 cases in which courts reached verdicts, the defense prevailed in 74 percent and plaintiffs won in 26 percent. Drawing from data compiled by the Bureau of Justice Statistics reporting on 1996 trial results in the 75 largest counties in the nation, the independent administrator noted that out of 1,201 medical malpractice cases, 272 (23 percent) resulted in verdicts in favor of plaintiffs.

The cost of paying arbitrators can pose a barrier to individuals seeking arbitration of a claim. The advisory

panel concluded that the party arbitrators routinely used in Kaiser's former arbitration process increased costs and caused more delays than would have occurred by using only a single neutral arbitrator. Therefore, the independent administrator encourages parties to use a single arbitrator to decide cases. Now, if the demand for arbitration seeks total damages of \$200,000 or less, disputes are heard by one neutral arbitrator and Kaiser will pay for the neutral arbitrator's fees and expenses if a claimant agrees to waive any potential objection arising out of such payment. The HMO also will cover the neutral arbitrator's fees and expenses if demands for arbitration seek total damages exceeding \$200,000 in cases where the claimant agrees to waive the right to a party arbitrator.

CALIFORNIA LEGISLATION

In California, controversy over the use of binding arbitration as a condition of coverage in HMO contracts led to the introduction of legislation (Assembly Bill 1751) that would prohibit "a health care service plan, application, or contract... from requiring binding arbitration to resolve disputes under the contract." However, the bill's sponsor, Assemblywoman Sheila James Kuehl (D) moved to withdraw the bill after it became apparent that it lacked enough support to pass. Another bill (Senate Bill 1934) introduced in the California legislature³² would further regulate the use of binding arbitration by health care service plans. Among this bill's stipulations are the following:

- Plan contracts shall not impose limits on damages that may be awarded in arbitration that differ from damages that could be otherwise awarded in a similar dispute by a court or jury trial.
- Enrollees or subscribers shall not be prohibited from being represented by counsel.
- Enrollees or subscribers shall not be prohibited from filing a written brief or making a closing argument before the arbitrator.
- Plan contracts shall provide that the same statute of limitations governing the timeliness of civil actions shall also govern the timeliness of a demand for arbitration.
- A court may vacate an arbitrator's award where there is evidence of manifest disregard for the law resulting in a substantial injustice.

Using the Supreme Court's logic in *Doctor's Associates, Inc. v. Casarotto*, both of the California bills might be preempted by the FAA because they appear to place

regulatory limits on the use of arbitration not applied to contracts generally. In 1999, for example, a California court of appeal cited *Casarotto* in finding that, although an Aetna Healths Plans of California, Inc., binding arbitration provision failed to comply with a state health and safety law setting out disclosure requirements, that statute was preempted by the FAA.³³ (In this case, a Medicare beneficiary who had enrolled in a managed care plan claimed that the plan's delay in covering a particular treatment for prostate cancer constituted a breach of contract and breach of good faith and also constituted negligence, negligent misrepresentation, infliction of emotional distress, and fraud. Aetna moved to compel arbitration based on a provision in its "Senior Choice" handbook requiring binding arbitration to settle disputes except those subject to Medicare's appeals procedure. Besides finding that the arbitration clause in question violated California law, the lower court also found that the arbitration clause was not sufficiently clear and unequivocal to be valid under state law. The appeals court reversed the judgment and granted Aetna's motion for arbitration.)

ADR PROTOCOL FOR HEALTH CARE

In 1997, the leading associations involved in ADR, law, and medicine formed a commission that made recommendations on how ADR methods such as arbitration and mediation should be employed in the health field. Appointed by the AAA, the American Bar Association (ABA), and the American Medical Association (AMA), the Commission on Health Care Dispute Resolution³⁴ issued recommendations in 1998, in part to provide guidance to MCOs considering adopting ADR programs as well as legislative and regulatory bodies considering the establishment of standards governing the use of ADR in the health environment.

Excluding disputes concerning malpractice from its scope of study, the commission unanimously recommended that ADR systems can and should be used to resolve disputes over health care coverage and access arising out of the relationship between private health plans (such as MCOs) and either patients or health care providers.³⁵ However, the commission made an important qualification: "In disputes *involving patients*, binding forms of dispute resolution should be used only where the parties agree to do so *after a dispute arises*" [emphasis added]. It should be noted, however, that a senior executive of the AAA interviewed by the author of this paper said that the AAA does not interpret this recommendation made by the commission to apply to binding arbitration clauses inserted in HMO contracts

before disputes arise. Furthermore, as the leading administrator of ADR services, the AAA administers arbitration programs for HMOs to settle disputes arising under HMO contracts with consumers that establish binding arbitration before disputes arise.

The dispute resolution commission also recommended that due process protections should be afforded to all participants in ADR processes. Finally, it recommended that ADR should complement the concept of internal review of determinations made by private MCOs.

When the question arose whether ADR as a form of external review of health plan determinations might be precluded by ERISA, the commission concluded that ERISA does not preclude parties from voluntarily adopting the use of ADR, even binding arbitration, but added that legislative clarification would be helpful to avoid confusion or concern over the appropriate use of ADR methods.

ARBITRATION UNDER FEDERAL PATIENT PROTECTION PROPOSALS

Legislation

The patient protection bills passed by the U.S. House and Senate in 1999 make no mention of binding arbitration, including whether it should be allowed to substitute for new internal or external review requirements that they contain. Neither bill would create a new federal cause of action to expand ERISA health plan participants' right to sue their health plans. The House bill, however, would strip back ERISA preemption to allow patients greater latitude to sue under state law. Neither bill addresses whether, or under what conditions, binding arbitration might be substituted for court remedies. After congressional conferees grappled for several months over how to resolve differences between the two bills, the Senate on June 29 passed a measure that would amend ERISA to allow injured health plan participants and beneficiaries to sue "designated decision-makers" for economic and noneconomic damages caused by their failing to follow an independent medical reviewer's decision reversing a benefit denial. The legislation also would allow similar lawsuits to proceed against "designated decision-makers" that acted in bad faith in delaying the provision of benefits approved by an independent medical reviewer. This bill also does not mention arbitration.

Proposed Rules

The Labor Department has issued a proposed regulation establishing new standards for how employee

benefit plans, including health plans, review coverage denials internally. The proposed regulation would end the special exception that currently allows single-employer collectively bargained plans to substitute an arbitration process for elements of the Section 503 claims appeals rules. The proposed regulations would be overridden by any of the patient protection bills currently before Congress. The proposed regulations state that a plan's benefit claims procedures may not include more than one level of mandatory appeal (many managed care organizations now require several levels of appeal) and that plans are precluded from requiring claimants to submit to binding arbitration as part of that single level of appeal or subsequently.³⁶ The Labor Department said that one of its major concerns in proposing the new rules was to prevent unnecessary delays in resolving claims disputes. The proposed rule states,

The Department considers it essential that claimants be free to decide, after having completed the minimum number of administrative appeals necessary to allow for a full and fair review of the claim, whether to continue to pursue a claim through the plan's additional procedures, if any, or to file suit under section 502(a) of the Act.

The proposed regulations amplify the provision in the current rules prohibiting the use of procedures that "unduly inhibit or hamper" the initiation or processing of plan claims. Any provision or practice requiring claimants to pay a fee or costs in order to make or appeal a claim would be considered unduly inhibiting.³⁷

CONCLUSION

Measures now being considered by Congress to bolster the appeal rights and expand the court remedies available to people contesting health benefit denials may expand potential liability faced by plan sponsors, health insurers, and MCOs. As this liability grows, so might the attractiveness of alternatives to going to court, including binding arbitration. Binding arbitration is currently used to resolve disputes between individuals and health plans in many types of cases, including disputes over coverage under ERISA. The use of binding arbitration presents a series of policy issues that have yet to be settled, especially with regard to disputes over coverage in which a patient's life or health may rest upon an arbitrator's decision and the process leading up to it. Among the many questions facing health policymakers are (a) when arbitration processes are appropriate to use, (b) how procedural fairness can be maintained, and (c) how an appropriate balance of

power can be maintained between individuals and institutions at all stages of the arbitration process.

Issues Raised

Among the issues raised by the use of binding arbitration to resolve health coverage disputes and other matters affecting patients are the following:

- Are binding arbitration processes operated by business organizations, such as managed care plans, fair and impartial? How might they be monitored to ensure procedural fairness?
- Should binding arbitration be allowed to resolve disputes involving patients or members of health plans? If so, under what conditions?
- When individuals purchase their own health insurance, is it appropriate for a health insurer to require them to agree to binding arbitration of disputes that might arise later, such as those over coverage issues or involving claims of medical malpractice? If so, how should such agreements be presented to individuals? Should an individual purchaser have the option not to waive legal remedies that otherwise would be available? Should insurers be allowed to offer discounted premiums to encourage consumers to sign predispute arbitration agreements?
- Should binding arbitration agreements between patients and health plans (or health services providers) be allowed before a dispute arises and the nature of the dispute is known?
- With regard to employee health plans, including those governed by ERISA, to what degree can binding arbitration agreements displace administrative appeal options (statutorily mandated internal and external review of coverage decisions, for example) and subsequent legal remedies? Should individual employees (and not just plan sponsors ostensibly bargaining on their behalf) be required to sign binding arbitration agreements for them to be enforceable? Should employers or unions sponsoring health coverage be allowed to sign away plan participants' statutory remedies for resolving coverage disputes, especially given that some of those disputes may arise between fiduciaries appointed by the sponsor and the participant over interpretation of what is a covered benefit?
- Are employee health benefit plans adhesion contracts (contracts allowing individual plan participants little or no room for negotiating their terms)? If so, what is the implication for the use of arbitration clauses inserted by plan sponsors?
- As a matter of public policy, which types of administrative appeals and court remedies could be waived in favor of an alternative method of dispute resolution such as binding arbitration? Which could not be? If binding arbitration of coverage disputes continues to be allowed, when should the process kick in?

ENDNOTES

1. ERISA regulates private-sector pensions and employee benefit plans organized by employers or unions, including health plans.
2. *Gilmer v. Interstate/Johnson Lane Corp.*, 500 U.S. 20 (1991).
3. According to *Black's Law Dictionary*, an adhesion contract is a standardized contract form offered to consumers of goods and services on essentially a "take it or leave it" basis without affording the consumer a realistic opportunity to bargain and under such conditions that the consumer cannot obtain the desired product or service except by acquiescing to the contract terms. A distinctive feature of an adhesion contract is that the weaker party has no realistic choice as to its terms. Not every adhesion contract is unconscionable. See *Black's Law Dictionary* (St. Paul, Minn.: West Publishing Co., 1983).
4. Margaret M. Harding, "The Clash between Federal and State Arbitration Law and the Appropriateness of Arbitration as a Dispute Resolution Process," *Nebraska Law Review*, 77, no. 3 (Summer 1998): 397-493.
5. Traci L. Jones, "State Law of Contract Formation in the Shadow of the Federal Arbitration Act," *Duke Law Journal*, 46, no. 3 (December 1996): 651-678.
6. 116 S. Ct. 1652 (1996).
7. Jones, "State Law."
8. According to the American Arbitration Association, the Uniform Arbitration Act was adopted by the National Conference of Commissioners on Uniform State Laws in 1955, amended in 1956, and approved by the House of Delegates of the American Bar Association in 1955 and 1956.
9. Information concerning state arbitration laws was provided to the author by Margaret Hosel, a researcher for the California Research Bureau, California State Library.
10. *Gilmer v. Interstate/Johnson Lane Corp.*, 500 U.S. 20 (1991).
11. See *Williams v. Imhoff*, 203 F. 3d 758 (10th Cir. 2000).
12. *Williams v. Imhoff*.
13. *Circuit City Stores v. Adams*, 194 F. 3d 1070 (9th Cir. 1999).

14. *Craft v. Campbell Soup Co.*, 177 F.3d 1083, 1094 (9th Cir. 1999).
15. *Randolph v. Green Tree Financial Corp.*, 178 F.3d 1149 (11th Cir. 1999).
16. Caroline E. Mayer, "High Court to Consider Arbitration Rules," *Washington Post*, April 4, 2000, E3.
17. Caroline E. Mayer, "Win Some, Lose Rarely? Arbitration Forum's Ruling Called One-Sided," *Washington Post*, March 1, 2000, E1.
18. The FAA strictly limits judicial review of arbitrators' decisions.
19. Roderick B. Mathews, "The Role of ADR in Managed Health Care Disputes," *Dispute Resolution Journal*, 54, no. 3 (August 1999): 8-13.
20. Elizabeth Rolph, Erik Moller, and John E. Rolph, "Arbitration Agreements in Health Care: Myths and Reality," *60 Law and Contemporary Problems*, 153 (Winter 1997).
21. For more information on issues relating to patient protection legislation passed by the House and U.S. Senate in 1999, see Karl Polzer, "ERISA Health Plan Liability: Issues and Options for Reform," background paper, National Health Policy Forum, George Washington University, January 2000 (available at <http://www.nhpf.org>).
22. Rolph, Moller, and Rolph, "Arbitration Agreements."
23. Henry J. Kaiser Family Foundation, "National Survey of Consumer Experiences with Health Plans," summary of findings and chart pack, Menlo Park, California, June 2000.
24. See Peter M. Panken and Robert D. Webb. "Arbitrating Collectively Bargained Benefit Claims: Reality or Illusion?" American Law Institute—American Bar Association course of study materials, April 2000.
25. For an analysis of ERISA's interaction with the FAA, see G. Richard Shell, "ERISA and Other Federal Employment Statutes: When Is Commercial Arbitration an 'Adequate Substitute' for the Courts?" *Texas Law Review*, 68, no. 3 (February 1990).
26. ERISA-governed health plans cover more Americans than any other of plan or program for providing health coverage (for example, Medicare, Medicaid, government employee plans, and individually purchased insurance). Available data can provide only a rough approximation of how many ERISA health-plan participants and their dependents are covered under collectively bargained plans. Based on the March 1999 Current Population Survey, the Department of Labor (DOL) estimates that about 131 million Americans, including dependents and retirees, receive health benefits from an ERISA health plan. It is difficult to tell how many of these are covered under union contracts. Other DOL data tabulations show that in 1999 about 14 percent of all U.S. wage and salary workers covered by health plans (including non-ERISA plans such as those offered by governmental agencies) received benefits under union contracts. From 1996 information submitted by plans to DOL (on ERISA "form 5500s"), agency analysts report that 2,236 multi-employer union plans provided some type of health benefits and covered 4.6 million active participants and 1.6 million retirees (dependents are not included on form 5500s) in welfare benefit plans including health plans. In addition, 4,737 single-employer union plans reported that they provided some form of health benefits and covered 9.4 million active employees and 3 million retirees in welfare benefit plans, including health plans. It is difficult to compare form 5500 data to estimates generated from surveys for many reasons. For one thing, ERISA plans with fewer than 100 participants are not required to submit form 5500s (so smaller single-employer union plans would be omitted). Also, the forms allow plan administrators to report a total number of participants in welfare benefit plans without breaking out which are in health plans. Finally, as noted above, covered dependents are not reported on form 5500s.
27. 29 C.F.R. 2560.503-1(b)(1997).
28. Information about Halliburton's dispute resolution program was provided to the author by company officials.
29. 15 Cal.4th 951.
30. Blue-Ribbon Advisory Panel on Kaiser Permanente Arbitration, "The Kaiser Permanente Arbitration System: A Review and Recommendations for Improvement," January 5, 1998.
31. "Office of the Independent Administrator, "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," Law Offices of Sharon Lybeck Hartmann, Los Angeles.
32. S.B. 1934 passed in the California senate but died in committee in the state assembly during the legislative term ending in September 2000.
33. *Donald Erickson v. Aetna Health Plans of California, Inc.*, 1999 Cal. App. LEXIS 347.
34. The commission was co-chaired by Jerome J. Shestack, president of the ABA, William K. Slate II, president and chief executive officer of the AAA, and Percy Wootton, M.D., president of the AMA. Each of the institutions had four representatives on the commission: for the AAA, Howard J. Aibel, Thomasina Rogers, J. Warren Wood III, and Max Zimny; for the ABA, Arlin Adams, Kimberlee K. Kovach, Lawrence A. Manson, and Roderick B. Mathews; and, for the AMA, Charles Barone, M.D., Donald Palmisano, M.D., Carter Phillips, and Ron Pollack.
35. Commission of Health Care Dispute Resolution, "Health Care Due Process Protocol: A Due Process Protocol for Mediation and Arbitration of Health Care Disputes," final report, American Arbitration Association, American Bar Association, American Medical Association, July 27, 1998.
36. *Federal Register*, 63, no. 174 (September 9, 1998): 48397.
37. *Federal Register*, 48392.