ARBITRATION AGREEMENTS IN HEALTH CARE: MYTHS AND REALITY

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I

INTRODUCTION

You won't learn much new about arbitration agreements from a survey of health care providers. They all use 'em.

This comment, offered by one well-positioned respondent to the study on which this article is based, reflects the widespread belief that alternative dispute resolution methods, particularly mandatory binding arbitration agreements, have become the rule in health care delivery.[1] This apparent trend has spurred vigorous debate about the merits of using such agreements. Our study is an effort to ascertain how widespread mandatory arbitration agreements between health plans and providers and their enrollees and patients really are, to assess how decisions regarding their use are made, and to evaluate the prospects of their future use. We found, contrary to popular belief, that arbitration agreements are not used widely in the medical setting, and, where they are used, it is typically because organizational policy explicitly directs their use.

A. Background

Dispute resolution in the context of health care delivery has been seen as a pressing problem for a number of years.[2] Traditionally, health care disputes centered on the medical malpractice issue of whether a medical provider's services met the legal standard of care. Unexpected and dramatic growth in claims during the 1970s led to a rapid growth in physician malpractice insurance premiums, in some cases sufficient to threaten the continuing availability of valued specialty services (for example, obstetrical services in some states). These dynamics, in turn, engendered a wave of state reforms, including the

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1. *See* Barry Meier, *In Fine Print, Customers Lose Ability to Sue*, N.Y. TIMES, Mar. 10, 1997, at A1.

2. For extensive discussions of the "medical malpractice crisis," evidence regarding litigation costs, and the probable effects of the many tort reform proposals on claiming, transaction costs, and awards, see generally PATRICIA DANZON, MEDICAL MALPRACTICE: THEORY, EVIDENCE AND PUBLIC POLICY (1985); PAUL WEILER, MEDICAL MALPRACTICE ON TRIAL (1991).

introduction of alternative dispute resolution mechanisms, general damage caps, regulation of attorneys' fees, and no-fault systems for a few specific injuries such as children's vaccines and prenatal injuries.[3]

With the growth of managed care, the potential for disputes has increased substantially. As plans and providers attempt to contain costs by limiting unnecessary care, they pave the way for a whole new class of disputes over coverage. In addition, managed care is giving rise to a proliferation of treatment decisionmakers, thereby opening the door to further disputes over who should be responsible for decisions regarding, for example, treatment plans or denial of coverage.[4] At the same time, in the new, more adversarial environment of managed care, patients may well be more likely to challenge the medical judgment and technical competence of providers. Thus, the problem of managing the dispute process efficiently, fairly, and in a manner that leaves disputant relationships intact, becomes ever more pressing. Anecdotal evidence suggests that doctors, hospitals, and health plans, in an effort to find more efficient, more predictable, and arguably less threatening mechanisms for dispute resolution in this new environment, are following the lead of certain other industries, such as banking, real estate, securities, and employment, by increasingly requiring plan enrollees and patients to agree in advance to binding arbitration of any disputes.[5]

It is worth noting that there are important differences between these mandatory, binding arbitration agreements and other forms of arbitration used to resolve disputes. Arbitration is an adjudicative process that takes place outside the court and uses independent neutrals to hear the evidence and render judgments. Parties can come to arbitration as a result of court rules or a contractual agreement to arbitrate. Contractual agreements to arbitrate include voluntary post-dispute agreements, pre-dispute agreements to arbitrate that are not a precondition of the business relationship, and mandatory pre-dispute agreements that are a precondition of the business relationship. Arbitrations can be nonbinding, allowing a dissatisfied party the right to take the dispute to the courts for another hearing, or binding, with no right of appeal.

Arbitration agreements emerging in the delivery of health care are mandatory and binding. They take the form of language embedded in health plan contracts with purchasers and enrollees, and of specific contracts presented to patients by hospitals and physicians at the outset of the relationship.[6] Such agreements stipulate that all future disputes between the

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3. For an excellent summary of specific tort reforms that have been enacted, and empirical evidence regarding their effects, see WEILER, *supra* note 2.

4. *See* HEALTH CARE DELIVERY AND TORT: SYSTEMS ON A COLLISION COURSE, 21-23 (Elizabeth Rolph, ed., 1992).

5. *See generally* Meier, *supra* note 1; William Sage, *Health Law 2000, The Legal System and the Changing Health Care Market*, 15:3 HEALTH AFF. 1 at 14-15 (1996).

6. Binding arbitration agreements may also govern resolution of disputes among business entities (plans and providers; employers and employees; buyers and vendors), as well as between patients and business entities. However, equity and consumer protection concerns are most salient when patients

parties to the agreement must be resolved through binding arbitration, while providing a broad definition of the rules governing the procedure. Parties to such agreements unequivocally waive their rights to trial or judicial oversight of their disputes.

As mandatory binding arbitration agreements are perceived to be more prevalent in health care delivery, the debate over the consequences of their use grows. Proponents of these agreements maintain, as they have for some years, that arbitration is preferable to the courts as a vehicle for resolving disputes for a number of reasons,[7] including the following:

1. *Efficiency*. Arbitrations, they argue, require less discovery than court proceedings, are typically much less formal in their evidentiary demands, and generally require substantially less hearing time. Thus, arbitrated disputes will cost less to pursue and will reach resolution faster.

2. *Informed, Consistent Decisionmaking*. Bolstered by well-publicized and arguably unfounded large malpractice and coverage verdicts, proponents assert that judges and juries lack the necessary expertise and objectivity to render fair judgments in complex and often emotionally charged medical cases. They argue that justice is better served when informed, objective arbitrators sit in judgment.

3. *Maintenance of Important Relationships*. Proponents also assert that the private, arguably less adversarial arbitration proceeding enhances the possibility of continuing positive relationships among patients, plans, and providers. They suggest that this attribute is a particularly important feature in the case of health care disputes where a claimant's well-being may depend on continuity of care.

4. *Claimant Satisfaction*. Proponents contend, because a dispute is more likely to go to a hearing if it is an arbitration case, claimants are more likely to have the satisfaction of a "day in court" under an arbitration agreement. Thus, arbitration better meets the psychological needs of claimants.[8]

5. *Confidentiality*. Providers, particularly physicians, welcome the confidentiality of the private arbitration forum. Allegations of negligence are often highly personalized attacks, which many providers prefer to keep from public view. Opponents of a rbitration agreements, while noting that many of

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are involved. Therefore, this study examines only use agreements between patients and providers and plans and enrollees.

7. For a fuller listing and a discussion of several of these issues, see Thomas Metzloff, *The Unrealized Potential of Malpractice Arbitration*, 31 WAKE FOREST L. REV. 203, 208-10 (1996).

8. For a summary of the early empirical research on this subject, see Deborah Hensler & Jane Adler, *Court Ordered Arbitration: An Alternative View*, LEGAL F. 399, 415-20 (1990). There is no comparable research examining disputant satisfaction in the context of private, mandatory arbitration.

these alleged benefits are unproven, also assert that pre-dispute arbitration contracts unfairly compromise the rights and interests of disputants, especially claimants.[9] Their principal concerns include:

6. *Compromise Awards.* Opponents, particularly those in the medical community, are concerned that arbitrators are overly reluctant to hand down a defense verdict. Instead arbitrators seem to prefer to "split the baby,"[10] sending the plaintiff home with a token award.

7. *The "Repeat Player" Advantage.* Opponents argue that because plans and providers are likely to be involved in numerous disputes over time, they are in a position to develop relationships with neutrals and neutrals are likely to favor them over claimants to gain future business.[11]

8. *Loss of the Right to Appeal.* Because binding arbitration is meant to be dispositive, arbitration statutes, supported by subsequent court interpretation, offer disputants few opportunities to challenge arbitration judgments in court. Thus, under the terms of most pre-dispute arbitration agreements, disputants have little recourse in the case of an unsatisfactory outcome, even in the event of egregiously poor adjudication.[12]

9. *Loss of Precedential Potential.* Unless disputants require otherwise, arbitrators need not provide a written statement of their reasoning. Even if such a statement is required, it has no precedential value. Thus, disputes proceeding to resolution in arbitration are not integrated into the dynamic process of creating case law. Precisely because health care delivery is undergoing such profound and rapid change, large numbers of health care disputes should not be removed from the courts.[13]

Both lawmakers and the judiciary are now being asked to decide on the appropriateness and value of these agreements, particularly in the context of health care delivery.[14] Unfortunately, the diffusion of arbitration agreements in

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9. *See* Elizabeth Rolph et al., *Escaping the Courthouse: Private Dispute Resolution in Los Angeles*, 1996 J. DISP. RESOL. 277, 280.

10. Metzloff, *supra* note 7, at 220; *see also* A COMPREHENSIVE REVIEW OF ALTERNATIVES TO THE PRESENT SYSTEM OF RESOLVING MEDICAL DISPUTES 49-50 (Physicians Insurers Association of America ed., 1989).

11. *See generally* S. Gale Dick, *ADR at the Crossroads*, 49 DISP. RESOL.J. 47 (Mar. 1994); Marc Galanter & John Lande, *Private Courts and Public Authority*, 14 STUD. IN L., POL. & SOC'Y 393, 393-415 (1992); Richard Reuben, *The Dark Side of ADR*, 14 CAL. LAW. 53, 53-58 (Feb. 1994).

12. *See* 9 U.S.C. §10 (1994) (limiting review of arbitrators' awards to instances of fraud, corruption, bias and misconduct); s*ee also* Advanced Micro Devices, Inc. v. Intel Corp., 885 P.2d 994 (Cal. 1994) (limiting grounds of review of arbitrators' awards to fraud and conflict of interest on the part of the arbitrator).

13. *See generally* Nicholas P. Terry, *The Technical and Conceptual Flaws of Medical Malpractice Arbitration*, 30 ST. LOUIS U. L.J. 571 (1986).

14. In California, for example, both the Senate Committee on Insurance and the Senate Committee on the Judiciary held hearings in 1995 to review the use of binding arbitration agreements in health care delivery and assess the need for regulation. Similar review is underway in other states. *See* 8:1 WORLD ARB. & MEDIATION REP. 1 at 4-5 (1997).

health care delivery, as well as nascent efforts to curb that diffusion, are both proceeding in the absence of strong empirical evidence documenting the actual numbers of medical arbitration agreements in use, or claims regarding their costs and/or benefits. Courts, legislators, and regulators need such evidence to support the policy decisions that they must make, while plans and providers need the same evidence to support their business decisions.

B. Study Goals

The research we report on here is intended to inform the policy debate in two important ways. First, we attempt to identify potential outcomes suggested by existing empirical literature on the use of binding contractual arbitration agreements. Second, in an empirically based study, we attempt to ascertain actual patterns of diffusion and implementation of arbitration agreements between enrollees/patients and plans/providers in health care delivery.

II

EFFECTS OF ARBITRATION AGREEMENTS: A REVIEW OF THE LITERATURE

The existing evaluations of ADR programs suggest that there is reasonable consensus on the dispute outcomes that should be measured. These include the following: caseload characteristics such as frequency and severity of claims; time to disposition; transaction costs; patterns of awards and settlements, including defense verdicts; disputant perceptions of fairness and satisfaction; and quality of neutrals.

The conclusions from these studies, however, are problematic.[15] Most of the published work reports on the effects of non-binding, court-mandated arbitration programs adopted as part of various court reform and tort reform packages. The few empirical evaluations of the effects of private, binding arbitration suffer critical deficiencies; in most cases the evaluation designs are eclectic and unclear, the arbitrated caseloads are small, and choices of comparison populations are often dubious.

Although evaluations of non-binding, court-mandated arbitration have produced interesting and somewhat consistent findings, it is important to remember that court-mandated arbitration differs markedly from binding contractual arbitration. Therefore, these results have limited applicability in predicting the effects of pre-dispute arbitration agreements.

The evidence indicates that non-binding, court-mandated arbitration is not a substitute for trial; rather, it is a substitute for settlement.[16] These programs do not significantly reduce trial rates. Where programs are in place, two to ten times as many civil cases go to some form of adjudicative procedure as in courts without them.[17] Consistent with this interpretation, the research reveals very

15. *See generally* Metzloff, *supra* note 7.

16. For an excellent summary and synthesis of the research on judicial arbitration, see Hensler & Adler, *supra* note 8, at 407-08.

17. *See id.* at 407.

mixed results with respect to time to disposition and private dispute costs.[18] At the same time, court-mandated programs consistently result in a high level of disputant satisfaction with respect to both process and outcome.[19]

The effects of private, binding arbitration are even more difficult to determine. Some organizations that use arbitration agreements have conducted internal evaluations,[20] but the data necessary for a broad-based, non-proprietary evaluation are widely dispersed, private, and often well guarded.[21] Consequently, few studies of private arbitration have been undertaken,[22] and those that have attempted to evaluate outcomes suffer from the problems described above.[23] Notwithstanding these continuing questions about the effects of binding arbitration, the next section of this article examines the use of arbitration agreements in health care delivery in the context of a single state, California.

III

USE OF ARBITRATION AGREEMENTS IN HEALTH CARE DELIVERY: A STUDY OF CALIFORNIA

A. Questions and Methods

In exploring patterns of diffusion and implementation of arbitration agreements, this article will address the following issues:

- The legal context in which diffusion and implementation is proceeding;
- The prevalence of such agreements;
- Patterns of use;
- Plan/provider reasons for use or non-use;
- Plan/provider perceptions regarding arbitration experiences; and
- Methods used to implement or execute agreements.

Despite a significant federal presence in this area, state legal and regulatory environments do much to shape the adoption and implementation of arbitration agreements. Therefore, we chose to examine the experience of one state in some detail, looking at both the contextual rules and the diffusion

18. *See id.* at 410-14; *see also* DEBORAH HENSLER ET AL., JUDICIAL ARBITRATION IN CALIFORNIA: THE FIRST YEAR 39-44 (1983); ELIZABETH ROLPH, INTRODUCING COURT-ANNEXED ARBITRATION: A POLICYMAKER'S GUIDE 19-20 (1984).

19. *See* HENSLER ET AL., *supra* note 18, at 15-18.

20. For example, respondents in our interviews reported internal, proprietary analyses of certain effects of arbitration agreements, e.g., defense costs, time to resolution, and award amounts.

21. For example, Kaiser, a long-time user of arbitration agreements, has as a matter of corporate policy been unwilling to share data that would permit external evaluation.

22. *See generally* Rolph et al., *supra* note 9, at 277-323; ERIK MOLLER ET AL., PRIVATE DISPUTE RESOLUTION IN THE BANKING INDUSTRY (1993); John P. Desmond, *Michigan's Medical Malpractice Reform Revisited: Tighter Damage Caps and Arbitration Provisions*, 11 COOLEY L. REV. 159, 173-77 (1994) (evaluating Michigan's voluntary arbitration program for medical malpractice disputes).

23. *See generally* Rhoda M. Powsner & Frances Hamermesh, *Medical Malpractice Crisis the Second Time Around: Why Not Arbitrate?*, 8 J. LEGAL MED. 283 (1987).

response. The state we selected is California, a state whose legal policies have been very supportive of arbitration agreements and where a large portion of the insured population, over forty percent,[24] is enrolled in managed care plans. Thus, in California there is both the possibility of using arbitration agreements and a health care delivery system that arguably may lead to a greater demand for innovative dispute resolution mechanisms. To the degree that legal environments in other states are similarly hospitable, it is reasonable to expect that, as managed care gains similar market share in these states, similar dispute resolution techniques are likely to follow.

We use a combination of methods for collecting empirical information regarding the prevalence, expectations for, and experiences with arbitration agreements. Given the extreme complexity and current ambiguity of liability relationships, we surveyed a broad variety of system participants, and, where possible, supplemented these interviews with relevant data from other sources. In presenting our results, we first describe the legal environment in California as it relates to arbitration agreements. We then describe the methods and results of our empirical study, and, finally, discuss the implications of these findings for the continuing diffusion of binding arbitration agreements.

B. California's Legal Context

The legal environment in which health care arbitration agreements occur is simultaneously complex and fluid in its operation, and is shaped by both federal and state law. We first examine federal arbitration law, which provides the fundamental limits on this area of law. Second, we examine regulation of health care arbitration agreements at the state level, the point at which most regulation actually occurs. In addition, we discuss federal law regarding employee benefits and state law on medical malpractice, both of which are likely to affect the desirability of arbitration agreements to potential users.

1. *Federal Arbitration Law.* Federal support of private dispute resolution agreements can be traced to the Federal Arbitration Act of 1925 ("FAA").[25] The FAA regulates the use of private agreements to arbitrate disputes and can be characterized as supportive, preemptive, and emphasizing a contractual approach to private arbitration agreements. The statute provides for the enforcement of agreements to have disputes resolved through mechanisms of the parties' own choosing, outside of traditional litigation. Thus, arbitration clauses are enforceable against the parties to a contract for all disputes arising out of the performance or interpretation of the contract.[26] Courts must enforce arbitration clauses "save upon such grounds as exist at law or in equity for the revocation of any contract."[27]

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24. *See* THE INTERSTUDY COMPETITIVE EDGE PART II: HMO INDUSTRY REPORT 28 (1997).
25. 9 U.S.C. §§ 1-16 (1994).
26. *See id* § 2.
27. *Id.*

Although arbitration and other alternatives to litigation existed prior to the enactment of the FAA,[28] such programs did not receive much government support. In fact, the judiciary traditionally opposed such alternatives.[29] In the years since the FAA was enacted, the use of arbitration in business disputes has increased, as has the statute's reach. In a series of decisions beginning in the late 1950s, the Supreme Court established a number of rules regarding the interpretation of the FAA, concluding that the FAA is substantive rather than procedural law,[30] and that it was enacted by Congress pursuant to its power to regulate interstate commerce.[31] As a result of these decisions, the FAA preempts state law[32] in all instances in which interstate commerce is affected, to the extent that state law is inconsistent with the FAA[33] or "to the extent that it 'stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.'"[34]

A recent U.S. Supreme Court opinion demonstrates the continuing support this legislation enjoys. In *Doctor's Associates v. Casarotto*,[35] the Court held that state legislation treating arbitration clauses differently than other standard contract language is inconsistent with the FAA.[36] This decision established that the basic issue of enforceability of contractual arbitration clauses is one answered by federal law, and limited the state role in such interpretation. *Casarotto* left unanswered the question of what remained within the state purview with respect to arbitration agreements.

Recent state court decisions attempt to clarify the role of state law in the interpretation of arbitration agreements by emphasizing that although *Casarotto* appears to establish FAA preemption regarding those areas of the law that Congress has chosen to occupy with that statute, only state law that is *inconsistent* with FAA provisions or intent is preempted. For example, prior to *Casarotto* some courts had broadly interpreted the FAA's preemptive effect to preclude the application of state unconscionability law to arbitration contracts

28. For example, arbitration has a history of use in international business disputes pre-dating the jurisdiction of national courts. Neither statutory nor common law, however, provided the appropriate terms and conditions of its use. Similarly, collective bargaining agreements often called for arbitration to resolve labor disputes, thus avoiding recourse to more drastic measures such as strikes and lockouts. For a discussion of the development of arbitration in the United States, see generally IAN R. MACNEIL, AMERICAN ARBITRATION LAW: REFORMATION, NATIONALIZATION, INTERNATIONALIZATION (1992).

29. *See id.*

30. *See* Bernhardt v. Polygraphic Co. of Am., 350 U.S. 198, 203 (1956).

31. *See* Prima Paint Corp. v. Flood & Conklin Mfg. Co., 388 U.S. 395, 403-05 (1967).

32. *See* Southland Corp. v. Keating, 465 U.S. 1, 11 (1984); Moses H. Cone Mem'l Hosp. v. Mercury Constr. Corp., 460 U.S. 1, 20 (1983).

33. *See* U.S. CONST. art. VI, cl. 2.

34. Volt Info. Sciences, Inc. v. Board of Trustees, 489 U.S. 468, 477 (1989) (quoting Hines v. Davidowitz, 313 U.S. 52, 67 (1941)).

35. 116 S. Ct. 1652 (1996).

36. *Id.* at 1657. In *Casarotto*, the Supreme Court reviewed a Montana statute which required that arbitration clauses be printed on the first page of any contract in underlined capital letters. The Court concluded that because the statute placed special burdens on arbitration clauses, and conditioned the enforcement of such provisions on compliance with requirements not applicable to contracts generally, it was preempted by the FAA. *See id.*

despite the fact that the statute did not address the issue of unconscionability.[37] *Casarotto*, however, specifically identifies unconscionability as a state law doctrine that "may be applied to invalidate arbitration clauses without contravening [FAA] Section 2," since the FAA does not speak to that issue.[38]

A recent California state court decision, in assessing the tension between federal preemption under *Casarotto* and state arbitration law, concluded that California law regarding the procedure used to compel arbitration is not preempted by the FAA.[39] The California Supreme Court stated that "[b]ecause the California procedure for deciding motions to compel serves to further, rather than defeat, full and uniform effectuation of the federal law's objectives, the California law, rather than Section 4 of the USAA [United States Arbitration Act] is to be followed in California courts."[40] Accordingly, although the FAA preempts state law where the two conflict, much of the substantive law affecting the use of arbitration clauses may still be formed by states.[41]

2. *California Arbitration Law.* In California, both legislative and judicial policy-making have created a climate that is particularly conducive to arbitration. The California legislature has been consistently supportive of arbitration agreements. The California Civil Procedure Code ("CCP") specifically authorizes the use of arbitration clauses, consistent with the spirit and terms of the FAA.[42] The CCP states that "[a] written agreement to submit to arbitration an existing controversy or a controversy thereafter arising is valid, enforceable, and irrevocable, save upon grounds as exist for the revocation of any contract."[43]

Other California statutes regulate the use of arbitration agreements between patients/enrollees and providers/plans, typically requiring particular contractual formats to insure adequate disclosure. Despite their regulatory nature, these provisions were enacted as part of an effort to facilitate arbitration of medical malpractice disputes by specifying standardized language and formats for arbitration agreements, so that plans and providers following these standards would know that their agreements were enforceable. CCP §1295(a) requires that arbitration clauses in contracts for the provision of

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37. *See, e.g.*, Cohen v. Wedbush, Noble, Cooke, Inc., 841 F.2d 282, 286 (9th Cir. 1988).

38. 116 S. Ct. at 1656.

39. Rosenthal v. Great Western Fin. Sec. Corp., 926 P.2d 1061 (Cal. 1996) (holding that whether a party is entitled to jury trial to determine validity of an arbitration claim is matter of state law; noting that the FAA does not state dispositively that jury trial is mandated to determine the issue of arbitrability).

40. *Id.* at 1070.

41. *See infra* notes 46-82. *See also* Broemmer v. Abortions Servs. of Phoenix, Ltd., 840 P.2d 1013 (Ariz. 1992) (holding an arbitration clause unconscionable under state law analysis).

42. CAL. CIV. PROC. CODE §§ 1280 et seq. (Deering 1981). The FAA became the model for most state laws that were subsequently enacted. The California statutes that include the rules regulating contractual arbitration clauses were in fact adopted in 1927, two years after the enactment of the FAA. Both the FAA and the California statutes were based on arbitration laws passed in New York.

43. *Id.* § 1281.

health care services must appear in the first article of the contract and must use specific language.[44] In addition, such contracts must have additional specific language in at least ten-point bold red type immediately preceding the signature line of the contract.[45] Section 1295(e) specifically states that any contract that complies with these requirements will *not* be deemed unconscionable.[46]

By its own terms, Section 1295 does not govern arbitration provisions in contracts between enrollees and health plans registered under the Knox-Keene Act,[47] which covers virtually all California HMOs.[48] Other statutes, however, require that HMOs that include binding arbitration agreements in their enrollment contracts disclose them in clear and understandable language.[49] The California Insurance Code contains similar requirements for contractual arbitration provisions in disability insurance policies and non-profit hospital service plans.[50]

The California judiciary has been equally supportive of arbitration, interpreting the CCP language as a broad policy declaration on the legitimacy of arbitration agreements. The California Supreme Court has explicitly addressed two issues: the scope of arbitration agreements and the enforceability of arbiters' awards. The court has generously interpreted the reach of arbitration contracts in the context of health service agreements, typically enforcing agreements in which parties attempted to escape arbitration by claiming that they did not sign the contracts. In *Madden v. Kaiser Foundation Hospitals*,[51] the court held that an employer acting as an agent for its employees had the implicit authority to agree to a medical services contract containing an arbitration clause.[52] *Madden* established that arbitration clauses can be enforced in the common situation where the enrollee against whom the arbitration clause is being enforced is not actually the signatory to the clause.

The state's lower courts have used similar analyses in other cases upholding

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44. If challenged today, it is likely that these statutes would be found preempted by the FAA, since the provisions of § 1295 are quite similar to the Montana statute struck down in *Casarotto*.

45. *See* CAL. CIV. PROC. CODE § 1295(b) (Deering 1981).

46. *Id.* § 1295(e).

47. CAL. HEALTH & SAFETY CODE §§ 1340-1399 (West 1990); the Knox-Keene Health Care Service Plan Act of 1975 ("Knox-Keene Act") was enacted to promote the provision of health care services in California. Health care service plans registered pursuant to the Knox-Keene Act include plans that provide health care services in return for prepaid or periodic charges and are subject to regulation by the Commissioner of Corporations.

48. CAL. CIV. PROC. CODE § 1295(f) (Deering 1981)(excluding all plans registered pursuant to the Knox-Keene Act).

49. *See, e.g.*, CAL. HEALTH & SAFETY CODE § 1363(a) (Deering 1988). This statute would arguably run afoul of the FAA. State laws that place burdens on arbitration agreements beyond those applicable to general contract law are inconsistent with the FAA and are therefore preempted. *See, e.g., Casarotto*, 116 S. Ct. at 1156.

50. *See* CAL. INS. CODE § 11512 (Deering 1988). Again, these provisions would likely be preempted by the FAA.

51. 552 P.2d 1178 (Cal. 1976).

52. *Id.* at 1184.

the scope of arbitration agreements. In *Pietrelli v. Peacock*,[53] the California Court of Appeals compelled arbitration of a claim brought by a minor against a health care provider where an arbitration agreement was signed by the minor's mother before the minor was conceived.[54] Additional decisions have established that, in situations in which the non-signatory is represented by a fiduciary (including an agent,[55] parent,[56] or spouse[57]) legally authorized to act on his or her behalf, the arbitration clause will be upheld. However, California cases have held that if the arbitration clause is being enforced against an individual who does not read or speak English, and if no attempt to communicate the consequences of the terms of the agreement is made by the care provider, no contract to arbitrate can be formed.[58]

California Supreme Court decisions regarding the enforceability of arbitration agreements have established that such agreements can be avoided only by showing fraud, duress, or unconscionability.[59] The leading case in this area is *Graham v. Scissor-Tail, Inc.*,[60] in which the court concluded that a contractual arbitration clause could be voided where the party injured by its operation could prove (1) that the contract was one of adhesion, in that it was imposed by a party with superior bargaining strength upon a party who had no opportunity to reject it, *and* (2) that enforcement of the agreement was either outside the reasonable expectations of the weaker party, or unduly oppressive or unconscionable.[61]

Other applications of the *Graham* principles in the health care area are illustrative. Arbitration clauses containing terms that are fundamentally one-sided will likely be found unconscionable. For example, in *Saika v. Gold*,[62] the arbitration clause at issue included the right to seek trial if the arbitrator awarded more than $25,000.[63] The court found that this provision would rarely assist patients, more often allowing physicians to escape unfavorable awards.[64] Additionally, in *Stirlen v. Supercuts, Inc.*,[65] a mandatory arbitration clause in an employment contract was found to be unconscionable where it allowed issues

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53. 16 Cal. Rptr. 2d 688, 691 (Cal. Ct. App. 1993).

54. *Id.* at 695.

55. *See* Madden v. Kaiser Found. Hosp., 552 P.2d 1178, 1184 (Cal. 1976).

56. *See* Doyle v. Giuliucci, 401 P.2d 1 (Cal. 1965); Wilson v. Kaiser Foundation Hosp., 190 Cal. Rptr. 649 (Cal. Ct. App. 1983).

57. *See* Hawkins v. Superior Court, 152 Cal. Rptr. 491 (Cal. Ct. App. 1979).

58. *See* Ramirez v. Superior Court, 163 Cal. Rptr. 223 (Cal. Ct. App. 1980).

59. *See, e.g.*, Advanced Micro Devices, Inc. v. Intel Corp., 885 P.2d 994 (Cal. 1994). This rule reflects contract law applicable to all contracts and is therefore consistent with both *Casarotto* and the language of California Civil Procedure Code § 1281.

60. 623 P.2d 165 (Cal. 1981).

61. *Id.* at 172-73. In *Graham*, the contract at issue required arbitration before the American Federation of Musicians. Since one of the parties to the contract was a member of the AFM, the court found that this contract was unconscionable, despite the fact that the party against whom the provision was to be enforced was a sophisticated businessman. *Id.* at 179-80.

62. 56 Cal. Rptr. 2d 922 (Cal. Ct. App. 1996).

63. *Id.* at 924.

64. *Id.* at 925-26.

65. 60 Cal. Rptr. 2d 138, 151-52 (Cal. Ct. App. 1997).

of importance to the employer to be litigated but required issues of importance to the employee to be arbitrated. Additionally, fair notice of the existence of an arbitration clause is likely necessary before the clause is deemed enforceable. In *Bell v. Congress Mortgage Co., Inc.*,[66] the California Court of Appeals held that an arbitration clause in mortgage documents was not enforceable where it was buried in non-negotiable, standardized agreements between elderly homeowners and a lender. The *Bell* court stated that "the enforceability of a compelled arbitration provision in a contract of adhesion requires that the provision appear in a clear and unmistakable form."[67] As previously stated, however, California courts have broadly interpreted the scope of arbitration clauses in the absence of fairly egregious flaws.

In addition to broadly interpreting the reach of arbitration clauses, California law also significantly limits review of an arbitrator's award. In general, an arbitrator's decision can be overturned only where "procured by corruption, fraud, or other undue means,"[68] or where the rights of a party were prejudiced by arbitrator misconduct.[69] The courts have used this legislation to afford arbitrators wide discretion. In *Moncharch v. Heily & Blase*,[70] the California Supreme Court held that the legislature intended to limit the review of arbitrator decisions to those grounds specifically delineated in Section 1286.2 (that is, corruption, fraud or other undue means) ruling that even where a decision may be in error, it cannot be reviewed by the courts absent a showing of fraud or bias on the part of the arbitrator. Likewise, in *Advanced Micro Devices, Inc. v. Intel Corp.*,[71] the court upheld an award fashioned by an arbitrator that was not sought by either party.[72] The *Advanced Micro Devices* court stated that an arbitrator has the power to create an award that is based on the contract at issue in the dispute, even if the basis of such an award is a tenuous one.[73]

The California Supreme Court recently revisited the issue of the enforceability of mandatory arbitration clauses in *Engalla v. Permanente Medical Group, Inc.*[74] In *Engalla*, the court held that the Kaiser-administered arbitration, as operated, might provide the basis for a fraudulent inducement or waiver defense to the enforcement of an arbitration clause. In the case, the claimants produced evidence that showed Kaiser, despite the persistent efforts of the claimants' attorneys to expedite the process, had delayed selection of the

66. 30 Cal. Rptr. 2d 205, 210 (Cal. Ct. App. 1994).

67. *Id.* at 210; *see also* Patterson v. ITT Consumer Fin. Corp., 18 Cal. Rptr. 2d 563, 566-67 (Cal. Ct. App. 1993) (Minnesota venue forced on a California consumer in a small-dollar dispute found unconscionable).

68. CAL. CIV. PROC. CODE §§ 1286.2(a),(b) (Deering Supp. 1997).

69. *See id.* §§ 1286.2(c), (e).

70. 832 P.2d 899, 919 (Cal. 1992).

71. 885 P.2d 994 (Cal. 1994).

72. *Id.* at 996.

73. *Id.* at 1005 ("The remedy awarded, however, must bear some rational relationship to the contract and the breach.").

74. 938 P.2d 903 (Cal. 1997).

third neutral arbitrator,[75] thereby preventing the case from going forward.[76] During this period, Mr. Engalla died. The claimants also produced evidence from a Kaiser-sponsored study documenting that, despite the terms of the Kaiser arbitration agreement, which required the selection of a third neutral arbitrator within sixty days of the claim,[77] neutral arbitrators were rarely appointed in that time, and that in fact the average time to appointment was 674 days.

The court held that Kaiser's actions arguably constituted both fraud in the inducement of the contract and waiver of its right to compel arbitration, and remanded the case to the trial court for further litigation on these issues.[78] The court, however, rejected the claimants' argument that the arbitration clause was unconscionable under *Graham*.[79] In reaching this conclusion, it stated that "although the present contract has some of the attributes of adhesion, it does not, on its face, lack 'minimum levels of integrity.'"[80] The terms of the contract itself were not defective; rather, it was the gap between the "contractual representations and the actual workings of the arbitration program."[81] In concurrence, Justices Kennard and Werdegar cautioned "that new possibilities for unfairness arise as arbitration ventures move beyond the world of merchant-to-merchant disputes in which it was conceived and into the world of consumer transactions."[82]

The court's analysis of the arbitration procedure in *Engalla*, coupled with the concurrence of Justices Kennard and Werdegar, suggests the possibility of an important shift in future legal analyses of arbitration agreements. It seems likely that the question of unconscionability has been adequately addressed and that future analyses will turn to the question of procedural fairness. Courts will focus less on the relationship between the parties and more on the specific practices employed in the execution of arbitration agreements.[83] Issues could include timeliness of proceedings, overall fairness of proceedings,[84]

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75. Kaiser arbitration agreements provide for two party arbitrators, one chosen by each side in the dispute, and one neutral arbitrator chosen by the two party arbitrators. The one neutral arbitrator thus becomes the lynchpin of the arbitration process.

76. *Engalla*, 938 P.2d at 911-12.

77. Kaiser arbitration rules require that each party choose a party arbitrator within 30 days of the service of the claim, and that the party arbitrators choose the neutral arbitrator within 30 days thereafter.

78. *Engalla*, 938 P.2d at 922-24.

79. *Id.* at 925.

80. *Id.*

81. *Id*

82. *Id.* at 926.

83. *See, e.g.*, Cheng-Canindin v. Renaissance Hotel Ass'ns, 57 Cal. Rptr. 2d 867, 874-76 (Cal. Ct. App. 1996) (refusing to enforce arbitration clause, where procedure required complaints to be heard by an internal review committee, because procedure did not constitute arbitration; clause did not, therefore, constitute waiver of right to trial).

84. Arbitrator bias is an aspect of procedural fairness that is already the subject of legislation and judicial review. *See* CAL. CIV. PROC. CODE § 1286.2 (Deering 1981). The California Supreme Court has ruled that although the possible bias of an arbitrator does not invalidate a mandatory arbitration agreement, it is grounds for vacating the arbitrator's decision. *See, e.g.*, Neaman v. Kaiser Found. Hosp., 11 Cal. Rptr. 2d 879 (1992).

qualifications of arbitrators, fairness of discovery and evidentiary rules, and fair allocation of costs.

The *Engalla* decision suggests that providers and health plans will have to exercise additional procedural diligence to ensure that their arbitration practices are above challenge. Whether or not such diligence imposes significant additional burdens on those choosing to use agreements, thus reducing their incentives to incorporate agreements into their business relationships, remains to be seen.

3. *Other Statutes Affecting the Use of Arbitration Agreements.* In addition to statutes directly regulating the use of arbitration agreements, two other statutes may well play a role in determining whether California health plans and providers find private, binding arbitration an attractive alternative to the courts. These statutes are the federal Employee Retirement Income Security Act of 1974 ("ERISA")[85] and California's Medical Injury Compensation Reform Act of 1975 ("MICRA"),[86] each of which has provisions that are likely to limit the attractiveness of private arbitration agreements.

ERISA preempts state control of employee health benefit plans, although it specifically preserves the rights of states to regulate the business of insurance.[87] The insurance savings clause notwithstanding, the practical effect of the statute has been that ERISA governs the terms and implementation of private sector employee benefits; it does not extend to insured but self-employed workers, government employees, or to those who purchase health insurance as individuals.[88] In general, ERISA preemption of state law is viewed as benefiting health plans because, in the event of a wrongful denial of coverage, ERISA limits damages to the difference between the benefits that should have been provided and the benefits that were provided, plus legal fees, and does not permit other damages of any kind.[89]

The courts have determined that coverage provisions and determinations pertain to "benefits due … under the terms of the [plan]"[90] and that state regulation of *coverage* is accordingly preempted by ERISA.[91] At the same time, recent federal judicial decisions have held that actions regarding the *quality* of benefits received are not claims to recover benefits, and are therefore

85. 29 U.S.C. §§ 1001-1461 (1994).

86. MICRA is codified at CAL. BUS. & PROF. CODE § 6146, CAL. CIV. CODE § 3333, and CAL. CIV. PROC. CODE §§ 340.5, 1295. The various provisions of MICRA were subject to and withstood constitutional challenge in the California courts over a ten-year period. *See, e.g.*, Roa v. Lodi Medical Group, 695 P.2d 164 (Cal. 1985) (upholding CAL. BUS. & PROF. CODE § 6146); Fein v. Permanente Med. Group, 695 P.2d 665 (Cal. 1985) (upholding CAL. CIV. PROC. CODE § 3333.2); Barme v. Wood, 689 P.2d 446 (Cal. 1984) (upholding CAL. CIV. PROC. CODE § 3333.1).

87. *See* 29 U.S.C. § 1144(b)(2)(a) (1994).

88. *See id.* § 1321(b).

89. *See id.* § 1132(g).

90. *See id.* § 1132(a)(1)(b).

91. *See id.* §1144(a) (ERISA "shall supersede any and all State laws insofar as they now or hereafter relate to any employment benefit plan.").

not claims preempted by ERISA.[92] These decisions also point out that the distinction between actions to recover benefits (coverage disputes) and actions over the quality of benefits (treatment decisions and technical competence) is not always easy to make.[93] Rather, commentators argue, it is an artificial distinction prompted by the existence of ERISA.[94]

ERISA in no way limits the use of binding arbitration or arbitration agreements to resolve disputes that might arise under its provisions. However, it does place the coverage provisions and decisions of employee health plans beyond the reach of state regulation. Even where fault on the part of a provider might exist, potential awards are severely limited, and, as such, will not attract the attention of many plaintiffs' attorneys. Thus, with ERISA in place, health plans might feel little pressure to initiate new forms of dispute resolution.

MICRA, the second statute that might be expected to provide a contextual influence on decisions to use medical arbitration agreements, without directly regulating such agreements, resulted from a perceived crisis in the health care industry in the early 1970s. Increases in claims and awards prompted private malpractice insurers to leave the market.[95] In response, almost every state adopted statutory tort reforms in the medical malpractice area. California enacted MICRA in 1975.

Among other prescriptions, MICRA imposes the following rules on all medical malpractice actions in California, including arbitration claims:

- Non-economic damages, including pain, suffering, inconvenience, and disfigurement are limited to $250,000;[96]
- Evidence of collateral sources for compensation of injuries, such as workers' compensation benefits or health or disability insurance, is admissible as evidence at the discretion of the defendant;[97]
- Future damage awards for lost wages or medical costs can be paid periodically instead of as a lump sum;[98] and

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92. *See, e.g.*, Rice v. Panchal, 65 F.3d 637 (7th Cir. 1995); Dukes v. U.S. Healthcare, 57 F.3d 350 (3d Cir. 1995); Lancaster v. Kaiser Found., 958 F. Supp. 1137 (E.D. Va. 1997); Roessert v. Health Net, 929 F. Supp. 343 (N.D. Ca. 1996). In *Dukes*, the Third Circuit reversed a trial court decision to remove a medical malpractice action to federal court, concluding that the plaintiff's complaint concerned the quality of a benefit provided under an ERISA plan, rather than coverage; accordingly, "complete [federal] preemption" did not apply. *Dukes*, 57 F.3d at 356-57.

93. *See Dukes*, 57 F.3d at 358. In addition, some states have attempted to legislate HMO liability for medical malpractice actions. New York and Texas have passed statutes that would hold HMOs to a "reasonable care" standard when they decide to delay or deny payment for treatment. These statutes would of course apply to cases in which there is no ERISA preemption. Their application to health care plans, which otherwise would be subject to ERISA regulation, depends on future interpretation of the courts.

94. *See, e.g.*, Sage, *supra* note 5, at 14-15.

95. *See generally* U.S. GEN. ACCOUNTING OFFFICE, MEDICAL MALPRACTICE: CASE STUDY ON CALIFORNIA (1986).

96. *See* CAL. CIV. CODE § 3333.2 (Deering 1984).

97. *See id.* § 3333.1.

98. *See* CAL. CIV. PROC. CODE § 667.7 (Deering 1983).

- Contingency fees are limited according to a sliding scale.[99]

Although there is no empirical evidence documenting the effects of MICRA on claiming behavior and awards, the statute will likely reduce interest in arbitration agreements. First, one of the traditional benefits attributed to arbitration is that it allows defendants to avoid the possibility of the "runaway" jury award. In the medical malpractice area, however, MICRA already limits jury discretion.[100] Therefore, the marginal value of arbitration to defendants in medical malpractice suits is likely to be less than in other areas of litigation.

Although the damage cap and other provisions of MICRA both reduce the potential size of any award and limit contingency fees, making medical malpractice claims less attractive to plaintiff attorneys than they were before MICRA, litigation costs may be lower if cases are subject to arbitration. Thus, plaintiffs' attorneys may be willing to accept lower valued cases providing that the cases are subject to arbitration. Potential defendants might then be expected to avoid using instruments that could increase the ability of a claimant to find representation and bring suit.

In sum, arbitration agreements in the context of health care delivery find a hospitable legal climate in California. Federal law is supportive and preemptive. State law is similarly supportive, generously interpreting the reach and enforceability of agreements. Substantial room exists, however, for further regulation of procedural requirements and practices. At the same time, statutes that are not in any way intended to regulate the use of agreements, such as ERISA and MICRA, have the potential to significantly affect the value of agreements to potential users. The next section explores these potential effects, among other issues, as it looks at the prevalence of agreements and the rationales underlying their implementation.

C. Decisionmakers and Data Collection

The legal climate in California presents no real barrier to the adoption of arbitration agreements, so diffusion of such agreements depends principally on the choices of those involved in the delivery of care. A central question is who, among the many participants in health care delivery, might see themselves as benefiting from the use of such agreements?

There are three major points of professional intervention in the rendering of health care where conflict may arise: coverage decisions; treatment decisions; and provision of treatment. As Table 1 indicates, different participants in the delivery system typically bear responsibility at each of these points; these participants may differ between fee-for-service and managed care plans. In the traditional, fee-for-service delivery environment, virtually all the disputes between enrollees/patients and plans/providers fall in the category of professional liability or negligence disputes, and they are disputes between

99. *See* CAL. BUS. & PROF. CODE § 6146 (Deering 1983).

100. *See supra* notes 96-98 and accompanying text.

patients and providers.[101] In managed care, payers scrutinize treatment plans and deny coverage for care, which not only raises additional opportunities for disputes but also paves the way for new types of disputants.

TABLE 1
WHO MAKES THE DECISIONS?

	Fee-For-Service	Managed Care
Coverage Decisions	Not Applicable	Self-Insuring Employer Or Health Plan HMO Other Capitating Provider
Treatment Decisions	Physicians	Health Plan Physician
Provision Of Treatment	Physicians Hospitals	Physician Hospital (Health Plan, Hmo*)

*As discussed above, statutory and case law are expanding the scope of responsibility for quality of care to include health plans and HMOs. In addition to coverage decisions, plans may become responsible for the treatment choices and technical competence of their providers.

This framework suggests that there are three important types of participants in health care delivery that might adopt arbitration agreements: physicians, hospitals, and insuring/risk-bearing entities such as self-insuring employers,[102] HMOs, and health insurance plans. These are all groups that would themselves be parties to the agreements.

In addition to these principals, one might readily imagine that a secondary tier of participants—medical malpractice insurers and trade associations—would play some role in encouraging or discouraging the use of agreements by principals. Medical malpractice insurers ultimately pay much of the cost of disputes and awards; thus they are likely to have strong preferences regarding arbitration agreements depending on whether they believe such agreements ultimately reduce their costs. The insurers might be expected to put strong pressure on their insureds either to use or avoid such agreements. It also seems possible that trade associations—organizations that often collect information from their membership to illuminate common problems—might have conducted some research into the value of arbitration agreements for their membership and are now playing some role in promoting or discouraging their use by members. This group of decision shapers and makers is the object of our current analysis.

101. As we use it, the term "provider" encompasses both physicians and hospitals.

102. Although self-insured employers do bear risk and make coverage decisions, we were not able to include them in this study. However, conversations with the California Business Group on Health suggest that large employers have not yet focused on dispute resolution alternatives. Their lack of concern may well be due to the fact that coverage disputes are very rare.

We used close-ended mail surveys to collect information from physicians and hospitals, mailing questionnaires to a random sample of 800 California physicians[103] and a stratified random sample of ninety-nine state hospitals. The physician sample was constructed from the List Source, a California Medical Association list of all resident and licensed physicians.[104] The hospital sample was constructed using the twelve largest hospitals (based on number of beds, occupancy rates, and outpatient visits) and a random sample of eighty-seven hospitals drawn from the 532 California hospitals listed in the *1995 American Hospital Guide*.[105] We achieved response rates of forty-seven percent and forty-nine percent respectively for the physician and hospital surveys.[106] Subsequent analysis points to some response bias in the hospital group; the data we present has been adjusted to account for the bias.[107]

We used open-ended personal interviews (some in person and some by telephone) to collect information from health plans, malpractice insurers, arbitration services, and trade associations. We interviewed the state's six largest HMOs (accounting for ninety percent of the state's enrollment), five health insurers with the largest PPO enrollments,[108] the state's five largest medical malpractice insurers, the two most prominent arbitration services, and three major trade associations (California Medical Association, California Healthcare Association, and the California Association of HMOs ("CAHMO")).[109] We augmented our health plan interview data with information from a 1995 survey of member HMOs conducted by CAHMO

103. We made additional attempts to collect information from nonrespondents in the form of two additional mailings and one telephone follow-up.

104. Before drawing our sample of 800 from the list of approximately 80,000 physicians, we excluded all retired and federally employed physicians and physicians who no longer practice in California.

105. AMERICAN HOSP. ASS'N, 1995 GUIDE TO THE HEALTH CARE FIELD A36-67 (1995). We made follow-up telephone calls to nonresponding hospitals.

106. We mailed questionnaires to a random sample of physicians and made further attempts to collect information from nonrespondents with two additional mail follow-ups and one additional telephone follow-up. Similarly, we performed two mailings with follow-up telephone calls to each nonrespondent hospital.

107. To address the possibility of meaningful differences between respondents and nonrespondents, we compared the available characteristics of the two groups. The physician list provided only addresses, and a comparison of the two groups of physicians by zip code suggested no statistically significant differences ($p<0.05$). Similarly, there was little evidence of response bias with respect to hospital size. An analysis of hospital location indicated a marginal statistically significant difference in response rates, with hospitals from Northern and Central California being somewhat more likely to respond to our surveys ($p<0.05$). At the same time, we should note that Kaiser hospitals made a uniform decision not to reply to our survey. Thus, the estimate of the use of agreements by hospitals in Table 2 is adjusted to account for no response by Kaiser. We separated the population of California hospitals into two groups, Kaiser and non-Kaiser. We estimated the non-Kaiser group's rate of using arbitration agreements from our hospital survey and estimated the Kaiser group's rate as 100%. We report weighted averages of these two rates using weights proportional to the fraction of hospitals and the fraction of admissions from Kaiser hospitals in lines 2 and 3 of Table 2.

108. Of the HMOs and health plans, we attempted interviews with Kaiser, Health Net, PacificCare/FHP, Blue Cross, Blue Shield, Aetna, CIGNA, and Prudential. Blue Cross declined to participate.

109. CAHMO has recently changed its name to California Association of Health Plans.

regarding the use of arbitration agreements.[110]

Our chief goals were to determine the prevalence of agreements, to identify concentrated groups of those with agreements in place, and to identify sources of data in an effort to determine the feasibility of a follow-up statistical evaluation of outcomes when agreements are in force. We also wanted to collect preliminary information on the rationales underlying choices regarding arbitration agreements. In both the mail survey and personal interviews, we asked for information on the following: whether respondents or their organizations used or recommended using arbitration agreements and the reasons for this choice; the implementation practices and satisfaction levels of those using or recommending the use of arbitration agreements; and the business characteristics and claims experience of providers, plans, and insurers.

D. Findings

1. *Prevalence of Agreements Among Providers.* Our survey of doctors and hospitals demonstrated that the use of arbitration agreements between providers and patients is not particularly widespread. As the Table 2 estimates show, only nine percent of the hospitals and nine percent of the physicians we surveyed use such agreements. Twenty percent of patients admitted to hospitals, however, are admitted to hospitals that use arbitration agreements. Thus, patients encounter agreements in hospital settings with some frequency.

TABLE 2*
PERCENTAGES OF PHYSICIANS AND HOSPITALS THAT USE AGREEMENTS

	Use Arbitration Agreements	Do Not Use Agreements	Sample Size
Percent Of Physicians	9%	91%	369
Percent Of Hospitals*	9%	91%	99
Percent Hospital Admissions*	20%	80%	NA

*The total number of physicians may vary across tables because of missing responses. See discussion in footnote 106 regarding the number of hospitals in the sample.

Although the percentage of physicians using agreements is small, it is increasing. More than sixty percent of physicians currently using agreements have adopted them since 1990, suggesting that a reasonably persistent diffusion

110. In 1995, CAHMO asked its members to provide information on their use of arbitration agreements in a broad range of business relationships, including their use of agreements with purchasers and enrollees. Twenty-eight of the 32 members responded, including all of the large HMOs. CAHMO made the results of this survey available in 1996. *See* CALIFORNIA ASS'N OF HEALTH PLANS, SURVEY ON USE OF BINDING ARBITRATION (1996).

process is underway in the physician community.[111]

Two factors that appear to underlie the diffusion of arbitration agreements among providers are insurer support for use of such agreements and practice in an HMO setting. Our survey indicates that arbitration agreements are concentrated in a few identifiable groups of physicians who share one or both of these traits. As the Table 3 estimates show, fifty percent of the physician members of CAP/MPT, a professional liability coverage provider that strongly encourages its members to use arbitration agreements in their practices, have agreements in place, compared with only six percent of physicians insured by other carriers.[112] We estimate that forty percent of those physicians who practice in an HMO setting use arbitration agreements, compared to only eight percent of those who do not.

Use of arbitration agreements also appears to be linked to a provider's claims experience. Only seven percent of the physicians reporting no malpractice claims in the last five years use agreements, compared to sixteen percent who have had claims against them in that period.[113] Whether or not physicians use agreements is not related to their years in practice.

TABLE 3
ONCE INSURER IS LINKED TO PHYSICIAN USE OF AGREEMENTS

Insurance Of Physician	Uses Agreements	Does Not Use Agreements	Total
Member Of CAP/MPT	50%	50%	32
Not Insured With CAP/MPT	6%	94%	335
TOTAL*	9.5%	90.5%	367

NOTE: Differences statistically significant($p<0.05$).

*Totals represent only those respondents answering the question.

2. *Prevalence of Agreements among Plans.* Use of arbitration agreements

111. For a comprehensive discussion of the research on innovation diffusion, see generally EVERETT M. ROGERS, DIFFUSION OF INNOVATION (1995).

112. CAP/MPT has a well-developed program to educate and encourage its members to use arbitration agreements; they particularly target the high-risk specialties, including orthopedic surgery, obstetrics, and neurosurgery. Each newly insured physician is presented with materials that explain arbitration and its benefits, suggest how agreements can be incorporated into the normal paperwork for new patients, and encourage the physician to make arbitration agreements the standard in his or her office. CAP/MPT also provides physicians with a continuous and complimentary supply of standardized agreement forms and offers to train the physician's office staff to obtain and file agreements. The company repeats its efforts to persuade physicians to incorporate the use of agreements into their standard office practice when physicians who have not been using agreements find themselves party to a malpractice claim.

113. This difference is statistically significant ($p<0.05$). These data may reflect the fact that CAP/MPT, as part of its physician education and risk management program, makes a special effort to introduce agreements into physicians' practices at the time of any suit.

by managed health plans[114] presents quite a different picture; most HMOs incorporate arbitration agreements into their contracts with purchasers and enrollees, while preferred provider organizations ("PPOs") do not.[115] CAHMO reports that twenty (seventy-one percent) of the twenty-eight HMO respondents in its 1995 survey of members used arbitration agreements with enrollees.[116] In sharp contrast, none of the health plans that provided information reported using agreements with those enrolling in their PPO plans. Insurers that offered both HMO and PPO products (for example, Prudential) reported using agreements differentially among products.

However, of the HMOs that used agreements, most designed them to apply only to contract disputes and not to the professional liability of their providers. In only eight of the twenty instances where HMOs reported using agreements with enrollees—the agreements of Kaiser, CIGNA, and six very small plans—did those agreements apply to both contractual *and* medical malpractice disputes.[117] These plans seemed to share no explanatory characteristics. Group members included the largest and some of the smallest plans, a mixture of types of plans, and plans owned by for-profit and not-for-profit companies.

3. *The Arbitration Caseload.* A full appreciation of the reach of arbitration agreements necessitates going beyond evaluation of the prevalence of such agreements. It is also important to consider whether these disputes are predominantly coverage or malpractice disputes and to determine the proportion of the dispute caseload that goes to arbitration.

Regarding the types of disputes that are typically arbitrated, only fragmentary information exists describing the dispute caseloads of providers and health plans. However, that information strongly suggests that arbitrated disputes are almost exclusively medical malpractice disputes. Despite the fact that most HMOs in California use arbitration agreements, their agreements typically apply only to coverage disputes, and the number of coverage disputes is negligible. In the CAHMO survey, responding plans reported an annual average of only four coverage disputes per one million enrollees in contrast to an annual average of 102 claims per one million enrollees for medical malpractice disputes.[118] While these data probably capture virtually all of the

114. We have restricted our inquiry to the two principal types of managed care plans: HMOs and PPOs.

115. We have limited our investigation to managed care products, reasoning that fee-for-service plans do not make coverage decisions or direct patients to providers.

116. Subsequent to the CAHMO survey, FHP merged with PacifiCare, and, since January, 1997, the merged HMO has used agreements in all new service agreements.

117. Subsequent to the CAHMO survey, CIGNA, formerly a staff model HMO, divested itself of its clinics and physician contracts, shifting to a network model. At the same time, it relinquished responsibility for any negligence on the part of its physicians, and its agreements now only apply to coverage disputes.

118. The CAHMO survey response rates for these questions was problematic. Respondents were asked for information for each of five years and many were able to provide information for only a few of these years. Regarding medical malpractice, only CIGNA and Kaiser responded. Thus, these figures are suggestive only of the great difference in the numbers of coverage and medical malpractice disputes currently being brought.

coverage claims brought in California, they do not begin to account for all of the medical malpractice disputes, most of which arise outside of the purview of reporting HMOs. These findings are consistent with the interpretation (despite public perceptions to the contrary)[119] that ERISA provisions, in combination with the mandatory Medicare appeals process,[120] have actually removed coverage, for the most part, as a matter for litigation.

Our information on the proportion of medical malpractice disputes that are arbitrated is inconclusive. Caseload data from Kaiser and the state's largest medical malpractice insurers suggest that approximately ten percent of their medical malpractice disputes are arbitrated, a number that is consistent with the proportion of physicians who report using arbitration. However, the physicians responding to our survey report arbitrating more than twenty-five percent of the claims against them, perhaps reflecting some confusion on their part regarding what arbitration is and/or how their claims were, in fact, handled. We do not have data on hospital disputes.[121]

4. *Incentives, Rationales, and Satisfaction Rates.* External pressures play a significant role in determining whether physicians choose to use arbitration agreements. As Table 4 shows,[122] more than half (fifty seven percent) of the respondents in our physician survey who use agreements reported that they do so because their insurer so recommends. Nearly one third (thirty-one percent) of those using agreements reported they do so because it is the policy of their practice group. Finally, more than one third (thirty-four percent) reported using them because they believe arbitration is a less expensive way to resolve disputes.[123]

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119. Media coverage of recent and extremely high awards has put coverage disputes in the public eye. *See, e.g.,* Dawn Hobbs, *Lawyer Raises Questions on Choosing HMO*, L.A. TIMES, Mar. 29, 1997, at B1 (reporting on $89.9 million damage award).

120. 42 U.S.C. §1395(c)(5) (Supp. V 1988). For a description of the Medicare appeals process, see Eleanor D. Kinney, *Medicare Managed Care from the Beneficiary's Perspective*, 26 SETON HALL L. REV. 1163, 1179-80 (1996).

121. Most hospitals self-insure, and we did not ask for information on their claims history in our survey.

122. Only physicians using arbitration agreements are included in Table 4 because only two hospitals reported using arbitration agreements; their reasons may be idiosyncratic and are not reported here.

123. Other reasons identified less frequently for using arbitration clauses include colleague recommendations and avoiding litigious patients.

TABLE 4
LEADING REASONS OF PHYSICIANS FOR USING
ARBITRATION AGREEMENTS

	Number Of Physicians (N=35)	Percent*
Insurer Recommends	20	57%
Arbitration Cheaper	12	34%
Policy Of Group	11	31%
Avoid Juries	8	23%
Avoid Courts	7	20%

*Percent sums to more than 100 because respondents were asked to "circle all that apply." Table reflects respondent physicians only.

Of the physicians in our sample with arbitration agreements in place, ninety six percent are generally satisfied with them. Satisfaction was as high among those with actual arbitration experience as it was among providers as a whole.

Physicians and hospitals gave similar but not identical reasons for *not* using agreements. Table 5 shows that the principal reason physicians gave for not using arbitration agreements was lack of familiarity with them (forty percent of those without agreements in place). Almost a third (thirty-one percent) of those without agreements reported they do not use them because "they set the wrong tone" for the patient. Other factors, including policies of insurers or of medical groups (twenty-three percent), or greater likelihood of winning in court, do not appear to play as large a role in their decision-making.[124] Similarly, more than one third (thirty-six percent) of the responding hospitals reported they do not use arbitration agreements because agreements "set the wrong tone" for patients. Twenty-six percent reported they do not use agreements in accordance with the policy of a hospital's corporate owner. Other rationales apparently play only minor roles in hospital decisionmaking.[125]

124. Respondents were asked to "circle all that apply." Therefore, these categories are not mutually exclusive.

125. Since most of the responding hospitals self-insure against malpractice suits, the influence of malpractice insurers is not relevant to this population.

TABLE 5
LEADING REASONS OF PHYSICIANS AND HOSPITALS FOR NOT USING AGREEMENTS

	Physicians	Hospitals
Not Familiar With Them	40%	19%
Wrong Tone For Patient	31%	36%
Policy Of Group Or Corporate Owner	23%	26%
Total Number	367	47

NOTE: Table reflects respondent sample only.

Health plans, HMOs, and PPOs reported different rationales for using arbitration agreements. The HMOs we interviewed reported a homogeneous set of rationales for adopting agreements, which typically related to controlling costs. They characterized arbitration as a cheaper, faster process that "insures that the right issues will be considered" and "protects against the "runaway award." One user emphasized that arbitration's procedural informality and speed greatly reduce the demands on their doctors. Respondents representing California's largest preferred provider health plans reported that their PPOs did not use agreements but that they did not know why; it appeared the plans had not seriously considered the question at a policy level.[126]

Although no malpractice insurers directly mandate use of agreements as a precondition of coverage, our research suggests that such insurers greatly influence decisions of physicians (see Table 3). The one malpractice insurer (of the five we interviewed) urging the use of agreements does so to reduce transaction costs, save time, reduce the demands on their insured physicians, and to get knowledgeable adjudicators - all the standard reasons. That insurer contends that its arbitrated caseload costs thirty-three percent less to defend than its trial track caseload.[127]

Only one of the four major California malpractice insurers that do not encourage their insureds to use arbitration agreements does so as a matter of policy. This insurer strongly avers that "with MICRA, we get better results in court." The other three report having "no policy" regarding agreements, although they, too, subscribe to the belief that arbitration is more likely to result in some indemnification of doctors because "arbitrators tend to split the baby." One insurance company representative attributes her firm's failure to adopt a position to the fact that it was a doctor-owned company and "doctors

126. Blue Cross, one of California's largest PPOs, declined to participate in our survey. We understand, however, that Blue Cross does use arbitration agreements, making that PPO the exception.

127. *Hearing on the Advantages of the California Arbitration System Before the California Department of Insurance* (Ca. 1997) (statement of Gordon T. Ownby, General Counsel, CAP/MPT).

believed use of agreements set the wrong tone" in the doctor-patient relationship.[128] Several respondents suggest that the perception that arbitrators are reluctant to render defense verdicts may be a significant barrier to the use of arbitration. Today's doctors are increasingly anxious to avoid any indemnification since all settlements and awards, irrespective of the size or forum of dispute resolution, must be reported to the National Practitioner Data Bank and become a matter of public record; any reports of judgments against providers may pose a serious obstacle to securing contracts with managed care plans.

Despite their negative comments, the four malpractice insurers not currently encouraging the use of arbitration indicated a moderate to strong interest in it. These insurers stated that if they could document the claimed efficiencies of the arbitration process, their companies would likely follow in CAP/MPT's footsteps. At the time of our interview, one insurer was actively considering a policy of proactive support for arbitration.

5. *Rules and Insights into Implementation.* Typically, the agreements in force are quite general in their provisions and are self-administering. Seventeen (eighty-five percent) of the twenty HMOs that use agreements, as well as a few physicians, report that their agreements specify that the American Arbitration Association ("AAA") or JAMS/Endispute will administer the arbitration of disputes according to the rather detailed rules and procedures of those organizations. However, consistent with our finding that there are very few coverage disputes, data from the two dispute resolution services reveal that neither one oversees more than a couple of health care disputes a year. In fact, both Kaiser and CAP/MPT physicians are parties in the vast majority of arbitrated disputes (which concern medical malpractice rather than coverage) and their agreements do not provide for the use of an arbitration service. Rather, their agreements set forth the rules for a self-administering process. These rules provide only the most basic procedural framework, and compliance is left up to the parties. To force the compliance of a recalcitrant party, an aggrieved party must go to court. Those matters not specified are left to the discretion of the neutral arbitrators.

In Table 6, we have grouped the rules that govern the conduct of disputes into eight basic categories to compare those used by Kaiser, CAP/MPT, and AAA.[129]

128. The medical malpractice carriers we interviewed all began as doctor-owned companies, although one recently went public.

129. We have not included the rules used by JAMS/Endispute because this service provider was specified as the provider of choice in only a few contracts. However, their rules do not differ markedly from those of AAA.

TABLE 6
VARIATION OF ARBITRATION RULES

	Kaiser	CAP/MPT	AAA
Number Of Arbitrators	1 If Damages <$200K; 3 If Damages >$200K.	3 Unless The Parties Agree To 1.	1 If Damages <$100K; 3 If Damages >$100K.
Arbitrator Selection Rules	Each Party Selects An Arbitrator. Party Arbitrators Choose One Neutral Arbitrator.	Each Party Selects An Arbitrator. Party Arbitrators Choose One Neutral Arbitrator.	Parties Choose From AAA Panel Of Candidates. AAA Controls Process.
Payment	Own Arbitrator & Share Of Neutral Arbitrator And Costs.	Own Arbitrator & Share Of Neutral Arbitrator And Costs.	Arbitrator And Other Costs Divided Equally.
Timing	30 Days After Demands To Choose Arbitrators; Otherwise, Arbitrators Decide. Due Diligence Required.	30 Days After Demands To Choose Arbitrators; Otherwise, Arbitrators Decide. Due Diligence Required.	10 Day Periods To Provide Filing Information And Choose Arbitrators; Otherwise, Arbitrators Decide.
Discovery Rules	Discretion Of Arbitrator As Authorized By Statute.	Discretion Of Arbitrator As Authorized By Statute.	Discretion Of Arbitrator As Authorized By Statute.
Written Opinion	Brief Written Summary Of Findings, Conclusions, And Award.	No Requirement.	No Requirement.
Governing Law	California, Including Micra.	California, Including Micra.	Not Specified.*
Enforcement Of Arb. Rules	Self-Administering/ Courts.	Self-Administering/ Courts.	AAA.

NOTE: This table was compiled using the following sources: American Arbitration Association, Health Care Claim Settlement Procedures (brochure offered to AAA users)(7/92); Kaiser's "Arbitration of Claims;" (memorandum of rules furnished to enrollees) (3/97); and CAP/MPT's standard form Physician-Patient Arbitration Agreement.

*AAA rules are drafted for nationwide application and do not specify governing law. It is likely that any contract drafted in California that specifies submission of a dispute to AAA will also include a clause specifying that the dispute will be resolved under California law.

The agreements of CAP/MPT and Kaiser differ from the AAA rules in several important respects. AAA sets a lower dollar threshold for using three arbitrators, and all arbitrators are neutral and chosen from a AAA-compiled list of candidates. These provisions contrast sharply with the Kaiser-CAP/MPT model of two-party arbitrators and one neutral arbitrator chosen at large. Although each set of rules provides time limits for selecting arbitrators, AAA's schedule is considerably faster, and there is no requirement of due diligence on the part of the plaintiff. AAA rules require a brief statement of findings and conclusions with the award. In terms of costs, CAP/MPT and Kaiser disputants pay a filing fee and their respective shares of the neutral arbitrator and other costs, while AAA disputants split all costs including costs for administrative services and facilities. Most notably, Kaiser and CAP/MPT rules are self-administering, as described above, while the AAA rules ascribe to the Association an active roll in administration and oversight and make provisions for expediting disputes despite the noncompliance of a party.

Although this study does not examine implementation practices in detail, there is some evidence that, at least in some respects, arbitration rules and agreements are more often honored in the breach. For example, there is ample evidence that dispute processing often experiences delays far exceeding time limits specified in the rules.[130]

Regarding enforcement of the agreement, CAP/MPT and Kaiser both report assiduously enforcing contractual agreements to arbitrate; if there is an agreement, they compel arbitration. CAP/MPT reports that even if its insured has no agreement in force, it will search for other agreements (for example an agreement between the claimant and a hospital co-defendant) that they might use to compel arbitration of the claim.

At the same time, almost two-thirds of the physicians who report using agreements also say that if a patient refuses to sign one, they nonetheless provide treatment. This finding probably reflects the discomfort physicians experience when beginning the doctor-patient relationship with discussions of disputing. But, as Table 7 shows, CAP/MPT's physicians are significantly less likely than other physicians to ignore noncompliance.[131]

130. Both Kaiser and CIGNA reported in the CAHMO Survey that the average annual time to disposition for an arbitrated medical malpractice case was between 2.5 and 3.5 years. More recently, evidence presented in *Engalla* documented that, despite Kaiser's rules, the average time to appointment of the neutral arbitrator in Kaiser disputes was 674 days. 938 P.2d at 913.

131. Responses of "unaware of their decision" and "informed but proceed to treat with no comment" are classified together as "no action."

TABLE 7
DOCTORS WHO ENFORCE AGREEMENTS

	No Action (N=21)	Doctor Discusses Arbitration & Provides Care (N=7)	Doctor Refuses To Provide Care (N=6)	Total
CAP/MPT	50%	31%	19%	16
Other Insurers	72%	11%	17%	18

NOTE: Table reports only survey respondents.

IV
CONCLUSIONS

Our research does not permit us to draw any evaluative conclusions regarding outcomes when binding arbitration agreements are in place.[132] Our survey results are inconclusive as to whether agreements lead to faster, less expensive, and/or more satisfying results or whether arbitrators show any biases toward defendants or plaintiffs. However, certain observations can be made regarding the diffusion of arbitration agreements and the resulting challenges faced by public and private policymakers.

This study suggests several conclusions of particular note:

(1) Few disputes are on the arbitration track. Our examination of agreements in California determined that the private, binding arbitration of health care disputes is not commonplace. Contrary to common perceptions, the prevalence of agreements between health plans/providers and enrollees/patients is surprisingly low. Although most HMOs have agreements with their enrollees, these agreements apply only to coverage disputes, which are remarkably rare.

(2) Although prevalence of arbitration agreements is low, their diffusion and application is dynamic. Our survey evidence strongly suggests a dynamic innovation environment. Organizations that are well positioned to stimulate use of agreements are aware of them and alert to information that may demonstrate they have value. Statutory and case law trends suggest that managed care organizations, especially HMOs, will be forced to assume increasing responsibility for the quality of care delivered under their auspices. Thus, agreements already in use by health plans will cover a broader array of disputes.

132. See Appendix for a discussion of the obstacles to conducting a valid empirical evaluation of the results of binding arbitration agreements in California.

(3) A major obstacle to more rapid diffusion of agreements appears to be physician opposition. In addition to determining whether to use agreements in their own practices, physicians, for the most part, control the policies of the major medical malpractice insurers. Physicians' perceptions that agreements "set the wrong tone" in patient relations translates into organizational policies. As insurance companies go public and expand their management beyond the physician community, attitudes and policies may change.

(4) Organizational policies drive use of agreements. This study documents the centrality of organizational policy in the diffusion process. Arbitration agreements are in use where medical malpractice insurers and managed care plans have proactive policies in place to support them. Absent those policies, agreements are not in use.

These conclusions have some important implications for both public and private policymakers. Given the current dynamic state of diffusion, small changes may have large effects on the prevalence of agreements. For example, better information regarding the benefits of arbitration is likely to have major effects on use. If it becomes possible to conduct a sound empirical evaluation, and that evaluation documents substantial efficiency gains with arbitration, organizations seem positioned to move rapidly toward adoption. Conversely, if the evidence suggests little in the way of benefit, diffusion is likely to stall. Similarly, if responsibility for quality of care continues to shift toward managed care organizations, we are likely to see rapid growth in arbitrated caseloads.

The potential for rapid change, in turn, suggests that public policymakers need to evaluate seriously the need for additional regulation of the private arbitration process. Should arbitration agreements be further regulated, given that they are private contractual agreements? If so, in what ways should they be managed? Creating well-targeted public regulation will require sound evidence regarding the effect of these agreements on procedural equity and the interests and concerns of all the parties.

APPENDIX

OBSTACLES TO AN EMPIRICAL EVALUATION OF BINDING ARBITRATION AGREEMENTS

One purpose of the study reported here was to investigate the feasibility of a carefully designed empirical evaluation of the use of binding arbitration agreements in the health care industry in California. Specifically, the goal of the empirical evaluation would be to compare the results of handling health care disputes when binding arbitration agreements are in place and when they are not. The question: All other factors being equal, are disputes concluded more quickly, and with lower costs, more satisfying results to participants, higher payments, and/or more plaintiff "wins" with or without binding arbitration agreements? Our information gathering activities in the present study were designed in part to ascertain whether the necessary ingredients for a valid evaluation are present. As explained below, we conclude that they are not.

A. Comparing Disputes With and Without Binding Arbitration Agreements

Disputes of interest in this context are medical malpractice claims and coverage disputes. However, as discussed in the text, there are too few coverage disputes to support a valid empirical evaluation. Thus, any empirical evaluation must be limited to the handling of medical malpractice claims.

Any actual claim is processed either with or without a binding arbitration agreement in place, making it impossible to compare the two methods on the same claim. Thus for a valid evaluation, we must compare the results (cost, payouts, time to disposition, etc.) of handling similar types of claims in similar legal environments, where the *only* significant difference is whether claims handling was governed by a binding arbitration agreement or not.

There are two conceptual approaches to evaluating the effects of binding arbitration agreements:

(1) A "before" and "after" comparison of populations of *similar* types of claims brought in the context of a single organization that has introduced the widespread use of arbitration agreements; or

(2) A side-by-side comparison of *similar* types of claims arising in two *similar* environments, one of which uses arbitration agreements and one of which does not.

B. Possible Environments for Evaluating the Effects of Binding Arbitration Agreements

To evaluate the effects of arbitration agreements effectively, it is necessary to identify claiming environments with enough similarity to be credibly

comparable in all dimensions that are likely to influence the outcomes of interest except the presence or absence of arbitration agreements. There are three possible claiming environments in California that might provide comparison data on malpractice claims: (1) physician malpractice insurers; (2) hospital malpractice risk bearers (insurers, hospitals, etc.); and (3) staff or group model HMOs.

1. *Physician Malpractice Insurers.* Physician malpractice insurers are not a promising focus. CAP/MPT is the only physician malpractice insurer in California that uses binding arbitration agreements to any appreciable degree. However, because it has promoted binding arbitration agreements among its insureds for more than ten years, it would not be possible to construct a credible "before" and "after" comparison. Even if it were possible to obtain data for the "before" and "after" caseloads, the claiming environments of the two periods are too different to permit credible comparisons. The other possibility—comparing the treatment sample of CAP/MPT cases with a control sample from other insurers—is equally problematic, because use of binding arbitration agreements appears to be specialty dependent. CAP/MPT reports, for example, that its pathologists and anesthesiologists do not use agreements, while its high risk surgical specialties do. Therefore, any comparison groups would be restricted to claims from those specialties using agreements and would be so limited in size that the study's conclusions would be severely restricted. Moreover, a design that depends on data from malpractice carriers is risky, given the reluctance of carriers to share such sensitive data and the poor definitional comparability among carriers of case information.

2. *Hospitals.* Problems in constructing a valid evaluation of the effects of arbitration agreements used by hospitals are even greater than in evaluating those used by physicians. As reported in the text, only two responding hospitals reported use of binding arbitration agreements, reflecting a population of hospitals using arbitration agreements that is too small to support a "before" and "after" comparison. Constructing a contemporaneous comparison is equally problematic. Hospitals use varying mixes of self insurance, third-party claims administration, and malpractice insurance to deal with liability. Building comparable treatment (those using arbitration agreements) and control groups (those with no arbitration agreements) would require careful matching of hospitals on a host of dimensions, including level and type of insurance, claims administration, implementation of arbitration agreements, and type of hospital, to name only the most obvious characteristics. Since only a small percentage of hospitals actually use agreements, the achievable sample size is again too small to support statistically valid comparisons.

3. *HMOs.* The potential for constructing an evaluation based on the experience of HMOs is no more promising. Kaiser Permanente is the only

HMO that uses arbitration agreements with a sufficiently large caseload to support any role in an evaluation. However, a valid "before" and "after" design is not feasible in this case, because Kaiser introduced arbitration agreements in the mid-1970s, too long ago to support a "before/after" design.

Alternatively one might hope to compare the experience of Kaiser and CIGNA until 1996 (when CIGNA stopped covering malpractice liability), using a number of smaller group/staff model HMOs as the control (non-treatment) group. This strategy is impractical for two reasons. First, Kaiser Permanente dominates the arbitration caseload. At the same time, it is arguably a unique organization, so structurally and culturally distinct that any differences in claiming outcomes could well be attributed to organizational differences rather than the presence of arbitration agreements. Second, the numbers of disputes—especially among HMOs in the control group—are too small to support a useful comparison.

The above analysis leads us to conclude that mounting a valid empirical evaluation of the effects of arbitration agreements in today's health care arena is not feasible. On the other hand, careful case studies of the adoption and implementation of binding arbitration agreements may produce useful insights into the problems and the benefits of this method of dispute handling.