

AMERICAN ARBITRATION ASSOCIATION

AMERICAN BAR ASSOCIATION

AMERICAN MEDICAL ASSOCIATION

**COMMISSION ON HEALTH CARE DISPUTE
RESOLUTION**

FINAL REPORT

July 27, 1998

The views expressed herein have not yet been approved by the ABA House of Delegates or the Board of Governors of the American Bar Association and accordingly should not be construed as representing the policy of the American Bar Association. Similar approval processes are also necessary at the AAA and AMA.

I. INTRODUCTION

In the Fall of 1997, the leading associations involved in alternative dispute resolution, law, and medicine collaborated to form a Commission on Health Care Dispute Resolution (the Commission). The Commission's goal was to issue, by the Summer of 1998, a Final Report on the appropriate use of alternative dispute resolution (ADR) in resolving disputes in the private managed health care environment. This Final Report discusses the activities of the Commission from its formation in September 1997 through the date of this report, and sets forth its unanimous recommendations.

II. SUMMARY OF RECOMMENDATIONS

The Commission unanimously makes the following recommendations:

- ◆ Alternative dispute resolution can and should be used to resolve disputes over health care coverage and access arising out of the relationship between patients and private health plans and managed care organizations.
- ◆ Alternative dispute resolution can and should be used to resolve disputes over health care coverage and access arising out of the relationship between health care providers and private health plans and managed care organizations.
- ◆ In disputes involving patients, binding forms of dispute resolution should be used only where the parties agree to do so after a dispute arises.
- ◆ It is essential that due process protections be afforded to all participants in the ADR process.
- ◆ Review of managed health care decisions alternative dispute resolution complements the concept of internal review of determinations made by private managed health care organizations.

These findings and recommendations are articulated in detail in this Final Report. They are meant to provide guidance not only to private managed health care organizations considering the voluntary adoption of ADR programs as a form of review of plan determinations, but also to legislative and regulatory bodies considering the establishment of standards governing the use of ADR in the health plan environment.

III. FORMATION OF THE COMMISSION

In August 1997, leaders of the American Arbitration Association (AAA), American Bar Association (ABA), and American Medical Association (AMA) met in Chicago and determined to form a commission to study and make recommendations on the appropriate use of ADR in the private managed health care environment. This first time joint effort by the AAA, ABA, and AMA underscored the need to provide the public with a fast, just, and efficient system of resolving health care disputes without having to resort to costly and time-consuming court litigation.

In forming the Commission, the convening institutions expressed the hope that as the health care environment continues to evolve, the dispute resolution models and due process safeguards developed by the Commission will be implemented by managed health care organizations across the nation to give consumers the opportunity to have a prompt resolution

of their disputes, while at the same time assuring that the parties' Constitutional and other legal rights and remedies are protected. A concomitant goal was to provide guidance to legislative and related bodies who are developing systems to regulate the managed health care relationship.

Another main goal identified in the early stages of the Commission's deliberations is promoting greater awareness and understanding of the use of mediation, arbitration, and other out-of-court settlement techniques as methods for resolving disputes over health care coverage and access in the managed health care environment.

The conveners established the following objectives of the Commission: studying and making recommendations on the application of alternative dispute resolution to coverage and access issues in the managed health care arena, the development of appropriate due process standards to be applied to ADR in this context, and the development of model ADR procedures for use in managed health care relationships.

In the weeks following the Chicago organizational meeting, each institution named its representatives to the Commission, and the first working session took place on September 22, 1997, in Chicago.

Each of the convening institutions possesses expertise and guidance essential to the success of the Commission:

The leader in conflict management since 1926, the **American Arbitration Association** is a not-for-profit, public service organization dedicated to the resolution of disputes through the use of negotiation, mediation, arbitration, and other voluntary dispute settlement techniques. In 1997, more than 78,000 cases were filed with the Association in a full range of matters. Through 37 offices nationwide and cooperative agreements with arbitral institutions in 38 other nations, the AAA provides a forum for the hearing of disputes, rules and procedures and a roster of impartial experts to hear and resolve cases.

The **American Bar Association** is the world's largest voluntary professional association with more than 392,000 members. As the national voice for the legal community, the ABA's mission is to serve the public and the profession by promoting justice, professional excellence, and respect for a just rule of law.

The **American Medical Association** is the nation's leading organization of physicians. Formed more than 150 years ago, the AMA is a partnership of physicians and their professional associations dedicated to promoting the art and science of medicine and the betterment of public health. The AMA serves its nearly 300,000 member physicians and their patients by establishing and promoting ethical, educational, and clinical standards for the medical profession and by advocating for the highest principle of all -- integrity of the patient/physician relationship.

The Commission met as follows:

- September 22, 1997 in Chicago
- October 27, 1997 in Chicago
- December 8, 1997 in New York City
- January 12, 1998 in Washington

- March 6, 1998 in New York City
- April 29, 1998 in Washington

In the course of these meetings, the Commission accomplished the following:

- established its membership and governance
- established its mission
- identified objectives
- identified substantive areas of study
- established its methodology
- issued a press release on November 17, 1997
- identified presenters (oral and written)
- established funding for presenter reimbursement
- heard presentations
- received written submissions
- made various governmental leaders aware of the Commission's work
- issued an Interim Progress Report on January 20, 1998
- issued this Final Report on July 27, 1998

IV. MEMBERSHIP AND GOVERNANCE

The Commission is co-chaired by Jerome J. Shestack, president of the ABA, William K. Slate II, president and chief executive officer of the AAA, and Dr. Percy Wootton, president of the AMA. The Secretary and Rapporteur is George H. Friedman, Senior Vice President of the AAA. The Recording Secretary is Scott Carfello, Regional Vice President of the Chicago office of the AAA.

Each of the institutions has four representatives on the Commission, as follows:

For the American Arbitration Association :

Howard J. Aibel, Esq.
Thomasina Rogers, Esq.
J. Warren Wood, III, Esq.
Max Zimny, Esq.

For the American Bar Association :

Hon. Arlin Adams
Kimberlee K. Kovach, Esq.
Lawrence A. Manson, Esq.
Roderick B. Mathews, Esq.

For the American Medical Association :

Dr. Charles Barone
Dr. Donald Palmisano
Carter Phillips, Esq.
Ron Pollack, Esq.

A roster describing the affiliations of the Commission members appears as Exhibit I of the Appendix of this Final Report.

V. MISSION

The Commission on Health Care Dispute Resolution adopted the following mission statement:

... to evaluate and make recommendations as to how alternative dispute resolution should be used to provide a just, prompt, and economical means of resolving disputes over access to health care treatment, and coverage, in the private health plan/managed care environment.

VI. IDENTIFIED NEED

The determination of the three sponsoring institutions to form the Commission was prescient. In the several months that followed the creation of the Commission, the general topic of health care has become a subject of national discourse. The President's Advisory Commission on Consumer Protection and Quality (President's Advisory Commission) in March 1998 issued a final report to the President. This group, comprised of representatives from a broad base of participants in the health care process, was formed in March 1997. In its final report to the President, this Commission urges the creation of a Patient's Bill of Rights. Legislative initiatives, at both the state and federal levels, were commenced with a goal of addressing the emerging issues in health care. Parties in the health care arena engaged in a national dialogue on how to address the many issues relating to the delivery of health care in the United States. A recurrent theme in all of these efforts was a recognized need to establish fair, neutral, swift, and economical means for settling disputes among participants in managed health care relationships.

While the Commission recognized that there are a variety of other health care relationships, its primary focus was on private managed care. According to the Final Report of the President's Advisory Commission (March 1998, p. 164), some 140 million Americans are covered by some form of private (i.e., non-governmental) health insurance. Today, three-fourths of Americans with private health insurance are enrolled in some form of managed care system (*Report of Proposed Recommendations on Process for Resolving Consumer Differences with Managed Health Care Plans*, ABA Commission on Legal Problems of the Elderly, June 1998, p.1). Given the nature of these relationships, and the sheer number of covered persons, disputes are inevitable.

Alternative dispute resolution has emerged as an accepted means of resolving disputes outside of the court system. The early working hypothesis of the convening institutions and the Commission members was that ADR can and should play an important, effective role in resolving disputes among participants in private managed health care relationships. After hearing often compelling presentations about the need for appropriate means of resolving disputes quickly, fairly, and efficiently, the Commission believes this hypothesis has been borne out.

The Commissioners note that a few states have enacted some form of legislation regulating the relationships between patients and managed health care organizations, (see, for example, Ohio's Physician-Health Plan Partnership Act of 1997), providing at some point for external review of certain health plan determinations. They also observe that similar legislation has been introduced in Congress, and that the President's Advisory Commission in Chapter Ten of its *Final Report to the President* encourages independent, external review of certain claim denials.

While these myriad efforts and activities to one extent or another involve various forms of ADR as part of the internal review process, external appeals, or both, the Commissioners concluded that there was a clear need to add definition and depth to these concepts. Stated differently, as managed health care organizations move to voluntarily embrace ADR as a form of external review, and as legislative and regulatory bodies provide direction to health plans regarding the development of external review programs, guidance and information will be needed to address how best to utilize ADR in this context. It is the Commission's objective to provide such guidance by issuing this Final Report.

VII. OBJECTIVES

There was unanimity among Commission members that ADR would facilitate the resolution of disputes in the private managed health care area which are not resolved through internal review procedures offered by the managed health care organization. In view of its overall objective of promoting the prompt and fair application of ADR in the managed health care area, the Commission identified the following main objectives:

- develop model ADR procedures for use in the managed care area (in effect, a "Restatement on Health Care ADR");
- identify substantive areas in the managed health care environment that would be suitable for resolution by alternative dispute resolution. Examples discussed included a host of coverage and access issues, such as access to specific healthcare providers, access to needed treatment or necessary care, experimental treatment, medical necessity, and reasonableness of cost;
- establish due process criteria for the use of ADR to resolve health care disputes. Examples discussed included due process procedures for ADR systems, timing of the agreement to use ADR, and informed, knowing, and voluntary use of ADR.

VIII. AREAS OF STUDY

The Commission's general focus was to study and make recommendations on the applicability of alternative dispute resolution in the private managed health care environment. It identified the following general subject matters for consideration:

- access to specific health care providers
- access to needed treatment
- access to specific health care facilities
- medical necessity of treatment
- experimental treatment
- reasonableness of cost
- continuity of care
- disclosure of information to consumers
- development of drug formularies
- out-of-area coverage
- provider communication with patients
- utilization management

Given the complexity and importance of ADR in the private managed health care setting, the Commission determined not to study the applicability of ADR to medical malpractice, Medicare, specific provisions of health care insurance contracts, or general access to health care outside of the private managed health care relationship. This does not mean that the concepts articulated in this report are not applicable to other health care relationships, such as indemnity plans (i.e., those in which the patient seeks reimbursement from a health insurer for the cost of medical care received). The Commission is also aware that managed health care tort liability concepts are developing. These concepts may result in new types of civil claims that may be resolved by means of ADR, just as ADR is used today in many jurisdictions for resolving personal injury civil claims.

IX. METHODOLOGY

The Commission's method of operation was to seek oral and written presentations from a wide array of key organizations and individuals, to inform the Commission's thinking in developing specific ADR models and areas of application. Included in this pool of advisors were: health care providers, patient advocacy groups, health care insurers (managed health care organizations, health maintenance organizations, and indemnity plans), health insurance associations, public health officials and groups, elder care groups, and law and medical school faculty.

Overall, thirty-seven individuals or organizations responded orally or in writing to 79 written invitations to submit comments or other information to the Commission. A listing of these individuals/organizations appears as Exhibit II of the Appendix of this Report (Individuals and Organizations Contacted by the Commission for Written Submissions). The Commission's Secretary also corresponded with the President's Advisory Commission, advising of the work of the AAA/ABA/AMA Commission. The information was directed specifically to Secretary of Health & Human Services Donna Shalala and Secretary of Labor Alexis Herman (co-chairs), with a copy delivered to President Clinton. Also, various Congressional leaders were advised of the work of the Commission. ABA President Shestack arranged for the Commission's work to be showcased at the ABA's 1998 Annual Meeting, in the form of a program devoted to the use of ADR to resolve health care disputes.

Oral presentations were made at Commission meetings held on October 27, 1997; December 8, 1997; January 12, 1998; March 6, 1998; and April 29, 1998, by the following individuals:

Mary Ellen Bliss

Federal Affairs Action Team
American Association of Retired Persons

Chris Carey

Staff Member
House Committee on Education and the Workforce

Edward Dauer

Dean Emeritus
University of Denver College of Law

Michael Duffy

Director
Office of Consumer Affairs and Business Regulation
Massachusetts Consumer Affairs Commission
(and Boaz Yavnai - research assistant)

Elizabeth Hadley

Legislative Counsel for Health Policy
National Association of Insurance Commissioners

Matt Keast

Staff Member
Office of Congressman Charles Norwood

Kurt Lawson

ABA Section of Taxation

Len Marcus

Director - Health Care Negotiations
Harvard School of Public Health

F. William McCalpin

Chair
ABA Commission on Legal Problems of the
Elderly

Julie Miller

Director - Policy Analysis
Blue Cross & Blue Shield Association

Dr. Donald Palmisano

Trustee
(member of Commission)
American Medical Association

Ron Pollack

Executive Director
Families USA
(member of Commission)

David Richardson

President
Center for Health Dispute Resolution

Elizabeth Rolph

RAND

Dr. Clarke Russ

Institute for Conflict Resolution in Health
Care
(Chair, Board of Medicine, Commonwealth
of Virginia)

Grey Till

General Counsel
Blue Cross & Blue Shield of Alabama

Oral presentations were followed by questioning from the Commission and its staff. In some instances, this process was quite intense, but the intention always was to illuminate the nature of the problem and to evaluate carefully the range of realistic alternatives available.

X. ALTERNATIVE DISPUTE RESOLUTION METHODS AND MODELS

A. Introduction

As courts and administrative agencies become less accessible to civil litigants, patients, health care providers, and managed health care organizations have begun to explore ADR as a way promptly and effectively to resolve disputes. A wide range of dispute prevention and resolution procedures allow the participants to develop a fair, cost-effective, and private forum to resolve disputes.

As part of its work, the Commission reviewed a number of ADR processes which may be appropriate for the resolution of disputes and disagreements which occur among patients, families, health care providers, and managed health care organizations. The use of external, independent ADR is typically not available until after all remedies are exhausted within the managed health care organization. Usually, managed health care plans will offer some form of internal review, by which a provider or participant can challenge the plan's action. While this review can and should include some elements of ADR, the Commissioners contemplate ADR playing a role in the next step - i.e., as a form of independent external review or appeal. Based on the information adduced during the course of its work, the Commission has concluded that there is a clear need to help all participants better understand how ADR works, what forms ADR takes, and what problems to avoid.

In submitting these ADR Models, the Commission does not wish to suggest that these methods are exclusive or that in some instances other procedures may not be appropriate. Rather, in its study the Commission has concluded that these are the primary ADR methods or procedures which would be most responsive to the types of managed health care disputes as outlined in [Section XI](#) of this Final Report (Areas in the Private Managed Health Care Environment Where ADR Can Be Helpful). The ADR processes summarized below also assume the presence and need for a neutral third party. To be sure, the Commission recognizes and affirms that direct negotiation among the parties and internal appeal mechanisms are often appropriate first steps in any dispute resolution scheme. The work of the Commission, however, was to explore processes which involve the use of a neutral third party dispute resolver, either to facilitate a negotiated resolution among the parties (e.g., mediation) or to render a decision (e.g., arbitration).

The Commission submits that perhaps of greatest importance are the fundamental guiding principles of efficiency, of both time and money, and fairness. Characteristics of the ADR procedures presented here, and in detail in [Exhibit III](#) of the Appendix to this Final Report (Alternative Dispute Resolution Models, are to be supplemented by the due process protocols set forth in [Section XII](#) (Due Process Standards).

B. ADR Models

The Commission submits the following proposed neutral models for ADR as prototypes for use in those matters or disputes involving managed health care. A consistent theme throughout is an effort to maintain a "level playing field" for all participants. Fully-developed models and explanations are set forth in Exhibit III of the Appendix.

Ombuds: A neutral third party (either from within or outside the program) is designated to receive information regarding managed health care disputes, and to confidentially investigate and propose settlement of complaints. The ombudsperson may also provide information on how the dispute resolution process works.

Fact-finding: The investigation of a complaint by an impartial third person (or team) who examines the complaint, considers the facts ascertained, and issues a non-binding report.

Consensus-building: A process which involves the use of a neutral third party, often referred to as a convener, who assists numerous persons or groups in arriving at a consensus through a structured negotiation among chosen representatives of all stakeholders.

Mediation: The process in which the parties discuss their disputes with an impartial person who assists them in reaching a settlement. The mediator may suggest ways of resolving the dispute but may not impose a settlement on the parties. Mediation offers the advantage of informality, with reduced time and expense needed to resolve disputes.

Arbitration: The submission of disputes to one or more impartial persons pursuant to established procedures, generally for final and binding determination. Variants include non-binding arbitration. There are four major types of arbitration agreements:

- pre-dispute, final and binding arbitration
- pre-dispute, nonbinding arbitration
- post-dispute, final and binding arbitration, and
- post-dispute, nonbinding arbitration.

The concept of the timing of the agreement to arbitrate is discussed in [Section XII](#) of this Final Report (Due Process Standards) and in Exhibit III of the Appendix (Alternative Dispute Resolution Models). *It is worth noting here, however, that the Commission's unanimous view is that in disputes involving patients and/or plan subscribers, binding arbitration should be used only where the parties agree to same after a dispute arises.*

ADR Hybrids: The combination of one or more ADR formats, frequently in sequence. For example: "Med/Arb" is mediation followed by arbitration in the event mediation is not successful. The number of potential ADR hybrids is virtually unlimited.

C. The "ERISA Problem"

As stated above, the Commissions focus was on the use of ADR in the private managed health care environment. It is worth noting that the overwhelming majority of individuals covered by private health plans obtained this coverage through an employer-provided health plan. According to the President's Advisory Commission, 123 million Americans receive health insurance through their employer, while only 10 to 16 million Americans purchase directly their own coverage (*Final Report*, p. 164). The Employee Retirement Income Security Act of 1974 (ERISA) governs, among other things, all health benefit plans that are employer-provided, establishing standards for the enforcement of "consumer" rights under employer-provided health plans.

By its terms, ERISA preempts the states from providing different remedies for denials of health benefits. Thus, an individual covered by an employer-provided health plan, under ERISA, may not invoke tort or contract law remedies in state courts, and is thus limited to seeking judicial intervention for only the following remedies:

- providing the covered service, or reimbursing the cost of the service;
- directing the plan to act;
- clarifying future benefits.

A question arose concerning whether the use of ADR as a form of external review of health plan determinations might be precluded by the ERISA preemption. It was the conclusion of the Commission, however, that ERISA does not preclude the parties from voluntarily adopting the use of ADR- even binding forms of ADR - to resolve disputes among them. It may well be that legislative clarification would be helpful to avoid confusion or concern over the appropriate use of ADR in the managed health care area, but specific recommendations in this regard would be beyond the scope of the Commission's charge from the convening institutions.

XI. AREAS IN THE PRIVATE MANAGED HEALTH CARE ENVIRONMENT WHERE ADR CAN BE HELPFUL

A. Introduction

The Commission's major focus was on one type of dispute in the private managed health care context – "**consumer v. plan.**" Nevertheless, the Commission recognizes that managed care involves a range of disputes (and alliances) among a number of participants, including buyers, plans, providers in the plans, providers not in the plans, as well as consumers. The disputes that exist in this area are those that exist in the traditional insurance context as well, i.e., the long-standing insurance coverage issues, which now more frequently arise because the insurer/managed plan may simply be saying "no" more frequently.

In addition, in managed care, the "**consumer v. plan**" dispute is often a "**consumer + provider v. plan**" dispute, in which the issue is whether the provider can perform services with the expectation of payment from the plan, and the consumer is convinced by the provider that the services will be beneficial. There are also "**provider v. plan**" disputes that can involve a provider not in the plan. For example, the provider may want to participate in, or dispute, some out-of-plan payment policy.

Finally, there are also a series of "**purchaser/plan/provider**" disputes arising. In some markets, the larger employers are beginning to determine and select provider networks without regard to a plan's decisions. Thus, it can be anticipated that "**provider v. purchaser v. plan**" disputes will arise, especially as data collection and reporting begin to dominate, and plans and providers dispute the data/reports.

B. Matching ADR Process to Dispute Type

The Commission considered developing a matrix that matched specific types of managed health care disputes to specific ADR methods. In the final analysis, however, it seemed more efficient and useful to identify both broad categories of potential disputes and subcategories of areas of conflict that would be well served by an ADR procedure. This is presented schematically in Exhibit IV of the Appendix (Matrix of Areas of Disputes Amenable to ADR). It was the consensus of the Commission that a form of ADR would be appropriate for resolving the identified categories and subcategories of disputes, but that identifying a particular form of ADR as *the* single most appropriate means of resolving a particular dispute type was an inappropriate limitation on the parties' discretion.

C. Detailed Analysis of Potential Disputes

Managed health care disputes for which alternate dispute resolution is particularly appropriate include: medical necessity; length of stay; medical appropriateness of place or provider; situations requiring early coordination of treatment by various disciplines such as mental health or substance abuse planning or planning for outcomes among medical, social, psychological, legal and ethical experts; reduction or termination of services; over or under-utilization of resources or facilities; physician or patient concerns about utilization incentives or disincentives; bioethical conflicts; staff disagreements; interpersonal disputes; access to appropriate procedures and equipment and access between providers and outside networks; and, in general, disputes involving non-monetary outcomes.

Health care ADR is best and most effective where the parties have legitimate and serious issues in dispute, and external review of a decision made by a managed health care organization is called for. Generally, limitations on such use of ADR processes for external review should be by exception only. At the same time, appropriate thresholds should be established so as not to overburden available health care ADR resources with either frivolous claims involving mere misunderstandings or miscommunications, or disputes of such high complexity as to defy resolution (e.g. whether the plan should be essentially re-written to cover new cutting edge, experimental technology or treatment). Unequivocal contract provisions, such as health care insurance eligibility requirements and coverage limitations and exclusions, are generally not appropriate for health care ADR because it is usually not the province of ADR to rewrite unambiguous contract provisions. Intra-family disputes over treatment plans or modalities are probably best dealt with by other means.

ADR processes are, however, well suited to managed health care situations where the need for specialized, confidential, non-precedential disposition is critical. ADR is particularly valuable when rules are unclear or are ambiguous or where the stakes for the interested parties are very high, or where strong emotions such as distrust or the need for retribution are present. In a typical indemnity health plan, grievances by consumers usually involve denial of payment to providers after services have been rendered. In a managed health care arrangement, services are pre-authorized and disputes usually involve denial of access to health care services. The

majority of disputes between the consumer and the private managed health care organization thus involve benefit coverage issues and coverage for out of plan services. These potential areas of conflict are set forth below.

1. Health Plan Coverage Issues (within health plan or with affiliated providers)

- a) Surgical procedures (denial for surgery, usually elective surgery)
- b) Cosmetic surgery (denial of request for service)
- c) Dental/oral surgery (denial of request for service)
- d) Durable medical equipment (denial of requests for equipment)
- e) Procedures and tests (denial of specific lab tests, x-rays, other diagnostic procedures)
- f) Physical therapy/occupational therapy (denial of request for services)
- g) Denial of referral from primary care provider to specialists or other providers requiring Referrals
- h) Mental health services (denial of request for specific therapy or treatment program length)
- i) Second opinions
- j) Restricted formulary (denial of specific medications and treatment regimens not included in health plan formulary)
- k) Excessive wait time for access to needed service
- l) Home health care benefits
- m) Length of stay (discharge from hospital or other health care facility before consumer feels he/she is able)
- n) Hospice

2. Out of Health Plan Coverage Issues (not part of plan or nonaffiliated providers)

- a) Out of area (out-of-state) coverage for needed medical services
- b) Emergency services (nonaffiliated hospital /ER)
- c) Access to nonaffiliated primary care providers
- d) Access to nonaffiliated specialty care providers
- e) Access to nonaffiliated mental health services
- f) Admission to nonaffiliated hospitals
- g) Second opinions with nonaffiliated providers (primary care or specialty care)
- h) Access to nonaffiliated dental/oral surgery

3. Access to nontraditional/"alternative" Medical Care

4. Experimental Care/"Last Chance" Therapy (as stated above, the issue amenable to ADR is not whether the contract should be re-written to include experimental care or "Last Chance" Therapies -- since managed health care plans may specifically exclude such coverage -- but, in instances in which experimental care is a covered benefit, whether such treatment is medically necessary or appropriate)

5. Continuity of Care Issues (continued treatment of preexisting conditions by current provider not affiliated with the health plan when health plan coverage is switched: pregnancy, oncology, primary care/continuation of treatment plan including prescriptions)

6. Time-Sensitive Situations (any dispute between a consumer and a health plan where the timing of access to the disputed service has a permanent adverse effect on treatment outcome: emergency care, out-of-state care, transplants, oncology, surgery, potentially terminal conditions)

7. Customer Service Issues (complaints regarding health care providers, health care workers, processes, wait times)

XII. DUE PROCESS STANDARDS

A. Background

The members of the Commission believe that mediation and arbitration of health care disputes - - conducted with proper due process safeguards -- should be encouraged in order to provide expeditious, accessible, inexpensive, and fair resolution of disputes. As ADR systems are developed for resolving private managed health care disputes, it is essential that such systems provide adequate levels of procedural due process protections for all involved.

The nature of the relationship between plans and patients or providers is such that little, if any, negotiation over terms – including external review or ADR systems – takes place. Since these ADR systems or external review procedures will invariably not be the product of a negotiated agreement, the Commission believes it would be especially useful to set forth key aspects of procedural due process, to ensure a "level playing field" for resolving health care disputes by ADR. Similarly, these due process protocols can serve as guidance for legislators or regulators as they focus on establishing fair and appropriate methods for resolving health care disputes.

Due process protocols for the use of ADR have also been developed in two other areas -- employment and consumer-- where, as in health care, the establishment and terms of the ADR system are matters not generally subject to negotiation. Those protocols, which the Commissioners drew upon in developing the *Due Process Protocol for the Resolution of Health Care Disputes*, appear respectively as [Exhibits V](#) and [VI](#) of the Appendix of this Report.

B. Covered Relationships

The *Due Process Protocol for the Resolution of Health Care Disputes* contained in this section was developed for a wide range of transactions arising out of the private managed health care relationship. As described in Section XI of this Report (Areas in the Private Managed Health

Care Environment Where ADR Can Be Helpful), these can include: "**consumer v. plan**" disputes, "**provider v. plan**" disputes, and "**purchaser v. plan v. provider**" disputes.

The purpose of the Protocol is not to define each and every type of health care dispute in which due process standards for the use of ADR are needed. The Commission believes that as a matter of general principle, any ADR system developed in the health care environment would be well-served by adhering to the due process concepts articulated below.

C. A Due Process Protocol for Resolution of Health Care Disputes

PRINCIPLE 1: FUNDAMENTALLY FAIR PROCESS

All parties are entitled to a fundamentally fair ADR process. As embodiments of fundamental fairness, these Principles should be observed in structuring ADR Programs.

PRINCIPLE 2: ACCESS TO INFORMATION REGARDING ADR PROGRAM

Full and accurate information regarding the program, in writing, should be provided by the plan to patients and providers in plain, easily understood language. If a substantial number of users speak languages other than English, the material describing the program should be available in other languages. The information regarding the program should include a description of the process, the role of the parties, the means of selecting neutrals, the rules of conduct of the parties and the neutrals, and an accurate description of fees and expenses.

After a dispute arises, participants should have access to all information necessary for effective participation in ADR. Disputes over exchanges of information should be resolved by the neutral.

PRINCIPLE 3: KNOWING AND VOLUNTARY AGREEMENT TO USE ADR

The agreement to use ADR should be knowing and voluntary. Consent to use an ADR process should not be a requirement for receiving emergency care or treatment. In disputes involving patients, binding forms of dispute resolution should be used only where the parties agree to do so after a dispute arises.

PRINCIPLE 4: NEUTRALITY AND INDEPENDENCE

- 1. Independent and Impartial Neutral:** *All parties are entitled to a neutral who is independent and impartial.*
- 2. Independent Administration:** *Administration of the ADR program should be neutral, and independent of the parties. In no event should the ADR program be administered by the health plan. Administrative services should include the maintenance of a panel of prospective neutrals, facilitation of neutral selection, collection and disbursement of neutral fees and expenses, oversight and implementation of ADR rules and procedures, and monitoring neutral qualifications, performance, and adherence to pertinent rules, procedures, and ethical standards.*
- 3. Standards for Neutrals:** *The rules of administration should guarantee impartiality in selecting neutrals and require conformity with ethical standards of conduct.*

4. **Selection of Neutrals:** *All parties should have an equal voice in the selection of neutrals in connection with a specific dispute.*
5. **Disclosure and Disqualification:** *Neutrals should be required to disclose to the administering agency any circumstance likely to affect impartiality, including any bias or financial or personal interest which might affect the result of the ADR proceeding, or any past or present relationship or experience with the parties or their representatives, including past ADR experiences. The administrator should communicate any such information to the parties and other neutrals, if any. Upon objection of a party to the continued service of a neutral, the administrator should determine whether the neutral should be disqualified and should inform the parties of its decision. The disclosure obligation of the neutral and procedure for disqualification should continue throughout the period of appointment.*

PRINCIPLE 5: QUALITY AND COMPETENCE OF NEUTRALS

All parties are entitled to competent, qualified neutrals. ADR administrators are responsible for establishing and maintaining standards for neutrals in ADR programs they administer. Neutrals serving in health care disputes should have knowledge and experience in health care matters. Disputes concerning the provision of medical care based on medical necessity standards should be resolved by neutrals who are qualified to render medical decisions in the particular medical branch and related specialty involved in the dispute.

The creation of a roster containing the foregoing qualifications dictates the development of a training program to educate existing and potential mediators and arbitrators as to the relevant law, and the substantive, procedural and remedial issues likely to be encountered in the conduct and control of arbitration hearings and mediation sessions.

PRINCIPLE 6: RIGHT TO REPRESENTATION

It is recommended that plans provide, at their expense, the services of an ombudsperson whose function would be to explain the dispute resolution process to patients, and to provide an initial screening of the case.

All parties participating in the ADR process have the right, at their own expense, to be represented by an attorney or other spokesperson of their own choosing. The ADR procedures should direct the parties to referral services for representation of bar associations, legal service associations, unions, consumer organizations, and the like.

PRINCIPLE 7: ADR HEARINGS

1. Fair Hearing: *The pre-hearing and hearing should be conducted with adequate notice and with a fair opportunity to be heard and to present relevant evidence and witnesses. There should be a right to examine and cross-examine witnesses, and to argue orally and/or in writing. The right to present relevant evidence should include access to relevant books and records. The hearing and determination through mediation or arbitration should be private and confidential, unless the parties agree otherwise.*

2. Place of Arbitration or Mediation: *The place of the proceedings should be reasonably accessible to the parties and to the production of relevant evidence and witnesses. In cases involving a patient, the place should be in close proximity to the patient's place of residence. If the parties are unable to agree on the place of arbitration or mediation, the administering*

agency or the neutral should determine that issue. In a case of acute emergency, it may be appropriate to conduct the arbitration or mediation by telephone or other electronic means.

3. Confidentiality: *Consistent with general expectations of privacy in ADR, the neutral should make reasonable efforts to maintain the privacy of ADR hearings to the extent permitted by applicable law. In arbitration, the arbitrator should carefully consider claims of privilege and confidentiality in addressing evidentiary issues.*

PRINCIPLE 8: REASONABLE TIME LIMITS

ADR proceedings should occur within a reasonable time, and without undue delay. The rules governing ADR should establish specific reasonable time periods for each step in the ADR process and, where necessary, set forth default procedures in the event a party fails to participate in the process after reasonable notice. The Commission recommends the following general timeframes for resolving disputes: acute emergencies – 24 hours; emergencies – 72 hours; non-emergencies – 60 days.

PRINCIPLE 9: SETTLEMENT IN MEDIATION OR AWARD IN ARBITRATION

1. Mediation Settlement: *Any settlement in mediation or other non-binding form of ADR should be in writing.*

2. Arbitration Award: *The arbitration award should be in writing, and should be accompanied by an opinion, where requested by any party. In the case of an acute emergency, the arbitrator may make a preliminary award orally. The arbitrator should be empowered to grant whatever relief would be available in court under law or in equity. There should be limited judicial review. Courts should defer to the arbitrator's award absent manifest disregard of clearly defined governing law.*

PRINCIPLE 10: COSTS IN MANDATED, NONBINDING ADR PROCESSES

If mediation is mandated, the cost thereof should be at the expense of the health plan.

As provided in Principle 3, binding ADR arbitration should not be mandated in cases involving patients. Nonbinding arbitration may be required, as can binding arbitration in cases not involving patients, in which case the plan should pay the costs of at least one day of hearing before a single arbitrator, including the arbitrator's fees and expenses. If there are additional days of arbitration, or more than one arbitrator, the costs should be shared equally, subject to the arbitrator's authority to determine the allocation of costs.

XIII. CONCLUSION

The Commission concludes that alternative dispute resolution has a valuable role to play in the resolution of disputes arising out of the private managed health care relationship. ADR complements internal review programs, serving as the next efficient and effective step for resolving unsettled claims. ADR can function effectively as a means of external review or appeal of determinations made by managed health care organizations. It is essential, however, that ADR programs be developed with due process safeguards for the rights of all participants in the process.

The Commission urges that its recommendations be used as guidance by legislative bodies, regulators, and policy leaders, as well as private managed health care organizations establishing ADR programs.

XIV. PLANNED COURSE OF FUTURE ACTION

The Commission met both its short-term major goal of the promulgation of an Interim Progress Report by late January 1998, and the longer-term goal of publication of this Final Report by the Summer of 1998. Each of the Commissioners has signed off on the Final Report as individuals representing, but not necessarily binding, their respective organizations. The Final Report will be presented for timely review by the three sponsoring organizations, and will then be widely disseminated to diverse groups (i.e., provider organizations, patient advocacy groups, employer groups, employee groups, labor, consumer groups, academia, government, regulatory agencies, managed health care organizations and health plans).

Following review by the three sponsoring organizations, a Final Report will be released.

The members of the Commission appreciate the opportunity to play a role in helping to shape the public debate over the use of ADR as a means of resolving disputes in the private managed health care arena.

Submitted this 27th day of July 1998

George H. Friedman
Commission Rapporteur and Secretary,

To the Co-Chairs: **Jerome J. Shestack, Esq.**
William K. Slate II, Esq.
Percy Wootton, M.D.

APPENDIX**I. COMMISSION ROSTER****Commissioners**

Jerome J. Shestack, Esq.
Commission Co-Chair
 President
 American Bar Association

William K. Slate II, Esq.
Commission Co-Chair
 President & CEO
 American Arbitration Association

Percy Wootton, M.D.
Commission Co-Chair
 President
 American Medical Association

For the AAA:

Howard J. Aibel, Esq.
 Partner
 LeBoeuf, Lamb, Greene &
 MacRae

Thomasina Rogers, Esq.
 Former Director
 Administrative Conference of the
 United States

J. Warren Wood, III, Esq.
 Vice President, General Counsel
 & Secretary
 The Robert Wood Johnson
 Foundation

Max Zimny, Esq.
 General Counsel
 UNITE

For the ABA:

Arlin Adams, Esq.
 Of Counsel
 Schnader, Harrison, Segal &
 Lewis

Kimberlee Kovach, Esq.
 University of Texas
 School of Law

Lawrence Manson, Esq.
 Partner
 Lord, Bissell & Brook

Roderick Mathews, Esq.
 Partner
 Hazel & Thomas, P.C.

For the AMA:

Charles Barone, M.D.
 Henry Ford Health System

**Donald J. Palmisano, M.D.,
 J.D.**
 Trustee, American Medical
 Association

Carter Phillips, Esq.
 Partner
 Sidley & Austin

Ron Pollack, Esq.
 Executive Director
 Families USA Foundation

Staff

George H. Friedman, Esq.
*Commission Rapporteur and
 Secretary*
 Senior Vice President
 American Arbitration Association

Scott Carfello, Esq.
*Commission Recording
 Secretary*
 Regional Vice President -
 Chicago
 American Arbitration Association

Jack Hanna, Esq.
 Director - Section of Dispute
 Resolution
 American Bar Association

Karla Kinderman, Esq.
 Health Law Division - American
 Medical Association

Marcia Kladder
 Director - Media Relations
 American Bar Association

Carol O'Brien, Esq.
 Director
 Division of Representation
 American Medical Association

Edwin Yohnka, Esq.
 Special Presidential Assistant
 American Bar Association

II. INDIVIDUALS AND ORGANIZATIONS CONTACTED BY THE COMMISSION FOR WRITTEN SUBMISSIONS

<u>First Name</u>	<u>Last Name</u>	<u>Title</u>	<u>Affiliation</u>
W. Andrew	Adams	CEO	National Health Care L.P.
Karen	Agnagni	CEO & President	American Association of Health Plans
Douglas	Arpert	Partner	Norton, Arpert, Sheehy & Higgins, P.C.
Mike	Astrue		Biogen, Inc.
Mary Ellen	Bliss	Federal Affairs Team	American Association of Retired Persons
Charles	Birkett	President & CEO	Advocate Inc.
Chris	Carey	Staff Member	House Comte. on Education & the Workforce
E. Thomas	Chaney	CEO Community	Health Systems, Inc.
Jay D.	Christiansen	Chair Health	Law Section, Faegre & Benson
Jeanne A.	Clement	Assoc. Prof.	Dept. of Community, Parent-Child & Psych.
Leah	Curtin	Editor	Nursing Mgmt. Editorial Office
James E.	Dalton, Jr.	CEO	Quorum Health Group, Inc.
Edward A.	Dauer	Dean	Emeritus University of Denver College of Law
Robert M.	Dohrmann	Chair	Schwartz, Steinsapir, Dohrmann & Sommers
Michael	Duffy	Director	Mass. Consumers Affairs Commission
Thomas	Frist, Jr.	CEO	Columbia/HCA
Jeff	Gabardi	Counsel & Legal Director	Health Insurance Association of America
John	Gillmor	Partner	Boult, Cummings, Connors & Berry
Elizabeth	Hadley	Legislative Counsel	National Association of Insurance Comms.
Jennifer	Harwell	General Counsel	American Home Patient
Martin	Hatlie	Executive Director	National Patient Safety Foundation at the AMA
Alexis	Herman	Secretary of Labor	U.S. Department of Labor
Thomas G.	Hermann	Chair	Squire, Sanders & Dempsey
Samuel H.	Howard	CEO	Phoenix Healthcare Corp.
William	Hubbard	Partner	Reed, Hubbard, Berry & Doughty
Cathy	Hurwit		AFSCME

<u>First Name</u>	<u>Last Name</u>	<u>Title</u>	<u>Affiliation</u>
Joseph C.	Hutts	CEO	PhyCor, Inc.
Michael A.	Jennings		The Prudential Insurance Co. of America
Tom	Jorgenson		Calfee, Halter & Griswold
Matt	Keast	Staff Member	Office of Hon. Cong. Charles Norwood
Irene	Koch	Assistant General Counsel	Maimonides Medical Center
William	Kowalski		AETNA
Kurt	Lawson	Representative	ABA Section of Taxation
Brian	Lindberg	Director	Coalition on Cons. Protection/Qty. Hlth. Care
Ronald E.	Mallen	Chair	Special Committee on Medical Prof. Liability
Mark	Manner	Partner	Harwell, Howard, Hyne, Gabbert & Manner
Len	Marcus	Director	Health Care Negotiations
F. William	McAlpin	Chair	ABA Commission - Legal Problems of the Elderly
Clayton	McWhorter	Chairman	LifeTrust America
Leigh B.	Middleditch, Jr.	Chair	McGuire, Woods, Battle & Booth, LLP
Julie	Miller	Director - Policy Analysis	Blue Cross & Blue Shield Association
Mary C.	Morgan		
Neil P.	Motenko	Partner	Nutter McConnen & Fish
Josephine	Musser	President	Office of the Commissioner of Insurance
Jay	Naftzger	Chair	Rush Prudential Health Plans
Martha R.	Nolan		United HealthCare
Margaret	O'Kane	President	National Comm. for Qual. Assurance ("NCQA")
Kevin Francis	O'Malley		
Donald	Palmisano	Trustee	American Medical Association
Scott	Phelps		
Ron	Pollack	Executive Director	Families USA Foundation
Samuel H.	Porter	Partner	Porter, Wright, Morris & Arthur
Richard G.	Porter	Partner	Grenn & Grenn, P.C.
Harriet	Rabb	General Counsel	Department of Health & Human Services

<u>First Name</u>	<u>Last Name</u>	<u>Title</u>	<u>Affiliation</u>
Paul Williams	Raymond	Chair	Employment Benefits Committee, Sec. of Taxation
David	Richardson	President	Center for Health Care Dispute Resolution
Elizabeth	Rolph	Representative	RAND Corporation
John	Rother	Director	Legislation & Public Affairs, AARP
Mary Clarke	Rowe Russ	Ombudsperson Director	Sloan School – Institute for Conflict Resolution in Health Care
Ronald L.	Sauders	Executive VP	Health Insurance Association of America
Andrea	Schleifer		Solo Practice & Small Firms
Alan G.	Selbst		Houston Endodontic Specialists
Howard	Shapiro		McCalla Thompson et al
Robin S.	Shapiro	Chair	Michael, Best & Friedrich
Robin	Siegel	Chair	Gordon, Feinblatt, Rothman et al.
Louis	Soccoccio	General Counsel	American Association of Health Plans
Robert A.S.	Silberman	Chair	Edwards & Angell
Carl M.	Stevens	Emeritus Professor	Reed College
Lance	Tibbles	Co-Director	Capital University Law School Ethics Institute
Grey `	Till General	Counsel	Blue Cross & Blue Shield Association
David	Vladeck	Director	Public Citizen Litigation Group
Katie	Wade		CIGNA
Robert	Wagener		Center for Medical Ethics & Mediation
Gayle	Warden	President & CEO	Henry Ford Health Systems
Linda R.	Williams		
Roger	Wilson	Senior VP & GC	Blue Cross & Blue Shield Association
Alan	Wise	CEO	Coventry Corp.
Edward K.	Wissing	CEO	American Home Patient, Inc.

III. ALTERNATIVE DISPUTE RESOLUTION MODELS

The models set forth below are by no means exhaustive; they represent sensible approaches to the major forms of alternative dispute resolution. In designing any ADR system, care should be taken to tailor the system to the specific needs of the parties. Guidance on the process of developing dispute resolution systems, as well as model language for various provisions and features of ADR clauses, can be found in *Drafting Dispute Resolution Clauses*, published by the American Arbitration Association (1997).

A. Ombuds

The ombuds process involves a neutral third party who is often employed or appointed by an institution, whose primary role is the investigation of complaints, as well as their prevention and resolution. An ombudsperson may also make recommendations with respect to the resolution of the matter, but cannot make a binding decision.

The most even-handed, fair, and appropriate ADR system will not work effectively if parties are not aware of the existence of the program, or are not educated as to how the system works. Therefore, another key role of the ombudsperson is to provide information on the dispute resolution process, both internal and external. In effect, the ombudsperson serves as a system guide to users, providing useful information about how the managed health care organization resolves disputes.

With regard to those matters involving the provision of health care, it is suggested that those plans which desire to put in place an ombuds system of dispute resolution observe the following guidelines. The ombuds should be a person with a medical education and experience. While the ombuds will likely be an employee of the managed health care organization, it is suggested that the ombuds process, if opted for, should also involve the participation of the patient's family and/or significant other, where desired and appropriate. While much should be left to the discretion of the ombudsperson, it is recommended that the health care provider, as well as the plan decision maker, also be included in the preliminary discussions and fact gathering.

In some models, the ombudsperson's function is strictly neutral. In others, the ombudsperson acts as a patient advocate. The Commission takes no position on which model is most desirable.

B. Mediation

In mediation, a neutral third party, the mediator, facilitates the voluntary and mutually acceptable resolution of a dispute. A non-adversarial approach to dispute resolution, mediation emphasizes direct communication among the parties and creativity in problem solving. The mediator's role is to help the disputants explore issues, needs and settlement options. The mediator may point out issues that the disputants may have overlooked and in some instances offer suggestions, but resolution of the dispute rests with the disputants themselves.

The benefits of successfully mediating a dispute to settlement vary, depending on the needs and interests of the parties. The most common advantages are that:

- parties are directly engaged in the negotiation of the settlement;

- the mediator, as a neutral third party, can view the dispute objectively and can assist the parties in exploring alternatives which they might not have considered on their own;
- as mediation can be scheduled at an early stage in the dispute, a settlement can be reached more quickly than in litigation;
- parties generally save money through reduced legal costs and less staff time;
- parties enhance the likelihood of continuing their business relationship;
- creative solutions or accommodations to special needs of the parties can become a part of the settlement;
- a high probability of settlement. A frequently-cited mediation settlement rate is 85% (statistical data provided by the American Arbitration Association, Client Services Group, June 1998).

1. Providing for Mediation

The parties can provide for the resolution of future disputes by including a mediation clause in their contract. A typical mediation clause reads as follows:

If a dispute arises out of or relates to this policy/contract or the breach thereof and if the dispute cannot be settled through negotiation, the parties agree first to try in good faith to settle the dispute by mediation administered by [named ADR provider], prior to resorting to arbitration, litigation, or some other dispute resolution procedure.

The clause may also provide for the qualifications of the mediator, the method of payment, the locale of meetings, and any other item of concern to the parties.

2. Requesting and Scheduling the Mediation

Although mediations can originate at various times, including as an adjunct procedure to pending litigation (including appeals), it is anticipated that mediation will occur when a dispute between the patient and the managed health care organization initially arises and before other, more formal means of dispute resolution such as arbitration or a lawsuit is initiated.

In the case of health care, timing is of the essence and the mediation agreement (or mediation clause) should specifically spell out the time within which a mediation must be conducted, after such has been requested or demanded. In fact, one of the primary advantages to the mediation process is that a mediation conference can be scheduled very quickly and requires a relatively small amount of preparation time. In cases of emergency, the mediation should be scheduled in accordance with the time frames in Principle 8 of the *Due Process Protocol for the Mediation and Arbitration of Health Care Disputes* ([Section XII](#) of this Final Report).

When a party files a Request for Mediation, the requesting party should forward a copy of the mediation clause contained in the contract under which the dispute arose.

The mediation should be conducted at a location which is convenient for both the patient and family as well as the provider and the plan decision maker. Priority consideration should also be given to the health and well being of the patient in terms of the ability to travel, when determining the location of the mediation session. The duration of the mediation session itself may also need to be abridged if the patient's health imposes such limitations. Consideration should also be given to the managed health care organization decision-maker, particularly in non-emergency matters, such as the ability to participate in several mediations at a given time.

In those situations where the health of a party makes it difficult for their personal appearance at the mediation, latitude should be given to the mediator for the use of telephones, video conferencing, and the Internet as alternative methods for communication and participation (*Protocol*, Principle 7(2)).

3. Qualifications and Selection of the Mediator(s)

Upon receipt of a Request for Mediation or the Submission to Dispute Resolution, the administrator will appoint a qualified mediator to serve on the case. All participants (which include family members or significant others of the patient seeking treatment, who are not considered actual parties) will be provided biographical information about the mediator. The parties are instructed to review the sketch closely and advise the administrator of any objections they may have to the appointment. Since it is essential that all parties have complete confidence in the mediator's ability to be fair and impartial, any mediator not acceptable to the parties will generally not serve. In the situation where there has not been a designation of an administrator, the party seeking the mediation should notify the other by the means specified in the mediation agreement, and the mediator will be selected as provided in the agreement of the parties.

Mediators serving in health care disputes should have knowledge and experience in health care matters. Disputes concerning the provision of medical care based on medical necessity standards should be heard by mediators who are qualified to render medical decisions in the particular medical branch and related specialty involved in the dispute (*Protocol*, Principle 5), although this is ultimately a matter for determination by the parties given the consensual, nonbinding nature of mediation. General dispute resolution qualities in mediators for these cases include, but are not limited to the following: commitment to impartiality and objectivity; dispute management skills, including excellent communication abilities; judicious temperament: impartiality; patience; courtesy; respect of bar or business community for integrity; strong academic background and professional or business credentials. The mediator must also be committed to compliance with the nationally-recognized [Model Standards of Conduct for Mediators](#), promulgated by the American Arbitration Association, the American Bar Association, and the Society of Professionals in Dispute Resolution.

In some instances, the use of co-mediation may be appropriate. Co-mediation involves two mediators who simultaneously and equally mediate the matter. For example, in situations that are quite complex in terms of technology or science, where expertise from two or more disciplines is needed, it is advocated that the parties consider using a co-mediation model. And, in some cases where the number of parties affected, and hence

participants in the process is large, or, where the issues presented for resolution are very diverse, co-mediation is also recommended.

4. Participant Preparation for Mediation

To prepare for mediation, each of the participants may wish to define and analyze the primary issues in dispute, and recognize the parameters of the given situation. This would include what can realistically be expected, time constraints, available resources, legal ramifications, generally accepted practices, options for alternative treatment, costs, and the like. Each person or organization should also attempt to identify and prioritize the needs and interests in settling the dispute. Determination of alternative courses of action, positions, tradeoffs, and exploration of a variety of possible solutions in advance of the session can be helpful. To reach a mutually acceptable agreement through mediation, it is usually necessary that each party be willing to make reasonable and legitimate proposals, which accommodate needs of the other party. Since disputes are often the result of misunderstandings or a lack of understanding about the matter, parties should be prepared with facts, documents, and sound reasoning to support claims and desired outcome. In doing so, it is also helpful to the process if some consideration is given to the other party's needs, demands, strengths and weaknesses, positions, and version of facts and perceptions.

5. Presence and Participation in the Mediation

All participants in the mediation should come to the session prepared with all of the information, including documentation that they feel will be necessary to discuss their respective cases. Parties are, of course, entitled to representation by counsel. At the beginning of the session, mediators describe the procedures and ground rules covering each party's opportunity to talk, order of presentation, decorum, discussion of unresolved issues, use of caucuses, and confidentiality of proceedings.

After the introductory matters, each party will be provided the opportunity to describe respective views of the dispute. The initiating party discusses his/her understanding of the issues, the facts surrounding the dispute, what he/she wants, and why. The other parties then have the same opportunity to make presentations. In this initial session, the mediator gathers as much information as possible and appropriate under the circumstances as well as attempts to clarify discrepancies. The mediator tries to understand the perceptions of each party, their interests, and their positions on the issues. It is imperative, however, that the mediator remain neutral on the issues, and refrain from providing an opinion on the ultimate outcome of the matter.

When joint discussions have reached a stage where no further progress is being made, the mediator may decide to meet with each party privately, or in caucuses. While holding separate sessions with each party, the mediator may shuttle back and forth. By discussing all options, parties can assess the consequences of continuing or resolving the dispute.

Gaining certain knowledge or facts from these meetings, a mediator can selectively use the information derived from each side to:

- reduce the hostility between the parties and help them to engage in a meaningful dialogue on the issues at hand;

- open discussions into areas not previously considered or inadequately developed;
- communicate positions or proposals in understandable or more palatable terms;
- probe and uncover additional facts and the real interests of the parties;
- help each party to better understand the other parties' views and evaluations of a particular issue, without violating confidences;
- narrow the issues and each party's positions and deflate extreme demands;
- gauge the receptiveness for a proposal or suggestion;
- explore alternatives and search for solutions;
- identify what is important and what is expendable;
- prevent regression or raising of surprise issues; and
- structure a settlement to resolve current problems and future parties' needs.

6. The Role of the Mediator

The mediator acts as a facilitator to keep discussions focused and avoid new outbreaks of disagreement. The mediator also assists the parties in communicating with, and ultimately understanding, the other parties. In particular, the mediator should work with the parties to: narrow the issues and each party's positions, and deflate extreme demands; gauge the receptiveness for a proposal or suggestion; explore alternatives and search for solutions; structure a resolution which will not only resolve current problems, but moreover is likely to meet and satisfy the parties' needs in the future. The mediator serves not as an advocate for any party or position, but rather as an "agent of reality." The mediator is likely to urge each party to think through demands, priorities, and views, and deal with the other party's contentions.

During the mediation, whether in private or joint sessions, the mediator works with the parties to narrow differences and attempts to acquire agreement on both major and minor issues. At appropriate times, the mediator may offer suggestions about a final settlement, stress the consequences of failure to reach agreement, emphasize the progress which has been made, and formalize offers to achieve an agreement.

The mediator will often have the parties negotiate the final terms of a settlement while together in a joint session. The mediator will then verify the specifics of the agreement and make sure that the terms are comprehensive, specific, and clear in the final session.

7. The Mediated Settlement

It is anticipated that in the majority of cases, the mediation session will result in an agreement among the parties. In these cases, when the parties reach an agreement, the terms should be reduced to writing, usually by the mediator, or in the event of legal representation, the parties' lawyers, signed by all present, and copies distributed. In those matters where pending litigation exists, the parties or their counsel may also request that

the agreement be put in the form of an agreed judgment or consent award. In the event that the issue is critical, from a medical standpoint, and time is of the essence, a party may elect to telephonically or electronically convey the agreement to the appropriate and necessary person or organization.

If the mediation fails to reach a settlement of any or all of the issues, the parties may agree to submit to binding arbitration. Such arbitration would be administered under the appropriate arbitration rules as agreed by the parties. In accordance with most available mediation rules, court rules of evidence, or the parties' submission to mediation, the information offered in mediation may not be used in arbitration (or in subsequent litigation).

8. Costs

As provided in Principle 10 of the *Due Process Protocol for the Resolution of Health Care Disputes*, if mediation is mandated by the managed health care organization, the costs of the process (mediation filing fee, and mediator compensation and expenses) should be borne by the plan. If the parties mutually agree to utilize mediation, these costs should be borne equally or as otherwise agreed to by the parties.

In no instance should the mediator's compensation be contingent upon a specific outcome. Should any dispute arise about the costs of the mediation, it is recommended that such be submitted first to mediation, and in the event of no agreement, to arbitration. The neutral mediator or arbitrator should have no interest in the outcome of the fee dispute.

C. Arbitration

Arbitration is referral of a dispute to one or more impartial persons for a decision on the matter. Arbitrations may result in either final and binding determinations, or alternatively, be merely advisory in nature. An adversarial process, arbitration results in a determination being made by a neutral third party, based upon the presentation of evidence and argument by the parties or their counsel. Private and confidential, it is designed for quick, practical, and economical settlements.

1. Providing for Arbitration

Arbitration clauses are common in a number of contracts. The clause will govern the procedure, and can be simple or quite detailed in the elements included. As provided in Principle 3 of the *Protocol*, in disputes involving patients, binding forms of ADR, such as arbitration, should be used only where the parties agree to same after a dispute arises. A binding arbitration clause, however, may be perfectly appropriate for other relationships in the private managed health care area, such as disputes between health care providers and managed health care organizations. A sample of a simple contractual arbitration clause for use in such instances is as follows:

Any controversy or claim arising out of or relating to this contract, or the breach thereof, shall be settled by arbitration administered by [named ADR provider] in accordance with its [applicable] rules and judgment upon the award rendered by the arbitrator may be entered in any court having jurisdiction thereof.

Parties can exercise additional control over the arbitration process by adding specific provisions to arbitration clauses or, when a dispute arises, through the modification of certain of the arbitration rules to suit a particular dispute. For example, stipulations may be made regarding confidentiality of proprietary information used, evidence, locale, the number of arbitrators, and the issues subject to arbitration. The parties may also provide for expedited arbitration procedures, including the time limit for rendering an award, if they anticipate a need for hearings to be scheduled on short notice. It is anticipated that this will likely be the case in a number of situations addressed in the health care area. All such mutual agreements will be binding on the administrator of the process, as well as the arbitrator.

For disputes involving patients, there are two ways to provide for post-dispute submission to binding arbitration. The first is to include a provision in the managed health care policy providing consideration of submission to binding arbitration, after a dispute arises. The following clause can be utilized:

Any controversy or claim arising out of or relating to this policy/contract that is not resolved by the parties, shall, upon the written agreement of the parties after the dispute arises, be settled by arbitration administered by [named ADR provider] under its [applicable] rules, and judgment upon the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof.

If the managed health care policy does not provide for optional, post-dispute binding arbitration, the parties are free to submit an existing dispute to arbitration by using the following clause:

We, the undersigned parties, hereby agree to submit to arbitration administered by the [named ADR provider] under its [applicable] rules the following controversy: (cite briefly). We further agree that the above controversy be submitted to (one) (three) arbitrator(s). We further agree that we will faithfully observe this agreement and the rules, that we will abide and perform any award rendered by the arbitrator(s), and that judgment of the court having jurisdiction may be entered on the award.

2. Timing of Agreement to Arbitrate

As stated in Section X(B) of this Final Report (ADR Models) there are four major types of agreements to arbitrate:

- pre-dispute, final and binding arbitration
- pre-dispute, nonbinding arbitration
- post-dispute, final and binding arbitration, and
- post-dispute, nonbinding arbitration.

It is worth elaborating on what these concepts mean:

Pre-dispute, final and binding arbitration: The parties agree in advance to use arbitration to resolve disputes and they are bound by the outcome.

Pre-dispute, nonbinding arbitration: The parties agree in advance to use arbitration to resolve disputes, but they are not bound by the outcome.

Post-dispute, final and binding arbitration: The parties have the option, after a dispute arises, of deciding to arbitrate unresolved issues, and they are bound by the outcome.

Post-dispute, nonbinding arbitration: The parties have the option, after a dispute arises, of deciding to arbitrate unresolved issues, but they are not bound by the outcome.

The first form of arbitration (pre-dispute, final and binding arbitration) engendered considerable discussion among the Commission members. As provided in Principle 3 of the *Due Process Protocol for the Resolution of Health Care Disputes*, the agreement to use arbitration (or any form of ADR) should be knowing and voluntary. This of course assumes that full and accurate information regarding the ADR program is provided by the plan to participants (*Protocol*, Principle 2). In the Commission's view, participation in ADR should not be a requirement for receiving emergency medical care or treatment, (*Protocol*, Principle 3), and good practice dictates that a patient in an emergency situation not be approached at that time to consent to ADR.

As regards binding arbitration, it may be technically correct that a provision in a managed health care plan requiring binding arbitration is "voluntary" in the sense that a patient or subscriber who has received clear notice of this fact has, by accepting the health coverage, agreed to this term of the policy. Nonetheless, it was the Commissioners view that in disputes involving patients, binding arbitration should be used only where the parties agree to arbitrate *after* a dispute arises (*Protocol*, Principle 3).

3. Benefits of Arbitration

Arbitration has several claimed or perceived benefits. To a certain extent, the benefits may be inferred either from experience or from knowledge of the arbitration process. There has been some research which sets forth the perceptions of participants in the ADR process (see, for example, Deloitte & Touche Litigation Services *1993 Survey of General and Outside Counsels: Alternative Dispute Resolution* (1993)). Major benefits of arbitration are as follows:

- **Expert Neutrals:** The arbitrators have expertise in the subject matter in dispute, as well as training in the arbitration process;
- **Speed:** There is no docket or backlog in arbitration. Hearings are scheduled as soon as the parties and the arbitrator have dates available;
- **Cost Savings:** Because of the limited discovery and the informal hearing procedures, as well as the expedited nature of the process, the parties save on legal fees and transactional costs;
- **Confidentiality:** Arbitration is a private process. There is generally no public record of the proceedings; and
- **Limited Discovery:** Extensive, litigation-like discovery is generally not associated with arbitration. Necessary document exchanges will take place as directed by the arbitrator.

4. Administration; Requesting and Scheduling Arbitration

It was the Commission's view that administration of ADR arising out of health plans be neutral and independent of the parties, and that in no event should an ADR program be administered by a health plan (*Protocol*, Principle 4(1)). This will ensure to a reasonable extent that administration of disputes will be handled with dispatch and without inherent conflicts of interest. This element of the *Protocol* is in accord with the leading court case dealing with the issue of independence of ADR case administration, *Engalla v. Kaiser Permanente Medical Group Inc.*, 938 P.2d 903 (Cal. 1998).

In an administered system, the administrator will be responsible for the management of most details and arrangements. In each matter, the designated administrator would consult all parties and arbitrators to determine a mutually convenient day and time for the hearing. If the parties cannot agree, the arbitrator is empowered to set dates.

All parties should endeavor to conduct the arbitration hearing at a location that is convenient for both the patient and family as well as the provider and the plan decision-maker. In some instances, this will require travel costs for the arbitrator, and such should be allocated in the agreement to arbitrate, if not in a prior arbitration clause. As provided in Principle 8 of the *Due Process Protocol*, consideration should also be given to the health and well-being of the patient in terms of the ability to travel, when determining the location of the hearing.

At the request of any party, or at the discretion of the administrator, an administrative conference with the administrator and the parties and/or their representatives will be scheduled in appropriate cases to expedite the proceedings. This is particularly pertinent in cases where time is critical and life threatening matters are at issue.

5. Qualifications and Selection of Arbitrators

Selected qualities in arbitrators include the following: commitment to impartiality and objectivity; dispute management skills; judicious temperament: impartiality, patience, courtesy; respect of bar or business community for integrity; and strong academic background and professional credentials. Arbitrators serving in health care disputes should have knowledge and experience in health care matters. Disputes concerning the provision of medical care based on medical necessity standards should be resolved by arbitrators who are qualified to render medical decisions in the particular medical branch and related specialty involved in the dispute (*Protocol*, Principle 5).

The conduct of arbitrators should be guided by the *Code of Ethics for Arbitrators in Commercial Disputes* of the AAA and ABA (*Protocol*, Principle 4(3)).

6. Preparation for the Arbitration Hearing

The administrator will usually be in contact with the parties and/or their representatives in advance of the hearing. Because arbitration is an adversarial procedure, direct communication between the parties should be generally prohibited so to avoid the danger that one side will offer arguments or evidence that the other has no opportunity to rebut.

In complex cases, at the request of any party or at the discretion of the arbitrator or the administrator, a preliminary hearing with the parties and/or their representatives may be conducted. In addition, in order to expedite the process, documents should be exchanged and

provided to the arbitrator(s) at least three days in advance, except for those cases scheduled within less than seven days. In those instances, the document exchange shall be no less than 24 hours, unless so waived by agreement.

The right to representation in arbitration by counsel or another authorized person is guaranteed by the *Due Process Protocol* set forth herein (Principle 6), as well all modern arbitration statutes. A party who desires to be represented should notify the other side and file a copy of the notice with the case administrator at least three days before the hearing. When arbitration is initiated by a representative or when the respondent replies through a representative, however, such notice is deemed to have been given.

If a transcript of the hearing is needed, the parties are responsible for making the arrangements and notifying the other parties of such arrangements in advance of the hearing. In those instances where a party is unable, due to health difficulties, to be present at the arbitration, the arbitrator should be immediately notified and measures undertaken to provide an alternative method of testimony, such as telephone, videotape, video-conferencing and the use of the Internet.

7. Presentation of the Case

Arbitration hearings are conducted somewhat like court trials, except that arbitration is usually less formal. Arbitrators are generally not required to follow strict rules of evidence, unless otherwise agreed by the parties. They must hear all of the evidence material to an issue but they may determine for themselves what is relevant. Arbitrators will therefore be inclined to accept evidence that might not be allowed by judges. However, this does not mean that all evidence will be considered of equal weight. Direct testimony of witnesses is usually more persuasive than hearsay evidence, and facts will be better established by documents and exhibits than by argument only.

In these situations where the health of one party makes it difficult for personal appearance at the arbitration hearing, wide latitude should be given by the arbitrator(s) for the use of video-conferencing, the Internet, and other modes of communication that can obviate the need for an in-person hearing, if deemed necessary by the arbitrator. Furthermore, in cases of acute emergency, the arbitrator may determine to conduct the hearing by telephone (*Protocol*, Principle 7(2)), and other creative means, such as the Internet.

It is customary for the claimant to proceed first with its case, followed by the respondent. This order may be varied, however, when the arbitrator thinks it necessary. In any event, the "burden of proof" is not on one side more than the other; each party must try to convince the arbitrator of the correctness of its position and no hearing is closed until both have had a full opportunity to do so. That is why it is equally the responsibility of the claimant and the respondent to present their cases to the arbitrator in an orderly and logical manner. This may include:

- An opening statement that clearly but briefly describes the controversy and indicates what is to be proved. Such a statement lays the groundwork and helps the arbitrator understand the relevance of testimony to be presented.
- A discussion of the remedy sought. This is important because the arbitrator's power is conferred by the agreement of the parties. Each party should try to show that the relief it requests is within the arbitrator's authority to grant.

- Introduction of witnesses in a systematic order to clarify the nature of the controversy and to identify documents and exhibits. Cross examination of witnesses is important, but each party should plan to establish its case by its own witnesses.
- A closing statement that should include a summary of the evidence and arguments and a refutation of points made by the opposition.

Above all, a cooperative attitude is essential for effective arbitration. Overemphasis or exaggeration, concealment of facts, introduction of legal technicalities with the objective of delaying proceedings is discouraged.

8. The Role of the Arbitrators

The arbitrator's role is akin to that of a judge hearing a case without a jury: to listen to the presentations, review the evidence presented, and upon evaluation, make a decision on the matter. The arbitrator is not bound by the strict rules of evidence or trial procedure, unless same is desired by the parties.

9. The Award

The award is the decision of the arbitrator on the matters submitted to him or her under the arbitration agreement. If the arbitration panel consists of more than one arbitrator, the majority decision is binding. The purpose of the award is to dispose of the controversy finally and conclusively, and to rule on each claim submitted. While the arbitrator is generally viewed as a "creature of the parties' contract," and must make his or her award within the limits of the arbitration agreement, the *Protocol* (Principle 9(2)) provides that "the arbitrator should be empowered to grant whatever relief would have been available in court under law or in equity."

The award as a matter of law must be in writing. The *Protocol* (Principle 9(2)) relaxes that requirement somewhat, in that in cases of acute emergency, the arbitrator is permitted to make a preliminary award orally. In such instances, however, a written award would still follow as required by law.

In general business disputes, arbitrators are not as a rule required to write opinions explaining the reasons for their decisions. In view of the issues involved in health care disputes, however, the Commission recommends that the award be accompanied by an opinion where requested by any party (*Protocol*, Principle 9(2)). An opinion would serve the dual purposes of helping a patient or provider better understand the outcome, and also serving as guidance to health plans in terms of future actions and behavior.

The power of the arbitrator ends with the making of the award. An award may not be changed by the arbitrator, once it is made, unless the parties agree to restore the power of the arbitrator or unless the law provides otherwise.

10. Costs

As provided in the *Protocol* (Principle 10) binding arbitration should not be mandated in disputes involving patients. It may be mandated in disputes not involving patients, as can nonbinding arbitration in any dispute. Where arbitration is mandated, the plan should pay the costs of at least one day of hearing before a single arbitrator (including the arbitrator's fee and

expenses). If there are additional days of arbitration, the costs should be shared equally, subject to the power of the arbitrator to allocate costs. In some jurisdictions, the dominant party may be required to pay all arbitrator compensation where the use of arbitration is mandated by that party (see, e.g., *Cole v. Burns International Security Services*, 105 F.3d 1465 (D.C. Cir. 1997) (employment arbitration)).

Where arbitration is consensual, the administrative fees and the costs of compensating the arbitrator will generally be borne as provided in the parties' arbitration agreement. Failing that, administrative fees are generally advanced by the filing party, and arbitrator's compensation is advanced equally by the parties. Both of these costs may be allocated by the arbitrator in the award.

Arbitrators generally charge a rate consistent with his or her stated rate of compensation, beginning with the first day of service. Should any dispute arise about the costs of the proceeding, it is recommended that such be submitted first to mediation, and, in the event of no agreement, to arbitration.

D. Hybrid Processes of ADR

In some instances, two or more ADR processes may be combined or used succeeding one another; this is often referred to as hybrid procedures. The advantage of such an arrangement is that if one process fails to achieve resolution, additional procedural options exist, and, where the final step is binding arbitration, comes with the assurance of finality. In situations where time is of the essence, it is important that the parties have the capability of achieving a final resolution rapidly.

One example of a hybrid ADR form is Mediation/Arbitration (Med/Arb). A clause can be inserted into a contract that provides first for mediation under an agreed upon set of mediation rules. In the event the mediation does not reach resolution of the matter, then the dispute would then go to arbitration under the agreed upon arbitration rules. Set forth below is a sample med/arb clause:

If a dispute arises out of or relates to this policy/contract, or the breach thereof, and if said dispute cannot be settled through direct discussions, the parties agree to first endeavor to settle the dispute in an amicable manner by mediation administered [named ADR provider] under its Mediation Rules. Thereafter, any unresolved controversy or claim arising out of or relating to this contract, or breach thereof, shall upon the written agreement of the parties after the dispute arises, be settled by arbitration administered by [named ADR provider] in accordance with its [applicable] Rules, and judgment upon the Award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof.

IV. MATRIX OF AREAS OF DISPUTES AMENABLE TO ADR In Plan

<i>Disputed Service</i>	<i>Timeframe for resolution</i>	<i>Example</i>	<i>Comments</i>
Surgical Services	Depends on procedure Maximum 30 days	Hysterectomy	2 nd opinion useful; clinical guidelines
Cosmetic Surgery	6 months +	Breast reduction or augmentation	Psychological effects of not doing need consideration
Dental/Oral Surgery	90 days	TMJ dysfunction	Separate dental insurance may cover
Durable Medical Equipment	30 days	Glucose monitor for diabetics, wheel chairs, nebulizers	Clinical standards/ guidelines useful
Procedures & Tests	30 days	CT Scan for headaches, repeat cholesterol tests, abdominal ultrasound	Clinical standards/ guidelines useful
Physical Therapy & Occupational Therapy	30 to 60 days	Excess services per plan speech therapy for children	For children:overlap Coverage with school system; work disability an issue
Denial of Referral	30 days	Dermatology, OB/GYN, Ortho	Limited referral may be acceptable; open access to OB/GYN recommended
Mental Health	30 to 60 days	Length of treatment, length of stay	2 nd opinion useful
Second Opinion	30 days	In Network vs out of Network 2nd opinion	Can be used in mediation
Hospice	30 days	Terminal cancer care	Quality of “end of life”
Restricted Formulary	60 days	Paxil instead of Prozac; generic vs nongeneric; switch of medication	2 nd opinion; clinical guidelines
Excessive Wait Times	30 days	Waits of 60 days for diagnostic services	Service standards should be in place
Home Health Care	30 days	Number of visits for specific care 24hr neonatal discharge follow-up; early discharge from hospital	With decreasing LOS in hospitals, more need for home health care nursing
Length of Stay	24 hours	Any discharge felt to be early	Goal of hospitalization should be communicated to patient on admission

<i>Disputed Service</i>	<i>Timeframe for resolution</i>	<i>Example</i>	<i>Comments</i>
Out of area coverage for medical services	30 days→ sooner if care is emergent	Dispute would normally be regarding payment after services rendered	Health plans should have provisions for out of area coverage
Emergency services	30-60 days if service has been rendered	Dispute would normally be regarding payment after services rendered	Health plans should have “prudent layperson” language for ER services
Access to non affiliated primary care providers	60 days	Desire to keep personal doctor	Continuity of care issues
Access to non affiliated specialty care providers	30 days	Desire to see previously seen specialist or specific program	Limited referral a possibility
Access to nonaffiliated mental health providers	30-60 days	Desire to keep current specialist; desire for specific program	Limited referral a possibility
Admission to nonaffiliated hospital	Depends on nature of admission	Desire for admission to University Hospital/Mayo Clinic	Limited referral a possibility
Second opinion with nonaffiliated providers	30 days	Desire for consultation at a University Hospital/Mayo Clinic	Limited referral a possibility
Access to nonaffiliated dental/oral surgery	30-60 days		Limited referral a Possibility
Access to nontraditional “alternative” medical care	60 days	Chiropractic/podiatry if not covered; herbal treatments, acupuncture	
Experimental care	30 days (or less depending on condition)	In the past, bone marrow treatments	Should be part of study conducted by reputable health science program
Continuity of care issues	30 days	Switch of insurance during pregnancy, cancer treatment	
Time sensitive situations	Depends on medical condition	Dialysis, cancer treatments, withdrawal	
Customer service	Varies	Failure to respond to inquiry	

V. DUE PROCESS PROTOCOL FOR EMPLOYMENT DISPUTES

A Due Process Protocol for Mediation and Arbitration Of Statutory Disputes arising Out of the Employment Relationship May 9, 1995

The following protocol is offered by the undersigned individuals, members of the Task Force on Alternative Dispute Resolution in Employment, as a means of providing due process in the resolution by mediation and binding arbitration of employment disputes involving statutory rights. The signatories were designated by their respective organizations, but the protocol reflects their personal views and should not be construed as representing the policy of the designating organizations.

GENESIS

This Task Force was created by individuals from diverse organizations involved in labor and employment law to examine questions of due process arising out of the use of mediation and arbitration for resolving employment disputes. In this protocol we confine ourselves to statutory disputes.

The members of the Task Force felt that mediation and arbitration of statutory disputes conducted under proper due process safeguards should be encouraged in order to provide expeditious, accessible, inexpensive and fair private enforcement of statutory employment disputes for the 100,000,000 members of the workforce who might not otherwise have ready, effective access to administrative or judicial relief. They also hope that such a system will serve to reduce the delays which now arise out of the huge backlog of cases pending before administrative agencies and courts and that it will help forestall an even greater number of such cases.

A. Pre or Post Dispute Arbitration

The Task Force recognizes the dilemma inherent in the timing of an agreement to mediate and/or arbitrate statutory disputes.

It did not achieve consensus on this difficult issue. The views in this spectrum are set forth randomly, as follows:

- Employers should be able to create mediation and/or arbitration systems to resolve statutory claims, but any agreement to mediate and/or arbitrate disputes should be informed, voluntary, and not a condition of initial or continued employment.
- Employers should have the right to insist on an agreement to mediate and/or arbitrate statutory disputes as a condition of initial or continued employment. Postponing such an agreement until a dispute actually arises, when there will likely exist a stronger predisposition to litigate, will result in very few agreements to mediate and/or arbitrate, thus negating the likelihood of effectively utilizing alternative dispute resolution and overcoming the problems of administrative and judicial delays which now plague the system.

- Employees should not be permitted to waive their right to judicial relief of statutory claims arising out of the employment relationship for any reason.
- Employers should be able to create mediation and/or arbitration systems to resolve statutory claims, but the decision to mediate and/or arbitrate individual cases should not be made until after the dispute arises.

The Task Force takes no position on the timing of agreements to mediate and/or arbitrate statutory employment disputes, though it agrees that such agreements be knowingly made. The focus of this protocol is on standards of exemplary due process.

B. Right of Representation

1. Choice of Representative

Employees considering the use of or, in fact, utilizing mediation and/or arbitration procedures should have the right to be represented by a spokesperson of their own choosing. The mediation and arbitration procedure should so specify and should include reference to institutions which might offer assistance, such as bar associations, legal service associations, civil right organizations, trade unions, etc.

2. Fees for Representation

The amount and method of payment for representation should be determined between the claimant and the representative. We recommend, however, a number of existing systems which provide employer reimbursement of at least a portion of the employee's attorney fees, especially for lower paid employees. The arbitrator should have the authority to provide for fee reimbursement, in whole or in part, as part of the remedy in accordance with applicable law or in the interests of justice.

3. Access to Information

One of the advantages of arbitration is that there is usually less time and money spent in pre-trial discovery. Adequate but limited pre-trial discovery is to be encouraged and employees should have access to all information reasonably relevant to mediation and/or arbitration of their claims. The employees' representative should also have reasonable pre-hearing and hearing access to all such information and documentation.

Necessary pre-hearing depositions consistent with the expedited nature of arbitration should be available. We also recommend that prior to selection of an arbitrator, each side should be provided with the names, addresses and phone numbers of the representatives of the parties in that arbitrator's six most recent cases to aid them in selection.

C. Mediator and Arbitrator Qualification

1. Roster Membership

Mediators and arbitrators selected for such cases should have skill in the conduct of hearings, knowledge of the statutory issues at stake in the dispute, and familiarity with the workplace and employment environment. The roster of available mediators and arbitrators should be established on a non-discriminatory basis, diverse by gender, ethnicity, background,

experience, etc. to satisfy the parties that their interests and objectives will be respected and fully considered.

Our recommendation is for selection of impartial arbitrators and mediators. We recognize the right of employers and employees to jointly select as mediator and/or arbitrator one in whom both parties have requisite trust, even though not possessing the qualifications here recommended, as most promising to bring finality and to withstand judicial scrutiny. The existing cadre of labor and employment mediators and arbitrators, some lawyers, some not, although skilled in conducting hearings and familiar with the employment milieu is unlikely, without special training, to consistently possess knowledge of the statutory environment in which these disputes arise and of the characteristics of the non-union workplace.

There is a manifest need for mediators and arbitrators with expertise in statutory requirements in the employment field who may, without special training, lack experience in the employment area and in the conduct of arbitration hearings and mediation sessions. Reexamination of rostering eligibility by designating agencies, such as the American Arbitration Association, may permit the expedited inclusion in the pool of this most valuable source of expertise.

The roster of arbitrators and mediators should contain representatives with all such skills in order to meet the diverse needs of this caseload.

Regardless of their prior experience, mediators and arbitrators on the roster must be independent of bias toward either party. They should reject cases if they believe the procedure lacks requisite due process.

2. Training

The creation of a roster containing the foregoing qualifications dictates the development of a training program to educate existing and potential labor and employment mediators and arbitrators as to the statutes, including substantive, procedural and remedial issues to be confronted and to train experts in the statutes as to employer procedures governing the employment relationship as well as due process and fairness in the conduct and control of arbitration hearings and mediation sessions.

Training in the statutory issues should be provided by the government agencies, bar associations, academic institutions, etc., administered perhaps by the designating agency, such as the AAA, at various locations throughout the country. Such training should be updated periodically and be required of all mediators and arbitrators. Training in the conduct of mediation and arbitration could be provided by a mentoring program with experienced panelists.

Successful completion of such training would be reflected in the resume or panel cards of the arbitrators supplied to the parties for their selection process.

3. Panel Selection

Upon request of the parties, the designating agency should utilize a list procedure such as that of the AAA or select a panel composed of an odd number of mediators and arbitrators from its roster or pool. The panel cards for such individuals should be submitted to the parties for their perusal prior to alternate striking of the names on the list, resulting in the designation of the remaining mediator and/or arbitrator.

The selection process could empower the designating agency to appoint a mediator and/or arbitrator if the striking procedure is unacceptable or unsuccessful. As noted above, subject to the consent of the parties, the designating agency should provide the names of the parties and their representatives in recent cases decided by the listed arbitrators.

4. Conflicts of Interest

The mediator and arbitrator for a case has a duty to disclose any relationship which might reasonably constitute or be perceived as a conflict of interest. The designated mediator and/or arbitrator should be required to sign an oath provided by the designating agency, if any, affirming the absence of such present or preexisting ties.

5. Authority of the Arbitrator

The arbitrator should be bound by applicable agreements, statutes, regulations and rules of procedure of the designating agency, including the authority to determine the time and place of the hearing, permit reasonable discovery, issue subpoenas, decide arbitrability issues, preserve order and privacy in the hearings, rule on evidentiary matters, determine the close of the hearing and procedures for post-hearing submissions, and issue an award resolving the submitted dispute.

The arbitrator should be empowered to award whatever relief would be available in court under the law. The arbitrator should issue an opinion and award setting forth a summary of the issues, including the type(s) of dispute(s), the damages and/or other relief requested and awarded, a statement of any other issues resolved, and a statement regarding the disposition of any statutory claim(s).

6. Compensation of the Mediator and Arbitrator

Impartiality is best assured by the parties sharing the fees and expenses of the mediator and arbitrator. In cases where the economic condition of a party does not permit equal sharing, the parties should make mutually acceptable arrangements to achieve that goal if at all possible. In the absence of such agreement, the arbitrator should determine allocation of fees. The designating agency, by negotiating the parties' share of costs and collecting such fees, might be able to reduce the bias potential of disparate contributions by forwarding payment to the mediator and/or arbitrator without disclosing the parties' share therein.

D. Scope of Review

The arbitrator's award should be final and binding and the scope of review should be limited.

Dated: May 9, 1995

Christopher A. Barreca, Co-Chair

Partner

Paul, Hastings, Janofsky & Walker

Rep., Council of Labor & Employment Section, American Bar Association

Max Zimny, Co-Chair

General Counsel, International

Ladies' Garment Workers' Union Association

Rep., Council of Labor & Employment Section, American Bar Association

Arnold Zack, Co-Chair

President, Nat. Academy of Arbitrators

Carl E. VerBeek

Management Co-Chair Union Co-Chair

Partner

Varnum Riddering Schmidt & Howlett

Arbitration Committee of Labor & Employment Section, ABA

Robert D. Manning

Angoff, Goldman, Manning, Pyle, Wanger & Hiatt, P.C.

Union Co-Chair

Arbitration Committee of Labor & Employment Section, ABA

Charles F. Ipavec, Arbitrator

Neutral Co-Chair

Arbitration Committee of Labor & Employment Section, ABA

George H. Friedman

Senior Vice President

American Arbitration Association

Michael F. Hoellering

General Counsel

American Arbitration Association

W. Bruce Newman

Rep., Society of Professionals in Dispute Resolution

Wilma Liebman

Special Assistant to the Director Federal Mediation & Conciliation

Joseph Garrison, President

National Employment Lawyers Association

Lewis Maltby

Director - Workplace Rights Project, American Civil Liberties Union

VI. DUE PROCESS PROTOCOL FOR CONSUMER DISPUTES

A Due Process Protocol for the Mediation and Arbitration of Consumer Disputes *April 17, 1998*

PRINCIPLE 1. FUNDAMENTALLY-FAIR PROCESS

All parties are entitled to a fundamentally-fair ADR process. As embodiments of fundamental fairness, these Principles should be observed in structuring ADR Programs.

PRINCIPLE 2. ACCESS TO INFORMATION REGARDING ADR PROGRAM

Providers of goods or services should undertake reasonable measures to provide consumers with full and accurate information regarding Consumer ADR Programs. At the time the Consumer contracts for goods or services, such measures should include (1) clear and adequate notice regarding the ADR provisions, including a statement indicating whether participation in the ADR Program is mandatory or optional, and (2) reasonable means by which Consumers may obtain additional information regarding the ADR Program. After a dispute arises, Consumers should have access to all information necessary for effective participation in ADR.

PRINCIPLE 3. INDEPENDENT AND IMPARTIAL NEUTRAL; INDEPENDENT ADMINISTRATION

1. Independent and Impartial Neutral. All parties are entitled to a Neutral who is independent and impartial.

2. Independent Administration. If participation in mediation or arbitration is mandatory, the procedure should be administered by an Independent ADR Institution. Administrative services should include the maintenance of a panel of prospective Neutrals, facilitation of Neutral selection, collection and distribution of Neutral's fees and expenses, oversight and implementation of ADR rules and procedures, and monitoring of Neutral qualifications, performance, and adherence to pertinent rules, procedures and ethical standards.

3. Standards for Neutrals. The Independent ADR Institution should make reasonable efforts to ensure that Neutrals understand and conform to pertinent ADR rules, procedures and ethical standards.

4. Selection of Neutrals. The Consumer and Provider should have an equal voice in the selection of Neutrals in connection with a specific dispute.

5. Disclosure and Disqualification. Beginning at the time of appointment, Neutrals should be required to disclose to the Independent ADR Institution any circumstance likely to affect impartiality, including any bias or financial or personal interest which might affect the result of the ADR proceeding, or any past or present relationship or experience with the parties or their representatives, including past ADR experiences. The Independent ADR Institution should communicate any such information to the parties and other Neutrals, if any. Upon objection of a party to continued service of the Neutral, the Independent ADR Institution should determine whether the Neutral should be disqualified and should inform the parties of its decision. The

disclosure obligation of the Neutral and procedure for disqualification should continue throughout the period of appointment.

PRINCIPLE 4. QUALITY AND COMPETENCE OF NEUTRALS

All parties are entitled to competent, qualified Neutrals. Independent ADR Institutions are responsible for establishing and maintaining standards for Neutrals in ADR Programs they administer.

PRINCIPLE 5. SMALL CLAIMS

Consumer ADR Agreements should make it clear that all parties retain the right to seek relief in a small claims court for disputes or claims within the scope of its jurisdiction.

PRINCIPLE 6. REASONABLE COST

1. Reasonable Cost. Providers of goods and services should develop ADR programs which entail reasonable cost to Consumers based on the circumstances of the dispute, including, among other things, the size and nature of the claim, the nature of goods or services provided, and the ability of the Consumer to pay. In some cases, this may require the Provider to subsidize the process.

2. Handling of Payment. In the interest of ensuring fair and independent Neutrals, the making of fee arrangements and the payment of fees should be administered on a rational, equitable and consistent basis by the Independent ADR Institution.

PRINCIPLE 7. REASONABLY CONVENIENT LOCATION

In the case of face-to-face proceedings, the proceedings should be conducted at a location which is reasonably convenient to both parties with due consideration of their ability to travel and other pertinent circumstances. If the parties are unable to agree on a location, the determination should be made by the Independent ADR Institution or by the Neutral.

PRINCIPLE 8. REASONABLE TIME LIMITS

ADR proceedings should occur within a reasonable time, without undue delay. The rules governing ADR should establish specific reasonable time periods for each step in the ADR process and, where necessary, set forth default procedures in the event a party fails to participate in the process after reasonable notice.

PRINCIPLE 9. RIGHT TO REPRESENTATION

All parties participating in processes in ADR Programs have the right, at their own expense, to be represented by a spokesperson of their own choosing. The ADR rules and procedures should so specify.

PRINCIPLE 10. MEDIATION

The use of mediation is strongly encouraged as an informal means of assisting parties in resolving their own disputes.

PRINCIPLE 11. AGREEMENTS TO ARBITRATE

Consumers should be given:

- (a) clear and adequate notice of the arbitration provision and its consequences, including a statement of its mandatory or optional character;
- (b) reasonable access to information regarding the arbitration process, including basic distinctions between arbitration and court proceedings, related costs, and advice as to where they may obtain more complete information regarding arbitration procedures and arbitrator rosters;
- (c) notice of the option to make use of applicable small claims court procedures as an alternative to binding arbitration in appropriate cases; and,
- (d) a clear statement of the means by which the Consumer may exercise the option (if any) to submit disputes to arbitration or to court process.

PRINCIPLE 12. ARBITRATION HEARINGS

1. Fundamentally-Fair Hearing. All parties are entitled to a fundamentally-fair arbitration hearing. This requires adequate notice of hearings and an opportunity to be heard and to present relevant evidence to impartial decision-makers. In some cases, such as some small claims, the requirement of fundamental fairness may be met by hearings conducted by electronic or telephonic means or by a submission of documents. However, the Neutral should have discretionary authority to require a face-to-face hearing upon the request of a party.

2. Confidentiality in Arbitration. Consistent with general expectations of privacy in arbitration hearings, the arbitrator should make reasonable efforts to maintain the privacy of the hearing to the extent permitted by applicable law. The arbitrator should also carefully consider claims of privilege and confidentiality when addressing evidentiary issues.

PRINCIPLE 13. ACCESS TO INFORMATION

No party should ever be denied the right to a fundamentally-fair process due to an inability to obtain information material to a dispute. Consumer ADR agreements which provide for binding arbitration should establish procedures for arbitrator-supervised exchange of information prior to arbitration, bearing in mind the expedited nature of arbitration.

PRINCIPLE 14. ARBITRAL REMEDIES

The arbitrator should be empowered to grant whatever relief would be available in court under law or in equity.

PRINCIPLE 15. ARBITRATION AWARDS

1. Final and Binding Award; Limited Scope of Review. If provided in the agreement to arbitrate, the arbitrator's award should be final and binding, but subject to review in accordance with applicable statutes governing arbitration awards.

2. Standards to Guide Arbitrator Decision-Making. In making the award, the arbitrator should apply any identified, pertinent contract terms, statutes and legal precedents.

3. Explanation of Award. At the timely request of either party, the arbitrator should provide a brief written explanation of the basis for the award. To facilitate such requests, the arbitrator should discuss the matter with the parties prior to the arbitration hearing.

Dated: April 17, 1998

Some of the signatories to this Protocol were designated by their respective organizations, but the Protocol reflects their personal views and should not be construed as representing the policy of the designating organizations

The Honorable Winslow Christian

Co-chair
Justice (Retired California Court of Appeals)

William N. Miller

Co-chair
Director of the ADR Unit
Office of Consumer Affairs
Virginia Division of Consumer Protection
Designated by National Association of
Consumer Agency Administrators

David B. Adcock

Office of the University Counsel
Duke University

Steven G. Gallagher

Senior Vice President
American Arbitration Association

Michael F. Hoellering

General Counsel
American Arbitration Association

J. Clark Kelso

Director
Institute for Legislative Practice
University of the Pacific
McGeorge School of Law

Elaine Kolish

Associate Director
Division of Enforcement
Bureau of Consumer Protection
Federal Trade Commission

Robert Marotta

Wolcott, Rivers, Wheary, Basnight & Kelly,
P.C.
Formerly Office of the General Counsel
General Motors Corporation

Robert E. Meade

Senior Vice President
American Arbitration Association

Ken McEldowney

Executive Director
Consumer Action

Michelle Meier

Former Counsel for Government Affairs
Consumers Union

Anita B. Metzen

Executive Director
American Council on Consumer Interests

James A. Newell

Associate General Counsel
Freddie Mac

Shirley F. Sarna

Assistant Attorney General-In-Charge
Consumer Frauds and Protection Bureau
Office of the Attorney General
State of New York
Designated by National Association of
Attorneys General

Daniel C. Smith

Vice President and Deputy General Counsel
Fannie Mae

Terry L. Trantina

Member
Ravin, Sarasohn, Cook, Baumgarten, Fisch
& Rosen, P.C.
Formerly General Attorney
AT&T Corp

Deborah M. Zuckerman

Staff Attorney
Litigation Unit
American Association of Retired Persons

Thomas Stipanowich

Academic Reporter
W.L. Matthews Professor of Law
University of Kentucky College of Law

Commission on Health Care Dispute
Resolution - Final Report