RESOLVED, that the American Bar Association endorses the five “Summary of Recommendations” principles and the ten Due Process Principles contained in the *Health Care Due Process Protocol: A Due Process Protocol for Mediation and Arbitration of Health Care Disputes* prepared by the AAA/ABA/AMA Commission on Health Care Dispute Resolution and dated July 27, 1998 and attached as Appendix A, and supports enactment of federal, state, and territorial legislation consistent with those principles.

FURTHER RESOLVED that the American Bar Association supports enactment of federal, state, and territorial legislation establishing alternative dispute resolution procedures as one remedy for resolving disputes between patients and group health plans, as part of a process that includes a rigorous system of internal review and an independent system of external review of benefit payment requests, adverse coverage determinations, and medical necessity determinations. Any system of internal or external review utilizing alternative dispute resolution should be consistent with the five “Summary of Recommendations” principles and the ten Due Process Principles contained in the July 27, 1998 Protocol and should ensure that the patient’s constitutional and other legal rights and remedies are protected.

*The “Recommendation,” but not the “Report” portion of this resolution, constitutes official ABA policy.*
REPORT

I. Introduction

In the Fall of 1997, leaders of the American Arbitration Association (AAA), American Bar Association (ABA), and American Medical Association (AMA) decided to form a joint Commission on Health Care Dispute Resolution (the “Commission”) to study and make recommendations on the appropriate use of alternative dispute resolution, or 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 litigation.

The decision by the three sponsoring institutions to create the Commission was indeed timely as the general topic of improving health care has recently become a subject of national discourse. In March 1998, the President’s Advisory Commission on Consumer Protection and Quality (“President’s Advisory Commission”), comprised of a broad cross-section of the health care community, issued a final report to the President which called for the creation of a “Patients’ Bill of Rights.” In addition, a number of bills were introduced in the 105th Congress which would have provided managed care patients with the right to internal and external review of health care coverage decisions, including H.R. 4250, H.R. 1091 and H.R. 3605 in the House and S. 2330, and S. 1890 in the Senate. These legislative efforts failed, however, over several contentious issues, including the question of whether patients should have new rights to sue HMOs.

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. This position is consistent with the ABA’s longstanding policy of encouraging the greater use of various types of ADR while preserving the rights of all parties.

Another goal of the Commission was to provide guidance to legislative and related bodies who are developing systems to regulate the managed health care relationship. In addition, the Commission sought to promote 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 Commission also established the following specific objectives: 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. Given the complexity and importance of ADR in the private...
managed health care setting, the Commission determined not to study certain other issues, including the applicability of ADR to medical malpractice.

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 health care disputes outside the court system, and there is a growing consensus that ADR can be used as part of an internal or external review process to help resolve these disputes short of litigation. The Commission has operated on the belief that there was a clear need to add definition and depth to these concepts.

In the weeks following the initial organizational meeting, the officers and members of the Commission were named, and the first working session took place on September 22, 1997 in Chicago. The Commission was co-chaired by Jerome J. Shestack, the then-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 was George H. Friedman, Senior Vice President of the AAA, and the Recording Secretary was Scott Carfello, Regional Vice President of the Chicago Office of the AAA. Each institution also named four representatives to the Commission. Representing the ABA were the Hon. Arlin Adams, Kimberlee K. Kovach, Lawrence A. Manson, and Roderick B. Mathews.

II. The Health Care Due Process Protocol

After studying the issue in detail and weighing all relevant factors, the Commission prepared a detailed report in the Summer of 1998. This report, titled Health Care Due Process Protocol: A Due Process Protocol for Mediation and Arbitration of Health Care Disputes (the “Protocol”) is attached to this Report as Appendix A. In the “Summary of Recommendations” portion of its Protocol, the Commission unanimously adopted the following set of five recommendations:

Recommendations 1 and 2:

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.

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. Ultimately, the Commission concluded that a number of different ADR processes could be successfully utilized to resolve such disputes, including mediation, voluntary arbitration, use of ombuds, fact-finding, consensus-building, and ADR hybrids. These various processes were discussed in some detail in the Protocol.

The Commission also noted that ADR could be used to help resolve a number of different types of health care disputes. While the Commission’s major focus was on resolving disputes among patients, health plans, and managed care organizations, it also considered other types of disputes, including those arising among health care providers, health plans, and managed care organizations.

Although ADR is useful to resolve many different managed health care disputes, the Commission concluded that ADR was particularly appropriate for resolving disputes involving the following issues: 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. 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 rewritten 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.

ADR processes are, however, well suited to managed 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. A detailed list of these potential areas of conflict are set forth in the Commission’s attached Protocol.

Recommendation 3:

In disputes involving patients, binding forms of dispute resolution should be used only where the parties agree to do so after a dispute arises.

The Commission concluded in its Protocol that binding forms of ADR, most notably arbitration, should be voluntary in order to ensure that the parties’ constitutional and other legal rights and remedies are protected. There are four major types of arbitration agreements: (1) pre-dispute, final and binding arbitration, (2) pre-dispute, nonbinding arbitration, (3) post-dispute, final and binding arbitration, and (4) post-dispute, nonbinding arbitration. It is the Commission=s unanimous view 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. This is the only way to guarantee that the agreement to arbitrate is both knowing and voluntary.

Recommendation 4:

It is essential that due process protections be afforded to all participants in the ADR process.

The Commission also concluded that whenever ADR systems are used 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--actually takes place. Since these ADR systems or external review procedures will rarely, if ever, 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--including Congress--as they focus on establishing fair and appropriate methods for resolving health care disputes.
In its Protocol, the Commission outlines ten important principles for preserving due process in health care disputes. Principle 3, for example, regarding “Knowing and Voluntary Agreement to Use ADR,” states that any agreement to use ADR should be knowing and voluntary. In order to ensure this, consent to use an ADR process should not be a requirement for receiving emergency care or treatment, and in disputes involving patients, binding forms of ADR should be used only where the parties agree to do so after a dispute arises.

Principle 8, dealing with “Reasonable Time Limits,” states in part that “ADR proceedings should occur within a reasonable time, and without undue delay.” The Commission believes that the rules and laws 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 also recommends general time frames for resolving different types of disputes, such as 24 hours for acute emergencies, 72 hours for emergencies, or 60 days for non-emergencies.

Another notable due process guideline, “Principle 10: Costs in Mandated, Nonbinding ADR Processes,” states that if mediation is mandated, the cost should be at the expense of the health plan, not the patient. The Commission also endorses the concept that if nonbinding arbitration involving patients is required, the plan should pay the costs of at least one day of hearing before a single arbitrator, including the arbitrator’s fees and expenses. For longer arbitrations, or for arbitrations involving multiple arbitrators, the costs should be shared equally unless the arbitrator decides to allocate the costs in another manner.

**Recommendation 5:**

> Review of managed health care decisions through alternative dispute resolution complements the concept of internal review of determinations made by private 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 Commission concluded that ADR definitely should play a key role in the next step--i.e. as a form of independent external review or appeal. Alternative dispute resolution complements, but will not replace, the existing system of internal review now utilized by many health care organizations.

In August, 1998, the Commission’s Protocol, including its five recommendations, was presented to the ABA’s Board of Governors. After reviewing the Protocol, the Board authorized its distribution to the general public.
III. “Patients’ Bill of Rights” Legislation

Before adjourning, the 105th Congress gave serious consideration to legislation with ADR implications that would have established standards for relationships between group health plans and health insurers with enrollees, health professionals and providers. The House passed its managed care bill, H.R. 4250, on July 24, 1998 by a vote of 216-210, with 12 Republicans voting against it and 3 Democrats supporting it. H.R. 4250 had been introduced by House Speaker Newt Gingrich (R-GA). The Senate Republican version of the legislation, S. 2330, never reached a vote on the Senate floor.

H.R. 4250 and S. 2330 provided an alternative dispute resolution method to appeal denials of coverage under health plans governed by the Employee Retirement Income Security Act (“ERISA”), and both bills allowed internal and external reviews of decisions to deny care. S.2330 limited external reviews to costs exceeding $1,000 and procedures that are medically experimental while H.R. 4250 required consumers to pay up to $100 for an external appeal but would not limit external reviews to costs exceeding $1,000. H.R. 4250 and S. 2330 were introduced as a compromise to take the place of H.R. 1415, a major piece of legislation introduced by Rep. Charles Norwood (R-GA) that eventually garnered over 200 cosponsors in the House. Another version of Norwood’s original bill was introduced in the Senate as S. 644 by Sen. Alfonse D’Amato (R-NY). The original Norwood/D’Amato legislation provided for grievance and appeals procedures and allowed patients who have been denied care to appeal those decisions to a neutral third party in all managed health care plans.

On March 31, 1998, a coalition of House and Senate Democrats introduced separate legislation--S.1890 (Daschle, D-SD) and H.R. 3605 (Dingell, D-MI)--that addressed a host of issues in the managed care area. Like the Republican bills, this legislation included internal and external appeals procedures for health plans governed by ERISA. Neither S. 1890 nor H.R. 3605 ever came up for a final vote in the Senate or the House, however.

Both Republican and Democratic leaders in the House and Senate have predicted that managed care legislation containing ADR provisions is likely to reemerge as a priority issue in the 106th Congress. If such legislation is introduced in the 106th Congress, the ABA should encourage Congress to incorporate the due process principles contained in the Protocol.

IV. Conclusion

After an exhaustive study, the AAA/ABA/AMA Commission on Health Care Dispute Resolution concluded 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 and can provide an efficient and effective next step for resolving unsettled claims. In addition, ADR has the potential to serve as an effective means of external review or to provide a mechanism for appealing adverse determinations made by managed health care organizations. In many cases, internal and external review, utilizing ADR processes, will result
in patients receiving the care that they are entitled to without the necessity of pursuing costly and time-consuming legal action. It is essential, however, that such ADR programs be developed with due process safeguards for the rights of all participants in the process.

To ensure that all patients’ rights are protected in a timely and cost-effective way, federal, state, and territorial legislation establishing alternative dispute resolution procedures as one remedy for resolving disputes between patients and group health plans needs to be enacted. Such legislation should create a rigorous system of internal review and an independent system of external review of benefit payment requests, adverse coverage determinations, and medical necessity determinations, among other things, and should ensure that the patients’ constitutional and other legal rights and remedies are protected.

The American Bar Association has taken a leading role in promoting procedural due process for consumers in the health care delivery system. ABA policy supports legislation to provide “quality health care (with) procedural due process for consumers, providers, and other interested parties.” (2/94) In addition, in August, 1998, the ABA adopted the following policy statement, proposed by the ABA Commission on Legal Problems of the Elderly:

RESOLVED, That the American Bar Association supports the right of all consumers to a fair and efficient process for resolving differences with managed health care plans, health care providers, and the institutions that serve such plans and providers. That process should include three elements recommended by the Consumer Bill of Rights and Responsibilities of the President’s Advisory Commission on Consumer Protection and Quality in the Health Care Industry: (1) timely written notification and explanation of a decision to deny, reduce or terminate services or deny payment for services; (2) a rigorous system of internal review; and (3) an independent system of external review.

FURTHER RESOLVED, That consumer education and ombudsman programs should provide information and assistance in resolving health care complaints; and that health care dispute resolution processes should be fully accessible.

The proposed recommendation complements and expands upon these existing ABA policies by supporting legislation that would create a system of internal and external review of adverse health care determinations while establishing a detailed set of due process protections for patients who seek such internal and external review. By adopting this proposed recommendation, the ABA can continue its efforts to enact legislation that will make the health care delivery system more equitable and efficient while protecting the rights of patients.

Pamela Chapman Enslen
Chair
ABA Section of Dispute Resolution
February, 1999