

Alternative Dispute Resolution in a New Health Care System: Will it Work for Everyone?

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PREFATORY NOTE: *This article was written prior to the conclusion of the most recent session of Congress, during which Congress took no action on President Clinton's health care reform package. Although this article uses that package's Early Resolution Program as an example of ADR in health care systems, its analysis, conclusions, and recommendations are equally applicable to whatever type of health care reform is adopted.*

I. INTRODUCTION

In October 1993, President Clinton released his proposal for health care reform, the Health Security Act (HSA or the Act). While most of the country focused on the benefits package, managed care structure, and associated costs, several observers wondered how the President's plan would affect disputes between patients and their health care providers,¹ health plans, and alliances. The HSA creates or permits several dispute resolution fora, including the Early Resolution Program (ERP). The ERP offers several forms of alternative dispute resolution (ADR).² Proponents point to ADR as one of the consumer protections that are "the heart of the Health Security Act."³

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¹ Throughout this article we will refer to doctors, nurses, therapists, and other health care professionals, as well as hospitals and clinics, as "providers."

² We recognize that ADR is a loosely and sometimes ill-defined term that covers procedures ranging from written grievance forms to mediation to quasi-formal administrative hearings. However, we are reluctant to narrow the scope of the term for purposes of this article, since the HSA would permit states and their health care cooperatives to utilize the entire range of such procedures.

³ *Health Security Act: Hearing Before the Subcomm. on Health of the House Comm. on*

During the most recent Congressional session, at least five other health care reform proposals were. Of those, at least three require some form of ADR in the resolution of disputes between consumers, health plans, and providers.⁴ Meanwhile, many state legislatures are also considering health care reform, and most of these proposals envision some use of ADR.

This Article first reviews some of the general advantages and disadvantages of ADR, and applies this critique to the health care dispute context. It then addresses the effects of ADR on traditionally disempowered people such as minorities, women, and the poor. Finally, it offers some conclusions and recommendations to ensure that ADR procedures protect *all* consumers in the newly emerging health care marketplace.

A. Consumer Disputes Under the Health Security Act

The HSA offers numerous ways to resolve health care disputes informally. Consumers must first attempt resolution through the health plan's grievance procedure and any other remedies the plan wishes to offer.⁵ Consumers may also seek help from an ombudsman, established by each regional alliance, to informally resolve the dispute.⁶ If a consumer continues to be dissatisfied and if the dispute satisfies applicable guidelines, the consumer may file a complaint with the state's complaint review office.⁷

The complaint review office only reviews complaints that allege a health plan or alliance denied or delayed payment or provision of benefits under the plan, and that the denial or delay was in violation of the terms of the plan or the HSA.⁸ Complainants are allowed to choose the forum of

Ways and Means, 103d Cong., 2d Sess. (Feb. 2, 1994) (statement of Philip R. Lee, M.D., Assistant Secretary for Health, Department of Health and Human Services).

⁴ Gina Kolata, *Will U.S. Be Healthier? Maybe Not, Experts Say*, N.Y. TIMES, Oct. 17, 1993, at 1 (chart) (discussing the use of ADR for malpractice claims).

⁵ H.R. 3600, 103d Cong., 1st Sess. § 1405(a) (1993); *Id.* § 5202(c).

⁶ *Id.* § 1326(a).

⁷ *Id.* § 5202(b). Each state must provide a complaint review office for each alliance established by that state. *Id.* § 5202(a)(1).

⁸ *Id.* § 5202(b). In addition, before the complaint review office will accept a complaint, the complainant must have exhausted all remedies provided under the plan (*i.e.*, the plan's grievance procedure). H.R. 3600, 103d Cong., 1st Sess. § 5202(c) (1993). Some problems, such as minor service complaints, are handled only at the plan level. The HSA calls for medical malpractice claims to be handled at the plan level using mediation and arbitration. If a complainant remains unsatisfied, a certificate of merit must be obtained before proceeding to court. Kolata, *supra* note 4, at 1 (chart).

The Health Security Act establishes a separate process for alternative dispute resolution of medical malpractice disputes. *Id.* §§ 5301-06 (1993). Discussion of this process is beyond

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resolution: they may choose to go directly to court (with limited exceptions),⁹ proceed with a hearing in the state's complaint review office,¹⁰ or submit the complaint to the ERP.¹¹

The Early Resolution Program offers various forms of ADR ranging from mediation to binding arbitration.¹² Complainants may choose mediation by entering into a written agreement (presumably with the ERP, although the Act does not specify this), and all parties selected by a complainant are required to cooperate with the proceedings.¹³ In mediation, formal rules of evidence do not apply, there are no formal proceedings and no statements or evidence under oath.¹⁴ Parties may be represented by attorneys in mediation and in other ERP proceedings.¹⁵ ERP mediator findings are advisory and non-binding.¹⁶ Settlements reached through mediation become enforceable through a settlement contract.¹⁷

It is clear from this brief overview that the Clinton Administration has determined ADR is preferable to litigation for solving health care disputes. The HSA requires consumers to attempt to resolve such disputes in numerous non-litigious ways before resorting to court. However, before adopting a health care system that relies so heavily on ADR, it would be wise to review the comparative advantages and disadvantages of ADR and litigation, especially as they apply to the health care context. It is to such a

the scope of this article.

⁹ This article does not address the implications of ERISA on complainants' rights to file a lawsuit against a health plan or alliance.

¹⁰ The state's — complaint review office — hearing is a process similar to other administrative hearing processes. It employs written complaints, answers, a hearing with a neutral hearing officer, witness testimony, and some written record. H.R. 3600, 103d Cong., 1st Sess. § 5204(a)-(c) (1993). The hearing officer writes an opinion and order which includes findings of fact and a decision for or against the complainant based on a preponderance of the evidence. *Id.* § 5204(d). Any party to the complaint may appeal the hearing officer's decision to the Federal Health Plan Review Board (FHPRB), which has limited review powers. *Id.* §§ 5204(e), 5205(c), (d). Decisions by the FHPRB may be appealed to the appropriate U.S. Court of Appeals and then to the U.S. Supreme Court, but only if the amount at issue exceeds \$10,000. *Id.* § 5205(e).

¹¹ *Id.* § 5203(a).

¹² H.R. 3600, 103d Cong., 1st Sess. § 5211(a) (1993). The Health Security Act prescribes the form of mediation only and leaves the prescription of other forms of ADR to the Secretary of Labor.

¹³ *Id.* § 5212(b) & (c).

¹⁴ *Id.* § 5213(e).

¹⁵ *Id.* § 5213(f).

¹⁶ *Id.* § 5214(a).

¹⁷ H.R. 3600, 103d Cong., 1st Sess. § 5214(b) (1993).

review that this article now turns.

II. ADR AS AN ALTERNATIVE TO LITIGATION

The shortcomings of litigation are well known: it is costly, time consuming, procedurally cumbersome, and requires great amounts of social resources. Many complain the results are unfair, or that certain cases are frivolous and a waste of valuable court resources. Moreover, even monetarily successful litigants frequently feel unsatisfied — and sometimes betrayed — by a process from which they are often kept at arms length.

Many have touted ADR as the solution to these problems: it costs less money, requires less time, utilizes fewer social resources, reduces court case loads, and usually involves the parties more directly in the process. But is ADR really the solution to our litigation problems in the health care context?

A. Advantages of Alternative Dispute Resolution

ADR is perhaps most helpful when a consumer wants a complaint taken seriously, but full-blown litigation is not the most appropriate way to resolve it. For those disputes primarily involving hurt feelings and misunderstandings, a less costly and time consuming mediation option will often be appropriate. Ann Kellett, writing about medical malpractice disputes, suggests that in these cases consumers do not really want money from the provider; they want an explanation, the opportunity to talk with the provider about their anxieties, or an apology.¹⁸ ADR offers the opportunity for open discussion of all issues, including underlying non-legal issues.¹⁹ This is particularly helpful in the health care context where consumers and providers often — and under the HSA may be required to — carry on long-term relationships. A second advantage of ADR is that its comparative privacy, informality, and shorter resolution time causes the defendant less “trauma”²⁰ than the more drawn out, public litigation

¹⁸ Catherine S. Meschievitz, *Mediation and Medical Malpractice: Problems with Definition and Implementation*, 54 LAW & CONTEMP. PROBS. 195 (1991); Ann J. Kellett, R.N., Comment, *Healing Angry Wounds: The Roles of Apology and Mediation in Disputes Between Physicians and Patients*, 1987 J. DISP. RESOL. 111, 124.

¹⁹ Andrew McMullen, Comment, *Mediation and Medical Malpractice Disputes: Potential Obstacles in the Traditional Lawyer's Perspective*, 2 J. DISP. RESOL. 371, 373-74 (1990).

²⁰ Thomas B. Metzloff, *Alternative Dispute Resolution Strategies in Medical Malpractice*, 9 ALASKA L. REV. 429, 435 (1992).

process.²¹ In the health care context, the less traumatic ADR setting should permit the provider to work more honestly with the consumer. Ultimately, ADR can maintain or even improve an ongoing relationship,²² such as the relationship between health care consumers and their providers, plan, and alliance. Conversely, litigation tends to polarize the parties and enhance hostilities,²³ and can disrupt ongoing relationships.²⁴

ADR also allows for unique solutions not available through litigation.²⁵ An ADR resolution need not be exclusively win or lose, money based, or grounded in the statutory or common law of remedies. For example, to resolve a health care coverage dispute, parties may decide on a compromise treatment that is less costly than the treatment originally requested, but which addresses most of the consumer's medical problems. Alternatively, the provider and patient may agree to split the treatment costs, or place an upper cost limit above which the provider pays. In these ways, ADR can help parties focus on the patient's health, rather than get bogged down in, and distracted by, the concerns of precedent and publicity associated with litigation.

One study found that parties in small claims court prefer ADR to trial and are much more likely to comply with ADR agreements.²⁶ Parties also felt they had a better opportunity to present their side of the case, understood the process better, and were more satisfied overall than those whose cases were decided by a judge.²⁷ No reason exists to believe health care consumers would feel differently from other disputants.

There is also a general consensus that ADR saves money, at least for providers. In the 1970's, the Hospital Arbitration Project found that

²¹ This is particularly true in the medical malpractice context, where providers see lawsuits as akin to criminal proceedings, and speak in terms of innocence and guilt. *Id.*

²² McMullen, *supra* note 19, at 373-74.

²³ Kellett, *supra* note 18, at 128.

²⁴ James F. Henry, *ADR and Personal Injury Litigation*, 23 TRIAL 73 (Apr. 1987).

²⁵ McMullen, *supra* note 19, at 373-74.

²⁶ Linda Singer et al., *Alternative Dispute Resolution and the Poor, Part I: What ADR Processes Exist and Why Advocates Should Become Involved*, 26 CLEARINGHOUSE REV. 142, 145-46 (May/June 1992) [hereinafter Singer et al., *Part I*] (citing Craig McEwen & Richard Maiman, *Small Claims Mediation in Maine: An Empirical Assessment*, 22 MB. L. REV. 237, 261-63 (1981)).

²⁷ Singer et al., *Part I*, *supra* note 26, at 145-46. However, another study found that litigants felt they understood the litigation process better than several forms of ADR, felt they had participated more in litigation than in any of the ADR options, and felt equally comfortable with all options. E. Allen Lind et al., *In the Eye of the Beholder: Tort Litigants' Evaluations of Their Experiences in the Civil Justice System*, 24 LAW & SOC'Y REV. 953, 967 (1990).

hospitals that used arbitration spent fifty-nine percent less on defense costs than other hospitals.²⁸ However, the General Accounting Office reported in 1990 that while medical malpractice arbitration was less time consuming, the average cost to litigants in Michigan was comparable in the litigation and arbitration systems; *i.e.*, arbitration was no cheaper than litigation.²⁹

Other advantages of ADR include the involvement of expert decision makers rather than judges who may not be well-versed in a particular subject area and the involvement of court-appointed experts rather than party-chosen experts. Health care disputants are likely to benefit from these features because medicine and insurance are highly specialized fields. ADR can also address smaller claims that consumers cannot afford to bring before a court.³⁰ In the health care context, consumers with smaller claims frequently cannot find an attorney willing to take their case on a contingency fee basis and are unwilling to hire an attorney on an hourly basis when the attorney's total bill is likely to exceed the value of the disputed claim. Finally, ADR provides an early review of claims and thus acts as a gatekeeper to the litigation system.³¹

B. General Disadvantages of Alternative Dispute Resolution

One of the most troubling aspects associated with alternative dispute resolution from the consumer's perspective relates to the same privacy that makes it so appealing to providers. For instance, the less publicity a malpractice claim receives, the less likely the provider will be investigated by the state medical examiners.³² It also means that the provider is less likely to lose patients who might otherwise learn of a malpractice suit in the media. This makes the provider, no matter how incompetent, feel more secure. Moreover, if the provider is incompetent or dangerous, the state medical examiners may not hear of the provider's behavior until after more consumers are harmed.

²⁸ Neil D. Schor, Note, *Health Care Providers and Alternative Dispute Resolution: Needed Medicine to Combat Medical Malpractice Claims*, 4 OHIO ST. J. ON DISP. RESOL. 65, 75 (1988).

²⁹ Metzloff, *supra* note 20, at 439, (citing U.S. GEN. ACCT. OFF., MEDICAL MALPRACTICE: FEW CLAIMS RESOLVED THROUGH MICHIGAN'S VOLUNTARY ARBITRATION PROGRAM (1990)). Much litigation in the health care context (at least for medical malpractice) is contingency fee based. Thus, no matter how little time it takes to resolve a case, the consumer often pays the same amount for legal services.

³⁰ *Id.* at 436.

³¹ *Id.* at 437.

³² Alicia Roberts, *Alternative Resolution Takes Less Money, Time; So Arbitrate or Negotiate - Just Don't Litigate*, 5 MANAGED CARE L. OUTLOOK 1, 4 (Jan. 1993).

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Privacy also harms the public at large in other health care disputes, such as those over claim denials. In ADR, frequent plan misbehavior may remain unknown to the public, and individual consumers may fight the same battles over and over again.³³ In the same vein, private dispute resolution makes it difficult for similarly wrongly-treated individuals from acting as a class against the wrongdoer. It also prevents the wider public interest from being represented.³⁴

Another problem related to the issue of privacy is that resolving disputes through ADR does not develop the law or establish precedent on which other consumers can rely. As CIGNA's senior vice president and chief counsel put it, the "result [of the dispute] will be based on current law and not on a new extension, expansion, or contraction of established principles of law."³⁵ Litigation is desirable when precedent needs to be set or changed.³⁶ This is especially important in the area of health care claim denials. Under many current insurance contracts, claims can be denied if the treatment is experimental or investigatory; the HSA contemplates that these grounds for denial will continue to exist.³⁷ However, what is experimental today may become generally accepted practice tomorrow. The law must continue to evolve along with medical practice. If consumers are limited by precedent to what was standard treatment in 1994, in 1996 they will be denied treatments that are due them under the HSA or their insurance contract. Thus, in disputes over experimental treatment, consumers are likely to have greater success with a lawsuit than ADR.³⁸

³³ Some health care reform proposals, including the HSA, call for a "report card" system. It would be appropriate for this report card to gather and make publicly available information about consumer complaints and how they are handled.

³⁴ Michele G. Hermann, *The Dangers of ADR: A Three-Tiered System of Justice*, 3 J. CONTEMP. LEGAL ISSUES 117, 118 (1989-90). On a macro-political level, the informal nature may inhibit change because without open hearings, discontent is hidden from view and political confrontations are reduced. *Id.* at 119-20.

³⁵ Robert L. Robinson, *ADR in the Insurance Industry: One Company's Perspective*, 45 ARB. J. 24, 25 (Sept. 1990). See also Singer et al., *Part I*, *supra* note 26, at 146-47 (arguing that some practitioners strongly dislike the use of mediation in family disputes and divorce because it cannot develop, expand, and enforce women's rights).

³⁶ Linda Singer et al., *Alternative Dispute Resolution and the Poor-Part II: Dealing with Problems in Using ADR and Choosing a Process*, 26 CLEARINGHOUSE REV. 288 (July 1992) [hereinafter Singer et al., *Part II*].

³⁷ H.R. 3600, 103d Cong., 1st Sess. § 5201(e)(2) & (3) (1993).

³⁸ Moreover, since ADR procedures normally do not allow for punitive damages (or place caps on such damages), they are less likely than litigation to compel an insurer to agree to cover the costs of a procedure which they consider to be experimental.

III. SPECIAL CONCERNS FOR WOMEN, MINORITIES, AND THE POOR ABOUT ALTERNATIVE DISPUTE RESOLUTION

In addition to the general disadvantages of ADR for health care consumers outlined above, additional problems exist particular to disempowered groups such as women, minorities, and the poor. These problems stem from the informality of ADR, which is often touted as one of its primary advantages. However, for disempowered groups, informality may make ADR too risky.

Critical race theorists and most feminist legal theorists agree that formal adjudication rules and procedures are important to fair outcomes.³⁹ These rules and procedures protect women and minorities by limiting discretion, which otherwise can be used to hide prejudice.⁴⁰ Adjudication bolsters weaker parties with rules to protect the oppressed, and judicial authority can be used to balance uneven sides.⁴¹ Adjudication also focuses on rights-claiming, or asserting and vindicating rights,⁴² which is especially important for women, minorities, and the poor. This process of asserting and vindicating rights focuses public awareness on the existence of those rights for the disempowered.⁴³

Alternatively, by shifting the focus (particularly in mediation) away from rights and toward compromise, ADR tends to maintain the *status quo* of disenfranchised parties.⁴⁴ In mediation, discussion of principles, blame, and rights is avoided or de-emphasized, while values of compromise and relationship are encouraged.⁴⁵ "One adverse consequence of de-emphasizing discussion of principle and fault is that some persons may be discouraged from asserting their rights when they have been injured."⁴⁶

Even worse, in emerging areas of the law or in those traditionally

³⁹ See, e.g., Hermann, *supra* note 34, at 118; Trina Grillo, *The Mediation Alternative: Process Dangers for Women*, 100 YALE L.J. 1545, 1557-58, 1566-67 (1991); Richard Delgado et al., *Fairness and Formality: Minimizing the Risk of Prejudice in Alternative Dispute Resolution*, 1985 WIS. L. REV. 1359, 1367-75. But see Eve Hill, *Alternative Dispute Resolution in a Feminist Voice*, 5 OHIO ST. J. ON DISP. RESOL. 337 (1990).

⁴⁰ Hermann, *supra* note 34, at 118.

⁴¹ In practice, however, it is unclear whether this really happens. There is sufficient evidence of great imbalances and misbehavior in court to find that courts are in fact failing in their ability to provide just, equal dispute forums. *Id.* at 118-19.

⁴² Grillo, *supra* note 39, at 1564.

⁴³ *Id.* at 1557-58.

⁴⁴ *Id.* See also Hermann, *supra* note 34, at 120 (critics of ADR say women's social disadvantages will be perpetuated in an informal process).

⁴⁵ Grillo, *supra* note 39, at 1561-62.

⁴⁶ *Id.* at 1565.

subject to informal resolution, such as domestic disputes, parties may not even be aware of their legal rights.⁴⁷ Similarly, in medical malpractice cases, consumers rarely have the knowledge to assess whether providers have violated the standard of care.⁴⁸ Assigning issues to ADR before parties know their legal rights can exacerbate the exploitation of those parties. "To the extent that the mediation process makes it difficult to assert rights, the positive implications of rights-assertion for women, the poor, and minorities of either sex will be lost."⁴⁹ The following subsections address dangers particular to women, minorities, and the poor, respectively.

A. Women

During the 1970's and early 1980's, many feminist legal theorists embraced the theories of cultural feminists, the most well-known of whom is Carol Gilligan.⁵⁰ These theorists criticize litigation for requiring women to speak "like men" and frame experience in male terms.⁵¹ They claim that law acts as a bar to women presenting women's experience on women's terms in the legal system.⁵² These authors feel that ADR, when conducted in a cooperative rather than competitive manner, has more room for female perspective, voice, and methods.⁵³ At the same time, they recognize that these advantages are limited by the possibility of competitive opposing parties abusing the cooperative nature of a process.⁵⁴

Other feminist theorists, including post-modernists, conclude that mediation is no more inherently just or humane than litigation.⁵⁵ While litigation has been criticized for not allowing participants to tell their stories by limiting what is brought to court through rules of legal relevance, admissibility, and the framing of legal issues, ADR, especially mandatory mediation, can also force parties to speak unnaturally:

[Mediation] can be destructive to many women and some men because it

⁴⁷ Singer et al., *Part I, supra* note 26, at 152-53.

⁴⁸ Moreover, our work in representing low income petitioners with denied health insurance claims demonstrates that many health care consumers are unaware of their right to challenge such denials, either through informal arbitration under their health insurance contract, through the State Commissioner of Insurance, or through litigation.

⁴⁹ Grillo, *supra* note 39, at 1567.

⁵⁰ See CAROL GILLIGAN, *IN A DIFFERENT VOICE* (1982).

⁵¹ Hill, *supra* note 39, at 356-62.

⁵² *Id.*

⁵³ *Id.* at 370-76.

⁵⁴ *Id.*

⁵⁵ Grillo, *supra* note 39, at 1548.

requires them to speak in a setting they have not chosen and often imposes a rigid orthodoxy as to how they should speak, make decisions, and be It is an orthodoxy that often excludes the possibility of the parties' speaking with their authentic voices.⁵⁶

For instance, mediators frequently discourage the expression of anger.⁵⁷ Such suppression can be highly detrimental to women by reinforcing the socialized message that anger is unfeminine.⁵⁸ Rather than express anger, women are taught to suppress it and make peace or suffer the discrediting title of "bitch."⁵⁹ However, anger can be an important source of power and strength.⁶⁰ Discouraging the expression of anger can disempower a woman who has only recently found it. The message that anger is not legitimate is particularly damaging to black women.⁶¹ Societal fear of anger from minorities, especially blacks, coupled with the fear of anger from women, compounds the disempowering and disabling effects of the discouragement of anger.⁶²

Rather than discouraging and discrediting women's anger, mediators must recognize its legitimacy. Disputes in the health care setting often involve issues of interpersonal insensitivity,⁶³ and if consumers are not allowed to fully and honestly express their anger over the other party's insensitivity, the resolution will likely be less than complete. On a macro-level, women's anger will continue to be discredited.

Both cultural and post-modern feminist legal theorists are concerned with how power imbalances between parties affect women in ADR. ADR, especially mediation, requires parties to frame the issues and explain matters.⁶⁴ Women have less social power, and, in the words of one author,

⁵⁶ Grillo, *supra* note 39, at 1548-50.

⁵⁷ *Id.* at 1548. Much of the research in this part of Grillo's article is based on the use of mediation in divorce and child custody disputes. However, because Grillo proceeds to generalize these findings to apply to women in all kinds of mediation, we feel comfortable doing the same.

⁵⁸ Grillo, *supra* note 39, at 1576.

⁵⁹ *Id.* at 1576-77.

⁶⁰ *Id.* at 1572.

⁶¹ *Id.* at 1581.

⁶² *Id.* at 1579-81.

⁶³ Kellett, *supra* note 18, at 123 (citing Marilyn L. May & Laura DeMarco, *Patients and Doctors Disputing: Patients' Complaints and What They Do About Them*, INSTITUTE FOR LEGAL STUDIES, DISPUTES PROCESSING RESEARCH PROGRAM, WORKING PAPERS SERIES 7 (Mar. 1986)).

⁶⁴ Hilary Astor, *Feminist Issues in ADR*, LAW INST. J., Jan./Feb. 1991, at 69-71.

speak in a voice that is “the voice of the victim.”⁶⁵ Put another way, women express an “ethic of care,” while men express a “morality of rights.” The latter is more valued in dominant society.⁶⁶ This causes decision makers and opponents to give less weight to what women say, and puts women at a particular disadvantage when they participate in ADR.⁶⁷ Thus, in the health care setting, power differentials will often put women at a disadvantage because providers tend to be white, male, and professional.

Finally, the confidential nature of ADR endangers women’s recently recognized and currently developing rights. In the health care setting, women experience harassment and discrimination in services and treatment. The danger of resolving these issues through ADR is that they may remain shrouded from public scrutiny.⁶⁸ They may also be resolved according to unarticulated, unappealable social norms.⁶⁹ Thus, many of the assumed “strengths” of alternative dispute resolution — compromise, informality, and individual expression — may also be its primary weaknesses, especially for women.

B. Minorities

Blacks and whites have significant differences in values and priorities, due to their very different social status and experience.⁷⁰ Blacks are more likely than whites to question traditional notions of individualism. Blacks also tend to put a higher premium on alternative values of social responsibility, even after controlling for social class differences.⁷¹

Whether such differences are truly accommodated and valued in ADR mechanisms is unknown, for no one has studied this claim. However, critical race theorist Richard Delgado’s theories relating to dominant norms and informal settings assert that dominant norms control, often unconsciously, in informal settings.⁷² Thus, white America’s norms and traditions such as individualism would control in arbitration. “[L]egal forums that deliberately give greater importance to such implicit social norms might work in process and outcome to disadvantage minority

⁶⁵ Hill, *supra* note 39, at 363-70.

⁶⁶ *Id.*

⁶⁷ Grillo, *supra* note 39, at 1550.

⁶⁸ Astor, *supra* note 64, at 71.

⁶⁹ *Id.*

⁷⁰ Lawrence Bobo, *Prejudice and Alternative Dispute Resolution*, 12 *STUD. IN L. POL. AND SOC’Y* 147, 158 (1992).

⁷¹ *Id.*

⁷² Delgado et al., *supra* note 39, at 1387-89.

disputants.”⁷³

Delgado also suggests that informality leads to the expression of prejudice, which makes ADR less accessible to minorities.⁷⁴ He cites professional codes, legal doctrines, rules of evidence and civil procedure as among the mechanisms that reign in prejudice.⁷⁵ The literal and institutional structures of the courtroom and the litigation process are imbued with the principle of the American creed: the public values of equality and humanitarianism that people are inclined to adopt while in that setting construct more fair proceedings and determinations.⁷⁶ Because such values are not as overtly a part of the arbitration structure, Delgado concludes “that formal dispute resolution is better at deterring prejudice than informal adjudication.”⁷⁷ Delgado asserts that while the lack of procedural rules make ADR time-saving and flexible, they it “open[s] the door wider” to prejudiced behavior.⁷⁸

Finally, Delgado asserts that since minorities recognize that public institutions are more subject to rational control, they trust them more than private, informal structures to deliver justice.⁷⁹ Even if this perception is not as true as minorities may believe, he says it becomes self-fulfilling.⁸⁰ Delgado’s assertion is supported by a survey conducted by The Wirthlin Group for the National Institute of Dispute Resolution. The study revealed that those who said they were “not at all likely” to use arbitration or mediation tended to be older, members of minority groups, and had a high school education or less.⁸¹ Similarly, those who said they were more likely to go to court tended to be males (of all races surveyed) between 30 and 39 with a high school education or less, and earned under \$20,000.⁸² These profiles indicate that those with less social power, *i.e.*, minorities, people with less education, and people with lower income, feel safer in court. No doubt that when people with little social power are in a dispute with some of the most socially, politically, and economically powerful people in the country, *i.e.*, health care providers and insurance companies, they may

⁷³ Bobo, *supra* note 70, at 150.

⁷⁴ Delgado, *supra* note 39, at 1367-75.

⁷⁵ *Id.*

⁷⁶ *Id.* at 1383-88.

⁷⁷ Delgado, *supra* note 39, at 1375.

⁷⁸ *Id.* (citing social science research on the operation of prejudice in formal and informal settings, not litigation and ADR).

⁷⁹ *Id.* at 1391.

⁸⁰ *Id.*

⁸¹ The Wirthlin Group, *National Survey Findings on: Public Opinion Towards Dispute Resolution* 26 (1992).

⁸² *Id.* at 16.

frequently — and rationally — prefer court to ADR.

C. The Poor

Poor people have had significant experience in the ADR setting. ADR programs are available on a voluntary basis in many areas of poverty law, and a growing number of courts and agencies have made participation in ADR mandatory in these areas.⁸³ However, it is unclear whether poor people fare better with ADR than with the courts. According to some practitioners, the poor may achieve more justice through ADR.⁸⁴ Some legal services lawyers find ADR appealing because clients appreciate the active role they play in it. Such client participation is consistent with the original conception of the legal services movement: empowerment of the poor.⁸⁵ However, other legal services attorneys have avoided ADR because many of its advocates are opposed to vigorous representation of the poor and attempt to use it to create a labyrinthine maze to the courthouse door.⁸⁶

Another problem is that poor people have no right and often no ability to receive legal advice before, during, or after ADR.⁸⁷ This may leave them vulnerable to the non-rights-focused weaknesses of ADR: poor people may never learn their legal (or non-legal) rights and options.⁸⁸ The Health Security Act specifically allows parties to proceed with a lawyer or *pro se* in the ERP.⁸⁹ While providers and health plans (or at least their attorneys) will undoubtedly know their legal rights before entering the ADR process, poor consumers may not. This will exacerbate the already wide power differential between consumers on one side, and providers and health plans on the other. In addition, the ERP does not provide winning consumers the opportunity to collect their costs and legal fees from their opponents,⁹⁰ while in the hearing process alternative, the HSA requires losing defendants to pay reasonable consumers' attorney fees, expert witness fees, and other hearing-related costs.⁹¹ This encourages parties to proceed *pro se* in the ERP so as not to incur these unrecoupable costs, and thus maintains the power and knowledge differentials that put poor people at a procedural disadvantage.

⁸³ Singer et al., *Part I*, *supra* note 26, at 143–44.

⁸⁴ Singer et al., *Part II*, *supra* note 36, at 289.

⁸⁵ Singer et al., *Part I*, *supra* note 26, at 152.

⁸⁶ Singer et al., *Part II*, *supra* note 36, at 289.

⁸⁷ Hermann, *supra* note 34, at 120–21.

⁸⁸ *Id.*

⁸⁹ H.R. 3600, 103d Cong., 1st Sess. § 5213(f) (1993).

⁹⁰ *Id.* § 5213.

⁹¹ *Id.* § 5204(d)(2)(A)(iv).

IV. SOCIAL AND PHILOSOPHICAL CONSIDERATIONS

According to legal theorist Sally Engle Merry, law is an important site for the construction of meanings in society.⁹² She argues that legal and therapeutic discourses are more powerful than the third discourse of morality because they require special training.⁹³ When officials require certain legal disputes to be resolved according to morality discourse, they give disputants the message that their problems are trivial and not suited for court.⁹⁴ This use of naming by legal institutions, she argues, is a form of cultural domination.⁹⁵ Merry found that the moral discourse is the primary discourse used in mediation.⁹⁶

Though Merry's study is of interpersonal disputes brought to court and assigned to mediation programs, her observations are relevant in the health care dispute context as well. In health care, disputes are usually between parties with ongoing relationships, and the power differences between the parties are often dramatic,⁹⁷ just as in traditional interpersonal problems. Party emotions are often significant factors in both contexts and may even be the main reason for the dispute, rather than the discrete incident actually complained of. When health care disputes are mediated and reconstructed in moral rather than legal terms, consumers may be made to feel like second-class citizens. While traditional legal remedies may be no "better" than those offered through mediation, exclusion of a class of parties from legal relief constitutes cultural domination.⁹⁸ Under the HSA, consumers do retain the choice between litigation, administrative review, and ADR in the Early Resolution Program.⁹⁹ The government must be sure that consumers make their choice freely and that the ERP does not become a dumping ground for consumer claims that officials deem less valuable.

The Lind study of tort litigants' evaluations of their experiences in

⁹² Sally Engle Merry, *The Discourses of Mediation and the Power of Naming*, 2 YALE J. L. & HUMAN. 1 (1990).

⁹³ *Id.* at 4-5.

⁹⁴ *Id.* at 34-35.

⁹⁵ Merry, *supra* note 92, at 5-6.

⁹⁶ *Id.* at 8.

⁹⁷ In health care relationships, providers hold all the medical information and knowledge, carry the deification of the physician, and have expert and professional status. Kellett, *supra* note 18, at 121. Consumers can rarely balance this vast professional and social power.

⁹⁸ Merry, *supra* note 92, at 35-36.

⁹⁹ H.R. 3600, 103d Cong., 1st Sess. § 5203(a) (1993).

several dispute resolution forums supports Merry's theory.¹⁰⁰ They found that litigants' degree of understanding and participation in their dispute resolution process was in direct proportion to the degree of process formality. In addition, "litigants were substantially more likely to view the procedure as fair when they felt the litigation process was dignified."¹⁰¹ This study supports Merry's theoretical discussion and suggests that the most important factor in participants' evaluation of process fairness is the amount of dignity and formality afforded. The authors explain:

Our findings show that reduced cost and delay, however desirable in their own right, cannot be counted on to increase litigant satisfaction and to enhance feelings of procedural justice. Indeed, if the innovation in question somehow interferes with the enactment of a sufficiently dignified procedure, our findings suggest it will lead to dissatisfaction and perceived unfairness.¹⁰²

Arbitration and other ADR processes can be structured so as to give participants a hearing that they will feel is fair. It is important that such processes afford sufficient formality, dignity, and objectively fair hearings. Without these features, ADR participants will lose faith in the process and feel that their disputes have second-class status.

A. Recommendations

Health care reform will bring many currently uninsured people into the health care system, a disproportionate number of whom are low-income, minorities, and women. Any revised health care system must accommodate all of its consumers, especially disenfranchised people, if it is to make the overall society healthier. One place to focus this accommodation is in the dispute resolution system. Whether or not such a system is indeed accessible to women, poor people, and minorities depends on how well designed and implemented it is. If the costs are lower and the delivery is not prejudiced, nor perceived to be so, then the result should be greater access to justice.

1. Training

Mediator and arbitrator training is absolutely essential to creating a process that is free of bias.¹⁰³ Along with their training in how to resolve

¹⁰⁰ Lind et al., *supra* note 27, at 982.

¹⁰¹ *Id.* at 972.

¹⁰² Lind et al., *supra* note 27, at 984.

¹⁰³ Hermann, *supra* note 34, at 120; Astor, *supra* note 64, at 71.

disputes, mediators must be made aware of their own socialized biases, so as to avoid unfair results.¹⁰⁴ They must also be taught how to identify and compensate or correct power imbalances between the parties appearing before them while not compromising their neutrality.¹⁰⁵

2. Formality

ADR procedures must be as formal as possible,¹⁰⁶ and all parties and officials must show respect for the process and each other. This will encourage a perception of procedural fairness, will give parties faith in the process, and will prevent parties from feeling like they have second-class status. The process should also be rights-focused and precedent-based. Decisions should be made on the merits of the case. Compromise should be encouraged, but not at the expense of legal rights.

Attorneys should be made available to poor consumers at the point that the dispute leaves the health care plan forum. In the HSA, this is when the consumer files a complaint with the state complaint review office.¹⁰⁷ Attorneys can help counteract the gross inequalities between consumers and providers in the ADR setting. Attorneys can also assist the consumer in choosing the best forum in which to resolve the dispute. If the consumer chooses the ERP program, the attorney can assist that person in choosing the mediator/arbitrator.

3. Consumer Education

Many consumers have only a vague idea of what ADR is. Providers and health care plans must be required to give consumers information booklets about ADR written by an independent third party. Such information will help consumers make the most informed choice between the Early Resolution Program, the state complaint handling process, or traditional litigation. Consumers should also receive information about their rights as plan members and health care consumers.

Finally, the HSA provides for a "report card" on health care plans. As currently drafted, the report card will provide consumers with outcome and cost data. It will also provide them with information on medical malpractice findings. While this information will be a vast improvement over what is

¹⁰⁴ Astor, *supra* note 64, at 71.

¹⁰⁵ *Id.* at 70-71.

¹⁰⁶ A trade-off will necessarily exist between formality on the one hand and cost-savings, flexibility, and compromise on the other. Every program must strike an appropriate balance between the two, keeping in mind the values of both sides.

¹⁰⁷ H.R. 3600, 103d Cong., 1st Sess. § 5202(b)(1) (1993).

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currently available to consumers, this report card should include many more items. For instance, while the HSA requires reporting of court findings on medical malpractice, it should also report results of ADR proceedings. Plans should be required to report on the details of findings from the ERP and the state complaint review process of unfair claim denial and delay. They should report the number and nature of all complaints brought against them, including those brought in court, ERP, the state complaint review process, and at the plan grievance level. Finally, they should be required to present information on other lawsuits or formal complaints brought against them. All of this data collection and analysis should be conducted by neutral third parties, and presented in a way that is comprehensible to the public.

V. CONCLUSION

Litigation is not always the appropriate way to resolve a conflict; it can sometimes exacerbate a problem, particularly if the parties are involved in an ongoing relationship. On the other hand, ADR supporters claim that relationships can be saved and even strengthened through the use of ADR. Litigation does not address the emotional wounds of parties, while ADR offers more opportunity to reconcile emotional issues. Litigation in the health care setting does not adequately meet the goals typically achieved in other kinds of litigation: pecuniary punishment and fair and equal compensation for the wrongs committed. Doctors who commit malpractice are not financially punished because they carry insurance.¹⁰⁸ Litigation cannot be used by all aggrieved consumers because only expensive claims are worth bringing to court, compensation takes years, and awards often do not correspond to injuries.¹⁰⁹

While ADR has a number of advantages, it also has serious disadvantages and risks, especially for women, minorities, and the poor. Those who design, implement, and preside procedures in any revised health care system must consciously endeavor not to allow these disadvantages to infiltrate the new system. Otherwise, all of the time, effort, and resources directed at meaningful health care reform will have done little to alleviate the long-standing power imbalances between consumers, providers, and insurers.

¹⁰⁸ Kellett, *supra* note 18, at 125.

¹⁰⁹ *Id.*

