ARBITRATION AND MEDIATION IN THE NEW HEALTH CARE UNIVERSE

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Arbitration and mediation ("ADR") have become the forums of choice for major health care business disputes. These disputes are domestic and worldwide, and may involve millions of dollars. Disputes over health care issues extend far beyond traditional lawsuits between patients and physicians. Most of the claims are contractual and are not covered by insurance. Chief executive officers and general counsel of large and small companies and medical practices dictate the strategy of the case. While some cases are filed in state or federal court, and diverted to ADR, most health care providers and payers do not enter the courtroom. Many of the contracts contain mandatory binding arbitration clauses. Some contain two-step mediation/arbitration processes. Parties involved in health care ADR include health systems, hospitals, physicians and their medical groups, insurance carriers, practice management and billing companies, managed care plans, laboratories, large and small pharmaceutical companies, durable medical equipment companies, contract research organizations, nursing homes, assisted-living and residential care facilities.

Major "bet the company" commercial disputes in health care frequently are decided outside of courts and administrative agencies. Arbitrators in Illinois rejected a health plan's claims in a contentious antitrust dispute, in which the plan had argued that providers violated state and federal antitrust laws in their negotiation of contracts. Tenet Healthcare Corporation was awarded $46 million by an arbitration panel in a dispute with one of its insurance carriers over payment of damages in a settlement involving two physicians alleged to have performed unnecessary heart procedures.[1]

A number of statutes mandate ADR in specific types of disputes between health care providers and payers. Medicare and other federal statutes establish their own arbitration and/or mediation processes. Where an agreement to arbitrate is contained in a contract signed by both parties, and one party seeks adjudication by the court, most federal and state courts return disputes to arbitration for resolution.[2] At the same time, consumer filings contesting mandatory binding arbitration clauses in health care contracts continue to proliferate in state courts.

The United States Supreme Court has held that the Federal Arbitration Act ("FAA") applies to all arbitrations that involve interstate commerce.[3] Where this issue arises, most courts determine that activities in health care constitute interstate commerce.[4] The FAA has been held to pre-empt contrary state law[5] unless a federal statute says otherwise, as is the case with state insurance laws. Thus, state insurance law, not the FAA, has been held to control where the health plan arbitration clause did not comply with state law in a dispute involving HMO's.[6]

In addition to broad-based state arbitration statutes patterned on the Uniform Arbitration Act, many states have statutes and regulations requiring some type of ADR and/or hearing process for reimbursement or other issues between health care parties. New Jersey is a good example. There, the Health Care Carrier Accountability Act[7] authorizes mediation and binding and non-binding arbitration instead of a hearing to determine the liability of an organized delivery system or carrier resulting from negligence in the denial or delay of the approval of medically necessary covered services[8]. Other examples include hearings for provider terminations from a health maintenance organization,[9] and the complaint and appeal system for members of HMOs established by state regulation.[10] The Health Claims Authorization, Processing and Payment Act,[11] and amendments related thereto, require health insurers and providers in New Jersey to arbitrate health care payment disputes. Under amendments to the Health Care Quality Act, a health care appeals program is established, which mandates a two-step process for dispute resolution. [12] Other states have similarly mandated ADR programs for complaints and grievances related to care rendered and to reimbursement in managed care and other health insurance modalities.

ADR Processes Used for Health Care Matters

The ADR processes most commonly used in health care cases are binding arbitration, mediation, mediation/arbitration, early neutral evaluation and mini-trials. Non-binding arbitration, private judging, fact-finding/special referee and voluntary settlement conferences are used less frequently. These processes may be mandated by statute, by the contract or by state or federal court, if the case was commenced in litigation.

Arbitration versus Mediation. Arbitration is private adjudication.[13] A single arbitrator, or a panel of three, hears evidence and renders an award (binding decision) in accordance with a set of rules. Because the grounds for appealing an arbitration award are very narrow, an arbitrator wields greater authority over an individual case than a trial court judge.

Mediation is assisted settlement. The mediator has no power to impose a solution on the parties, who must make the decisions themselves. Rather, the mediator facilitates communication between the parties and helps them overcome barriers to agreement, often by assisting them to analyze the strengths and weaknesses of their case objectively.

Early Mediation. All too often, attorneys delay mediating until they are almost literally on the courthouse steps. The time and cost savings are far greater if mediation takes place early on in the pre-trial (or pre-hearing) process.[14] Moreover, in complex cases, mediation can be highly productive long before the parties are ready to discuss settlement. The mediator can help parties refine the issues and structure an efficient and effective discovery process. For example, instead of engaging in an expensive battle of experts, parties may agree to secure an opinion from a single trusted source. A neutral who has worked with the parties on managing discovery will be well prepared to assist in reaching a settlement when the time is ripe.

Health Care Matters Frequently Decided through ADR include:

1. Managed care disputes between payers and providers involving contract interpretation, risk sharing, insurance, reimbursement and/or administrative issues;
2. Employment contract disputes between physicians and medical groups or between physicians and hospitals (including covenants not to compete);
3. Medical staff, credentialing and peer review disputes;
4. Shareholder disputes with physician practices;
5. Contract and reimbursement disputes involving health care joint ventures;
6. Laboratory billing disputes;
7. Disputes between third party vendors, durable medical equipment providers and health care facilities;
8. Disputes over the dissolution of a medical practice or other health care entity;
9. Insurance carrier disputes with providers over coding, billing and claims payment;
10. Disputes involving management services companies, providers and third party vendors;
11. Class actions over coverage and claims payment;
12. Contested guardianship disputes;
13. Medical necessity disputes;
14. Long term quality of care and billing issues;
15. National and international contract disputes involving pharmaceutical companies, research and clinical trials of new drugs; and
16. Medical malpractice cases.

New Areas of ADR Use Include:

1. Disputes in ACOs involving shared savings programs, termination or restriction of participating physicians, reimbursement and financial incentives, use of quality metrics/clinical practice guidelines and others;
2. Decisions about inclusion of physician groups in limited provider networks;
3. Federal and/or state False Claims Act allegations;
4. Non-par reimbursement disputes over "reasonable and customary" allowances;
5. Fair market value disputes; and
6. Allegations of Medicare/Medicaid marketing fraud.

Characteristics of the ADR Process

Among the many factors that have led to the widespread acceptance of ADR as a means to resolve both simple and complex problems in the health care arena are the following:

Duration, Cost and Unpredictability of a Trial. Health care disputes are categorized by the court system as "complex" litigation. Thus, it can take years to complete discovery, motions, a bench or jury trial and appeals. It is not unusual for health care litigation to be pursued concurrently or successively in administrative tribunals and in both state and federal court on the same or different issues. Scheduling and outcomes are unpredictable and litigation is costly. Cases also become delayed in attempts to explain complex industry regulations and concepts to

courts which are not familiar with the scientific, administrative and reimbursement terminology and regulations.

In ADR, these issues and problems need not exist. Cases can be scheduled to accommodate the needs of the parties, experts and counsel, many of whom come from around the country to participate in a health care arbitration. There is no possibility of a long and expensive jury trial. Arbitration hearings are not delayed by the formal requirements for admission of evidence. (In health care cases, evidence is often medical records, cost and expense data, biological or other scientific research studies and/or reimbursement algorithms or formulas.) Due to the more abbreviated time frame, arbitration cases should be less costly. To the extent that there have been complaints that arbitration has become another form of litigation, the AAA, the College of Commercial Arbitrators and the Chartered Institute of Arbitrators are all working on protocols to improve upon these concerns.[15]

Parties Can Choose Qualified Expert Arbitrators. One of the major benefits of ADR for health care providers and payers is that the parties can select their own dispute resolvers. In the case of a highly complex and technical field such as health care, it becomes important to appoint an individual who is experienced in and has knowledge of the customs and usage, terminology and legal and regulatory framework for the industry. In recognition of this need, organizations have begun to develop specialized lists of experienced health care decision makers. Two of these are the American Arbitration Association ("AAA") and the American Health Lawyers Association ("AHLA") Alternate Dispute Resolution Service. To be selected to participate on the AAA National Healthcare Panel, candidates must be able to meet the Qualification Criteria and Responsibilities, which requires significant expertise in the technical, business and legal aspects of health care disputes.

Flexibility of the ADR Process. Another attribute of arbitration process is the ability to reach solutions to difficult health care legal and factual problems, which the parties could not achieve within the strictures of the court process. It is the flexibility of arbitration and mediation, coupled with the detailed knowledge of specially selected arbitrators that enables this process to take place. For example, major contract disputes and losses may be remedied through a combination of payment of damages and reformation of the organizational relationships and obligations set forth in a long-term contract. These solutions could not be achieved without guidance by an arbitrator or panel with detailed knowledge of the regulatory framework applicable to the issue at hand, as well as the factual idiosyncrasies and requirements of the particular health care sector at issue.

Limited Discovery. Discovery has been said to account for ninety percent of the cost of litigation. In arbitration, discovery is often limited by the arbitrator or by the rules of the case. For example, Rule 19 of the AAA Healthcare Payer Provider Arbitration Rules limits discovery to one deposition "unless otherwise agreed to by the parties or ordered by the Arbitrator for good cause shown." These same Rules also specify which initial disclosures of information will be exchanged between the parties. While the Payer Provider Rules were developed for a specific type of payment dispute, arbitrators in health care disputes often severely limit the discovery that will take place and the timeframe within which it will occur. This is done in the interests of efficiency and containment of the cost of the process. The challenge for the arbitrator in a health

care dispute is to administer a fair and even-handed discovery process when the parties may have very different levels of resources and capabilities to analyze large bodies of electronic and other data that is not easily accessible.

Complexity of the Technical, Regulatory and Reimbursement Issues. The health care industry is one of the largest employers in the United States. Along with Defense, it is also the most highly regulated. Federal and state health care regulations encompass everything from Food and Drug Administration rules about the introduction of new pharmaceuticals into the marketplace, state and federal managed care accounting and operational requirements, federal and state fraud and abuse laws pertaining to physicians, hospitals, the pharmaceutical industry, nursing homes, durable medical equipment providers and others, licensure requirements for professionals and institutions, as well as Medicare (federal) and Medicaid (state and federal) laws and regulations. This body of law and regulation is expansive, technical and complicated. It is not easily understood, even by attorneys who have worked with it for years. And, it is constantly changing, as evidenced by the Patient Protection and Affordable Care Act ("PPACA") and new laws related tofederal health care reform, effective between 2011 and 2014. Arbitration allows health care parties to select decision-makers who are familiar with this complex and convoluted area of the law. Arbitrators knowledgeable about the industry are also conversant with the many factual professional and institutional arrangements and relationships between the various types of health care parties involved in disputes. Parties to litigation cannot predict whether a fact-finder or court will possess the type of specialized knowledge essential to reach meaningful solutions to the many disputes that arise in this contentious environment.

Highly Emotional Nature of the Disputes. Disputes among parties in the health care industry often involve high stakes. For a physician, the case may decide his ability to practice medicine in the specialty or geographic area of his choice, or to practice at all. For a hospital, the dispute may determine whether or not the institution can offer specific medical services in the community where it is located, and/or which providers it must work with to render these services. The amount of payment and contract rules for payment to a health care provider also may be at stake. In some cases, the contract terms for payment or management of health care services are nationwide. These types of disputes involve individual and institutional parties that are highly emotional, as their livelihood may be at issue. For reasons noted in this article, many prefer the ADR forum.

Maintenance of Continuous Long-Term Business Relationships. Many health care contract disputes involve providers and/or insurers who want to continue business with each other in the future. Thus, they do not want to engage in the hostile and adversarial nature of the litigation process, which could damage their ability to contract with each other and/or conduct business together in the longer term. Private arbitration and mediation are not as prone to the histrionic nature of an adversarial courtroom proceeding. To the extent that litigation counsel conduct arbitration hearings in the same way that they pursue litigation, they may be sanctioned by the arbitrator, or by their own client. It is not unheard of for a physician or in-house counsel to a large health care provider or insurer to ask litigation counsel to recuse himself during the course of an arbitration proceeding if his tactics or strategy has become too hostile or litigious.

Privacy and Confidentiality of Proprietary Business and Patient Information. Avoidance of Bad Publicity. Many health care stakeholders prefer to have their cases resolved and/or settled through a hearing or confidential settlement document, where the information or data presented is not available to anyone but the parties themselves. The private nature of the ADR process also lessens the precedential value of the result. This is particularly important in cases involving employment matters, reimbursement issues, medical malpractice, medical staff privilege issues and/or other large commercial disputes, which could lead to class action treatment. As a major component of the economy, the health care industry is covered vigorously by the media. Unlike the public nature of litigation, arbitrations are not known or open to the media. This is advantageous to the parties, as publicity could affect stock prices of large for-profit entities, and could affect market position and patient selection for smaller health care institutions or individual providers and groups. In other words, the highly competitive and fast-paced nature of the industry lends itself to a preference for private adjudication, rather than to forums where confidential and proprietary business information or trade secrets may be in the public domain. Where individual medical records, patient data and personal health information is involved, privacy is a matter of multiple federal and state laws and can more easily be protected in arbitration than in a public judicial forum. (See discussion of "HIPAA" below.)

Binding Nature of the Process. The finality of binding arbitration is a major attraction for health care providers and patients. In arbitration, there is a limited right to long and costly appeals. Awards generally are rendered promptly and are followed by the parties. In those cases where parties attempt to repudiate the binding arbitration clause in the contract they signed, courts are reluctant to grant access or to allow appeals from an arbitration award, absent very limited grounds established by state statute or the FAA. Courts give deference to arbitral awards, and usually will not overturn an arbitrator's award for an error of law. In an instructive opinion on this point, the court in *Heartland Surgical Specialty Hospital, LLC v. Reed*, refused to vacate the award of an arbitrator, where the hospital alleged that it was denied an evidentiary hearing during the arbitration and the arbitrator engaged in ex parte contact with defendant's counsel.[16] Thus, parties can save significant time and money by avoiding the appellate process that is inherent in court litigation.

Similar Remedies as in the Courtroom. Arbitrators in many states have similar authority as judges in the courtroom. All types of remedies are granted in arbitration, including monetary damages and equitable relief, within the limits of the contract's arbitration clause and state and federal law. The AAA Commercial Arbitration Rules authorize arbitrators to award "any relief that the arbitrator deems just and equitable" in disputes involving exchange of information. There is some case authority that an arbitrator can order dismissal of a case as a sanction for discovery abuses.[17] Arbitrators also can allocate fees and costs of the proceeding, bar claims or defenses, preclude evidence or testimony or refuse to permit adverse inferences.[18] Effective January 31, 2011, the AAA adopted its new "Healthcare Payer Provider Arbitration Rules". These allow the grant of, "any remedy or relief the arbitrator deems just and equitable and within the scope of the agreement of the parties…" Interim, interlocutory or partial awards also are allowed, as are the apportionment of appropriate fees, expenses and compensation related to the award. Attorneys' fees and interest may also be granted, if authorized by law, arbitration agreement and/or deemed appropriate by the arbitrator.[19]

Arbitration involving Non-Parties

Increasingly, parties that did not enter into an agreement to arbitrate (non-signatories) are required to adjudicate their claims in arbitration The Federal Arbitration Act requires that agreements to arbitrate be placed "upon the same footing as other contracts."[20] Under traditional principles of state law, a contract may be enforced by or against a non-party through "assumption, piercing the corporate veil, alter ego, incorporation by reference, third-party beneficiary theories, waiver and estoppel."[21] Thus, the U.S. Supreme Court has held that a federal district court may equitably estop a claimant from litigating claims that fall within the terms of an agreement to arbitrate that the claimant did not sign.[22]

Since arbitration is a creature of contract, courts are more inclined to side with a non-party who is seeking to enforce an arbitration agreement against a signatory than a signatory who is seeking to enforce such an agreement against a non-party. To bind a signatory to the contract, a non-party need only show that:

- "The issues in dispute are intertwined with the agreement that the signatory signed";
- "There is a close relationship between the entities involved and between the alleged wrongs and the contract"; or
- "The claims are intimately founded in and intertwined with the underlying contract obligations."[23]

In contrast, a signatory generally may enforce an agreement to arbitrate only against a non-party who directly benefitted from the contract containing the arbitration clause.[24]

For example, in *Pearson v. Hilton Head Hospital*,[25] the South Carolina Court of Appeals held that Dr. Pearson, who had contracted with Locum Tenens, LLC to perform locum services at the Hilton Head Hospital, was required to arbitrate his claims pursuant to a contract between Locum and the Hospital. Dr. Pearson was not a party to this contract and had no direct contact with the hospital. However, the court determined that he was a third party beneficiary of this contract and was therefore required to arbitrate under its terms.

To the contrary, the court denied the insurer's motion to compel arbitration against the plaintiff medical professional associations in *DAC Surgical Partners, P.A. v. United Healthcare Servs., Inc.*.[26] In this case, the court refused to enforce binding arbitration clauses in network participation agreements, because they were signed by the physician owners, but not by the professional associations. The court refused to "pierce the corporate veil", as urged by United Healthcare, and the professional associations were not required to arbitrate their dispute.

Pre-Hearing Process under the New AHLA Rules of Procedure for Arbitration

One school of thought is that, since arbitration is a creature of contract, parties should be able to tailor the process any way they see fit. No discovery at all or full-blown discovery; no motions at all or any motion recognized under court rules. Whatever the parties say goes. The

other school of thought holds that, since arbitration should be a streamlined process, attorneys should not be able to encumber it with all the trappings of litigation. Rather, organizations that administer arbitrations should move cases along quickly and efficiently.

The new AHLA Rules of Procedure for Arbitration, which will take effect in 2014, balance these competing considerations. Rule 5.5 invests the arbitrator with discretion to permit only as much discovery as is relevant and necessary. Similarly, Rule 5.6 affords the arbitrator discretion to permit only motions that will add to the fair and efficient resolution of the case. With limited exceptions, however, parties may amend the rules as they see fit.[27]

AAA Payer Provider Arbitration Rules

On January 31, 2011, the AAA released a new set of rules specifically for the arbitration of disputes between health care payers and providers. Payer is defined in these rules as an, "insurance company or other party responsible for: (1) paying all or part of a claim relating to the rendering of health care services, or (2) administering the payment of such a claim for another entity…" This includes HMO's and administrators of self-funded and other health plans. Provider is defined broadly to include all types of health care professionals, including non-par providers. A contract between payer and provider is not required to access these Rules. However, the Rules do not apply to disputes with health care consumers.

The Payer Provider Rules call for a single arbitrator for all cases, regardless of size, unless the parties agree otherwise. Payer provider disputes are a type of commercial dispute, yet the AAA has established a National Healthcare Panel of arbitrators, who are knowledgeable about health care, arbitration and the Payer Provider Rules.

An important distinguishing feature of the Payer Provider Rules is the opportunity to choose from three tracks for resolution of the case: 1) the Desk or telephonic track; 2) the Regular track; or 3) the Complex track. All of these tracks are designed to limit discovery and provide for a more streamlined and cost-effective process. The Desk track consists of a resolution of the case by the arbitrator, either upon written submissions by the parties only, or after a telephonic hearing with the arbitrator. Depositions are not permitted and there is no formal, in-person, hearing with this track. The Regular track limits each side to one deposition, and the Complex track affords two depositions per party. The Rules contain a checklist suggesting core documents for disclosure in the case: 1) provider information; 2) patient and insured information; 3) billing information; and 4) administrative information (contract and appeal documents). These aid the arbitrator in his/her decision. The Rules further provide that the arbitrator's award will not have a preclusive or precedential effect on subsequent disputes between the same parties. A comprehensive review of the AAA Healthcare Payer Provider Arbitration Rules and a comparison with the AAA Commercial Arbitration Rules can be found at: www.adr.org/healthcare.

Applicability of HIPAA to Health Care Arbitration

The Health Insurance Affordability and Accountability Act ("HIPAA")[28] has been raised as a defense and/or an excuse to prevent arbitration in a health care case. This line of reasoning

holds that to proceed with the arbitration process, where patient records are part of the evidence in the case, violates the confidentiality of patients' individually identifiable health information protected by HIPAA.

This argument, however, ignores the explicit exception to HIPAA nondisclosure for protected health information during the course of litigation or administrative proceedings.[29] A covered entity may disclose protected health information in the course of any judicial or administrative proceeding in response to an order of court or administrative tribunal or in response to a subpoena, discovery request or other lawful process if "satisfactory assurance" or a "qualified protective order" is obtained by the party seeking the information. It is likely that the litigation exception applies to alternate dispute resolution procedures.[30] In addition, a covered entity may use or disclose protected health information for payment purposes.[31] Thus, production of protected health information in any arbitration or mediation in which payment is the issue may not present a HIPAA problem. It was not the intent of the HIPAA statute and regulations to prevent private adjudication from taking place in matters where protected health information is a crucial part of the evidence.

Even if one assumes that the HIPAA exception for litigation does not apply to ADR, it is possible to redact individual identifying information from any patient records (i.e. to de-identify the patient in the material used as evidence in the case). Second, it may be possible to aggregate the material from patient records, so that no individual identifying information is used in the case. In this way, confidential information would not be revealed, even if material from the records is admitted during the proceedings.

Consumer Disputes

Arbitration arose as a forum for resolving disputes between companies in the same industry.[32] Thus, agreements to arbitrate were negotiated at arm's length between parties with roughly equal bargaining power.

This is a new era. Many companies now insert arbitration clauses into agreements with consumers that are, or appear to be, contracts of adhesion. Many consumer disputes in the health care arena involve nursing homes. Either the patient disputes the quality of care rendered and the amount of the charges, or the institution invokes the binding arbitration clause in the services contract to collect on unpaid charges. A frequently litigated issue is whether the arbitration clause is unfairly tilted in the company's favor. In 1997, the California Supreme Court found that Kaiser Permanente's mandatory in-house arbitration system unduly delayed claims from patients and was biased in Kaiser's favor.[33] Similarly, a California appellate court held that an arbitration clause located three paragraphs before the final signature line on a health plan enrollment form, and written in the same font and size as every other paragraph in the agreement, was unenforceable under California state law. California Health and Safety Code Section 1361.1 (arbitration clauses in health plans must be "prominently displayed" and located "immediately before" the subscriber's signature line.) [34] Nonetheless, a different California appeals court found that under the state's Knox-Keene Health Care Service Plan Act of 1975 there was no authority in the federal or state constitution to uphold plaintiffs' claim that an

insured has a constitutional right to choose between arbitration and a jury trial in the context of a group health insurance plan.[35]

An arbitration clause must provide consumers with an effective means of vindicating their statutory rights. Otherwise, it may be struck down as contrary to public policy. Arbitration need not offer all the procedural protections available in court, such as full blown discovery or strict rules of evidence.[36] But the terms cannot be "so one-sided that their only possible purpose is as to undermine the neutrality of the proceeding."[37] A clause that raises the burden of proof, or limits damages or attorney's fees, may be struck down. A court may also refuse to order arbitration, or refuse to enforce an award, if the cost to a consumer to vindicate a right through arbitration is significantly greater than the cost of litigating the same claim in court.[38]

Courts also will strike down arbitration clauses that are unconscionable under applicable state law. Standards vary but typically require proof of both procedural and substantive unfairness. Procedural unconscionability generally means that one party has had no meaningful opportunity to draft the contract terms. Substantive unconscionability means the terms of the agreement unreasonably favor the drafting party.[39] For example, a Florida appellate court ruled that the manner in which the plaintiff was required to sign an arbitration provision before her father was admitted to a nursing home was procedurally unconscionable, and that the agreement was substantially unconscionable because it denied the patient rights to which he was entitled under Florida statutes, namely non-economic damages, punitive damages and attorneys' fees, as well as access to discovery to prove statutory violations.[40]

The Mississippi case of *Covenant Health & Rehab. of Picayune, LP v. Estate of Moulds*[41] overruled an earlier state Supreme Court decision in which the court found that the agreement to arbitrate in the admissions agreement for a nursing home was a contract of adhesion, but it was not unconscionable in that the patient who signed was competent, and had knowingly and voluntarily executed the document with his daughter present.[42] In the *Covenant* case, the Supreme Court reviewed the same admissions agreement with the same arbitration provision, and found the contract to be unconscionable, thus unenforceable.[43]

Agreements to arbitrate with consumers of health care services often raise two additional concerns. First, they may have been signed in exigent circumstances. Admitting a loved one for emergency surgery or hospice care can be far more stressful than shopping for a cell phone or mattress. Second, the consumer is often incapacitated, and the family member signing on her behalf may not have the legal authority to do so. Case law on whether an arbitration agreement signed under these circumstances is enforceable varies considerably from state to state. Key concerns are whether the consumer or representative signing the agreement to arbitrate: (a) comprehended what she was agreeing to; and (b) believed that signing was voluntary (i.e., believed that if she refused to sign the facility would nevertheless provide the same care or treatment). In light of the exigent circumstances under which admission agreements often are signed, some courts have held that a consumer or her representative must have been granted the right to revoke consent to arbitration for up to 30 days after signing the admission papers.[44]

The health care facility may argue that it is unfair to permit a suit arising out of the relationship created by an admission agreement while invalidating a clause (the agreement to

arbitrate) contained within this agreement. Why should a consumer be able to obtain the benefit of an admission agreement (care or treatment) and then disavow a clause she does not like (the agreement to arbitrate)? Some courts have circumvented this parity argument by finding that a health care proxy or a general power of attorney is sufficient authorization to admit a family member for care or treatment, but is not sufficient to bind this family member or her heirs to arbitrate disputes arising from such care or treatment.[45] For example, the Florida District Court of Appeal, Second District, recently reversed a lower court's grant of a nursing home's motion to compel arbitration, and found that a daughter's power of attorney was limited to decision-making about the provision of medical care, and did not authorize the daughter to bind her mother to arbitration.[46] In Arkansas, however, a federal trial court upheld an arbitration agreement signed by an individual who had the power of attorney for a nursing home resident was enforceable under the Federal Arbitration Act and not violative of Medicaid.[47]

In response to arbitration agreements that were heavily one-sided, some states enacted laws that prohibit nursing homes from requiring consumers to arbitrate negligence or wrongful death cases. However, the Federal Arbitration Act preempts these outright bans.[48] Courts must determine case by case whether an agreement to arbitrate runs afoul of a statute or precedent applicable to all contracts.[49]

Not all consumer cases involve nursing homes or other health care facilities. In an unusual malpractice case, the Texas appeals court found that the trial court had wrongfully denied a chiropractor's request for arbitration. In this case, the chiropractor was sued by his patient for gross negligence. The chiropractor presented a valid arbitration clause in the contract with his patient, and the plaintiff's claims were within the scope of the agreement. The court found that the FAA governed the written arbitration clause, as the transaction between the chiropractor and his patient involved interstate commerce.[50]

In an extremely interesting case decided in January of 2013, the North Carolina Court of Appeals held that a nursing home agreement requiring plaintiffs to arbitrate their claims against that nursing home, using arbitrators from the AAA, was unenforceable. The "Voluntary Agreement for Arbitration" in this case, *Crossman v. Life Care Centers of America, Inc.*, required the parties to submit all claims arising out of the care the patient received at Life Care Centers to binding arbitration before a panel of arbitrators selected by the AAA. However, the AAA has a Healthcare Policy Statement, promulgated in 2003, that its arbitrators would not hear medical negligence claims, without a post-dispute agreement signed by the patient or his/her representative. Mr. Crossman signed the agreement before the dispute arose, but Ms. Crossman, the administrator of the patient's estate, had not signed this agreement. The nursing home had attempted to require the administrator of the patient's estate to bring in arbitration a wrongful death claim based on negligence by the home.[51] The court's thorough discussion of pre-dispute arbitration agreements signed upon admittance to a nursing home is most instructive.

The new AHLA Rules of Procedure for Arbitration, which will take effect in 2014, include special rules that address legal and policy concerns about consumer arbitration in health care. To minimize litigation about whether an agreement to arbitrate is enforceable, the new rules set forth clearly and specifically what the agreement must state and how it must be presented to the consumer.

Conclusion

Arbitration and mediation have become the forums of choice for parties seeking resolution of health care disputes. Parties look for arbitrators and mediators knowledgeable about state and federal health care and insurance regulation, quality of care and compliance issues, health care litigation, reimbursement and billing, coding, claims and management practices in the industry. The reason for this is that the issues in dispute in health care contracts are overlaid with convoluted and complex regulatory schemes that are changing constantly, and now encompass the Patient Protection and Affordable Care Act. ("PPACA"). The subject matter of Medicare, Medicaid, managed care, ACOs, private carrier reimbursement and health care fraud and abuse cannot be learned on the job. Arbitration and mediation often are successful in health care where the neutral can assist the parties to reach a creative, practical and private solution to a significant problem. This cannot be done without familiarity with the operations, functioning and multiple state and federal regulatory schemes applicable to payers, providers and other multi-faceted and risk-sharing entities within the health care industry.

ENDNOTES

[1] *In re Arbitration between United Healthcare of Illinois, Inc. and Advocate Health Care Network,* AAA, No. 51 195 Y 01990 03, Nov. 18, 2005. *Tenet awarded $46million by arbitration panel,* Modern Healthcare, August 15, 2008.
[2] *See,e.g., Brandon, Jones, Sandall, Zeide v. Medpartners,* 312 F.3d 1349 (11th Cir. 2002).
[3] *Mitsubishi Motors Corp. v. Soler Chrysler-Plymouth, Inc.*, 473 U.S. 614, 105 S.Ct. 3346, 3353, 87 L.Ed.2d 444 (1985). *See also, Equal Employment Opportunity Comm'n v. Waffle House, Inc.*, 534 U.S. 279, 122 S.Ct. 754, 762, 151 L.Ed.2d 755 (2002) for the proposition that: where the agreement to arbitrate is unambiguous, the scope of disputes subject to arbitration is defined by the contract.
[4] *Morrison v. Colorade Permanent Medical Group, P.C.*, 983 F. Supp. 937, 943-944 (D. Colo. 1997); *Toledo v. Kaiser Permanente Medical Group*, 987 F. Supp. 1174, 1980 (N.D. Cal. 1997).
[5] *Allied-Bruce Terminix Companies, Inc. v. Dobson*, 513 U.S. 265, 115 S. Ct. 834 (1995).
[6] *See, Smith v. Pacificare Behavioral Health of California, Inc.,* 93 Cal. App.4th 139, 113 Cal Rptr.2d 140 (2001).
[7] N.J.S.A. 2A:53A-30 *et seq*.
[8] N.J.S.A. 2A:53A-33(a).
[9] N.J.A.C. 8:38-3.6.
[10] N.J.A.C. 8:38-3.
[11] N.J.S.A. 17B:30-48 to 17B:30-57.
[12] N.J.S.A. 26:2S-11 and 26:2S-12. *See also*, N.J.S.A. 2A:53A-34.
[13] Some statutes dictate the procedures under which certain disputes must be arbitrated and/or require participation in arbitration. See. e.g.,, 29 C.F.R. § 4221.5 (ERISSA); Cal. Bus. & Prof. Code § 6200 et seq. (attorney fee disputes). Some state arbitration statutes are specific to health care disputes.
[14] John Lande, *The Movement Toward Early Case Handling in Courts and Private Dispute Resolution*, Ohio State Journal on Dispute Resolution, 24:1 (2008), p. 103-106.
[15] *See*, Thomas J. Stipanowich, Curtis E. von Kann and Deborah Rothman, Eds., *Protocols for Expeditious, Cost-Effective Commercial Arbitration: Key Action Steps for Business Users, Counsel, Arbitrators & Arbitration Provider Institutions*, College of Commercial Arbitrators, March 3, 2010.
[16] *Heartland Surgical Specialty Hospital, LLC v. Reed*, 287 P.3d 933, 48 Kansas App.2d 237 (2012).
[17] *First Preservation Capital v. Smith-Barney*, 939 F.Supp.1559, 1565 (S.D. Fla. 1996).
[18] *See*, Michele R. Fron and Kelly M. McIntyre, *Sanctions in Arbitration*, 1264 PLI/Corp. 1143, 1145, 1151 (2001) for examples.
[19] *See*, R-42. Scope of Award. AAA Healthcare Payer Provider Arbitration Rules, Effective January 31, 2011.
[20] *Volt Information Sciences, Inc. V. Stanford University,* 489 U.S. 468, 478 (1989).
[21] 21 R. Lord, Williston on Contracts § 57:19, p. 183 (4th ed. 2001).
[22] *Arthur Anderson LLP v. Carlisle*, 129 S. Ct. 1896 (2009).
[23] M. Rosenhouse, *Application of Equitable Estoppel to Compel Arbitration By or Against Nonsignatory—State Cases*, 22 A.L.R. 6th 387 (2007).
[24] Rosenhouse, *supra,* note 23.

14 S.C. Ct. App., No. 5036, 10/3/12.
[26] No. H-11-1355 (S.D. Tex. Aug. 10, 2011).
[27] If an employment claim arises out of an agreement that the employer drafted and required the employee to sign, the arbitrator must disregard any contract clause that would unreasonably prejudice the employee. Rule 10.5 (c). Similarly in a consumer case, the arbitrator may depart from any contract provision that is inconsistent with Rule 5.5 with respect to discovery, and must disregard any contract clause that would unreasonably prejudice the consumer. Rule 11.7 (c) and (d).
[28] 42 U.S.C. § 1320d-2, *et seq.*
[29] 45 C.F.R.§ 164.512(e).
[30] Scott D. Stein, *What Litigators Need to Know About HIPAA*, 36 J. Health Law 433 (Summer 2003).
[31] 45 C.F.R. §164.502(a)(1)(ii).
[32] E. S. Wolaver, *The Historical Background of Commercial Arbitration* 83 Penn. Law Review, Vol. 2, 132-146 (Dec., 1934).
[33] *Engalla v. Permanente Medical Group, Inc.*, 15 Cal.4th 951 (1997).
[34] *Robertson v. HealthNet of California, Inc.*, 34 Cal. Rptr. 3d 547, 132 Cal. App. 4th 1419 (Cal. Ct. App. 2005).
[35] *Viola v. California Dept. of Managed Health Care*, 133 Cal. App.4th 299, 34 Cal. Rptr.3d 626 (2d Dist. 2005).
[36] *Gilmer v. Interstate/Johnson Lane Corp.*, 500 U.S. 20, 31-32 (1991).
[37] *Hooters of America, Inc. v. Phillips*, 173 F.3d 933 (4th Cir. 1999).
[38] *American Express Co. v. Italian Colors Restaurant*, 133 S. Ct. 2304, 2310 (2013); *Green Tree Financial Corp. v Randolph*, 531 U.S. 79, 90 (2000).
[39] See, e.g., *Brown v. MHN Government Services*, Inc., 306 P.3d 948 (Sct. Wash. 2013).
[40] *Prieto v. Healthcare and Retirement Corp. of America*, 919 So.2d 531 (Fla. Dist. Ct. App. 2006).
[41] 14 So.3d 695 (Miss. 2009).
[42] *Vicksburg Partners, L.P. v. Stephens*, 911 So.2d 507 (Miss. 2005).
[43] *Covenant Health & Rehab. of Picayune, LP v. Estate of Moulds*, 14 So. 3d 695, 706 (Miss. 2009).
[44] See J. Pavlic, *Reverse Pre-Empting the Federal Arbitration Act: Alleviating the Arbitration Crisis in Nursing Homes*, 22 Journal of Law and Health 375, 384-387 (2009); S.M. Scheller, *Arbitrating Wrongful Death Claims for Nursing Home Patients: What is Wrong with this Picture and How to Make it "More" Right* 113 Penn State Law Review 528, 549-551 (2008).
[45] S.M. Scheller, *supra*, note 44.
[46] *Estate of Irons v. Arcadia Healthcare, L.C.*, No. 2D10-5712 (Fla. Dist. Ct. App. Aug. 3, 2011).
[47] *Northport Health Services of Arkansas LLC v. O'Brien*, W.D. Ark., No. 2:10-cv-2013, 5/10/11.
[48] *Nitro-Lift Technologies v. Eddie Lee Howard*, 133 S.Ct. 500 (2012).
[49] *Marmet Health Center v. Brown*, 132 S.Ct 1201 (2012).
[50] *Kroupa v. Casey*, 2005 Tex. App. LEXIS 10212 (Tex. App. Dec. 8, 2005).
[51] N.C. Ct. App., No. COA12-702, 1/15/13.