WHY ADR AND NOT LITIGATION FOR HEALTHCARE DISPUTES?

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Arbitration and mediation (ADR) have become the forum of choice for major healthcare business disputes. These disputes are domestic and worldwide, and may involve millions of dollars. Disputes over healthcare 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

The complexity of many healthcare disputes, the parties' desire to continue in business, and many features of arbitration and mediation make these processes more advantageous for healthcare parties to use than litigation.

federal court and then diverted to court-annexed ADR, most disputes between healthcare providers and payors do not enter the courtroom. Many of the contracts between these parties contain a mandatory arbitration clause. Some contain a two-step mediation/arbitration process. Parties involved in payor-provider disputes 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 healthcare frequently are decided outside of courts and administrative agencies. For example, arbitrators in Illinois rejected a health plan's claims in a contentious antitrust dispute, in which the plan had argued that the providers violated state and federal antitrust laws in their contract negotiation. In another case, Tenet Healthcare Corp. 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 healthcare providers and payors. 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 an 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 healthcare contracts continue to proliferate in state courts.

The United States Supreme Court has held that the Federal Arbitration Act (FAA) applies to all contracts that involve interstate commerce.[3] Where this issue has arisen, most courts have determined that activities in healthcare constitute interstate commerce.[4] While the FAA has been held to preempt contrary state law,[5] state insurance law, and not the FAA, has been held to control where the health plan arbitration clause did not comply with that law.[6]

Many states have broad-based arbitration statutes as well as statutes and regulations requiring some type of ADR and/or a hearing process for reimbursement or other issues between healthcare parties. New Jersey is a good example. The New Jersey Health Care Carrier Accountability Act[7] authorizes mediation and binding and nonbinding arbitration to determine the liability of an organized delivery system or insurance carrier resulting from negligence in the denial of coverage, or delay in the approval of medically necessary covered services.[8] Another New Jersey statute calls for a hearing when a former provider contests his or her termination from a health maintenance organization,[9] while state regulations establish a complaint and appeal system for patients who are members of HMOs.[10] In addition, the Health Claims Authorization, Processing and Payment Act[11] (and amendments related thereto), requires health insurers and providers in New Jersey to arbitrate healthcare payment disputes. Amendments to the New Jersey Health Care Quality Act established a healthcare appeals program, which mandates a two-step dispute resolution process.[12]

In arbitration parties have access to arbitrators and mediators knowledgeable about healthcare and insurance regulation, quality of care and compliance issues, healthcare litigation, reimbursement and billing, coding, claims and management practices in the industry.

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 Healthcare Matters

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

Some of the types of healthcare matters frequently decided through ADR processes include:

- Managed care disputes between payors and providers involving contract interpretation, risk sharing, insurance, reimbursement and/or administrative issues;
- Employment contract disputes between physicians and medical groups, or between physicians and hospitals (including disputes arising out of covenants not to compete);
- Medical staff, credentialing and peer review disputes;
- Shareholder disputes with physician practices;
- Contract and reimbursement disputes involving

healthcare joint ventures;

- Laboratory billing disputes;
- Disputes between third-party vendors, durable medical equipment providers and healthcare facilities;
- Disputes over the dissolution of a medical practice or other healthcare entity;
- Insurance carrier disputes with providers over coding, billing, and claims payment;
- Disputes involving management services companies, providers and third-party vendors;
- Class actions over insurance coverage and claims payment;
- Contested guardianship disputes;
- Medical necessity disputes;
- Long term quality of care and billing issues;
- National and international contract disputes involving pharmaceutical companies, research and clinical trials of new drugs; and
- Medical malpractice cases.

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 healthcare arena are the following:

Shorter Duration and Less Cost

Healthcare disputes are categorized by the court system as complex litigation. Thus, it can take years to complete a litigated case, from filing through discovery, motions practice, the trial, and appeals. It is not unusual for healthcare litigation to be pursued concurrently or successively in administrative tribunals and in both state and federal court on the same or different issues. Scheduling problems can delay cases. Cases can also take longer to try when there is a need to explain complex industry regulations, scientific terminology and difficult reimbursement concepts to jurors and judges who are probably not familiar with them. All of this makes litigation quite costly.

In ADR, these issues and problems should not exist. Cases can be scheduled to accommodate the needs of the parties, their counsel and expert witnesses. Arbitration hearings are not bogged down by the formal requirements for admission of evidence. (In healthcare 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 of arbitration, cases should be less costly to resolve. However, there have been complaints that arbitration has become another form of litigation. The American Arbitration (AAA), the College of Commercial Arbitrators and the Chartered Institute of Arbitrators have issued protocols to improve upon these concerns.[13]

Ability to Choose Expert Arbitrators

One of the major benefits of ADR for parties to healthcare disputes is that they can select the neutral mediator or arbitrator. In a complex, technical field like healthcare, it is important to appoint an individual who is experienced in and has knowledge of the customs and usage of the industry, as well as the terminology and legal and regulatory framework in use. In recognition of this need, some ADR organizations have begun to develop specialized panels of experienced healthcare decision makers. Two of these are the 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 meet the Association's rigorous Qualification Criteria and Responsibilities, which require significant expertise in the technical, business and legal aspects of healthcare disputes.

Flexibility of Arbitration and Mediation

Another attribute of ADR is the flexibility to reach creative solutions to difficult healthcare and factual problems, which the parties would be unable to achieve within the strictures of the court process. For example, an arbitrator could award a combination of damages and reformation of the parties' organizational relationships and obligations set forth in a long-term contract. These solutions could not be achieved without an arbitrator who knows the industry, the regulatory framework, and understands the factual idiosyncrasies, requirements and interests of the parties.

Limited Discovery

Discovery has been said to account for 90% of the cost of litigation. In arbitration, discovery and the time frame for its completion is often limited by the arbitrator, pursuant to the applicable arbitration rules. This is done in the interests of efficiency and containment of the cost of the process. For example, Rule 19 of the AAA's National Healthcare Payor Provider Arbitration Rules limits discovery to one deposition per party "unless otherwise agreed to by the parties or ordered by the Arbitrator for good cause shown." These same rules, developed for a specific type of payment dispute, list the kinds of initial disclosures of information that the parties may agree to exchange.

The challenge for arbitrators in healthcare disputes is to administer a fair and even-handed discovery process when the parties have very different levels of resources, including the capability to analyze large amounts of electronic and other data.

Complexity of the Issues

The healthcare industry is one of the largest employers in the United States. It is also one of the most highly regulated. The Food and Drug Administration regulates the introduction of new pharmaceuticals into the marketplace. State and federal governments regulate managed care accounting and operational requirements, and prohibit fraud and abuse by physicians, hospitals, the pharmaceuti-

cal industry, nursing homes, durable medical equipment providers and others. States have licensure requirements for professionals and some institutions, while Medicare (federal) and Medicaid (state and federal) laws and regulations govern those regimes. This body of law and regulation is technical, complicated and not easily understood, even by attorneys who have worked with it for years. And it is constantly changing, as evidenced by the new body of law on federal healthcare reform, effective between 2011 and 2014.

Highly Emotional Disputes

Disputes among parties in the healthcare industry often involve high stakes. The case may decide a physician's ability to practice medicine in the specialty or geographic area of choice, or to practice at all. Or it may determine whether or not a hospital 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 the interpretation of payment provisions also may be at stake. In some cases, the contract's terms for payment or management of healthcare services apply nationwide to all providers in the payor's network. These types of disputes can be highly emotional, as livelihoods may be at issue.

Maintaining Business Relationships

Many healthcare providers and payors want to continue to do business with each other in the future, despite the fact that they are involved in a dispute. Thus, they do not want to engage in the more hostile and adversarial litigation process, which could damage their ability to work together in the longer term. Arbitration and mediation are not as adversarial as a courtroom proceeding. Litigation attorneys who behave in arbitration hearings in the same way that they litigate in court may be sanctioned by the arbitrator, or reprimanded by their own client. It is not unheard of for a physician or in-house counsel to a large healthcare provider or insurer to ask its counsel to recuse himself from the arbitration proceeding if his tactics or strategy becomes too hostile or litigious.

Privacy and Confidentiality

Many healthcare stakeholders prefer to have their cases resolved in a private ADR process, like mediation or arbitration, where the results are not available to anyone but the parties themselves. The private nature of ADR processes also means that the results have no precedential value in future cases between other parties or even between the parties themselves, unless the parties agree otherwise. 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.

The healthcare industry, a major component of the economy, is covered vigorously by the media. Since arbitration proceedings are not open to the public, the media may not know about them. This privacy is advantageous to the parties, as bad publicity could affect stock prices of large for-profit entities, and could affect market position and patient selection for smaller healthcare institutions, provider groups and individual providers. In other words, private adjudication in arbitration or a facilitated mediation, rather than forums where confidential and proprietary business information or trade secrets may find their way into the public domain, are especially attractive to participants in the highly competitive and fast-paced healthcare industry.

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Binding Nature of the Process

The so-called finality of binding arbitration is a major attraction for providers and patients. In arbitration, there is a limited right to appeal an arbitrator's award, which makes the award final for practical purposes. Awards generally are rendered promptly and are followed by the parties. In cases where one party to the arbitration attempts to repudiate the award, despite the binding arbitration clause this party signed, courts are reluctant to second guess the arbitrator, absent evidence of the very limited grounds in the FAA or state arbitration statute allowing the award to be vacated. Courts give great deference to arbitral awards, and usually will not overturn an award for an error of law. Thus, parties can save significant time and money by avoiding the appellate process that is inherent in court litigation.

Similar Remedies to the Courtroom

Arbitrators in many states have authority similar to that of judges. All types of remedies are available in arbitration, including monetary damages and equitable relief, if within the scope of the parties' contract and consistent with state and federal law. The AAA Commercial Arbitration Rules, as well as the new AAA Healthcare Payor Provider Arbitration Rules, authorize arbitrators to award "any relief that 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, the arbitration agreement, or deemed appropriate by the arbitra-

tor.[14] There is some case authority for an arbitrator dismissing a case as a sanction for discovery abuses.[15] Arbitrators also can allocate fees and costs of the proceeding, bar claims or defenses, preclude evidence or testimony, or refuse to permit advocacy that elicits the drawing of adverse inferences.[16]

Applicability of HIPAA to Healthcare Arbitration

The Health Insurance Portability and Accountability Act (HIPAA)[17] has been raised as a defense to the use of arbitration in a healthcare dispute. The argument is that to proceed with the arbitration process where patient records are part of the evidence in the case would violate the confidentiality of individually identifiable patient health information, which is protected by HIPAA.

This argument, however, ignores the explicit exception to HIPAA nondisclosure for protected health information used during the course of litigation or administrative proceedings.[18] Under this exception, 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. In addition, a covered entity may use or disclose protected health information for payment purposes.[19] It is likely that the HIPAA exception applies to ADR processes.[20] Thus, production of protected health information in an arbitration or mediation in which payment is an issue may not present a HIPAA problem. It could be argued that it was not the intent of the HIPAA statute and regulations to prevent administrative 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 and administrative proceedings does not apply to ADR, it is possible to use patient health information without violating HIPAA. For example, one could redact the patient's name and any other identifying information from the patient's records. Also, it may be possible to aggregate information from patient records without disclosing individual-identifying information. In this way, material from patient records could be admitted during a proceeding without disclosing statutorily protected confidential information.

Litigation Over Agreements to Arbitrate in Healthcare

An agreement to arbitrate contained in a larger contract may not be upheld if it is found to be a contract of adhesion or violative of rights secured by a party under state statute. This issue often arises in ADR cases involving patients in post-acute care (i.e., nursing home settings). In a typical case, either the patient or the patient's family disputes the quality of care rendered, and/or the amount of the charges, and refuses to pay. The nursing home invokes the arbitration clause in the services contract, seeking to collect the unpaid charges. In a Florida case, an appellate court ruled that the circumstances surrounding the manner in which the plaintiff was required to sign an arbitration provision as a condition of her father's admission to a nursing home were procedurally and substantively unconscionable. The court found that the agreement 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.[21] Recently, a Florida appellate court reversed a lower court order granting a nursing home's motion to compel arbitration after finding that the patient's daughter did not have authority under the power of attorney (POA) to bind her mother to arbitration; her POA was limited to decision making about the provision of medical care.[22] In a case in Arkansas, however, a federal trial court enforced an arbitration agreement signed by an attorney in fact under a POA. The court found the arbitration agreement was enforceable under the FAA and not violative of the Medicaid laws.[23]

California has been the site of litigation over the validity of mandatory binding arbitration in consumer healthcare cases. In 1997, the California Supreme Court found that Kaiser Permanente's mandatory in-house arbitration system unduly delayed the resolution of claims from patients and was biased in Kaiser's favor.[24] Similarly, a California appellate court held that an arbitration clause located three paragraphs before the final signature line on Kaiser's health plan enrollment form, which was typed in the same font and size as every other paragraph in the agreement, was unenforceable under state law.[25] Nonetheless, a different California appeals court panel 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.[26]

The Mississippi case of *Covenant Health & Rehabilitation of Picayune, LP v. Estate of Moulds*[27] overruled an earlier state Supreme Court decision that enforced an arbitration clause in a nursing home admissions agreement. The earlier decision ruled that the admission agreement was a contract of adhesion, but it was not unconscionable, because the patient was competent when he signed the agreement and knowingly and voluntarily did so with his daughter present.[28] In the Covenant case, the Supreme Court found the identical nursing home contract to be unconscionable and thus unenforceable.[29]

In an unusual malpractice case in Texas, an appeals court found that a chiropractor's request for arbitration of a patient's negligence claim should have been granted since the chiropractor presented the court with a valid arbitration clause, the plaintiff's claims were within the scope of their agreement, and the FAA governed as the transaction between the chiropractor and his patient involved interstate commerce.[30]

In *DAC Surgical Partners, P.A. v. United Healthcare Services, Inc.*, another recent Texas case, the court denied the insurer's motion to compel arbitration against the plaintiffs, which were medical professional associations.[31] It refused to enforce the arbitration clause in the insurer's network participation agreements because they were signed by the physician owners, but not by the professional associations themselves. The court refused to "pierce the corporate veil," as urged by the insurer.

Many healthcare providers and payors do not want to engage in the more hostile and adversarial litigation process, which could damage their ability to work together in the longer term.

Conclusion

Arbitration and mediation have become the forum of choice for parties seeking resolution of healthcare disputes. Parties look for arbitrators and mediators knowledgeable about state and federal healthcare and insurance regulation, quality of care and compliance issues, healthcare litigation, reimbursement and billing, coding, claims and management practices in the industry. The reason for this is that the issues in dispute in healthcare contracts are overlaid with convoluted and complex regulatory schemes that are changing constantly. The subject matter of Medicare, Medicaid, managed care and private carrier reimbursement and healthcare fraud and abuse cannot be learned on the job. Arbitration and mediation often are used successfully in healthcare disputes 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 payors, providers and other multi-faceted entities within the healthcare industry. ■

ENDNOTES

[1] *In re Arbitration between United Healthcare of Ill., Inc. and Advocate Health Care Network*, AAA, No. 51 195 Y 01990 03, Nov. 18, 2005. Tenet awarded $46 million by arbitration panel, *Modern Healthcare* (Aug. 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 (1985). See also, *Equal Employment Opportunity Comm'n v. Waffle House, Inc.*, 534 U.S. 279 (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 Med. Group*, 987 F. Supp. 1174, 1980 (N.D. Cal. 1997).

[5] *Allied-Bruce Terminix Cos., Inc. v. Dobson*, 513 U.S. 265 (1995).

[6] See, *Smith v. Pacificare Behavioral Health of Calif. Inc.*, 113 Cal Rptr. 2d 140 (Cal. Ct. App. 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] See College of Commercial Arbitrators Protocols for Expeditious, Cost-Effective Commercial Arbitration: Key Action Steps for Business Users, Counsel, Arbitrators & Arbitration Provider Institutions (Thomas J. Stipanowich et al., eds., 2010), downloadable from www.thecca.net; International Centre for Dispute Resolution (ICDR) Guidelines for Arbitrators Concerning Exchanges of Information, available at www.adr.org/si. asp?id=5288.

[14] See, R-42. Scope of Award. AAA Healthcare Payor Provider Arbitration Rules, effective January 31, 2011, available at www.adr.org.

[15] *First Preservation Capital v. Smith-Barney*, 939 F.Supp.1559, 1565 (S.D. Fla. 1996).

[16] See Michele R. Fron & Kelly M. McIntyre, *Sanctions in Arbitration*, 1264 PLI/Corp. 1143, 1145, 1151 (2001), for examples.

[17] 42 U.S.C. § 1320d-2, et seq.

[18] 45 C.F.R. § 164.512(e).

[19] 45 C.F.R. § 164.502(a)(1)(ii).

[20] Scott D. Stein, "What Litigators Need to Know About HIPAA," 36 *J. Health L.* 433 (Summer 2003).

[21] *Prieto v. Healthcare & Retirement Corp. of Am.*, 919 So. 2d 531 (Fla. Dist. Ct. App. 2006).

[22] *Estate of Irons v. Arcadia Healthcare, L.C.*, No. 2D10-5712 (Fla. Dist. Ct. App. Aug. 3, 2011).

[23] *Northport Health Servs. of Ark. LLC v. O'Brien*, W.D. Ark., No. 2:10-cv-2013, (May 10, 2011).

[24] *Engalla v. Permanente Med. Group, Inc.*, 15 Cal. 4th 951 (1997).

[25] California Health and Safety Code § 1361.1 (arbitration clauses in health plans must be "prominently displayed" and located "immediately before" the subscriber's signature line).

[26] *Viola v. California Dept. of Managed Health Care*, 34 Cal. Rptr. 3d 626 (Ca. Ct. App. 2d Dist. 2005).

[27] 14 So. 3d 695 (Miss. 2009)

[28] *Vicksburg Partners, L.P. v. Stephens*, 911 So. 2d 507 (Miss. 2005).

[29] *Covenant Health & Rehab. of Picayune, LP v. Estate of Moulds*, 14 So. 3d 695, 706 (Miss. 2009).

[30] *Kroupa v. Casey*, 2005 Tex. App. LEXIS 10212 (Dec. 8, 2005).

[31] No. H-11-1355 (S.D. Tex. Aug. 10, 2011).