



PACKAGING THE ARBITRATION AGREEMENT

LYNN WAGNER

The escalating medical malpractice liability crisis is driving a growing number of long term care providers to seek an alternative to costly, time-consuming litigation. As multimillion dollar jury awards and soaring insurance costs increasingly threaten to destabilize the health care marketplace, one method of dispute resolution, arbitration, is gaining favor across the spectrum of health care settings, including nursing facilities, legal experts say.

Arbitration lifts patient care disputes from the emotional hothouse of a courtroom to a private setting in which arbitrators, who are typically lawyers and judges with some expertise in the medical malpractice arena, weigh evidence and assess liability and damages in lieu of a jury trial.

Jury trials are often packed with “high emotion, high drama, and it is difficult to explain the evidence relative to the death of an elderly patient,” says Gavin Gadberry, a shareholder in Underwood, Wilson, Berry, Stein & Johnson, a law firm in Amarillo, Texas. “These are complex cases with high stakes.” Arbitration takes a case “out of a high-emotion forum and puts it in

front of a neutral arbitrator who is not as swayed by emotion.”

Benefits Of Arbitration

Proponents say arbitration offers both sides key advantages. For providers, the amount awarded to a plaintiff is unlikely to match so-called runaway jury verdicts, which can add up to millions. By tempering awards, arbitration brings down the ultimate cost of a dispute. For consumers, the process holds the promise of an expedited resolution, compared with a court proceeding, which can take years.

Research measuring the impact of arbitration is spotty. But data highlights from various surveys and studies, which appear on the National Arbitration Forum’s Web site, suggest that benefits accrue to both sides in arbitration:

■ A survey published in February 2004 by *Corporate Legal Times* reported that 78 percent of business attorneys found arbitration led to faster recovery than litigation, 60 percent said it was less expensive, and 83 percent said



*Patients
may accept
or reject the
concept of
arbitration
based on
how the
agreement is
presented.*

it was equally or more fair than litigation.

■ Seventy-eight percent of litigation attorneys surveyed by the American Bar Association's (ABA) Section of Litigation Task Force last year said arbitration was more timely than litigation, and 56 percent said it was more cost effective.

■ Claimants prevail more frequently in arbitration involving employment disputes—46 percent of the time, compared with 34 percent in court—according to a study published by ABA in 2003. Furthermore, median awards were higher, \$100,000 for arbitration, compared with \$95,554 in court, and the median resolution time from filing to judgment was significantly shorter, 16-1/2 months for arbitration, compared with 25 months for litigation.

■ An April 2003 update to a 1999 survey of Americans' awareness, knowledge, attitudes, and experiences regarding arbitration found that 64 percent of respondents would choose arbitration over a lawsuit in disputes involving monetary relief, a 5 percent increase over the four-year period. The survey, conducted for the Institute for Advanced Dispute Resolution by the market research firm RoperASW, also found that two-thirds of Americans feel lawsuits take too long.

Arguments Against Arbitration

Arbitration has detractors, however, who claim it strips consumers of their constitutional right to due process, as written arbitration agreements invariably include a waiver of the right to jury trial. Debate over the role of this decades-old approach to civil justice in the medical malpractice arena is ongoing, and in some parts of the country challenges have become contentious.

Last year, for example, Utah legislators passed a law that allowed health care providers to present patients with mandatory arbitration agreements, meaning they would be required to sign an agreement to arbitrate future disputes as a condition of receiving



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treatment, with the exception of emergency services. When physicians working for one of the state's largest insurers and hospital chains sent a letter informing 170,000 patients in the Salt Lake City area of the new policy, however, the result was a consumer backlash that ultimately forced lawmakers to reverse themselves this year, barring providers from requiring such agreements before rendering care.

Providers and legal experts say Utah's experience underscores the importance of presenting arbitration in a way that fully explains its benefits and rationale. In the current climate, it is also critical for providers to develop fair and balanced arbitration agreements that stand up to legal challenge and take the time to describe the merits of this alternative dispute resolution process to consumers, observers say.

"The approach that makes the difference is when there is a good explanation of the process and the reasons for arbitration," says Ann Nevers, founder of the Health Law and Resolution Center in Salt Lake City and author of the paper, "Medical Malpractice Arbitration in the New

Millennium: Much Ado About Nothing?", published in 2000 by the *Pepperdine Dispute Resolution Law Journal*.

Consumers need to know that their rights will be protected in arbitration, Nevers adds. They will have the right to legal counsel, the right to present witnesses and evidence, and to get a fair hearing.

"What makes arbitration favorable is looking at it in light of the big picture in health care," she adds. Rising costs and the malpractice liability crisis may drive out some providers, cutting off access to patient care, Nevers says. "Arbitration is a more reasonable alternative to losing providers. It's not always explained to consumers that way."

Laying A Foundation For Arbitration

A longstanding statutory foundation exists for arbitrating disputes rather than taking them to court. The Federal Arbitration Act (FAA), signed into law by President Coolidge in 1925, asserts the validity of arbitration and prohibits states from barring or restricting such agreements. Under the FAA, written arbitration agreements are "valid, irrevocable, and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract."

"The purpose of the FAA is to compel courts to honor contractual covenants to arbitrate disputes, even in the face of state legislative efforts to restrict the enforceability of arbitration agreements," says a May 2004 report on arbitration by attorney Gadberry and co-author Dan Schapp.

Prior to enactment of the FAA, U.S. courts had a tradition of "judicial hostility" toward arbitration, a bias that can be traced to English courts where judges' pay was based on the number of cases they decided, according to a 2002 report by the Congressional Research Service (CRS) on the history of the FAA. As a result, "arbitration infringed on [judges'] livelihood," and

English courts were reluctant to cede jurisdiction over disputes.

An inherited disdain for arbitration in the U.S. judicial system ebbed, however, during industrialization as business disputes mounted, and in 1924 the U.S. Supreme Court “upheld a New York law that compelled arbitration in a dispute involving a maritime contract,” creating an opening for enactment of the FAA, CRS said.

The original statute, which has since been fine-tuned through amendments and interpreted by courts through legal challenges to specific arbitration cases,

ensured “the validity and enforcement of arbitration agreements in any ‘maritime transaction or a contract evidencing a transaction involving commerce,’” CRS reported. But for decades following enactment, courts remained divided over the breadth and application of the phrase “involving commerce.” In 1995, the U.S. Supreme Court decided a case that interpreted this language as affecting all interstate commerce, both the physical shipment of goods and contracts related to such commerce.

As a result, many of the legal challenges to arbitration agreements in recent years have focused on whether they represent valid, enforceable contracts based on the terms of the agreements and the circumstances under which they were signed.

Crisis Drives Interest In Arbitration

While arbitration is not a new form of legal recourse, its relatively new application to long term care disputes is linked to liability costs, which have spiked in recent years.

A June 2004 report by Aon Risk Consultants found that the average annual cost for general and professional liability rose from \$310 per long term care bed in 1992 to \$2,290 in 2003. Nationwide, long term care operators incur 15.3 claims annually for every 1,000 occupied skilled nursing facility beds, a threefold increase in frequency since 1992, Aon reported. Based on data gathered from providers representing 24 percent of the long term care market, nursing facilities reported a cumulative \$3.1 billion in liability claims from 1992 to 2003 and expect the ultimate cost for this period to reach \$5.2 billion.

The emerging preference for arbitration among long term care providers is “driven by the lawsuit crisis,” which is costly even for companies that don’t get sued, as insurance premiums skyrocket, says Edward Anderson, managing director of the National Arbitration Forum (NAF) in

Minneapolis. “Arbitration is becoming a hot idea now,” says Elise Brennan, a partner in the law firm Doerner, Saunders, Daniel & Anderson, in Tulsa, Okla., and chair of the alternative dispute resolution service of the American Health Lawyers Association (AHLA). In the midst of a medical malpractice liability crisis, “people see this as a way to keep a case away from what some consider outlandish jury verdicts. The theory is if it goes in front of an arbitrator, a lawyer or judge is unlikely to make huge financial decisions for plaintiffs for reasons of passion,” Brennan adds. “Nursing homes in particular are looking at putting binding arbitration in contracts with patients.”

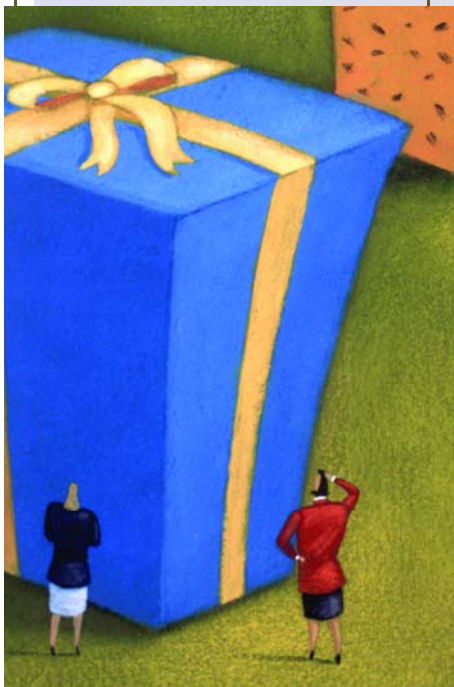
The Arkansas Health Care Association, for example, has hosted training for nursing facility owners on implementing arbitration and surrounding issues, says Randy Wyatt, executive vice president of the organization.

Arkansas was identified in the Aon report as one of the nation’s highest-cost states for liability, with per bed losses of \$5,760. An analysis by the Arkansas Health Care Association of state Medicaid cost reports found that aggregate liability insurance costs for Arkansas nursing facilities rose from \$777,740 in fiscal year 1999 to a staggering \$27.48 million in fiscal 2003. A May 2003 survey conducted by the association, which drew responses from 203 of the state’s 237 facilities, found that 106 had no liability insurance, and an additional 60 identified themselves as “self-insured,” Wyatt says.

Insurers have pulled out of the state, and one of the largest remaining underwriters for nursing facilities charges such high premiums that coverage availability “is a joke,” Wyatt says. “It is almost impossible to get insurance.” As a result, a growing number of Arkansas nursing facilities are including arbitration agreements in admission packets, he says.

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tion] pick up,” says Elizabeth Andreoli, an attorney with Mitchell, Williams, Selig, Gates & Woodyard in Little Rock, Ark.

Comparing Costs, Time

Scant data exist comparing the cost of arbitration to litigation, but experts say the difference can be substantial. R. Chet Loftus, general counsel for the Utah Medical Association in Salt Lake City, gives the example of two similar cases in his state involving newborns. Defense costs for the litigated case totaled \$500,000, while the case in arbitration cost \$100,000.

The arbitration time frame is also compressed, says NAF’s Anderson. In general, an arbitrated case can be resolved in six to nine months, compared with litigation times up to seven years in California, six years in Chicago, and more than five years in Washington, D.C.

“No one is incentivized in the court system to get the case over with,” Anderson says. While all parties may be of good will, the judge receives the same salary no matter how long it takes, and lawyers “are incentivized to drag out and use every possible process in the rules.”

That is “not necessarily bad,” Anderson adds. “But as a business person it is rational to trade prolonged remedies for a process that takes one-quarter as long and costs one-third the amount.” Both sides are entitled to all the same remedies in arbitration as they would be in court, but the “motion process and gamesmanship is reduced,” he says.

According to attorney Brennan, however, arbitration is not always less costly, “particularly in a very complicated or highly charged case,” which can be “so controversial that lawyers for patients frequently spend time in court litigating whether arbitration should go forward or be handled in court.”

Legal challenges to the enforceability of arbitration agreements add to the

cost of a case, says Brennan, who arbitrates disputes among businesses but not consumers. “Frequently, there is so much litigation going on over whether arbitration should go forward that you end up with trial and arbitration expenses,” she adds. Discovery and investigative work related to the case must be done, much as it would be for a court trial, and some arbitration agreements call for a panel of three arbitrators rather than one, in which case all of those parties must be paid.

Some consumer arbitration cases, including patient care disputes, have become so mired in legal challenges and controversy that a few large arbitration firms have pulled out of consumer and medical malpractice disputes, Brennan says. AHLA’s alternative dispute resolution service no longer takes such cases, and the American Arbitration Association has discontinued its representation in medical malpractice cases.

NAF accepts patient care disputes, but would not arbitrate a case in which the provision of care was contingent on the patient signing an arbitration agreement, says Anderson.

“Our bill of rights requires that individuals have a reasonable opportunity to consent” and a period of time in which they can opt out of the agreement, he says.

Because arbitration services operate according to a set of rules and those rules vary, Brennan advises providers that use such services to select one whose terms do not conflict with their own arbitration agreement.

“A lot of services are marketing to nursing homes, but there’s a Catch 22,” she adds. “If a service is seen as too nursing-home-friendly, they are not seen as neutral,” and that becomes an issue consumers can challenge in court.

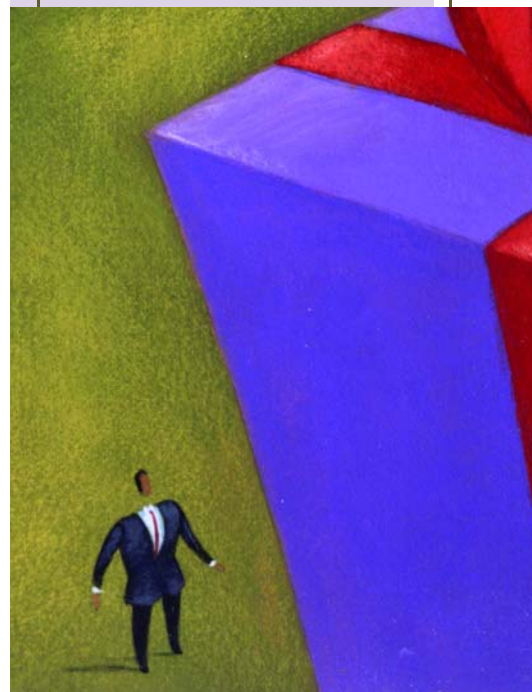
State Courts Weigh In

While arbitration is supported by federal law, state courts retain jurisdiction over the arbitration agreement in the

realm of contract law and are often asked to determine whether an agreement is enforceable according to the state’s contract standards.

These decisions run the gamut and are governed by a patchwork of differing statutes and precedents. Nevertheless, they serve as a guide for drafting agreements that have the best chance of surviving a legal challenge, experts say. “Courts want to make sure that if there is unequal bargaining power, which there would be between a nursing home and resident or family, that there are safeguards in place that

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make it not heavy-handed on the nursing home side,” says Andreoli.

“In an abundance of caution,” arbitration agreements should be drafted in a way that “cures every defect found, so that no matter where it is litigated, it is upheld,” says Karen Goldsmith, a principal in Goldsmith Grout & Lewis, the Winter Park, Fla., firm that serves as general counsel to the Florida Health Care Association.

In an Oklahoma case described by attorney Brennan, for example, the court declined to uphold an arbitration agreement that required that the proceedings take place in New Mexico, where the nursing facility was headquartered. This imposed an onerous travel burden on elderly patients “to get their day in court,” she says.

A case in Utah, which also went against the provider, involved an arbitration agreement that was “fairly one-sided,” requiring consumers to pay additional fees if they lost and giving the provider control over the process, including selection of the arbitrator, says Nevers.

In one of the most widely known cases, the California Supreme Court in 1997 reversed an appellate court decision and invalidated an arbitration agreement when it determined that Kaiser Permanente had dragged its feet so long in an arbitration case that there was a “gap between its contractual representations and the actual workings of its arbitration program.”

Court decisions often turn on two critical legal concepts:

■ **Contract of adhesion** This is a contract offered on a take-it-or-leave-it basis without giving consumers an opportunity to bargain. Arbitration contracts between health care providers and patients “tend to fit this description,” though nursing facility care is often not required on an immediate or emergency basis, giving patients an opportunity to shop for long term care services, says Gadberry in his report on arbitration. While an arbitration agreement may be deemed



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a contract of adhesion, this does not automatically invalidate it, legal experts say. It means, however, that providers must ensure they are fair and balanced and take reasonable steps to ensure that patients understand what they are signing.

■ **Unconscionable** Courts may deem a contract unconscionable, and therefore unenforceable, on procedural grounds, such as the unequal bargaining power of the parties and their ability to understand the terms of the agreement, or for substantive reasons related to the terms of the contract itself. In 1985, for example, the Nevada Supreme Court upheld a trial court ruling that a physician-patient arbitration was unenforceable because the patient had no opportunity to revoke consent and claimed that clinic staff had failed to explain the agreement. As a result, “informed consent was not offered, and no meeting of the minds occurred,” Gadberry says.

Cases Supporting Arbitration

Several pivotal rulings, however, have upheld arbitration:

■ Last October, the Supreme Court

of Alabama agreed with a lower court ruling and enforced an arbitration agreement signed by the patient’s daughter. The court found that since the daughter was acting as guardian and sponsor and had handled all of the paperwork upon admission, the agreement was valid even though the nursing facility did not explain arbitration to the patient herself. The agreement, a freestanding document, was not hidden, nor did it contain terms that were “grossly favorable” to the nursing facility or convey to it “overwhelming bargaining power,” the court said.

■ In a second Alabama case in the same year, the state’s Supreme Court reversed lower court rulings that invalidated arbitration agreements in two separate but consolidated cases alleging wrongful death. Executors of the estates argued they were not bound by arbitration because they hadn’t signed them in their capacity as executors, though they had done so at admission, as agents for the patients. The executors also claimed that the arbitration provision was part of a contract of adhesion and was unconscionable because the agreement stipulated that arbitration would be administered by the National Health Lawyers Association (NHLA), which they claimed was a “puppet for the health care and long term care industries.” As a result, the arbitration procedure was “unreasonably favorable to the industry and is oppressive, one-sided, [and] patently unfair to the typical, aged nursing home resident.”

The court said the executors were bound by the agreement and that there was no evidence showing NHLA was biased in its arbitration proceedings, or that the arbitration provision significantly favored the nursing facility.

Fair And Balanced Agreements

Gadberry’s arbitration report includes a description of several arbitration cases and their outcomes, among them a case decided last December, *Howell v NHC Healthcare-Fort Sande*, in which

a Tennessee appellate court refused to enforce an arbitration agreement and listed key factors in its decision: The admission agreement was 11 pages long, and the mediation and arbitration provisions were buried on page 10; arbitration procedures were not adequately explained; the patient had to be admitted to the nursing facility quickly, and the admission agreement had to be signed first; the admission agreement was offered on a take-it-or-leave-it basis to the patient's husband, who had no real bargaining power; and the husband could not read, and the provision that waived the patient's right to jury trial was not adequately explained to him.

In cataloguing these problems, the Tennessee court "shed some additional light" on how to draft and present to consumers supportable arbitration agreements, Gadberry says.

Designing An Appropriate Agreement

Gadberry developed a boilerplate agreement that the American Health Care Association makes available to members. The one-page document addresses a variety of concerns raised in legal challenges.

The agreement discloses that parties waive their right "to have any claim decided in a court of law before a judge and a jury" in bold capital letters, incorporates the widely accepted procedures of the National Arbitration Forum, stipulates that signing the agreement is not a precondition for the provision of services, and gives consumers 30 days after signing to rescind the agreement.

Florida attorney Goldsmith says providers should be careful about the wording of arbitration agreements, print them in large enough type for an elderly person to read, and ensure that the residents who sign them are competent, or that their agents have the legal authority to sign on that person's behalf.

"You have to make sure the person signing understands" the document,

she adds. Otherwise, "you may not have an enforceable contract."

Goldsmith also warns against burying arbitration agreements in larger admissions contracts, where they are likely to be overlooked.

In Arkansas, attorney Andreoli says the agreement should be written in

"plain language" and emphasize important rights in bold type, most notably that by signing the agreement, the individual gives up the right to a judicial proceeding.

If a resident cannot read, the arbitration agreement should be read aloud, she adds. Furthermore, providers

should not include in their arbitration agreements provisions such as a limit on damages that “foreclose any remedies provided by state law,” Andreoli says.

Nevers advises providers to make sure the arbitration process described in the agreement is fair. One concern that “resurfaces continually with arbitration in medical malpractice cases” is ensuring that consumers have a “fair shake” in the arbitration process. “Generally, courts have upheld arbitration when the process is set up in a fair way,” she adds. “It’s when providers try to make the arbitration process too one-sided and unfair that courts have said we are not going to uphold it.”

Consumers and providers should both be bound by the terms of the agreement, and consumers should have an opportunity to select an arbitrator and gather evidence through a discovery process, Nevers says.

Legal experts also agree that arbitration agreements should include an “opt-out” period, during which time consumers can revoke or rescind the agreement.

Mandatory Or Voluntary?

A critical issue is whether arbitration is mandatory or voluntary. A mandatory agreement means consumers must sign onto arbitration at the time of admission as a condition of receiving care. A voluntary agreement does not make a signed arbitration agreement a requirement for the provision of care.

Facilities that take a mandatory approach should “pay attention to procedural safeguards,” such as the availability of other nursing facilities to choose from in the area, says Andreoli.

The Centers for Medicare & Medicaid Services (CMS) released a memo on this issue early last year, in which it gave no indication that mandatory arbitration violated federal rules. The agency said the decision to

have a binding arbitration agreement was between a nursing facility and patient and that CMS’ role was to focus on “the quality of care actually received by nursing home residents that may be compromised by such agreements.” CMS said a nursing facility could not require existing patients to sign an arbitration agreement as a condition of remaining in the facility and deferred to state law on allowing



binding arbitration for Medicaid patients.

In Utah, the legislative debacle over mandatory arbitration “probably set back arbitration five years,” says attorney Nevers. “There is a negative perception of arbitration, and it will take a while to overcome it.”

At the Utah Health Care Association (UHCA), Deputy Director Deb Burcombe says the organization had hoped mandatory arbitration could be used by nursing facilities “to negotiate liability insurance [premiums] down.” UHCA had conducted seminars “encouraging facilities to enter into arbitration agreements,” but members were hesitant to embrace it, concerned about raising the issue of a potential patient care dispute at the point of admission, she says.

Because arbitration is not widely embraced in the long term care community, the legislative reversal did not have a big impact on providers, she adds.

Nevertheless, Utah’s experience reflects the difficulty and importance

of an effective consumer rollout of arbitration, especially mandatory arbitration, observers say. The collapse of state-sanctioned mandatory arbitration is widely traced to Intermountain Health Care (IHC), which stirred a consumer backlash when it mailed materials to 170,000 patients informing them that on their next scheduled visit they would be asked to sign arbitration agreements or seek services elsewhere.

Case Study

Harlan Hammond, assistant vice president of risk management services for health care giant IHC, said the organization’s intent was to be open, inform patients in advance, and give them an opportunity to review the agreement so they would not have to make a decision to sign it on the spot.

Materials were pilot-tested before the large mailing. In September 2003, the 17,000 patients of an IHC clinic in Sandy, Utah, received a letter explaining the shift to mandatory arbitration, a brochure about the process, and a copy of the agreement they would be asked to sign.

The result was that only 17 patients refused to sign the document and “indicated they would seek a provider elsewhere,” Hammond says.

Encouraged by the response, IHC sent the same materials to patients in the larger Salt Lake City region. But the response was not the subdued reaction IHC encountered in Sandy. Angry patients organized, hired a law firm, launched a Web site, and held a news conference, all of which generated broad public awareness and reaction, Hammond says.

The company set up a hotline to answer consumer questions and concerns, but it was not enough to appease the public outcry.

In hindsight, Hammond says the company could have told a more

expansive story up front about why arbitration was needed. “Many in the public didn’t catch on to the idea that we had a medical malpractice crisis that was causing some physicians to contemplate leaving their practice” and that arbitration was an attempt to respond to that “in a way that ensures future access to medical care,” Hammond says.

IHC also could have “eased more gradually” into arbitration by making it voluntary at the outset. Some observers outside IHC say the furor erupted primarily because the company has such a large presence in the state.

“A smaller provider could have done the same thing and not made a stir,” says Nevers. With large providers, “more care needs to be taken so people feel [arbitration] is a fair process.”

Be Prepared For Opposition

Hammond says the experience underscores a “reality surrounding arbitration that [providers] can’t afford to overlook: There will be opposition [among those who] feel their interests are compromised by shifting to an arbitration system.”

Providers considering moving in that direction should anticipate resistance and develop a plan for dealing with it, he adds. IHC had such a plan, but did not expect the level of opposition it encountered.

“Whatever you can do to plan ahead, be prepared, and make a case to the public would be helpful,” Hammond says.

IHC is proceeding with arbitration on a voluntary basis and hopes to have enough participants to generate comparative data. At the end of each arbitrated case, IHC will track the time it took to reach a resolution and compare that to the litigation time frame, Hammond says. The company will also “make our most reasonable best estimate” of what the case would have cost had it gone to litigation and a jury verdict. The goal will be to evaluate “whether it really is saving us costs.”

Some legal and long term care experts remain skeptical about the potential for arbitration to serve as a quick fix for the medical malpractice crisis, saying it may mitigate costs over time if coupled with a reduction in jury awards.

Tom Metzloff, professor of law at Duke University Law School, says arbitration can make dispute resolution “more timely and fairer.” It may also take the bite out of high-end awards, but at the same time it may generate more claims because the process is easier to access than the courts, he adds. ■

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