

## **Arbitration and Long-Term Health Care**

By Christopher J. Marchand, Esq.

---

Long-term health care has become increasingly expensive in the United States. In 2002, the national spending for long-term and nursing home care exceeded \$240 billion. On average, the cost of long-term care across all service categories was \$72,240 in 2004, and analysts expect the cost of long-term care to grow five percent annually, doubling by 2018 and again doubling by 2033. A major component of the rising cost of long term care is the rising cost of medical malpractice insurance.

A tremendous amount of litigation is generated in the health care industry every year, and long-term care providers are turning to arbitration in an attempt to combat the rising cost of resolving disputes with their residents and the accompanying rising cost of insurance. Arbitration has proven to be a viable and cost-effective alternative to prolonged and costly litigation for resolving disputes in the health care industry, and has proven to benefit residents as well as providers of long-term health care.

In general, alternative dispute resolution (“ADR”) is an increasingly popular process employed to resolve disputes between feuding parties who would otherwise end up embroiled in lengthier and more costly litigation in the civil courts. Its success as an arena to resolve disputes has led many courts around the country to require parties to attempt to resolve their differences through ADR. In Maryland many courts require parties to engage in court ordered mediation and in some circumstances, such as medical malpractice cases, to engage in mandatory arbitration.

ADR’s effectiveness as a forum for resolving disputes is complemented by various cost savings attributable to arbitration. Generally speaking, the cost of arbitration is lower than that of litigation because the procedure is streamlined and discovery is more limited. In arbitration, the parties typically engage in only “paper” discovery, such as interrogatories and document production.

The parties often do not have the right to take depositions and must obtain permission from the arbitrator, which is difficult to. The parties also do not have the same rights to appeals as they do in the judicial system, so that post-trial practice is more limited and, therefore, less costly. Additionally, there is no right to a jury in arbitration which further streamlines the process.

The majority of disputes resolved through arbitration result from a contractual agreement voluntarily agreed to before a dispute arises, and not from legislative mandate. It is unusual for parties to agree to arbitration after a dispute arises because one party often believes that he or she

is giving up leverage by agreeing to have the parties' differences resolved by an arbitrator. Probably the most substantial benefit lost is the right to be heard by a jury.

## The Pros and Cons of Arbitration and Long-Term Health Care.

While some view long-term health care providers' attempts to route their disputes into arbitration as a one-sided attempt to gain a tactical advantage, statistics compiled by Michael Delikat and Morris Kleier, *Comparing Litigation and Arbitration of Employment Disputes: Do Plaintiffs Better Vindicate Their Rights in Litigation?* A.B.A. Conflict Mgmt., Vol. 6 Issue 3 (Winter 2003) show that claimants are actually more likely to prevail in arbitration than in court. Even so, because of the cost factors discussed in this article, long-term health care providers still gain when medical malpractice cases are resolved through arbitration and it is, therefore, generally favored as a preferred method of dispute resolution. In turn, the cost-savings are passed along to the consumer.

Arbitration will always have its perceived pros and con, no matter what the context. With regard to health care, some view arbitration and the inability to be heard by a jury as a negative for the health care provider as "some lawyers think it is easier [for a patient] to win in arbitration because most good [arbitrators] will recognize liability and will see through the smoke and mirrors that some juries don't." *Arbitration Cuts Both Ways in Claims Against Hospitals*, Rebecca Vesley, The Oakland Tribune, Apr. 7, 2003. On the other side, some view arbitration as favoring the health care provider because "arbitrators are reluctant to grant large awards to patients who deserve them, [and] even egregiously bad decisions cannot be appealed . .

..” *Binding Arbitration Is Not Frequently Used to Resolve Health Care Disputes*, Rand Institute for Civil Justice (1999).

Arbitration takes the decision out of the hands of a jury and into the hands of a fact finder and legal decision maker who often has particular expertise in the area surrounding the dispute, and who is chosen by the parties or pursuant to an agreed upon method. One commentator observed that “[m]any arbitration advocates question the ability of a lay jury to decide complex malpractice disputes and have looked to ADR to decide complex malpractice disputes and have looked to ADR to provide more qualified decision makers.” Thomas B. Metzloff, *The Unrealized Potential of Malpractice Arbitration*, 31 *Wake Forest L. Rev.*, 203 (1996).

A jury consists of six to twelve decision makers who most likely have very little if any knowledge regarding the background of the case they hear. Their lack of particularized knowledge requires attorneys not only to present the facts of a case, but often to attempt to teach the jurors what the facts mean. Through no fault of their own, jurors may never have been exposed to medical terms and standards, while an arbitrator who hears medical malpractice cases will likely be familiar with such term and standards.

An arbitrator brings background knowledge that makes it easier for him to understand the case and makes it easier for an attorney who is trying a complex case to present the facts. Because of the knowledge an arbitrator brings to the table, his decision is more likely to be informed. It is not surprising that many states require medical malpractice cases to be arbitrated, often times by a panel that includes a physician as an arbitrator.

Some plaintiffs perceive bias, however, when the arbitrator is a physician and argue they are deprived of an impartial decision maker. Such attacks have withstood court scrutiny. In *Morris v. Detroit Memorial Hospital*, 418 Mich. 423, 344 N.W.2d 736 (1984) the plaintiff contended that her right to due process was violated because she was deprived of a fair and impartial decision maker under Michigan's Medical Malpractice Arbitration Act, which authorizes physicians to act as arbitrators. Rejecting the challenge, the Supreme Court of Michigan stated that “[n]either physicians nor hospital administrators have professional interests that are adverse to patients or even malpractice claimants . . . [and] any identity of interest with [the provider] is not so strong as to create a subliminal bias for one side against the other.”

## **Arbitration and Long-Term Health Care in Maryland**

### *a. Arbitration Under Maryland's Health Care Malpractice Claims Act*

In 1976, Maryland enacted the Health Care Malpractice Claims Act (the “HCMCA”), which subjects to arbitration claims involving “medical injury” occurring when in the care of a “health care provider.” The panel hearing claims under the HCMCA is composed of a lawyer, a health care provider and a lay person.

The HCMCA arose out of the medical malpractice insurance crisis that occurred in Maryland in the mid-1970s. In 1975, the largest medical malpractice insurer in Maryland gave notice that it was withdrawing from the market because it was no longer profitable. Maryland's legislature created a committee to study the issue, which proposed adoption of mandatory medical malpractice arbitration on the basis that it 1) would discourage litigation of non-meritous claims because evidentiary weakness would become apparent during arbitration; 2) would

encourage early settlement of meritorious claims because a panel finding liability would encourage health care professionals and insurers to settle; and 3) would lead to accurate decisions in more cases as well as reasonable and predictable damage awards. The purpose of the HCMCA, as Judge Rodowsky stated in *Alder v. Hyman* 334 Md. 568, 640 A.2d 1100 (1994) “is to screen malpractice claims, ferret out meritless ones, and, in theory, thereby lower the cost of malpractice insurance and the overall costs of health care.”

The HCMCA applies to long-term care providers by defining a “health care provider” to include “a . . . home that . . . maintains . . . facilities . . . to provide domiciliary, personal, or nursing care for 2 or more unrelated individuals who are dependant on the administrator, operator, or proprietor for nursing care or the sustenance of daily living in a safe, sanitary, and healthful environment; and. . . admits or retains the individuals for overnight care.” Md. Code Ann./ Cts& Jud. Proc. S 3-2A-01 (2004) and Md. Code Ann., Health Gen II. S 19-301 (2004).

Although the HCMCA initially subjects medical malpractice claims to mandatory arbitration, it allows the parties, either mutually or unilaterally, to opt-out of the process and have the case heard in the court system. Therefore, many health care providers are now considering taking steps to keep medical malpractice cases exclusively in the arbitrator’s arena through preexisting agreements with their residents.

*b. Agreements to Arbitrate Disputes in Long-Term Care Admission Contracts*

The Maryland Office of Health Care Quality (“OHCQ”) has recently addressed the issue of arbitration agreements as they are utilized by nursing facilities in Maryland. OHCQ

recognizes that many insurance companies require or offer favorable rates to nursing facilities that employ arbitration agreements in their resident contracts, and has identified no law or precedent that prohibits arbitration agreements. Such provisions, however, must satisfy certain requirements.

COMAR 10.07.09.07 requires all nursing facilities in Maryland to “execute an admission contract which has been approved by [OHCQ].” Thus, an arbitration agreement contained in the admission agreement must be in compliance with COMAR 10.07.09.04, which requires, among other things, that the arbitration agreement must be clear and “easily understood.”

The requirement that the arbitration provision must be “easily understood” means that it must be easily understood by a layperson. OHCQ approval, therefore, requires that the agreement avoids legalese as much as possible and makes clear what matters will be subject to mandatory arbitration. OHCQ also requires that the arbitration agreement be truly voluntary, not a prerequisite to admission, and that the resident should have an opportunity to have the provision reviewed by a family member or friend.

Effort must be made to draw the arbitration provision to the resident’s attention. To this end, OHCQ also suggests that an arbitration provision be signed separately by the resident and a family member or guardian. Review by someone other than the resident is suggested because the resident often times is in declining health and not in the best position to make decisions or to understand the ramifications of those decisions.

A family member's signature should never be substituted for the resident's signature because an arbitration agreement is a contractual commitment that requires privity. In *Community Care of America of Alabama v. Davis*, 850 So.2d 283 (2002) the Supreme Court of Alabama recently determined that an arbitration clause contained in an admission contract signed by the resident's son was unenforceable with regard to the resident's medical malpractice claim. The court so held because the resident's son had signed the admission agreement, not the injured resident, and because the claim was one for medical malpractice, rather than for a violation of the admission contract.

Since a resident is often admitted to a long-term care facility under stressful circumstances for both the resident and his or her family, a court may view the bargaining process as being heavily tilted in favor of the provider. To even the playing field and avoid an attack that the arbitration provision is an unconscionable contract of adhesion, a grace period should be permitted during which the resident can opt out of the requirement that disputes be resolved through arbitration.

In *Broemmer v. Abortion Services of Phoenix*, 173 Ariz. 148, 840 P.2d 1013 (1992) the Supreme Court of Arizona struck down an arbitration agreement on the basis that it was an adhesion contract and beyond the patient's reasonable expectations when there was "no conspicuous or explicit waiver of the fundamental right to a jury trial or any evidence that such rights were knowingly, voluntarily and intelligently waived." In *Broemmer*, the arbitration agreement was presented as a condition to treatment and the provider's staff did not explain to the patient that she was free to refuse to sign the agreement.

To avoid this result, the arbitration agreement should make clear that it is voluntary and not a condition to receiving treatment. Additionally, an opt out period gives the resident and his family time to consider the agreement and an opportunity to seek advise regarding the provision and make an informed decision. In turn, the provider will have a stronger defense to a claim that the provision is an adhesion contract and unconscionable on the basis that it was unknowingly entered into.

In addition to state requirements, arbitration agreements in long-term health care admission contracts are governed by the Federal Arbitration Act (“FAA”). In a recent National Arbitration Forum (NAF) article, *Mediating and Arbitrating Long Term Care Disputes*, The National Arbitration Forum, January 2005, the NAF states that “virtually all arbitration agreements in the [long term heath care industry] are subject to the FAA guidelines . . . [which may] pre-empt state laws that are inconsistent with its guidelines.”

The NAF’s position is that arbitration provisions contained in long-term health care resident agreements are as enforceable as those contained in any other contract. It states that “[i]n short, federal law requires the enforcement of contracts to arbitrate future disputes [and] the FAA preempts states law that restricts those contracts.”

Arbitration is an underused but fair method for resolving disputes. The rising cost of long-term healthcare requires the providers to employ such cost saving measures, or long-term care will be out of reach of a majority of people. The jury system, while a very important and indispensable facet of the American judicial system, has its failings. Some matters are beyond

the everyday knowledge that jurors bring to the table and for that matter, beyond the knowledge of many attorneys.

Arbitration does not take away a patient's right to redress in the face of a medical injury. It merely puts the decision into the hands of an expert who can produce a more informed and thorough decision, and reduce the costs incurred by all involved parties.