

2018

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Recommended Citation

Sarah Sachs, *The Jury is Out: Mandating Pre-Treatment Arbitration Clauses in Patient Intake Contracts*, 2018 J. Disp. Resol. (2018)

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The Jury is Out: Mandating Pre-Treatment Arbitration Clauses in Patient Intake Contracts

SARAH SACHS*

I. INTRODUCTION

Each year, more than two hundred thousand people are killed and more than one hundred and thirty thousand people are injured by medical error, much of which is preventable.¹ Traditionally, the tort system provided means of recovery for wrongful deaths and patient injuries through malpractice claims. However, in an era where practitioners are attempting to deter publicity, jury awards, punitive damages, extensive discovery, and class actions, arbitration is viewed as a shield from these “evils.”²

Mandatory arbitration clauses have become ubiquitous in a broad range of industries, including the healthcare industry.³ Doctors, hospitals, and health plans are following the lead of other industries by requiring plan enrollees and patients to agree to mandatory arbitration of disputes prior to receiving treatment.⁴ Arbitration clauses emerging in the healthcare setting are in many cases mandatory and binding.⁵ These clauses are embedded in health plan contracts with insurance purchasers and presented to patients by hospitals and physicians at the outset of treatment.⁶ Such clauses stipulate that all future disputes between the patient and the hospital or physician must be resolved through mandatory arbitration, which results in parties waiving their right to trial or judicial oversight of their disputes.⁷

Unfortunately, most patients are unaware they are waiving their right to a jury trial or judicial oversight of their disputes when signing health providers’ patient intake contracts. A vast majority of patients do not read medical disclosures, or have the sophistication to understand the information contained within them.⁸ Even if patients were to read the fine print of health providers’ contracts, patients are still likely to fail to recognize that the contract contained an arbitration clause.⁹ Further,

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1. Lydia Nussbaum, *Trial and Error: Legislating ADR for Medical Malpractice Reform*, 76 Md. L. Rev. 247, 248-49 (2017).

2. Jean R. Sternlight, *Creeping Mandatory Arbitration: Is It Just?*, 57 Stan. L. Rev. 1631, 1631 (2005).

3. *Id.*

4. Elizabeth Rolph et. al., *Arbitration Agreements in Health Care: Myths and Reality*, 60 L. & CONTEMP. PROBS. 153, 154 (1997).

5. *Id.*

6. *Id.*

7. *Id.*

8. Myriam E. Gilles, *Operation Arbitration: Privatizing Medical Malpractice Claims*, 15 THEORETICAL INQUIRES IN LAW 671, 687 (2014).

9. *Id.*

if a patient recognized and refused to sign a mandatory arbitration clause, doctors and hospitals containing mandatory arbitration clauses in their patient intake contracts reserve the right to forfeit treatment if the patient refuses to sign. Refusal to sign is a ground to refuse treatment, unless the patient faces a medical emergency. Doctors, hospitals, and health plans requiring mandatory arbitration concern patient advocates because often times patients are not in a position to negotiate at the time the contract is executed.¹⁰ In fact, no negotiation occurs when patients sign arbitration clauses buried in a doctor's office or hospital admissions paperwork.¹¹ The repercussions on patients forced into mandatory and binding arbitration after a dispute arises from medical treatment can be catastrophic for patients and their loved ones, while beneficial for doctors, hospitals, and health plan providers.

This Comment advocates against the use of mandatory arbitration clauses in healthcare providers' patient intake contracts and discusses the interplay between federal and state statutes that create disparities in enforceability and unenforceability of mandatory arbitration clauses in state courts. Part II discusses the history of mandatory arbitration and its development in healthcare providers' patient intake contracts. Part III examines state statutory limitations on pre-treatment arbitration clauses. Finally, Part IV addresses how courts analyze these agreements and possible approaches to avoid mandatory arbitration arising in healthcare providers' patient intake contracts.

II. HISTORY OF MANDATORY ARBITRATION AND PATIENT INTAKE CONTRACTS

The United States Supreme Court has taken a "bipolar approach to arbitration."¹² During the nineteenth and early twentieth centuries, courts were hostile towards arbitration¹³ agreements.¹⁴ However, in recent years the Supreme Court has largely supported arbitration agreements, even when mandatory.¹⁵ Courts enforcing mandatory arbitration clauses in healthcare providers' patient intake contracts are governed and guided by the Federal Arbitration Act (FAA).

A. *The Federal Arbitration Act*

Federal support for alternative dispute resolution (ADR) agreements, such as arbitration clauses, surfaced in 1925 when Congress enacted the United States Arbitration Act.¹⁶ After the enactment of the act, courts generally disfavored arbitration clauses and deemed them unenforceable because the courts viewed arbitration

10. Nussbaum, *supra* note 1, at 275.

11. *Id.*

12. Lauren Gaffney, *The Circle of Assent: How "Agreement" Can Save Mandatory Arbitration in Long-Term Care Contracts*, 62 VAND. L. REV. 1017, 1023 (2009).

13. Arbitration is defined as "a dispute-resolution process in which the disputing parties choose one or more neutral parties to make a final and binding decision resolving the dispute." BLACK'S LAW DICTIONARY (10th ed. 2014).

14. See *Kulukundis Shipping Co., S/A, v. Amtorg Trading Corp.*, 126 F.2d 978, 984 (2d Cir. 1942); Jodi Wilson, *How the Supreme Court Thwarted the Purpose of the Federal Arbitration Act*, 63 CASE W. RES. L. REV. 91, 98 (2012).

15. *Id.*; (Arbitration is considered mandatory when required by contract.)

16. United States Arbitration Act, ch. 392, 61 Stat. 883 (1925) (current version at 9 U.S.C.).

as encroaching on its domain of jurisdiction.¹⁷ However, starting in 1947, courts began to favor arbitration agreements when the enactment was codified under the FAA.¹⁸ The FAA governs the enforcement of contractual agreements to arbitrate disputes involving maritime transactions and interstate commerce.¹⁹ Section 2 of the FAA, which is the “primary substantive provision of the Act,”²⁰ provides that arbitration agreements in writing are valid, irrevocable, and enforceable, save upon such grounds that exist at law or in equity for the revocation of any contract.²¹ Under Section 2, the Supreme Court has held the FAA as a “liberal federal policy favoring arbitration agreements.”²² After a series of Supreme Court rulings, the reach of the FAA statute has expanded over the years.

Beginning in the late 1950s, the Supreme Court deliberated on a number of cases interpreting the FAA.²³ The Court held that the FAA is a substantive rather than procedural law,²⁴ and that it was enacted by Congress pursuant to its power to regulate interstate commerce.²⁵ These rulings established that the FAA preempts state law to the extent that state law is inconsistent with the FAA or “to the extent that it stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.”²⁶ Therefore, the FAA gave courts broad preemptive power over state laws disfavoring arbitration. Following these rulings, many states consented to the federal government’s endorsement of arbitration and adopted their own versions of the FAA.

As states began adopting their own versions of the FAA, the Supreme Court enhanced the FAA’s strength by further preempting state law. For example, in *Doctor’s Associates v. Casarotto*, the Court held that Montana’s state statute treating arbitration clauses differently than standard contract language was inconsistent with the FAA.²⁷ The Court concluded that the state statute placed special burdens on arbitration clauses that conditioned the enforcement of such provisions on the compliance with the state statutory requirements, and therefore preempting the FAA.²⁸ The decision in *Casarotto* established that state statutes’ role in interpreting arbitration clauses is limited, and that basic issues of enforceability of contractual arbitration clauses are answered by federal law.²⁹ *Casarotto* opened the door for states to limit the enforceability of arbitration clauses. Yet, it left unanswered bright-line rules for state statutes to preempt the FAA.

Recent state court decisions attempted to clarify the power left to states in determining the validity of arbitration agreements. While *Casarotto* seems to establish that the FAA preempts all areas of law that Congress has addressed in the statute, courts have held that only state statutes that are inconsistent with the FAA are

17. Gaffney, *supra* note 12, at 1023.

18. 9 U.S.C. §§ 1-16 (2018).

19. 9 U.S.C. §§ 1-14 (2018).

20. *Moses H. Cone Mem’l Hosp. v. Mercury Contr. Corp.*, 460 U.S. 1, 24 (1983).

21. 9 U.S.C. § 2 (2018).

22. *Moses H. Cone Mem’l Hosp.*, 460 U.S. at 24.

23. Rolph, *supra* note 4, at 160.

24. *See Bernhardt v. Polygraphic Co. of Am.*, 350 U.S. 198, 203 (1956).

25. *See Prima Paint Corp. v. Flood & Conklin Mfg. Co.*, 388 U.S. 395, 403-05 (1967).

26. Rolph, *supra* note 4, at 160.

27. 517 U.S. 681, 681-82 (1996).

28. *Id.* at 682.

29. Rolph, *supra* note 4, at 160.

preempted.³⁰ Prior to *Casarotto*, some state courts interpreted the FAA's preemptive effect to preclude application of state contract law, despite the fact that the FAA did not address issues of state contract law.³¹ However, *Casarotto* identifies unconscionability as a state law doctrine which "may be applied to invalidate arbitration clauses without contravening Section 2," because the FAA does not address that issue.³² Therefore, state courts may generally regulate arbitration clauses "under general contract law principles,"³³ such as fraud, duress, or unconscionability without conflicting with the FAA.³⁴ However, state courts cannot invalidate arbitration clauses solely based on state laws specific to arbitration. The tension between the FAA and state statutes may motivate doctors and hospitals to add pre-treatment arbitration clauses to their patient intake contracts because the FAA's broad reach is likely to preempt state statutes limiting arbitration clauses.

B. Use of Mandatory Arbitration Clauses in Patient Intake Contracts

The use of alternative dispute resolution emerged in the healthcare industry after unexpected growth in medical malpractice claims in the 1970s.³⁵ Legislatures believed that large jury awards led to rapid growth in physician malpractice insurance premiums and in some states threatened specialty care.³⁶ State legislatures responded to the increase in medical malpractice claims by implementing forms of alternative dispute resolution as well as tort reform to control the risk and costs of large jury verdicts.³⁷ State legislatures implemented shortened statutes of limitations, caps on damages, collateral source rules requiring courts to avoid double compensation for the same injury, and mediation and binding arbitration as a favored means to resolve disputes.³⁸ These legislative initiatives intended to make it harder for patients to bring medical malpractice claims and reduce the rising cost of medical expenses.³⁹

With the continued expansion of healthcare services, the potential for disputes has drastically increased despite implementation of state legislation.⁴⁰ As insurance plans and providers attempt to contain the cost of healthcare, a whole new class of disputes arose over coverage.⁴¹ Insurance companies and managed care plans created a new class of disputes by denying treatment to patients and acting as treatment decision-makers.⁴² Denial of treatment or coverage can result in patients forgoing necessary treatment, which can result in further health complications and even death. As a result, some patients are more likely to challenge the medical judgments and competence of providers. Thus, doctors, hospitals, and health plans, to find a

30. *Id.*

31. *Id.*

32. *Id.* at 161.

33. *Allied-Bruce Terminix Cos., Inc. v. Dobson*, 513 U.S. 265, 281 (1995).

34. *Casarotto*, 517 U.S. at 687.

35. Rolph, *supra* note 4, at 153.

36. *Id.*

37. *Id.*

38. See Scott Forehand, *Helping the Medicine Go Down: How a Spoonful of Mediation Can Alleviate the Problems of Medical Malpractice Litigation*, 17 OHIO ST. J. ON DISP. RESOL. 907, 912-13 (1999).

39. Nussbaum, *supra* note 1, at 251.

40. Rolph, *supra* note 4, at 154.

41. *Id.*

42. *Id.*

more efficient, more predictable, and arguably less threatening mechanism for dispute resolution, are following the lead of certain other industries by requiring patients to agree to pre-treatment mandatory binding arbitration.⁴³

While the use of mandatory arbitration clauses may not be an industry norm, the use of such clauses is on the rise.⁴⁴ The use of pre-treatment clauses are popping up in physician and patient contracts, physician and malpractice insurance provider contracts, as well as patient and insurance company or HMO contracts. State legislatures' advancement of these clauses in the healthcare setting is evident through notable nationwide support of state statutes regulating pre-treatment and post-treatment arbitration clauses.

Six states have authorized pre-treatment arbitration clauses by statute—Alaska, California, Colorado, Louisiana, South Dakota and Utah.⁴⁵ The statutes in these states require one of the following provisions: (1) right of revocation;⁴⁶ (2) notification that treatment is conditioned on acceptance of the agreement;⁴⁷ and/or (3) notice of waiver of rights.⁴⁸ The California and Colorado statutes contain mandatory language that must be included in the contract for the pre-treatment arbitration clause to be held enforceable.⁴⁹ Michigan, Wyoming, and Maine had pre-treatment arbitration statutes that were later repealed.⁵⁰

Sixteen other states have statutes which provide that parties *may* agree to arbitrate post-treatment medical disputes.⁵¹ Some of these statutes also provide mandatory language that must be included in the contract for the arbitration clause to be held enforceable. Eighteen other states use other forms of alternative dispute resolution such as mediation and panels to resolve post-treatment medical disputes.⁵²

43. *Id.*

44. A. Thomas Pedroni & Ruth F. Vadi, *Mandatory Arbitration or Mediation of Health Care Liability Claims?*, 39 MD. B.J. 54, 56 (2006).

45. *Id.*

46. *Id.* (Alaska (ALASKA STAT. § 6.5.485); California (CAL. HEALTH & SAFETY CODE § 1363.1); Colorado (COLO. REV. STAT. § 13-64-403); Louisiana (LA. STAT. ANN. § 9:4230 *et seq.*); South Dakota (S.D. CODIFIED LAWS § 21-25B-1 *et seq.*); and Utah (UTAH CODE ANN. § 78b-3-416 *et seq.*); Right of revocation allows a patient to revoke from the contract without the need to provide any reason.

47. *Id.* (Alaska, Colorado, and Utah).

48. *Id.* (California, Colorado, and Utah).

49. *Id.*

50. Pedroni & Vita, *supra* note 45, at 57. (Michigan (MICH. COMP. LAWS § 60.5040); Wyoming (WYO. STAT. ANN. § 9-2-1502); Maine (ME. REV. STAT. ANN. §§ 2701-15).

51. Heather Morton, *Medical Liability/ Malpractice ADR and Screening Panels Statutes*, NAT'L CONFERENCE OF ST. LEGISLATORS (2014), <http://www.ncsl.org/research/financial-services-and-commerce/medical-liability-malpractice-adr-and-screening-panels-statutes.aspx>; Alabama (ALA. CODE § 6-5-485); Delaware (DEL. CODE ANN. tit. 18, § 6803); Florida (FLA. STAT. § 766.207); Maryland (MD. CODE ANN., CTS. & JUD. PROC. § 3-28-01); Ohio (OHIO REV. CODE ANN. § 2711.22); Virginia (VA. CODE ANN. § 8.01-581.12); Georgia (GA. CODE ANN. § 9-9-61); Illinois (750 ILL. COMP. STAT. 15); Vermont (VT. STAT. ANN. tit. 12, § 7001); Louisiana (LA. STAT. ANN. § 9:4230); New Jersey (N.J. REV. STAT. § 2A:23A-20); New York (N.Y. C.P.L.R. 3045); North Carolina (N.C. GEN. STAT. § 90-21.60); South Carolina (S.C. CODE ANN. § 15-79-120); Texas (TEX. CIV. PRAC. & REM. CODE ANN. § 74.451); Washington (WASH. REV. CODE § 7.70A.010).

52. *Id.*; Connecticut (CONN. GEN. STAT. § 52-190c); District of Columbia (D.C. CODE ANN. § 16-2821); Hawaii (HAW. REV. STAT. § 671-11); Idaho (IDAHO CODE § 6-1001); Indiana (IND. CODE § 34-18-8-4); Kansas (KAN. STAT. ANN. § 60-3413); Maine (ME. REV. STAT. ANN. tit. 24, § 2851); Massachusetts (MASS. GEN. LAWS ANN. ch. 231, § 60B); Montana (MONT. CODE ANN. § 27-6-101); Nebraska (NEB. REV. STAT. § 44-2840); Nevada (NEV. REV. STAT. § 41A.081); New Hampshire (N.H. REV. STAT. ANN. § 519-B:1); New Mexico (N.M. STAT. ANN. § 41-5-14); North Dakota (N.D. CENT. CODE § 32-42-01); Oregon (OR. REV. STAT. § 31.250); Pennsylvania (40 PA. CONS. STAT. § 1303.714); West Virginia (W. VA. CODE § 55-7B-6); Wisconsin (WIS. STAT. § 655.42).

The remaining ten states only have general arbitration statutes, which are applied to guide enforcement of arbitration agreements in all industries including disputes arising in health care contracts.⁵³ State statutes requiring the use of some form of alternative dispute resolution, whether it be arbitration or mediation, have drastically increased as the healthcare industry has evolved into a business focused on volume and profitability of services provided.

i. Consumer Versus Patient

Profit driven interests in the healthcare industry alter the physician-patient relationship into a producer-consumer relationship. Doctors, hospitals, and health plan providers blur the line between patients and consumers by including pre-treatment mandatory arbitration clauses. Unlike companies such as banks, phone companies, internet service providers, and e-commerce merchants, where mandatory arbitration clauses are commonplace in consumer contracts, the healthcare industry provides a service that deviates from a typical producer-consumer relationship.

The producer-consumer relationship assumes, perhaps incorrectly, that both parties have equal bargaining power.⁵⁴ Where there is unequal bargaining power, however, the law attempts to compensate for some inequality in power by regulating producers to an extent so that consumers are able to make informed and voluntary choices.⁵⁵ However, consumer protection laws are solely concerned with the consumer's freedom to make voluntary choices, not their possession of specialized knowledge.⁵⁶

The patient-physician relationship is different because it assumes inequality between the patient and the physician.⁵⁷ The physician is likely to have more knowledge about medical information than the patient, thus imposing a fiduciary duty on the physician to apply their expertise in the best interest of the patient according to professional standards.⁵⁸ The presumption that patients are on unequal bargaining grounds does not suggest patients are incapable of making medical decisions. Rather the assumption suggests that patients lack access to specialized knowledge other than reliance on their physician. Therefore, the law treats consumers and patients differently. Whereas consumers do not solely rely on producers to make their purchasing decisions, patients are likely to solely rely on physicians' specialized knowledge in order to make informed medical decisions.⁵⁹

Transforming the physician-patient relationship into a producer-consumer relationship through mandatory arbitration clauses abuses the unequal bargaining

53. *Id.* (Arizona, Arkansas, Iowa, Kentucky, Minnesota, Mississippi, Missouri, Oklahoma, Rhode Island, Tennessee).

54. See generally Wendy K. Mariner, *Standards of Care and Standard Form Contracts: Distinguishing Patient Rights and Consumer Rights in Managed Care*, 15 J. CONTEMP. HEALTH L. & POL'Y 1, 8 (1998).

55. *Id.* at 5.

56. *Id.* at 8.

57. *Id.*

58. *Id.* (“[The] inherent imbalance in knowledge and skill is a defining characteristic of the physician-patient relationship. Moreover, patients are usually sick and not able to function at their own normal capacity.”)

59. *Id.* at 9.

power of patients. Furthermore, treating patients as consumers takes medical malpractice claims primarily rooted in tort law to be governed by contract law.⁶⁰ In other words, even though the merits of the claim will still be governed by tort law, the initial proceedings are governed by contract law. The initial proceedings governed by contract law could result in different treatment of the claim by the arbitration panel, depending on the contractual provisions of the agreement.

ii. Tort Law versus Contract Law

Medical malpractice liability is grounded in tort law.⁶¹ The objective of the tort system is to compensate patients for their injuries and damages sustained by a negligent party. Therefore, the tort system acts in two parts: To dispense “corrective justice” and to deter negligence.⁶² Negligent medical care or medical malpractice is generally the failure to do what a reasonable doctor or provider in the same situation would have done under similar circumstances.⁶³ A patient is only entitled to compensation for financial losses, such as lost earnings, medical bills, and non-economic damages for pain and suffering, when a judge or jury finds that the patient’s injury was caused by the negligence of the doctor’s substandard care.⁶⁴

The emerging use of mandatory binding arbitration takes medical malpractice claims outside the realm of tort law and restricts such claims to contract law. Combining claims of health plans grounded in contract law and patient treatment grounded in tort law, further complicates resolution of medical malpractice claims to the detriment of patients. For example, in *Kuhl v. Lincoln National Health Plan of Kansas City, Inc.*,⁶⁵ the Eight Circuit held that a medical malpractice claim was not valid because it involved an HMO provider’s refusal to pay for treatment outside its network. The health plan denied surgery at an out-of-network hospital, eventually resulting in the patient’s death. The court evaluated the denial of treatment by the health plan as a contractual issue. Therefore, the claim was not evaluated under a negligence standard pursuant to tort law, but could only be challenged or voided by contract law.⁶⁶ The court’s holding resulted in no recovery for the injury sustained by the patient. Distinguishing between contract law and tort law is outcome determinative for a patient’s damages recovery. Allowing contract law to govern, often results in no recovery for patients and full protection of doctors, hospitals, and health plans. Mandatory arbitration protects doctors, hospitals, and health plans at the expense of patients.

60. Elizabeth G. Thornburg, *Contracting with Tortfeasors: Mandatory Arbitration Clauses and Personal Injury Claims*, 67 L. & CONTEMP. PROBS. 253, 254 (2004).

61. Nussbaum, *supra* note 1, at 254.

62. *Id.*

63. *Id.* at 255.

64. *Id.*

65. *Kuhl v. Lincoln Nat’l Health Plan of Kansas City, Inc.*, 999 F.2d 298 (8th Cir. 1993).

66. *See id.*

III. REGULATORY TENSION BETWEEN STATE STATUTES, THE FEDERAL ARBITRATION ACT AND THE MCCARRAN-FERGUSON ACT

A. Texas Medical Liability Act

In the spring of 1977, the Texas legislature passed the Medical Liability and Insurance Improvement Act (MLIIA), which was codified as Article 4590i of the Texas Revised Civil Statutes.⁶⁷ During the intervening decades, parts of the statute have been declared unconstitutional and other parts have been judicially redefined.⁶⁸ In 2003, the legislature made changes to the MLIA and re-codified it in the Civil Practice and Remedies Code.⁶⁹ As part of the revisions, the Texas Medical Liability Act (TMLA) authorized counties to adopt alternative dispute resolution systems. The statute did not mandate medical malpractice claims to arbitration or screening panels. However, the statute left it to the discretion of health care providers to utilize ADR procedures, such as mandatory arbitration clauses in patient intake contracts. The legislature attempted to add a layer of consumer protection for patients by requiring the signature of the patient's attorney for the agreement to be held valid.⁷⁰ The statute also requires an arbitration agreement to contain written notice in bold-type, ten-point font that conspicuously warns the patient.⁷¹ Despite efforts to protect patients, issues of enforceability have arisen when arbitration clauses fail to strictly comply with the TMLA.⁷²

Until recently, Texas's lower courts routinely rejected the argument that the FAA preempts strict compliance with the TMLA.⁷³ However, a recent Texas Supreme Court decision changed the landscape for arbitration clauses in medical malpractice claims.⁷⁴ In *Fredricksburg Care Co., L.P. v. Perez*,⁷⁵ the Texas Supreme Court held that the FAA preempts the more stringent arbitration requirements set forth in section 74.451 of the TMLA. The Court also held that the McCarran-Ferguson Act ("MFA")⁷⁶ does not "reverse preemption" from the FAA.⁷⁷

i. The Fredricksburg Case

In *Fredricksburg*, the company moved to compel arbitration based on a pre-admission contract signed by the patient.⁷⁸ Despite the pre-admission arbitration

67. Texas Medical Association, *Summary of Texas Medical Professional Liability Law*, <https://www.texmed.org/StatuteOfLimitations/> (last visited Oct. 14, 2017).

68. *Id.*

69. *Id.*

70. TEX. CIV. PRAC. & REM. CODE ANN. § 74.451.

71. TEX. CIV. PRAC. & REM. CODE ANN. § 74.451(a).

72. TEX. CIV. PRAC. & REM. CODE ANN. § 74.451(b).

73. Michael L. Hood & David M. Merryman, *Med Mal Game Changer The Texas Supreme Court Strikes Down Bar to Arbitration Agreements*, 78 TEX. B.J. 638 (2015).

74. *Id.*

75. *Frederickson Care Co., L.P. v. Perez*, 461 S.W.3d 513 (Tex. 2015), reh'g denied (June 26, 2015), cert. denied sub nom; *Perez v. Fredricksburg Care Co., L.P.*, 136 S. Ct. 798 (2016).

76. 15 U.S.C. §§ 1011-1015.

77. *Fredricksburg*, 461 S.W.3d at 513.

78. *Id.* at 516.

clause's failure to strictly comply with the TMLA,⁷⁹ *Fredricksburg* asserted that federal law determined the enforceability of the arbitration clause under the FAA because the underlying patient-provider transaction involved interstate commerce.⁸⁰ The beneficiaries did not dispute that the FAA would normally preempt TMLA section 74.451 because the two laws directly conflicted, and therefore the FAA prevented the arbitration clause from being invalidated.⁸¹ However, the beneficiaries argued that TMLA section 74.451 was part of a state law enacted "for the purpose of regulating the business of insurance," which falls under the protection of the MFA.⁸² Under the MFA, Congress created an exemption from preemption for any federal law that can be "construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance."⁸³

The Texas Supreme Court held that the FAA applied and therefore strict compliance of TMLA section 74.451 did not invalidate the arbitration clause.⁸⁴ The court acknowledged that the TMLA was enacted with the intent to make health care more affordable, but held that the legislator's goal of lowering costs was "too tenuous of a connection to the business of insurance" to qualify for MFA protection.⁸⁵ The court also concluded that section 74.451, which applies between patients and providers, has little to do with the relationship between the insurance company and its policyholders.⁸⁶

The ruling in *Fredricksburg* has granted health care providers more flexibility to adopt pre-treatment arbitration agreements.⁸⁷ If a health care provider can establish the FAA applies to the arbitration clause and preempts the TMLA, then the agreement must only satisfy the FAA's requirements. FAA agreements are still subject to state law contract defenses, but preemption of the TMLA significantly reduces patient safeguards. As a result, many providers may start including arbitration clauses in their pre-treatment contracts with patients.

B. Colorado Health Care Availability Act

The Colorado legislature passed the Health Care Availability Act (HCAA) in 1989.⁸⁸ In 2003, the legislature amended the HCAA and declared that no individual or entity, other than the patient's physician, may be held liable in any medical malpractice claim.⁸⁹ Similar to the TMLA, the HCAA requires written notice in at least ten-point font with bold-faced type.⁹⁰ The Colorado legislature protects patients by allowing a patient to rescind from the agreement by written notice to the physician within ninety days after signing the agreement or after release or discharge from the

79. *Id.*

80. *Id.* at 516-17. (Fredricksburg Care Company received Medicare payments on behalf of the deceased, which the court found sufficient to establish interstate commerce.)

81. *Id.* at 517.

82. *Id.*

83. *Fredricksburg*, 461 S.W.3d at 517, citing 15 U.S.C. § 1012(b).

84. *Id.* at 528.

85. *Id.* at 524.

86. *Id.* at 526-27.

87. Hood & Merryman, *supra* note 74, at 638.

88. 1989 Colo. Legis. Serv. H.B. 1294 (West).

89. The amendment promulgated the Colorado Supreme Court's decision in *Pediatric Neurosurgery, P.C. v. Russell*, 44 P.3d 1063 (Colo. 2002) (Holding the corporate entity may be held vicariously liable for negligence through respondent superior).

90. COLO. REV. STAT. ANN. § 13-64-403.

hospital.⁹¹ Unlike Texas state courts, Colorado state courts have upheld the enforceability of pre-treatment arbitration clauses *only* when the agreement strictly complies with the HCAA.

Recently the Colorado Court of Appeals reinforced strict compliance with HCAA in *Fischer v. Colorow Health Care, LLC*.⁹² The court held in *Fischer* that the HCAA demands strict compliance with section 13-64-403(4).⁹³ Therefore, non-compliant arbitration clauses will be rendered unenforceable if challenged.

i. The Fischer Case

In *Fischer*, Colorow Health Care, LLC (Colorow) moved to compel arbitration and plaintiffs opposed the motion based on noncompliance with HCAA requirements in section 13-64-403(3) and (4).⁹⁴ The trial court rescinded the arbitration agreement explaining that “the entity seeking to enforce the arbitration agreement must be held to strict compliance with [the statutory] requirements.”⁹⁵ The Court of Appeals affirmed the order of the trial court denying the motion to compel arbitration. The Court determined that strict compliance was necessary based on the legislative intent which is focused on ensuring binding arbitration clauses are “voluntary agreement[s] between a patient and health care provider. . . .”⁹⁶ The Colorado Supreme Court has granted *certiorari* in the *Fischer* case. However, the current law requires any pre-treatment arbitration clause to strictly comply with HCAA section 13-64-403.

In *Fischer*, Colorow did not raise the issue that the arbitration clause is preempted by the FAA because the contract lacked interstate commerce or maritime transactions. However, Colorow probably could invoke interstate commerce if the patient used any form of Medicare or insurance to pay for the health care services. The Court’s focus on strict compliance versus substantial compliance may have resulted in a different outcome than if the provider argued the FAA preempts the HCAA.

Eventually state arbitration statutes regulating medical malpractice claims could come before the United States Supreme Court for review. The Supreme Court rejected to take up an appeal from the *Fredricksburg* case. However, if other states, such as the Colorado Supreme Court, uphold strict compliance with state statutes for arbitration agreements, the United States Supreme Court may take up the issue to provide guidance on when the FAA preempts state statutes enforcement of arbitration clauses in healthcare contracts.

91. COLO. REV. STAT. ANN. § 13-64-403(3).

92. *Fischer v. Colorow Health Care, LLC*, 2016 COA 130, cert. granted, No. 16SC814, 2017 WL 825315 (Colo. Feb. 21, 2017).

93. *Id.* at 8.

94. *Id.* at 1.

95. *Id.*

96. *Id.* at 6-7 (quoting Colo. Rev. Stat. Ann. § 13-64-403(1)).

IV. CHALLENGING MANDATORY ARBITRATION IN PATIENT INTAKE CONTRACTS

Arbitration clauses are subject to contract law. Therefore, courts must first determine whether a valid contract exists prior to assessing the validity of the arbitration clause.⁹⁷ To prove that a valid contract exists, four elements must be met: (1) the parties possessed the capacity to enter into a contract, (2) the parties mutually assented, (3) there must be a certain object for the contract, and (4) the contract must have a lawful purpose.⁹⁸ If a valid contract does not exist, then a motion to compel mandatory arbitration is invalid because the FAA “does not require parties to arbitrate when they have not agreed to do so.”⁹⁹

When a valid arbitration clause exists, parties may seek to defeat a motion to compel arbitration by attempting to escape the purview of the FAA to apply more favorable state law.¹⁰⁰ However, defeating a motion to compel arbitration is difficult because of the FAA’s broad reach.

A. Avoiding The FAA

Avoiding the FAA is advantageous to a party seeking to evade a motion to compel arbitration because many state laws disfavor arbitration. To avoid applying the FAA to an arbitration agreement, the party must prove that the underlying transaction does not involve interstate commerce.¹⁰¹ The Supreme Court has interpreted “interstate commerce” broadly¹⁰² and construed Section 2 of the FAA as applying to every arbitration agreement that private parties entered into with the full reach of the Commerce Clause.¹⁰³ Applying the reach of the Commerce Clause to the FAA has expanded the applicable scope even further. Courts have upheld arbitration clauses in individual cases without a showing of any specific impact upon interstate commerce. Under the Commerce Clause, the FAA is invoked when a party proves a transaction represents a general practice subject to federal control and the general practice substantially affects interstate commerce.¹⁰⁴ Therefore, a physician’s clinic or a hospital’s interstate transactions will likely satisfy the “interstate commerce” requirement, and the FAA will govern the pre-treatment arbitration agreement between the physician and patient.¹⁰⁵

97. See *TranSouth Fin. Corp. v. Rooks*, 604 S.E.2d 562 (2004).

98. See *Wallace v. Sherve Mem’l Library*, 79 F.3d 427, 430 n.4 (5th Cir. 1996).

99. See *Volt Info. Scis., Inc. v. Bd. of Trs. of Leland Stanford Junior Univ.*, 489 U.S. 468, 478 (1989).

100. Gaffney, *supra* note 12, at 1029.

101. 9 U.S.C. § 2; See *Allied-Bruce Terminix*, 513 U.S. at 268.

102. *Allied-Bruce Terminix*, 513 U.S. at 268 (holding “a contract evidencing a transaction involving commerce” should be read broadly to extend the FAA to the outer limits of “Congress’ Commerce Clause power”).

103. *Perry v. Thomas*, 482 U.S. 483, 490 (1987).

104. *Citizens Bank v. Alafabco, Inc.*, 539 U.S. 52, 56 (2003).

105. *McGuffey Health & Rehab. Ctr. v. Gibson ex rel. Jackson*, 864 So. 2d 1061, 1063 (Ala. 2003) (holding Medicare funds moving across state lines should be considered to establish the interstate commerce connection); *Owens v. Coosa Valley Health Care, Inc.*, 890 So. 2d 983 (Ala. 2004) (holding that nursing home services involved interstate commerce is unquestionably economic in nature under *Citizens Bank v. Alafabco, Inc.*, and can be within reach of the Commerce Clause); *In re Nexion Health at Humble, Inc.*, 173 S.W.3d 67, 68 (Tex. 2005, as supplemented on denial of reh’g (Oct. 14, 2005) (holding Medicare funds crossing state lines makes the pre-admissions contract involve interstate commerce).

Courts have considered the receipt of Medicaid or Medicare funds, receipt of materials from other states, and any out-of-state offices in determining whether an agreement involved “interstate commerce.”¹⁰⁶ Further, parties wishing to compel arbitration can argue that their facility is subject to federal regulation, which subjects their arbitration clause to be governed by the FAA. However, under rare circumstances, parties may escape the FAA in an “involving commerce” argument. In *Bruner v. Timberlane Manor Ltd. P’ship*, the Oklahoma Supreme Court held that accepting Medicare and Medicaid payments was insufficient to invoke the FAA “interstate commerce” clause.¹⁰⁷ While other states have recognized Medicare or Medicaid funds to trigger preemption of contrary state law to the FAA, the Oklahoma Supreme Court refused to follow such precedent because the United States Supreme Court has not ruled that Medicare or Medicaid is “an exercise of Congress’ Commerce Clause power.”¹⁰⁸ Thus far, no other state has followed Oklahoma’s interpretation of interstate commerce.¹⁰⁹ Therefore, it is largely difficult for the parties to escape the broad reach of the FAA.

B. Standard Contract Defenses

Courts can refuse to enforce pre-treatment mandatory arbitration clauses in patient intake contracts based on standard contract defenses, such as fraud, duress and unconscionability without contravening the FAA.¹¹⁰ The most compelling standard contract defenses in pre-treatment arbitration contracts are unconscionability and lack of capacity.

i. Unconscionability

Unconscionability¹¹¹ arguments appear particularly promising to pre-treatment mandatory arbitration clauses because pre-dispute clauses are frequently found in contracts that are adhesive¹¹² in nature.¹¹³ However, unconscionability arguments are rarely successful because unequal bargaining power or unfairness is usually not enough to invalidate a contract.¹¹⁴

106. See *Summit Health, Ltd. v. Pinhas*, 500 U.S. 322, 329 (1991) (holding purchase of out-of-state medicines and acceptance of out-of-state insurance established interstate commerce); *Triad Health Mgmt. of Ga., III, LLC v. Johnson*, 679 S.E.2d 785, 788 (Ga. App. 2009) (applied FAA to nursing home contract when facility purchased supplies from out-of-state vendors, treated out-of-state patients, and received Medicaid and Medicare funding); *Kansas City Urology, P.A. v. United Healthcare Servs.*, 261 S.W.3d 7, 10 (Mo. App. 2008) (holding the FAA applies when some of the plaintiffs and the defendants reside in different states and their activities affect interstate commerce).

107. *Bruner v. Timberlane Manor Ltd. P’ship*, 155 P.3d 16, 31-32 (Okla. 2006).

108. *Id.* at 29-30.

109. Gaffney, *supra* note 12, at 1032.

110. See *Swain v. Auto Servs., Inc.*, 128 S.W.3d 103, 107 (Mo. App. 2003).

111. BLACK’S LAW DICTIONARY (8th ed. 2004) (Unconscionability is defined as an unfair or oppressive contract to one party).

112. BLACK’S LAW DICTIONARY (8th ed. 2004) (An adhesion contract is drafted by one party and signed by another party with weaker bargaining power. Courts carefully scrutinizes adhesion contracts and sometimes void provisions because of the possibility of unequal bargaining power, unfairness, and unconscionability).

113. David Allen Larson & Dr. David Dahl, *Medical Malpractice Arbitration: Not Business as Usual*, 8 Y.B. on Arb. & Mediation 69, 75 (2016).

114. *Id.*

Unconscionability has two elements: procedural and substantive.¹¹⁵ Procedural unconscionability refers to the contract formation process and may include “fine print clauses, high pressure sales tactics or unequal bargaining positions.”¹¹⁶ Substantive unconscionability refers to undue harshness in the contract terms.¹¹⁷ A showing of procedural and substantive unconscionability is considered in determining whether an arbitration clause is unconscionable and void.¹¹⁸

A critical question in determining unconscionability is whether each party made a meaningful choice. Circumstances surrounding the transaction are considered in evaluating a meaningful choice, such as obvious education or lack of it, reasonable opportunity to understand the terms of the contract, or notification of important terms hidden in fine print or minimized by deceptive sales practices.¹¹⁹ Unconscionability is a powerful defense because it invalidates contract terms “when a party of little bargaining power, and hence little real choice, signs a commercially unreasonable contract with little or no knowledge of its terms.”¹²⁰ In such cases, courts may deem a contract in part or in whole unenforceable.

The nature of pre-treatment patient intake contracts and mandatory arbitration clauses contained in them place patients at more of a risk of unconscionability. For example, in *Wheeler v. St. Joseph Hospital*, the California Court of Appeals held an arbitration clause unconscionable when signed by a patient in a hospital admissions contract.¹²¹ The court held that “a hospital’s standard printed ‘CONDITIONS OF ADMISSION’ form possesses all the characteristics of a contract of adhesion” because the would-be patient is in no position to reject the proffered agreement, to bargain with the hospital, or *in lieu* of agreement to find another hospital.¹²² Further, the court justified its finding of unconscionability because the patient realistically had no choice but to seek hospital admission as directed by his physician and sign the printed forms necessary to gain admission.¹²³ Unconscionability can be a powerful contract defense against standard print forms in patient intake contracts. However, standard print terms in pre-treatment patient contracts may not always be held unconscionable if a patient is reasonably aware of the terms and given the opportunity to read the terms.¹²⁴ Therefore, patients may not rely on an unconscionability defense based solely on a pre-treatment contract containing standard print terms. Depending on the surrounding circumstances, an unconscionability defense may or may not be a valid argument to avoid pre-treatment mandatory arbitration clauses.

ii. Lack of Capacity

A valid arbitration clause requires mutual assent by competent parties at the time the contract is executed. Challenging an arbitration agreement based on lack

115. *AT&T Mobility LLC v. Concepcion*, 563 U.S. 333, 340 (2011).

116. *Manfredi v. Blue Cross & Blue Shield of Kansas City*, 340 S.W.3d 126, 132 (Mo. App. 2011).

117. *Id.*

118. *Id.*

119. *Williams v. Walker-Thomas Furniture Co.*, 350 F.2d 445, 449 (1965).

120. *Id.*

121. *Wheeler v. St. Joseph Hosp.*, 63 Cal. App. 3d 345 (1976).

122. *Id.* at 357.

123. *Id.* at 789.

124. Stanley D. Henderson, *Contractual Problems in the Enforcement of Agreements to Arbitrate Medical Malpractice*, 58 VA. L. REV. 947, 986 (1972).

of capacity is a difficult defense because courts assume individuals are competent to enter contractual relationships.¹²⁵ A party arguing a contract is unenforceable because the signor lacked mental capacity bears the burden of proving such incapacity.¹²⁶ Most courts will void contracts upon adequate showing that a party lacked mental capacity.¹²⁷ In the healthcare setting, issues of capacity to consent to pre-treatment mandatory arbitration clauses arise uniquely when patients sign contracts under extreme physical or mental distress.

However, proving lack of capacity because of physical or mental distress is difficult. Generally, courts have followed the contract principle that “mere weakness of mind or body, or of both, do not constitute what the law regards as a mental incompetency sufficient to render a contract voidable.”¹²⁸ Weak-mindedness alone may not be sufficient to make a contract voidable, but could be highly relevant in determining overreach or fraud.¹²⁹

For example, in *Kindred Hospitals Limited Partnership v. White*,¹³⁰ the Kentucky Court of Appeals reversed the circuit court’s finding that an arbitration clause was void due to lack of capacity when a patient had previously been diagnosed with Stage III lung cancer and recently undergone a tracheostomy procedure. The Court of Appeals concluded that the record evidenced the patient was very ill, but that alone does not equate to lack of capacity to enter a contract.¹³¹ The Court distinguishes *White* from *Pikeville Med. Ctr. Inc. v. Bevins*.¹³² In *Bevins*, the Court of Appeals affirmed the circuit court’s denial of a motion to compel arbitration because the patient was deemed to lack capacity to enter into a complex arbitration agreement at the patient’s admission to the hospital.¹³³ The Court distinguishes these two cases by stating, “if substantial evidence supports a lack of capacity, a finding of lack of capacity *could* be sustained.”¹³⁴ A lack of capacity defense is determined at the discretion of circuit courts. Therefore, while a lack of capacity defense may be reasonable, because it is at the discretion of the court, it is not necessarily a reliable defense to avoid a motion to compel pre-treatment arbitration clauses.

125. Autumn Smith, *You Can’t Judge Me: Mental Capacity Challenges to Arbitration Provisions*, 56 BAYLOR L. REV. 1051, 1055 (2004).

126. *Id.* at 1056.

127. *Id.*

128. See 5 WILLISTON ON CONTRACTS § 10.8 (4th ed. 2017).

129. *Id.*

130. *Kindred Hosps. Ltd. P’ship v. White*, 2017 WL 4464339 (Ky. Ct. App. Oct. 6, 2017).

131. *Id.* at *3 (The circuit court based its conclusion on seven reasons: “1) Medical records indicating that the patient was awake and alert when she executed the agreement does not necessarily support she had contractual capacity to enter into the arbitration agreement at that time; 2) The patient’s prescription glasses had been misplaced; 3) The patient was alone and had no family members to assist her; 4) The patient was administered pain medications including oxycodone; 5) It was late at night; 6) The patient had been diagnosed with Stage III lung cancer and had recently undergone a procedure in which she was subjected to the insertion of a metal tracheostomy tube; and 7) The patient was unable to speak”).

132. *Pikeville Med. Ctr., Inc. v. Bevins*, 2014 WL 5420002 (Ky. Ct. App. Oct. 24, 2014).

133. *Id.* at *1. (Holding that an individual who was very sick at the time of his admission yet who was deemed capable of providing responses to questions regarding the course of medical treatment, *could* nonetheless be deemed incapable of reviewing and signing a complex contract in which he would be agreeing to waive a number of substantive rights).

134. *Kindred Hosps. Ltd. P’ship*, at *7 n.3.

V. CONCLUSION

As the healthcare crisis continues to develop, health providers will attempt to lower expenses at any cost. Many health providers view arbitration clauses as a cost-saver for medical malpractice claims. Therefore, physicians and hospitals are discretely placing pre-treatment mandatory arbitration clauses in patient intake contracts. Arbitration clauses are becoming more common and could become an accepted practice in the medical field, without patient awareness until after a dispute arises.

In the healthcare context, patients signing a contract with an arbitration clause are often the weaker party and have not yet envisioned the possibility of future medical malpractice disputes arising. Pre-treatment mandatory arbitration becomes fundamentally unjust when patients' rights are inconspicuously taken during vulnerable times. Reforms must take place to protect patients.

Despite the Supreme Court's holding in *Marmet Health Care Center, Inc. v. Brown*¹³⁵ that prohibits states legislatures from implementing laws that make pre-disputed arbitration clauses in personal injury or wrongful death claims unenforceable, Congress and state legislatures should pass legislation to protect patients. Congress could prohibit mandatory, pre-treatment, binding arbitration clauses based on concerns of public policy. Further, state legislatures could pass legislation that ensures meaningful consent is given during execution of contracts containing mandatory arbitration. Lastly, educating the public and mandating physicians and hospital systems to give adequate notice of pre-treatment mandatory arbitration clauses contained in patient intake contracts can help patients make meaningful choices in selecting a physician or a hospital system.

At some point all individuals rely on medical care from a physician or a hospital system. Dependence on physicians and hospital systems is critical to individuals' well-being. It is vital that the legal system protects vulnerable patients and provides a fair and impartial forum for redress when medical malpractice claims arise.

135. *Marmet Health Care Ctr., Inc. v. Brown*, 565 U.S. 530 (2012).