HEALTH CARE REFORM
Will It Impact ADR?

By Jerry P. Roscoe

ADR flourished during the last three decades not only because it was promoted by such luminaries as Roger Fisher and Frank Sander, but also because it made sense in industries and judiciaries where the transaction costs of managing conflict often outweighed the value of the underlying disputes. Not so with health care. The unique structure of our health care delivery system, where information flow is channeled vertically ("siloed") or is impeded by horizontal stratification ("layered"), has slowed awareness of the opportunities for ADR use. It is not uncommon for the health care delivery system to be referred to as "the last bastion" of ADR consumers.

The last 10 years have witnessed an evolution, but not a revolution. ADR provider organizations, including the American Arbitration Association (AAA), JAMS, and the International Institute of Conflict Prevention and Resolution (IICPR) developed health care specialty panels to assure ADR users that the ADR profession offered neutrals with subject matter experience. Health-care-related organizations, notably the American Health Lawyers Association (AHLA), developed their own arbitration and mediation programs to meet the perceived need of neutrals with subject-matter expertise. These organizations market ADR to the health care delivery system and have been largely responsible for a steady increase in the use of arbitration and mediation to resolve health care disputes. At the same time, medical institutions have developed independent, in-house ADR mechanisms to manage internal conflict as well as take advantage of the value of apology and information exchange in the event of adverse outcomes.

Recent legislative efforts at health care reform may write a new chapter in ADR's relationship with health care delivery. Although no one can be certain how, the author queried an array of experts with decades of experience in health care law—Stephen E. Ronai, chairman of the Health Care Department at Murtha Cullina in New Haven, Connecticut; Jim Henry, former head of CPR, the Center for Public Resources; and Peter Leibold, the executive vice president and chief executive officer of the AHLA—for their perspectives on ADR's foray into this country's health care delivery system and their perspectives on major issues Congress faces as it considers health care reform.

Jerry Roscoe: Why hasn't ADR in health care developed more rapidly?

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Jim Henry: Health care is subject to a large and diverse range of conflict. Unfortunately, pervasive inertia, ignorance, and strong economic disincentives prevent ADR from being recognized for its potential to reduce costs and achieve better outcomes for health providers and consumers. In 1995, a task force assembled by CPR and the American Hospital Association published an outstanding manual on ADR use in the health care sector.[1] In the intervening years, models of ADR use that demonstrate the potential of ADR have been developed by different health institutions as well as the ADR sector. So far, however, the reduction of the enormous direct and indirect costs of conflict remains an ancillary topic in health care reform—if raised at all. What was called a "quiet revolution" 20 years ago is still pretty quiet.

JR: Where has the need for ADR in health care arisen?

Stephen E. Ronai: Primarily in pursuit of the goals of patient safety, delivery of high-quality patient care, and adequate and timely reimbursement for services performed. The four prevalent areas of controversy include claims over alleged adverse outcomes; disputes between payors and providers over whether medical necessity justifies coverage and cost; disagreement regarding the amount and accuracy of the payers' reimbursements; and finally, controversy over the credentialing of providers and its relationship to patient care and dissatisfied patients.

Peter Leibold: I agree. The American health care system is conductive to alternative dispute resolution because there are millions of transactions every year not only between consumers and providers and payors, but also between the providers and payors with regard to rates, delays, and medical necessity. Neither side necessarily wants these grievances aired publicly. The same is true of physician practices that have disputes with physicians who depart before their contractually obligated period to set up a competing venture. The AHLA's dispute resolution service handles all of these types of disputes.

JH: Steve and Peter have answered the question well. My own concern is that, as the political negotiations on health reform have been centered on the important subject of inclusion in health care of millions more, together with the well-financed issues of commercial interests, the subject of health care costs, and particularly the direct and indirect costs of conflict, will get meager attention, if any. Thus, I believe that it remains for the ADR sector to undertake a proactive initiative to develop the analysis and a platform to gain sound attention to ADR as a tool of reform.

JR: But aren't there other factors as well?

SR: Yes, several. Overutilization of health services, the cost impact of the new regulatory limitations and sanctions on physicians and hospitals, the intensive competitiveness within the health care provider and payor environment, the hierarchical structure of health care service entities that help create the status of dominating and "disruptive" physicians, and the attitude of perfection exhibited by many clinicians who are trained to "never make mistakes."

Finally, the Joint Commission's January 1, 2009, mandatory directive that hospitals adopt informal conflict management programs will result in a need for neutrals as well as training in managing conflict.

JH: The AHA-CPR manual divided health care disputes into five broad categories: coverage disputes, bioethical disputes, disaffiliation, general business disputes, and workforce conflicts. One area of conflict that should not be neglected is malfeasance and the potential for the use of ADR systems and practices in the courts and privately.

Litigation is a flawed process to deal with the direct and significant indirect costs of malpractice disputes. Equally important, and largely ignored, is the fact that the prohibitive costs to retain lawyers to litigate malpractice suits prohibit many, if not most, proper grievances from being justly pursued.

The judiciary and court bureaucracy are often poorly equipped to manage the growing number of large class actions where neutrals have proved to be effective in managing and gaining resolution. In this era of accelerating technological and scientific change, ADR and qualified neutrals have an important role to play in avoiding costly delay and poor results.

PL: It is not only the structure of health care that creates so many disputes—it is also the nature of health care. The reason that ADR makes so much sense is because of its emphasis on maintaining relationships and keeping disputes confidential. In health care, there are numerous disputes between participants who had had, and need to continue to have, strong relationships. On the consumer side, the patient/provider relationship is more than an arm's-length transaction. People have formed relationships with their providers when they are most vulnerable. Unless something really negative has happened, people prefer to rehabilitate those relationships rather than cut them off.

The same is true on the commercial side. Specifically, hospitals in disputes with physicians want resolution but want also to maintain a strong and congenial relationship. These providers and professionals are mutually dependent on one another to achieve success. The same is true of providers and payors in a certain community. At times, a physician or a hospital does not have multiple health plans with which to contract for services. Therefore, if there is a dispute, both sides want to settle it quickly and privately because the structure of the local health care economy means that they must continue to work with one another on an amicable basis.

SR: And there are clear examples of disputes that have developed over the differing understandings of regulatory or statutory language: for example, conflicts over the definition of *hospital* and *hospital-based physician* under a provision of the American Recovery and Reinvestment Act. There are also disputes over the

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Centers for Medicare and Medicaid Services (CMS) rules for Medicare provider service "never events" payment reductions for provision of health care services that "never should have happened."

CMS's requirement that hospitals report categories of "hospital acquired conditions" also creates conflict. CMS will contest some hospital reimbursement claims that may involve a posthospital discharge and a subsequent readmission for further treatment of a condition related to the original treatment. There have been disputes over Medicare's pay-for-performance patient care reimbursement payments, which the hospital claims should be increased due to the improved patient care that conforms to standardized patient care diagnostic and treatment quality procedures.

PL: Steve makes excellent points related to the surge in disputes that will result from recent federal, state, and accreditation organization activity in the health care arena. I would only elaborate by pointing out that in the payment and regulatory area, the federal government's actions often provide a road map for private payors. Therefore, Steve's point about Medicare rules on "never events" leading to significant disputes is correct. Private payors have already initiated their own programs to withhold payment for never events. Thus, the federal government's action will not only lead providers to have disputes with CMS, but it will also lead to significantly more disputes between providers and private payors as private payors institute never-event policies of their own.

The same can be said of CMS's requirements on hospital-acquired conditions. Private payors will look to that requirement as a model, and the disputes that arise between public and private will be multiplied when the dispute is private to private. And for all the reasons stated earlier, both payors and providers will have an incentive to resolve those disputes quickly and privately.

JR: What ADR opportunities will health care reform create?

JH: The Senate bill to date seems to call for the organization of an independent commission to recommend certain procedures for subsequent approval by Congress. As a practical matter, a good way to implement ADR procedures throughout the reform is for Congress to endorse the broad experimentation with ADR procedures and protocols throughout the health care system (in the style of the Reform Act of 1967) and leave to a similar commission to craft recommendations drawing on existing models and experience that fit different conflicts throughout the health system. At that point, the ADR sector can make an important contribution in analyzing and developing appropriate systems and practices.

PL: Simply increasing coverage by millions of people, introducing mandates, and reallocating a finite number of dollars is a recipe for more disputes—the perfect storm. A major emphasis of the bill is eliminating waste, and that will surely cause targets to push back and protest that certain costs are essential and not wasteful.

The proposed legislation is expected to reduce the growth in Medicare and Medicaid expenditures by roughly $500 billion over 10 years. If, as I alluded to before, private payors adopt Medicare's payment methodologies, there are likely to be increased payment disputes between payors and providers. ADR would be ideal to resolve such disputes over payment. If the federal government employs new payment mechanisms like bundling, which would pay a lump sum to a particular entity for an episode of care, various business-to-business disputes will arise as the lump sum is divided between the different participants in the health care system. ADR would be an effective way to address the disputes that will arise in this context.

The federal government is also expected to be more aggressive in its use of bonuses and penalties in an effort to promote quality among providers. If the private sector adopts similar methodologies, one can expect numerous conflicts over whether the quality mechanisms and the bonuses or penalties have been applied correctly. These disputes emerge in the context of ongoing relationships. Therefore, ADR will serve both parties more effectively than the judicial system.

SR: One of the most popular reform provisions would bar insurers from using a subscriber's preexisting clinical condition to deny coverage. Another provision would prohibit imposition of an annual or lifetime cap on benefits. The legal definition of the term *preexisting condition* has already fostered many disputes. This is sure to open up the ADR health care process to many more health benefit policy terminations. Denial of care coverage based on preexisting conditions will surely continue as recurring conflict.

A pilot program provision provides for incentive payments to states that enact alternative medical liability laws that make the medical liability system more reliable through prompt and fair resolution of disputes. More ADR procedures are likely to evolve from state-based liability systems.

PL: I agree. There will be a proliferation of disputes perfect for ADR, particularly over the meaning of the insurance market reforms in the current bill. One of the principal purposes of the legislation is to reduce or eliminate the practice of underwriting. The Senate and House bills contain different provisions, and there will be a significant number of disputes over what the underwriting and rate factor provisions mean and how to apply them.

I also believe that there will be disputes in the application of the pilot projects related to accountable care organizations and bundling. The projects will have precedential value as the federal government studies and emulates them, particularly in the areas of reimbursement and cost containment systems. ◆

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