

11-1-2010

Between a Rock and a Hard Place: The Plight of Health Care Arbitration Agreements Under Federal Law

James C. Dunkelberger

Follow this and additional works at: <https://digitalcommons.law.byu.edu/lawreview>

 Part of the [Dispute Resolution and Arbitration Commons](#), and the [Health Law and Policy Commons](#)

Recommended Citation

James C. Dunkelberger, *Between a Rock and a Hard Place: The Plight of Health Care Arbitration Agreements Under Federal Law*, 2010 BYU L. Rev. 1869 (2010).

Available at: <https://digitalcommons.law.byu.edu/lawreview/vol2010/iss5/9>

This Note is brought to you for free and open access by the Brigham Young University Law Review at BYU Law Digital Commons. It has been accepted for inclusion in BYU Law Review by an authorized editor of BYU Law Digital Commons. For more information, please contact hunterlawlibrary@byu.edu.

Between a Rock and a Hard Place: The Plight of Health Care Arbitration Agreements Under Federal Law

I. INTRODUCTION

During the national health care reform debate that gripped the United States in 2009, President Barack Obama addressed the American Medical Association. Speaking of a number of proposed reforms, President Obama stated, “Now, I recognize that it will be hard to make some of these changes if doctors feel like they’re constantly looking over their shoulders for fear of lawsuits.”¹ After describing a number of proposals to reform medical malpractice, the President wrapped up the subject by stating, “So this is going to be a priority for me. And I know, based on your responses, it’s a priority for you. . . . But all this stuff is going to be difficult. All of it’s going to be important.”²

One element of the doctor-patient relationship that has not received much attention in the recent health care reform frenzy is the use of medical arbitration agreements. Arbitration is a form of alternative dispute resolution whereby parties select one or more unofficial persons to resolve a disputed matter instead of resorting to a judicial proceeding.³ An arbitration agreement is essentially a contract to arbitrate, and no party can be required to arbitrate a claim unless that party has agreed to submit to arbitration.⁴ By agreeing to arbitration, parties trade the procedural safeguards available in the courtroom for the “simplicity, informality, and expedition of arbitration.”⁵ Thus, as with all contracts, arbitration agreements are a way that parties allocate rights between themselves. The extent to which such agreements are enforceable—whether

1. Press Release, Office of the Press Secretary, Remarks by the President at the Annual Conference of the American Medical Association (June 15, 2010) (on file with author).

2. *Id.*

3. 4 Am. Jur. 2d *Alternative Dispute Resolution* § 2 (2010).

4. *Id.* §§ 2, 46.

5. *Id.* § 2.

under the common law or state statutes—can have important implications for the parties' relationship.

Lawmakers and judges are increasingly recognizing arbitration agreements as an important and evolving area of medical malpractice law. This Comment will discuss the delicate balance that policy-makers and judges have forged between stemming the tide of frivolous medical malpractice cases and doing justice for the wronged patient.⁶ In doing so, it will explore Utah's Health Care Malpractice Act ("UHCMA")⁷ as a convenient case study of this balancing act. Although politically controversial,⁸ the UHCMA represents a common state-law practice of codifying provisions governing the enforceability of arbitration agreements.⁹ At the same time, the

6. For a thorough review of the relative merits of arbitration for doctors and patients, see, e.g., Stanley A. Leasure & Kent P. Ragan, *Arbitration of Medical Malpractice Claims: Patient's Dilemma and Doctor's Delight?* 28 MISS. C. L. REV. 51, 57–58 (2009); Kenneth A. DeVille, *The Jury is Out: Pre-Dispute Binding Arbitration Agreements for Medical Malpractice Claims*, 28 J. LEGAL MED. 333, 356–62 (2007). Although the various policy considerations inherent in arbitration are beyond the scope of this Comment, a perusal of the cited portions of the articles above reveals no clear answer as to which party medical arbitration will favor. The truth is most likely that both doctors and patients make trade-offs when it comes to arbitration. Sorting through these competing interests must therefore fall squarely on state legislatures. An examination of the FAA and the MFA in this Comment will reveal that the more explicit the legislative findings concerning the aims and purposes behind these state statutes, the better.

7. UTAH CODE ANN. § 78B-3-421 (2008).

8. As discussed below, the current UHCMA represents enormous effort on the part of legislators, medical industry lobbyists, and patients' rights groups to work out a tenable compromise. See Greg Burton, *IHC Policy Gets an Earful*, SALT LAKE TRIB., Nov. 29, 2003, at A1 (reporting public outcry to arbitration policies enacted by Utah's largest health care provider, IHC); Lois M. Collins, *Doctors Turn to Arbitration*, DESERET NEWS, Oct. 14, 2003, at B01 (discussing various justifications advanced by doctors for their increased use of arbitration agreements); Lois M. Collins, *Arbitration Foes Rally to Protect IHC Policy*, DESERET NEWS, Dec. 24, 2003, at B01 ("The debate on medical arbitration has heated up considerably since IHC's physician group sent out letters to its patients telling them if they think a doctor harms them they must settle it in arbitration rather than the court system."); Carey Hamilton, *Protestors: Arbitrate This, IHC!*, SALT LAKE TRIB., Dec. 3, 2003, at C1.

9. See, e.g., ALA. CODE § 6-5-485 (LexisNexis 2005); ALASKA STAT. § 09.55.535 (2008); CAL. CIV. PROC. CODE § 1295 (West 2007), *limited on constitutional grounds by* Rodriguez v. Superior Court, 176 Cal. App. 4th 1461 (2009); COLO. REV. STAT. ANN. § 13-64-403 (West 2005) (discussed in the reverse preemption context below); FLA. STAT. ANN. § 766.207 (West 2005); 710 ILL. COMP. STAT. ANN. § 15/9 (West 2007); KY. REV. STAT. ANN. § 417.050 (LexisNexis 2005), *limited on preemption grounds by* In re Transport Associates, Inc., 263 B.R. 531, 533 (Bankr. W.D. Ky. 2001); LA. REV. STAT. ANN. § 9:4231 (2009); MICH. COMP. LAWS ANN. § 600.2912g (West 2000); MISS. CODE ANN. § 11-15-1 (2004); N.J. STAT. ANN. § 2A:23A-20 (West 2010); N.Y. PUB. HEALTH LAW § 4406-a (McKinney 2002); N.C. GEN. STAT. § 90-21.60 (2009); OHIO REV. CODE ANN. § 2711.23 (LexisNexis

Federal Arbitration Act (“FAA”) preempts state laws that restrict the enforceability of arbitration agreements or place them on different “footing” than other contracts.¹⁰ Some state courts, facing the preemption question, have concluded that the McCarran-Ferguson Act (“MFA”)¹¹ will “reverse preempt” the FAA and allow states to legislate in this area.¹² There are, however, logical inconsistencies in extending the MFA—originally enacted to address insurance regulation—to medical arbitration agreements. Hence, this Comment will ultimately argue that, in view of existing problems and inadequate alternatives, Congress should amend the FAA to exempt pre-dispute medical arbitration agreements from FAA preemption.

Very little of the scholarly discussion surrounding arbitration examines specific state statutes and their consistency with current federal law. Accordingly, this Comment fills a gap in the literature by demonstrating how the UHCMA and other state statutes run afoul of the FAA and discusses why preemption is often misunderstood or ignored by courts, legislatures, and commentators. Part II of this Comment will examine portions of the UHCMA in some detail and discuss a Utah appellate case that will factor into the FAA and MFA analysis in later Parts. Part II will also compare the UHCMA to a number of different statutes in other states containing similar provisions. Part III will then discuss the FAA and relevant federal and state cases that address the issue of preemption and highlight some of the problems with state statutes under current federal law, identifying, in addition to Utah’s statute, at least eight statutes that

2008); R.I. GEN. LAWS § 10-3-2 (1997); S.D. CODIFIED LAWS § 21-25B-3 (2004); TENN. CODE ANN. § 29-5-101 (2000); VT. STAT. ANN. tit. 12, § 7002 (2002); VA. CODE ANN. § 8.01-581.12 (2007); *see also* Fillmore Buckner, *A Physician’s Perspective on Mediation Arbitration Clauses in Physician-Patient Contracts*, 28 CAP. U. L. REV 307, 319–20 (2000) (offering practical advice for physicians implementing arbitration agreements either under specific state health care arbitration statutes or the state’s version of the Uniform Arbitration Act).

10. *EEOC v. Waffle House, Inc.*, 534 U.S. 279, 289 (2002) (reasoning that Congress enacted the FAA to “place arbitration agreements upon the same footing as other contracts”).

11. 15 U.S.C. §1012(b) (2006). The MFA mandates that state law controls where it is passed for “the purpose of regulating the business of insurance.” *Id.*

12. *See infra* Part IV.C.

should be preempted under the FAA.¹³ Part IV then identifies three reasons for the current confused state of the law, offering a detailed look at the MFA and a critique of reverse preemption in this context. Finally, Part V offers a brief conclusion.

II. ARBITRATION UNDER STATE LAW

Setting forth statutory enforceability standards for arbitration agreements is a dynamic and evolving approach, both on a state and national level. This Part will first briefly discuss unconscionability, which represents a common approach to regulating medical malpractice arbitration agreements in the absence of statutory provisions. It will then examine Utah's statutory alternative, the UHCMA, which sets forth a codified standard for enforceability. It will also discuss a Utah appellate case that explores the policies underlying the Utah arbitration provisions and provides background for some of the analysis in the following Parts. Finally, this Part examines provisions from a number of other states in order to demonstrate a crucial comparative link between the UHCMA and other statutory regimes.

A. Unconscionability: Utah's Conceptual Precursor to Arbitration Statutes

Because courts often look to common law contract defenses such as unconscionability where no state statute specifically regulates the enforceability of arbitration agreements, these defenses are an important element of arbitration agreement enforceability. In the doctor-patient context, almost all challenges to arbitration agreements arise from a doctor's efforts to compel arbitration under an agreement previously signed by a patient. Understanding the common law defenses asserted by patients is key to understanding why legislatures, seeking to balance the equities between doctors and patients, might favor a statutory alternative.

13. ALASKA STAT. § 09.55.535 (2008); CAL. CIV. PROC. CODE § 1295 (West 2007); COLO. REV. STAT. ANN. § 13-64-403 (West 2005); N.C. GEN. STAT. § 90-21.60 (2009); OHIO REV. CODE ANN. § 2711.23 (LexisNexis 2008); N.Y. PUB. HEALTH LAW § 4406-a (McKinney 2002); S.D. CODIFIED LAWS § 21-25B-3 (2004); VT. STAT. ANN. tit. 12, § 7002 (2002).

To illustrate one such case, consider *Sosa v. Paulos*, Utah's seminal decision on unconscionability.¹⁴ In *Sosa*, the Utah Supreme Court refused to enforce an arbitration agreement where the patient signed the agreement, along with two other documents, less than an hour before her scheduled surgery when she was already dressed for the procedure.¹⁵ The patient claimed that she felt "rushed and hurried" by the process and did "not realistically contemplate postponement or cancellation [of her procedure] at that late stage."¹⁶ The physician argued that no one told the patient that she was required to sign the document to proceed to surgery and that the patient had all the time that she needed to read the documents and ask any questions that she had.¹⁷ The court held that the agreement was procedurally unconscionable and, ultimately, unenforceable.¹⁸ After identifying six factors relevant to procedural unconscionability,¹⁹ the court reasoned that the arbitration

14. *Sosa* is commonly cited by commentators nation-wide in their discussion of unconscionability doctrine. See, e.g., Robert S. Adler & Elliot M. Silverstein, *When David Meets Goliath: Dealing with Power Differentials in Negotiations*, 5 HARV. NEGOT. L. REV. 1, 45 n.173 (2000) (noting that *Sosa* stands for the proposition that "procedural unconscionability, if extreme, can nullify contract term which is not substantively unconscionable"); Lucian A. Bebchuk & Richard A. Posner, *One-Sided Contracts in Competitive Consumer Markets*, 104 MICH. L. REV. 827, 829 n.8 (2006); Kenneth R. Davis, *The Arbitration Claws: Unconscionability in the Securities Industry*, 78 B.U. L. REV. 255, 284 n.176, 291 n.219 (1998); Paul Bennett Marrow, *Squeezing Subjectivity from the Doctrine of Unconscionability*, 53 CLEV. ST. L. REV. 187, 204 (2006) ("*Sosa v. Paulos* illustrates the lengths that a court will go to impose its views about public policy.") (footnote omitted); David G. Wirtes, Jr., *Suggestions for Defeating Arbitration*, 24 AM. J. TRIAL ADVOC. 111, 139-40 n.114 (2000) (suggesting unconscionability factors that may bear on whether an arbitration agreement may be enforced); Carol A. Crocca, Annotation, *Arbitration of Medical Malpractice Claims*, 24 A.L.R. 5th 1 (2010) (discussed in a supplemental update covering contracts not governed by statute); 17 C.J.S. *Contracts* § 151 (Supp. 2009).

15. 924 P.2d 357, 362-63 (Utah 1996).

16. *Id.* at 362.

17. *Id.*

18. *Id.* at 364-65.

19. *Id.* at 362. The six factors are as follows:

(1) whether each party had a reasonable opportunity to understand the terms and conditions of the agreement; (2) whether there was a lack of opportunity for meaningful negotiation; (3) whether the agreement was printed on a duplicate or boilerplate form drafted solely by the party in the strongest bargaining position; (4) whether the terms of the agreement were explained to the weaker party; (5) whether the aggrieved party had a meaningful choice or instead felt compelled to accept the

agreement was not negotiated in a fair manner and that the patient did not have a meaningful choice regarding whether to sign.²⁰ The court further reasoned that the physician could have taken the time to discuss the agreement with the patient prior to the surgery to give her a “somewhat reasonable opportunity to understand the terms and conditions of the agreement.”²¹ Instead, a staff person gave the patient the document without explanation when the patient was already dressed and nervous about the surgery. Although parties to a contract usually have a duty to read and understand a contract before signing it, “that duty is obviated when the party’s failure to read the agreement results from the . . . behavior of the party in the stronger bargaining position.”²²

The result in *Sosa* is by no means typical. Rather, as one court noted, of all cases where courts consider whether unconscionability may defeat an otherwise valid arbitration agreement, “[m]ost have rejected the claim.”²³ Nevertheless, *Sosa* is important in illustrating one way that state contract law may operate to defeat an arbitration agreement.²⁴ In Utah, courts have express statutory authority to “decide whether an agreement to arbitrate exists or [whether] a controversy is subject to an agreement to arbitrate.”²⁵ However, as the next section illustrates, since *Sosa*, the Utah legislature has

terms of the agreement; and (6) whether the stronger party employed deceptive practices to obscure key contractual provisions.

Id. (internal citations omitted). These factors are among those used by other courts in considering procedural unconscionability, even in cases where the court ultimately finds the agreement enforceable. *See, e.g.*, *Cleveland v. Mann*, 942 So.2d 108, 114 (Miss. 2006); *see also*, *Leasure & Ragan*, *supra* note 6, at 58–60 (discussing *Mann* and *Sosa* to contrast cases in which state courts reached opposite results on procedural unconscionability in medical malpractice arbitration cases).

20. *Sosa*, 924 P.2d. at 363.

21. *Id.*

22. *Id.*

23. *See In re Conseco Fin. Servicing Corp.*, 19 S.W.3d 562, 570 n.3 (Tex. App. Waco 2000) (citing *Sosa* among a number of cases dealing with procedural unconscionability).

24. Unconscionability is one way that arbitration agreements are commonly invalidated notwithstanding the FAA’s strong presumption in favor of arbitration agreement validity. *See* 9 U.S.C. § 2 (2006); *see also* UTAH CODE ANN. § 78B-11-107(1) (2008) (expressly incorporating the language from section 2 of the FAA that an agreement to arbitrate is “valid, enforceable, and irrevocable *except upon a ground that exists at law or in equity for the revocation of a contract*”) (emphasis added).

25. UTAH CODE ANN. § 78B-11-107(2).

enacted a comprehensive guide for courts, setting out requirements for enforceable arbitration agreements.

B. Statutory Framework of the Utah Health Care Malpractice Act

The Utah Legislature passed the UHCMA in response to a growing number of health care suits and the increasing amount of the settlements in the years leading up to its passage.²⁶ It contains numerous provisions, of which sections 78B-3-402 (“Findings”) and 78B-3-421 (“Arbitration Provisions” or “Section 421”) are most relevant to this Comment.

1. Findings: The legislative purposes of the Utah Health Care Malpractice Act

The findings and purposes behind the UHCMA can be broken into three parts. First, the legislature found that the growing number of claims and amount of awards had increased the cost of malpractice insurance, which had in turn increased health care costs by forcing physicians to practice defensive medicine and to pass the costs of increased premiums on to patients. Second, the legislature found that protecting the public interest required measures “designed to encourage private insurance companies to continue to provide health-related malpractice insurance.”²⁷ Finally, the legislature stated that its purpose was to “provide a reasonable time in which actions may be commenced against health care providers while limiting that time to a specific period for which professional liability insurance premiums can be reasonably and accurately calculated; and to provide other procedural changes to expedite early evaluation and settlement of claims.”²⁸

These legislative findings and purposes are important for a number of reasons. Perhaps the most important is that they demonstrate a clear legislative pronouncement of the policy considerations that the Utah legislature has chosen to favor. This will become important in the discussion below, as both the preemption

26. *Id.* § 78B-3-402(1).

27. *Id.* § 78B-3-402(2).

28. *Id.* § 78B-3-402(3). This subsection presumably references UTAH CODE ANN. § 78B-3-404, which sets the statute of limitations for a health care malpractice claim.

and reverse preemption analysis calls for some inquiry into legislative purpose.²⁹

2. Arbitration Provisions: Requirements for enforceable arbitration agreements under the UHCMA

A physician that employs a pre-dispute arbitration agreement in compliance with section 421 must inform a patient, in writing, of the procedural requirements and substantive rights under the agreement.³⁰ The agreement requires that a panel of three arbitrators hear any dispute.³¹ In a dispute, one arbitrator is chosen: (1) collectively by all persons claiming damages, (2) by the health care provider, and (3) jointly by the health care provider and all persons claiming damages.³² If the parties cannot agree as to the third arbitrator, the other two arbitrators jointly select the third from a list of approved arbitrators in Utah's state and federal courts.³³ The statute also provides that a single arbitrator may hear the dispute, if all parties agree.³⁴ The health care provider must also inform the patient of his or her responsibility for any "arbitration-related costs under the agreement."³⁵ The agreement has a one-year term and will be automatically renewed each year unless either party cancels it in writing.³⁶

Section 421 also grants the patient a number of rights that must be included in any enforceable agreement. For example, the agreement must give the patient the right to rescind it within ten days of signing.³⁷ The patient also has the right to retain legal counsel and to make other procedural requests, including mandatory mediation.³⁸ Further, the health care provider must verbally encourage the patient to read the information required under the

29. *See infra* Part IV.

30. *See* UTAH CODE ANN. § 78B-3-421(1)(a).

31. *Id.* § 78B-3-421(1)(b)(i).

32. *Id.* §§ 78B-3-421(1)(b)(i)(A)–(C).

33. *Id.* § 78B-3-421(1)(b)(i)(C).

34. *Id.* § 78B-3-421(1)(b)(ii).

35. *Id.* § 78B-3-421(1)(a)(iii).

36. *Id.* § 78B-3-421(1)(b)(v).

37. *Id.* § 78B-3-421(1)(b)(iv).

38. *Id.* §§ 78B-3-421(1)(b)(vi), (2)(b)(i).

statute and ask any questions the patient might have about his or her rights under the agreement.³⁹

Finally, the health care provider may not deny health care to a patient solely because he or she refuses to be bound by an arbitration agreement.⁴⁰ This last provision is probably the most important in the overall preemption analysis. It represents a series of amendments and policy decisions made by lawmakers in response to health care lobbyists and patients' rights groups. In 2003, the Utah legislature amended the original UHCMA to give health care providers the right to deny non-emergency care to anyone who refused to sign an arbitration agreement.⁴¹ This amendment sparked immediate public outcry, which was exacerbated after Intermountain Health Care—Utah's largest health care provider—put mandatory arbitration into effect.⁴² The issue was revisited a year later, and “after months of political posturing by health care providers, patients, lawyers, and politicians,” the Arbitration Provisions were revised to their current form.⁴³ This was seen as a “compromise,” with providers giving up mandatory arbitration, but no longer being required to inform patients of their rights by verbal explanation, and requiring that doctors give patients only ten days to rescind the agreement, rather than thirty.⁴⁴ These policy choices by lawmakers play an important role in subsequent cases interpreting section 421 and also will factor into the preemption dilemma discussed in later parts of this Comment.

3. *Retroactivity of Section 421 and Soriano v. Graul*

*Soriano v. Graul*⁴⁵ is one of the few reported cases in which Utah appellate courts have interpreted the language and scope of section 421. This case, by deciding the question of section 421's

39. *Id.* § 78B-3-421(1)(c).

40. *Id.* § 78B-3-421(3).

41. Medical Malpractice Amendments, 2003 Utah Laws 925; see Brian P. Rosander, *Medical Arbitration in Utah: A Plea for Greater Fairness and Equal Bargaining Positions*, 2005 UTAH L. REV. 969, 974–75.

42. Rosander, *supra* note 41, at 976.

43. *Id.* at 976–77.

44. *Id.* at 977.

45. 186 P.3d 960 (Utah Ct. App. 2008).

retroactivity, gives some insight into the various policy concerns surrounding health care arbitration. In *Soriano*, the Utah Court of Appeals held that an arbitration agreement was unenforceable where its provisions did not reflect certain requirements passed by the Act's 2004 amendment.⁴⁶ The patient and doctor in that case had entered into the agreement before the 2004 amendments were signed.⁴⁷ The doctor argued that because the statute did not expressly use the term "retroactive," the additional requirements did not apply and the agreement should be enforced.⁴⁸ The court rejected this argument and held that the underlying statute's clear statement that it applies to agreements made "after May 2, 1999" demonstrated clear legislative intent to apply any future amendments retroactively to that date.⁴⁹ The court further buttressed this reasoning with a number of exchanges between then Representative Steve Urquhart and other legislators during the floor debates on the 2004 amendments.⁵⁰ When asked about retroactivity, Representative Urquhart first stated that he did not know whether the amendments would apply retroactively, but after further questioning, he claimed that they would.⁵¹

The court did acknowledge two potential weaknesses in its reasoning: namely, that the 2002 amendments of section 421 also contained the "after May 2, 1999" language, and that Representative Urquhart's responses were inconsistent.⁵² Nevertheless, the court concluded that the underlying statute's language and Representative Urquhart's statements, taken together, made up the requisite legislative intent to apply the amendment retroactively, notwithstanding the legislature's failure to use the term

46. *Id.* at 964. As discussed above, the language of the 2003 version of § 421 reserved patients the right to refuse arbitration agreements and still receive treatment only in the "emergency department of a general acute hospital." See Medical Dispute Resolution Amendments, 2004 Utah Laws 318 (omitting restrictive language).

47. *Soriano*, 186 P.3d at 961.

48. *Id.* at 962.

49. *Id.* (emphasis omitted).

50. *Id.* at 963–64.

51. *Id.* at 963.

52. See *id.* at 962–63 n.1, 963–64.

“retroactive”⁵³ and the general rule that no statute is retroactive “unless expressly so declared.”⁵⁴

In so holding, the court did not utterly fail to address the potential logistical problems that retroactivity would raise, but it was unsympathetic towards physicians who would face those problems. The doctor had argued that retroactivity would be a hardship to practitioners “who see patients only one or two times and have few occasions to renew [or revise] their agreements.”⁵⁵ The court responded that “physicians were not precluded from contacting patients” for the purpose of entering into new agreements.⁵⁶

In addition, the court paid special attention to the policy surrounding the 2004 amendments. The specific provision at issue in *Soriano* required that the patient be informed that “he or she ‘may not be denied health care on the sole basis that the patient . . . refused to enter into a binding arbitration agreement with a health care provider.’”⁵⁷ The court pointed out that the amendment was passed as “a response to the public outcry requesting that the status of medical arbitration be changed from mandatory to voluntary.”⁵⁸

Soriano is an important demonstration of the Utah Court of Appeals’s conceptualization of arbitration. On the one hand, the entire UHCMA was apparently enacted for the purpose of lowering health care liability costs. On the other hand, the 2004 amendments implicated important patients’ rights. The court’s decision upheld patients’ rights notwithstanding shaky evidence of legislative intent for retroactivity and a general presumption against it. Hence, by upholding patient’s rights in the face of increased cost to physicians, *Soriano* illustrates how the UHCMA has stepped into the shoes of unconscionability and other contract defense doctrines. *Soriano* also shows the inherent tension within the UHCMA itself as the statute

53. *Id.* at 962.

54. *Id.* (quoting UTAH CODE ANN. § 68-3-3 (2004)). The language of the statute has changed since *Soriano* was decided. See UTAH CODE ANN. § 68-3-3 (Supp. 2010) (“A provision of the Utah Code is not retroactive, unless the provision is expressly declared to be retroactive.”).

55. *Soriano*, 186 P.3d at 964 n.3.

56. *Id.*

57. *Id.* at 964 (quoting UTAH CODE ANN. § 78B-14-17(3) (Supp. 2007), which has since been renumbered as § 78B-3-421(3)) (omission in original).

58. *Id.* at 961.

attempts to reconcile patient fairness with a pro-physician tort reform agenda. This conceptual dissonance is characteristic of many state arbitration statutes and will become very important in the MFA reverse preemption discussion below.⁵⁹

C. Statutory Provisions Outside Utah

While an exhaustive survey of state law in this area is beyond the scope of this Comment, it is important to note some key similarities between the Utah statute and others. Many of these statutes, like the UHCMA, have apparently attempted to protect patients' interests by inserting provisions meant to impose certain enforceability requirements on arbitration agreements. This may be problematic under the FAA, which protects the enforceability of arbitration agreements and will invalidate a conflicting state statute that singles out arbitration agreements for special restrictions on enforceability.⁶⁰ Thus, this subsection is meant to help place the UHCMA and various other state statutes on a spectrum according to the degree to which they restrict the enforceability of arbitration agreements. This will serve as the basis for the preemption discussion in Part III below.

While statutory approaches to arbitration vary widely among states, many states, like Utah, initially adopted mandatory arbitration in order to streamline the litigation process and decrease expenses.⁶¹ Thereafter, most amended their provisions to make arbitration voluntary.⁶² Some state provisions appear to apply both to voluntary,

59. *See infra* Part IV.C. For the purposes of this subsection, however, the resulting take-home lesson for legislators seeking to respond to constituents' concerns over mandatory arbitration is to be mindful of the practical implications of a proposed statute. Even something as seemingly benign as retroactivity may have important ramifications for parties seeking to enforce their agreement. This is especially true for physicians that use a standard agreement and either treat a high volume of patients or see patients only once or twice for a specialized procedure.

60. *Southland Corp. v. Keating*, 465 U.S. 1, 16 (1984).

61. *See* Florence Yee, Note, *Mandatory Mediation: The Extra Dose Needed to Cure the Malpractice Crisis*, 7 *CARDOZO J. CONFLICT RESOL.* 393, 409–11 (2006) (discussing the “rise and fall” of mandatory arbitration statutes).

62. *Id.* at 410. *See also* NATIONAL CONFERENCE OF STATE LEGISLATURES, *STATE MEDICAL MALPRACTICE TORT LAWS* (2004), available at <http://www.ncsl.org/print/standcomm/sclaw/tortchart04.pdf>. As of 2004, Alabama, Alaska, Arkansas, California, Colorado, Georgia, Iowa, Kentucky, Louisiana, Michigan, Mississippi, Montana, New Jersey,

pre-dispute arbitration agreements and to those agreements reached after the patient's claim arises.⁶³ Other provisions apparently apply only to one or the other. Recall the provision in Utah's section 421 mandating that a physician shall not deny medical services to a patient refusing to enter into an arbitration agreement.⁶⁴ Other states employ similar requirements. For example, the Alaska statute reads, "[e]xecution of an agreement under this subsection by a patient may not be made a prerequisite to receipt of care or treatment by the health care provider."⁶⁵ Ohio, South Dakota, and Colorado's statutes contain very similar language.⁶⁶ Such provisions make sense only if physicians are seeking to bind patients to an arbitration agreement before treating the patient.⁶⁷ Vermont and North Carolina's statutes take an even more direct approach. Although both the North Carolina and Vermont statutes allow for voluntary arbitration agreements after the patient's claim arises, they apparently forbid any pre-dispute agreement.⁶⁸

New York, Ohio, Rhode Island, South Dakota, Tennessee, Texas, Utah, Vermont, and Virginia all had voluntary arbitration provisions of one form or another.

63. NATIONAL CONFERENCE OF STATE LEGISLATURES, STATE MEDICAL MALPRACTICE TORT LAWS (2004), available at <http://www.ncsl.org/print/standcomm/sclaw/tortchart04.pdf>.

64. See UTAH CODE ANN. § 78B-3-421(3) (2008).

65. ALASKA STAT. § 09.55.535(a) (2008).

66. See COLO. REV. STAT. ANN. § 13-64-403(7) (West 2005); OHIO REV. CODE ANN. § 2711.23(A) (LexisNexis 2008); S.D. CODIFIED LAWS § 21-25B-3 (2004).

67. Often state statutes will simply fail to declare explicitly whether the statute's requirements apply to both pre-dispute arbitration agreements and those entered into after the claim arises. Thus, the reader is left to infer whether a given provision would apply based on the statutory language. For example, the Alabama statute reads, "After a physician, dentist, medical institution, or other health care provider has rendered services, or failed to render services, to a patient out of which a claim has arisen, the parties thereto may agree to settle such dispute by arbitration." ALA. CODE § 6-5-485(a) (LexisNexis 2005) (emphasis added). Thus, the statute apparently applies only to arbitration agreements signed once the claim arises. Other state statutes are similarly vague. See, e.g., UTAH CODE ANN. § 78B-3-421 (making no explicit mention of whether the statute applies equally to all agreements to arbitrate). But see ALASKA STAT. § 09.55.535 (providing that the section applies to both pre-dispute and post-claim arbitration agreements). Ultimately, however, whether or not a statute allows for pre-dispute agreements only makes a difference if the provision restricts the enforceability of an otherwise valid arbitration agreement. Such restrictions may run afoul the FAA, which will invalidate state laws that single out arbitration agreements for special, restrictive treatment. See *infra* Part III.B.

68. N.C. GEN. STAT. § 90-21.60 (2009) ("[A]ny contract provision or other agreement entered into prior to the commencement of an action that purports to require a party to elect

Many state statutes provide for patient cancellation of the arbitration agreement within a certain time. Many also include an expiration term. Among the statutes that include these terms, almost no two are alike.⁶⁹ Utah gives the patient ten days to decide whether to rescind the agreement.⁷⁰ By contrast, Illinois allows the patient to cancel the agreement within sixty days of signing it, or within sixty days of the patient's discharge from the hospital, whichever is later.⁷¹ Although Utah's section 421 provides for automatic renewal of the arbitration agreement from year to year,⁷² Illinois law invalidates an arbitration agreement after two years.⁷³ Ohio's provision takes the rescission question in a different direction entirely: if a patient files a claim within thirty days of signing the agreement, that filing is deemed a withdrawal from the agreement.⁷⁴

Utah's section 421 differs from several statutes because it does not contain any formal type-set requirement or special visual warning for the patient on the face of the agreement itself.⁷⁵ Conversely, California's statute requires a special notice to appear "[i]mmediately before the signature line" of the contract.⁷⁶ It must read:

arbitration under this Article is void and unenforceable."); VT. STAT. ANN. tit. 12, § 7002(a) (2002) ("After discovery of an alleged injury, persons asserting a claim based on medical malpractice may submit the claim in writing to arbitration prior to the commencement of any trial as to said claim, but not thereafter, providing that all parties having an interest in the claim agree to arbitration. *A patient may not be requested to enter into such an agreement to arbitrate until after the patient is aware of the nature and the existence of the claim.*" (emphasis added)).

69. See, e.g., ALASKA STAT. §§ 09.55.535(c), (e) (providing thirty days for patients to cancel and requiring re-execution of a new agreement every time the patient is admitted to the hospital); CAL. CIV. PROC. CODE § 1295 (West 2007) (allowing thirty days from the date of signature for rescission); COLO. REV. STAT. ANN. § 13-64-403(4) (giving patient ninety days to rescind); LA. REV. STAT. ANN. § 9:4231 (2009) (providing, in advisory language, that the agreement should expire after five years and allowing the parties themselves to fill in the date of effectiveness of the agreement); N.Y. PUB. HEALTH LAW §§ 4406-a-2 to -4 (McKinney 2002) (requiring that HMO enrollees be given notice that they may cancel their arbitration agreement without mentioning a specific time frame); S.D. CODIFIED LAWS § 21-25B-1 (2004) (providing that parties may terminate a valid arbitration agreement as to future services by giving written notice to all the parties at any time).

70. UTAH CODE ANN. § 78B-3-421(1)(b)(iv) (2008).

71. 710 ILL. COMP. STAT. ANN. § 15/9(c) (West 2007).

72. UTAH CODE ANN. § 78B-3-421(1)(b)(v).

73. 710 ILL. COMP. STAT. ANN. § 15/9(c).

74. OHIO REV. CODE ANN. § 2711.23(I) (LexisNexis 2008).

75. See UTAH CODE ANN. § 78B-3-421.

76. Cal. Civ. Proc. Code § 1295(b) (West 2007).

“NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.”⁷⁷

The notice must be set off from the rest of the text and appear “in at least 10-point bold red type.”⁷⁸

Other state statutes require the special notice to be even more expansive. South Dakota and Colorado include language advising the patient of his or her right to receive medical services regardless of the patient’s decision whether to sign the contract.⁷⁹ New York requires explanation and notice of arbitration in bold-face type if the arbitration agreement is between a health maintenance organization (HMO) and its enrollees.⁸⁰

Another common statutory feature, closely related to formal type-setting requirements, is requiring that an arbitration agreement contain a basic outline of the arbitration procedures.⁸¹ For example, the Michigan statute, in addition to requiring that patients be informed that an arbitration agreement constitutes a waiver of the right to trial and appeal, requires that the agreement contain “[a] process for the selection of an arbitrator.”⁸² Selection of the arbitrator is another mechanism that varies widely between states, but most statutes contain some combination of arbitrator selection by the patient and the doctor.⁸³ If states, like Utah, allow both the

77. *Id.*

78. *Id.*

79. *See* S.D. CODIFIED LAWS § 21-25B-3 (2004); COLO. REV. STAT. ANN. § 13-64-403(4) (West 2005).

80. N.Y. PUB. HEALTH LAW § 4406-a(2) (McKinney 2002).

81. *See, e.g.*, MICH. COMP. LAWS ANN. § 600.2912g(1) (West 2000).

82. *Id.*

83. *See, e.g.*, ALA. CODE § 6-5-485(b) (LexisNexis 2005) (requiring a three-arbitrator panel with one arbitrator chosen by the claimant, one by the defendant, and one chosen by the parties’ selected arbitrators); ALASKA STAT. § 09.55.535(f) (2008) (providing for a panel of three arbitrators: one designated by claimants, one by the health care provider, and one by mutual agreement); FLA. STAT. ANN. § 766.207(4) (West 2005) (providing for an arbitration panel consisting of one arbitrator selected by the claimant, one arbitrator selected by the defendant, and one administrative law judge from the Division of Administrative Hearings who serves as the chief arbitrator); OHIO REV. CODE ANN. § 2711.23(F) (LexisNexis 2008)

patient and the doctor to choose arbitrators, they will generally have some mechanism for overcoming deadlock on the tie-breaking arbitrator.⁸⁴

Some state statutes contain provisions that have little in common with other statutes, but which are nonetheless important in the preemption analysis. For example, Louisiana's law is unique in providing an advisory form for physicians to use in drafting arbitration agreements.⁸⁵ The Louisiana statute makes clear, however, that the form is "merely a sample" and that the form's provisions are "not required as a matter of law."⁸⁶

As the foregoing state statutes demonstrate, different states have enacted widely varying provisions restricting the enforceability of arbitration agreements. Some provisions appear to restrict enforceability to a greater degree than others. Some provisions seem to strike at the heart of the parties' substantive rights (e.g., whether a physician can refuse to treat a patient who refuses to sign), while others affect only the arbitration proceedings themselves. Whether and to what degree a statute restricts the enforceability of arbitration agreements and, to a lesser extent, whether the restrictions are "substantive" or "procedural,"⁸⁷ plays an important role in determining whether a statute that conflicts with the FAA will avoid preemption.

III. THE FEDERAL ARBITRATION ACT

Although arbitration enjoys a favored status in American law, such status came about only as a result of purposeful legislative efforts. On the federal level, such efforts culminated in the FAA, which Congress passed to reverse the historical judicial hostility toward arbitration agreements in English and American common law

(requiring three arbitrators, with no more than one being a physician or a hospital representative).

84. *See, e.g.*, ALA. CODE § 6-5-485(b) (providing that if the parties' selected arbitrators cannot select a third arbitrator within thirty days, the court will select one); ALASKA STAT. § 09.55.535(f) ("If the parties cannot agree on the third person, the court will provide a choice of three or more persons who might serve as chairperson of the arbitration board, which shall be from a list of qualified arbitrators furnished by the attorney general.").

85. *See* LA. REV. STAT. ANN. § 9:4231 (2009).

86. *Id.*

87. *See* Volt Info. Scis., Inc. v. Bd. of Trs. of Leland Stanford Junior Univ., 489 U.S. 468, 476, 477 n.6 (1989).

and “to place arbitration agreements upon the same footing as other contracts.”⁸⁸ Subsequent case law has confirmed that Congress intended the FAA to create a “national policy” in favor of arbitration.⁸⁹ Under the FAA, courts should resolve doubts in favor of arbitration.⁹⁰ This is true “whether the problem at hand is the construction of the contract language itself or an allegation of waiver, delay, or a like defense to arbitrability.”⁹¹ This Part begins by summarizing the FAA’s basic provisions and the complex case law surrounding the FAA. It then discusses the applicability of the FAA to medical arbitration agreements and, assuming the FAA applies, examines how preemption operates on a state statute like Utah’s section 421. This discussion will examine whether the state provisions should be preempted because they violate the “national policy” by going too far in restricting health care providers’ right to enforce arbitration agreements.⁹² This background will also help highlight an important dilemma that presents major problems for practitioners under the UHCMA and other similar statutory regimes.

A. Basic Provisions of the FAA

The FAA greatly enhances the enforceability of arbitration agreements governed by it. Section 2 states, in pertinent part, that “an agreement in writing to submit to arbitration an existing

88. *EEOC v. Waffle House, Inc.*, 534 U.S. 279, 289 (2002) (quoting *Gilmer v. Interstate/Johnson Lane Corp.*, 500 U.S. 20, 24 (1991)); *see also* *Buckeye Check Cashing, Inc. v. Cardegna*, 546 U.S. 440, 443 (2006) (“To overcome judicial resistance to arbitration, Congress enacted the Federal Arbitration Act (FAA).”).

89. *Hall St. Assocs. v. Mattel, Inc.*, 552 U.S. 576, 581 (2008) (“Congress enacted the FAA to replace judicial indisposition to arbitration with a ‘national policy favoring [it] and plac[ing] arbitration agreements on equal footing with all other contracts.’” (quoting *Buckeye*, 546 U.S. at 443) (alteration in original)).

90. *Moses H. Cone Mem’l Hosp. v. Mercury Constr. Corp.*, 460 U.S. 1, 24–25 (1983).

91. *Id.* at 25.

92. The idea that state statutory limitations on medical arbitration agreements could be preempted under the FAA is not new. For example, Christine Melucci has identified a number of statutory limitations on other types of arbitration agreements that are probably preempted under recent Supreme Court precedent. Christine Melucci, *Arbitration Agreements: When Does the Federal Arbitration Act Preempt State Law?*, 19 AM. J. TRIAL ADVOC. 691, 695–96 (1996); *See also* Thomas B. Metzloff, *The Unrealized Potential of Malpractice Arbitration*, 31 WAKE FOREST L. REV. 203, 212 (1996) (“Even the most restrictive statutes could be challenged now relying on [FAA precedent].”).

controversy arising out of such a contract, transaction, or refusal, shall be valid, irrevocable, and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract.”⁹³ Thus, for contracts falling within the purview of the FAA, this provision fulfills the underlying policy of the Act that “[c]ontracts to arbitrate are not to be avoided by allowing one party to ignore the contract and resort to the courts.”⁹⁴ Such avoidance could lead to protracted litigation, which is what the parties sought to avoid in the first place by contracting for arbitration.⁹⁵

Another factor contributing to the FAA’s important nationwide impact on arbitration agreements is its far-reaching applicability—it applies to any “contract evidencing a transaction involving commerce.”⁹⁶ Although the Act itself provides a specific definition of those transactions “involving commerce,”⁹⁷ subsequent cases have construed that language very broadly.⁹⁸ The Supreme Court has held that “involving” is the functional equivalent of “affecting” and “signals an intent to exercise Congress’ commerce power to the

93. 9 U.S.C. § 2 (2006).

94. *Southland Corp v. Keating*, 465 U.S. 1, 7 (1984).

95. *Id.* Notwithstanding the broad scope of the FAA and its strong policy favoring the enforceability of arbitration agreements, the Act also contains procedural safeguards allowing courts to vacate arbitration awards in a narrow set of circumstances. For example, courts may vacate arbitration awards in cases of misconduct by arbitrators or if the award was otherwise “procured by corruption, fraud, or undue means.” 9 U.S.C. § 10. It also provides other grounds for review including the following: where there is evidence of “material miscalculation of figures” or “mistake in description of any person, thing, or property referred to in the award”; where the arbitrators grant an award on matters not submitted to them; or where the award “is imperfect in matter of form not affecting the merits of the controversy.” *Id.* at § 11. Circuit courts were long split over whether parties could contract for expanded judicial review beyond those reasons enumerated by statute. *See Hall St. Assocs. v. Mattel, Inc.*, 552 U.S. 576, 583 n.5 (2008). The Ninth and Tenth Circuits held that parties could not, while the First, Third, Fifth, and Sixth Circuits reached the opposite conclusion. *Id.* *Hall Street* resolved the split in favor of exclusivity. *Id.* at 585 (holding that sections 10 and 11 “respectively provide the FAA’s exclusive grounds for expedited vacatur and modification”).

96. 9 U.S.C. § 2.

97. *See id.* § 1 (“[C]ommerce’, as herein defined, means commerce among the several States or with foreign nations, or in any Territory of the United States or in the District of Columbia, or between any such Territory and another, or between any such Territory and any State or foreign nation, or between the District of Columbia and any State or Territory or foreign nation, but nothing herein contained shall apply to contracts of employment of seamen, railroad employees, or any other class of workers engaged in foreign or interstate commerce.”).

98. *See, e.g., Snyder v. Smith*, 736 F.2d 409, 417–18 (7th Cir. 1984), *overruled on other grounds by Felzen v. Andreas*, 134 F.3d 873, 876–77 (7th Cir. 1998).

full.”⁹⁹ The Court later expanded this power even further by concluding that the Commerce Clause power may be exercised in individual cases “if in the aggregate the economic activity in question would represent ‘a general practice . . . subject to federal control.’”¹⁰⁰

The broad standard of “involving commerce” has generally prompted courts to apply the FAA to medical malpractice cases.¹⁰¹ For example, in *Triad Health Management of Georgia, LLC v. Johnson*, the Georgia Court of Appeals held that the FAA applied to an arbitration agreement where the patient’s representative signed it upon the patient’s admission to a nursing home.¹⁰² The court reasoned that although the facility was located in the state, the parent company had additional offices in Maryland.¹⁰³ Further, the court reasoned that the in-state facility “purchased supplies from out-of-state vendors, . . . treated out-of-state patients and had patients insured through medicaid and medicare and private insurance providers, and some of the private insurance claims were handled in locations outside the state.”¹⁰⁴ Given this broad interpretation of “involving commerce,” the FAA would apply to nearly all medical transactions.

B. Effect on State Law

The FAA creates a body of federal substantive law applicable in both state and federal courts.¹⁰⁵ Although the FAA itself does not specifically address its relationship with conflicting state law, after a string of litigation “[t]he FAA’s displacement of conflicting state law

99. *Allied-Bruce Terminix Cos. v. Dobson*, 513 U.S. 265, 277 (1995).

100. *Citizens Bank v. Alafabco, Inc.*, 539 U.S. 52, 57 (2003) (quoting *Mandeville Island Farms, Inc. v. Am. Crystal Sugar Co.*, 334 U.S. 219, 236 (1948)) (omission in original). For a more expanded history of FAA interpretation under the Commerce Clause, as well as the provisions of the Act itself, see *Leasure & Ragan, supra* note 6, at 52–56.

101. *See, e.g., Triad Health Mgmt. of Ga., III, LLC v. Johnson*, 679 S.E.2d 785, 787–88 (Ga. Ct. App. 2009).

102. *Id.* at 787.

103. *Id.*

104. *Id.* at 787–88.

105. *See Moses H. Cone Mem’l Hosp. v. Mercury Constr. Corp.*, 460 U.S. 1, 25 n.32 (1982); *see also Volt Info. Scis., Inc. v. Bd. of Trs. of Leland Stanford Junior Univ.*, 489 U.S. 468, 485 (1989) (Brennan, J., dissenting).

is ‘now well-established’¹⁰⁶ State and federal courts must equally acknowledge the “national policy” favoring arbitration. This policy serves to foreclose attempts by legislatures to undermine the enforceability of arbitration agreements.¹⁰⁷ Thus, although the FAA ostensibly leaves states some room to draft their own arbitration statutes,¹⁰⁸ the FAA aims to ensure the enforceability of private agreements to arbitrate according to their own terms.¹⁰⁹ At times, this requires that a court simply invalidate the state’s conflicting provisions.¹¹⁰

The Supreme Court has also further clarified the types of state law preempted by the FAA. For example, in *Doctor’s Associates, Inc. v. Casarotto*,¹¹¹ the Supreme Court reversed the Montana Supreme Court and held that an arbitration agreement was enforceable even though it failed to meet the notice requirements under a state statute.¹¹² The Montana law required that an arbitration clause be “typed in underlined capital letters on the first page of the contract.”¹¹³ In upholding the statute, the Montana Supreme Court did not focus on the actual language of § 2 of the FAA, but it had determined that invalidating the arbitration agreement would not undermine the underlying policy of the FAA.¹¹⁴ Regarding the Montana statute, the Supreme Court held that the FAA preempted the state statute and that courts may not “invalidate arbitration

106. *Preston v. Ferrer*, 552 U.S. 346, 352 (2008) (quoting *Allied-Bruce Terminex Cos., Inc. v. Dobson*, 513 U.S. 265, 272 (1995)).

107. *Id.*; see also *Southland Corp. v. Keating*, 465 U.S. 1, 16 (1984).

108. See *infra* Part IV.A.

109. See *Volt Info. Scis., Inc.* 489 U.S. at 476. Hence, in *Southland Corporation v. Keating*, the Supreme Court rejected the proposition that the FAA created a procedural rule applicable only in federal courts and held that “the ‘involving commerce’ requirement in § 2, [should be viewed] not as an inexplicable limitation on the power of the federal courts, but as a necessary qualification on a [state] statute intended to apply in state and federal courts.” 465 U.S. at 14–15. The court reasoned that confining the scope of the FAA to parties seeking to enforce arbitration agreements in federal courts would frustrate Congress’s broad enactment in light of the policies behind the FAA. *Id.* at 14. The *Southland* Court specifically mentioned two of these policies: Congress’s intent to overcome the traditional judicial hostility toward arbitration and the failure of state arbitration statutes to adequately protect a party’s right to enforce arbitration agreements. *Id.*

110. See, e.g., *Doctor’s Assocs., Inc. v. Casarotto*, 517 U.S. 681, 683 (1996).

111. *Id.*

112. *Id.*

113. *Id.* (quoting MONT. CODE ANN. § 27-5-114(4) (1995)).

114. *Id.* at 685.

agreements under state laws applicable *only* to arbitration provisions.”¹¹⁵ The Court reasoned that because the law conditioned “enforceability of arbitration agreements on compliance with a special notice requirement not applicable to contracts generally,” the statute directly conflicted with § 2.¹¹⁶ The Court further reasoned that such a requirement violated the FAA’s policy to put arbitration agreements “upon the same footing as other contracts.”¹¹⁷

Nevertheless, the underlying arbitration agreement must be valid to be enforced under the FAA. In determining whether a party agreed to arbitration, courts usually “should apply ordinary state-law principles that govern the formation of contracts.”¹¹⁸ Thus, as one court noted, the “trial court rather than the arbitrator decides gateway matters, such as whether a valid arbitration agreement exists.”¹¹⁹ Therefore, notwithstanding the ironclad policy surrounding the enforceability of arbitration agreements under the FAA, *Sosa v. Paulos*, discussed above, and similar state cases demonstrate how contract defenses—including fraud, duress, and unconscionability—may operate to invalidate an arbitration agreement.¹²⁰

C. The Role of the FAA in Current Medical Malpractice Arbitration

In attempting to draft cognizable guidelines for courts to use in determining the enforceability of arbitration agreements, state legislators have, in some cases, gone too far in imposing stringent requirements for enforceability. As discussed above, the FAA preempts these conflicting state laws.

1. Utah’s Section 421 and FAA preemption

Utah’s Medical Arbitration statute provides an excellent case study of the potential anomalies and problems that arise when

115. *Id.* at 687 (emphasis in original).

116. *Id.*

117. *Id.* (quoting *Scherk v. Alberto-Culver Co.*, 417 U.S. 506, 511 (1974)).

118. *First Options of Chi., Inc. v. Kaplan*, 514 U.S. 938, 944 (1995).

119. *Tex. Cityview Care Ctr., L.P. v. Fryer*, 227 S.W.3d 345, 351 (Tex. App. 2007).

120. *See Doctor’s Assocs., Inc. v. Casarotto*, 517 U.S. 681, 687 (1996) (“[G]enerally applicable contract defenses, such as fraud, duress or unconscionability, may be applied to invalidate arbitration agreements without contravening § 2 [of the FAA].”).

considering whether a state arbitration statute conflicts with federal law. On its face, section 421 acknowledges the preeminence of the FAA. It reads in pertinent part that “[t]his section does not apply to any arbitration agreement that is subject to the Federal Arbitration Act.”¹²¹ However, given the pervasive scope of the FAA, it is difficult to hypothesize an agreement between a patient and a health care provider that would not fall within the purview of the FAA. Hence, this provision apparently attempts to avoid preemption by alluding to a small corner of the arbitration field where Utah’s UHCMA applies but the FAA does not. As discussed above, such a corner almost certainly does not exist.

The Utah Legislature foresaw this possibility when it passed section 421 and its subsequent amendments. In an annotation to the proposed 2004 amendment, which expressly stated that no health care provider could refuse services to patients solely on the basis of their failure to be bound to arbitration, the Utah Office of Legislative Research and General Counsel (“The Office”) reviewed the bill in light of the FAA.¹²² The Office noted that the language as amended would mandate a relationship between the health care provider and the patient. The Office pointed out that, under the Supreme Court’s decision in *Doctor’s Associates*, cited above, states may not single out arbitration for special, restrictive treatment.¹²³ The Office concluded that “[i]f this bill was found to violate the Federal Arbitration Act,” the language of section 421 “would eliminate the intended effect of this bill.”¹²⁴

The first part of the Office’s analysis appears correct, at least in the abstract. In most typical contract negotiations, parties are free to walk away from the proposed relationship or transaction if the terms do not meet their satisfaction. Requiring a physician to enter into a relationship with a patient even though the patient refused one of the physician’s proposed terms (that parties would arbitrate any dispute) singles out arbitration agreements as a suspect category, placing them on different footing than other contracts.

However, the Office’s conclusion that the intended effect of the bill would be eliminated only “[i]f this bill was found to violate the

121. UTAH CODE ANN. § 78B-3-421(7) (2008).

122. See S.B. 117, Gen. Sess. at 4 (Utah 2004); S.B. 245, Gen. Sess. (Utah 2004).

123. S.B. 117.

124. *Id.*

Federal Arbitration Act” is confusing. On the plain language of the statute, none of the enforceability requirements even apply to an arbitration agreement that falls within the scope of the FAA. On the other hand, the wide scope of the FAA would not leave courts room to find that an arbitration agreement is not covered under the FAA anyway. Perhaps the Utah Legislature merely glossed over this fact when it passed the bill. Interestingly enough, the Office’s note was not included in the 2004 bill that passed from the Senate to the House and the sponsoring senator did not mention the possible interaction between the FAA and what later became section 421 in his statements on the Senate Floor.¹²⁵ Thus, this provision in section 421 provides a cautionary tale to legislators drafting statutes similar to the UHCMA in other states. Although the UHCMA anticipates interaction with the FAA, it should be clearer in how it purports to escape preemption, given the broad scope of the FAA in the health care context.¹²⁶ As it stands, the UHCMA is wide-open for federal preemption, which, theoretically, leaves absolutely no room for its strict enforceability requirements.

2. FAA and preemption of other state statutes

Utah’s UHCMA is not the only statute vulnerable to preemption. Similar statutes in other states also require physicians to treat patients regardless of whether the patient signs the arbitration agreement. Hence, if the Utah statute is preempted on this ground,

125. *See generally* Floor Debate, 55th Utah Leg., Gen. Sess. (February 20, 23, 25, 2004) (transcript on file with author), *audio available at* <http://le.utah.gov/asp/audio/index.asp?> Most of the debate instead centered on whether the bill should provide for a three-arbiter panel or a single arbiter and the policy implications of both approaches. *Id.* However, the bill’s sponsor, Senator Blackham, did note the public outcry over mandatory arbitration as a catalyst for the provision requiring doctors to treat patients even though the patient refused to sign the arbitration agreements. Senator Blackham called the provision “very unusual” and said, “as far as I know it is the only area of practice or services where we actually deny that ability of a provider to say that if you don’t agree, I cannot refuse you services.” *Id.* at 33–47.

126. It seems that the legislature chose to simply skirt the issue. However, it is unclear whether legislators simply did not fully appreciate the import of the Office’s caution or whether the state of the law really is unclear. Although it seems fairly clear that the UHCMA violates the FAA, evolving case law and the specter of reverse preemption makes it less clear-cut.

surely the Alaska, Colorado, and Ohio statutes would be preempted for this reason alone.¹²⁷

Similarly, Utah does not have the most restrictive statutory regime. Other statutes strike even closer at the FAA's "national policy" favoring arbitration. For example, Vermont's and North Carolina's statutes, which seem to flatly invalidate pre-dispute arbitration agreements, run directly contrary to the FAA's basic tenet that arbitration agreements are "valid, irrevocable, and enforceable."¹²⁸ The Louisiana statute, on the other hand, probably escapes preemption because, although it gives an actual form to guide agreement drafters, and the form contains provisions for heightened patient protection, the statute explicitly makes those provisions advisory.¹²⁹ Similarly, provisions that are less restrictive on an agreement's enforceability, such as those that merely set forth the method for selecting the arbitrators,¹³⁰ probably escape preemption under the same analysis that would condemn the Vermont and North Carolina provisions.

The continued validity of more restrictive statutes—such as those requiring specific, bold-faced notices—presents the most shocking example of FAA/state law dissonance. After all, in *Doctor's Associates*, the Supreme Court held a statute preempted for this very reason.¹³¹ Accordingly, the California, Colorado, South Dakota, and New York statutes should have already gone the way of the Montana statute reviewed in *Doctor's Associates*. Why these statutes are still on the books despite clear grounds for preemption is both a complex and enigmatic question—the potential answers to which are discussed in the next Part.

127. See ALASKA STAT. § 09.55.535 (2008); COLO. REV. STAT. ANN. § 13-64-403 (West 2005) (discussed in the reverse preemption context below); OHIO REV. CODE ANN. § 2711.23 (LexisNexis 2008).

128. See 9 U.S.C. § 2 (2006).

129. The Louisiana statute is admirable on several levels. First, the statute expressly incorporates the FAA's mandate making arbitration contracts valid, irrevocable, and enforceable once parties forge them. Nevertheless, the statute also makes clear that these contracts must be voluntary on the part of the patient. Finally, the form provides a safe harbor for physicians' attorneys drafting these agreements, which is why many physicians' representatives favor medical malpractice arbitration statutes in the first place. See LA. REV. STAT. ANN. § 9:4231 (2009).

130. See, e.g., ALA. CODE § 6-5-485(b) (LexisNexis 2005); ALASKA STAT. § 09.55.535(f); FLA. STAT. ANN. § 766.207(4) (West 2005); OHIO REV. CODE ANN. § 2711.23(F).

131. 517 U.S. 681, 687 (1996).

IV. SHORTCOMINGS IN THE CURRENT LEGAL FRAMEWORK

There are three main reasons for the current confusion in this area of the law. First, Supreme Court case law, which draws a distinction between substantive and procedural statutes, leaves grounds for FAA preemption unclear. Second, because neither patients nor practitioners have an incentive to invoke the stern provisions of the FAA, there is no voice calling for preemption when state statutes are challenged in state courts. Finally, courts have recently begun to use the McCarran-Ferguson Act (“MFA”) to “reverse preempt” the FAA and allow states to pass more stringent standards for arbitration agreement enforceability in the health care arbitration context. However, extending the MFA to health care threatens to swallow the FAA by allowing reverse preemption in an infinite range of arbitration contexts. Instead, Congress should simply amend the FAA to allow states to continue acting as laboratories¹³² to reach political equilibrium between doctors and patients, without doing violence to the original scope of the MFA.

A. Substance v. Procedure: The Supreme Court Muddies the Water

As discussed in Part III, courts’ traditionally broad readings of the FAA leave little room for states to impose requirements for enforceable arbitration agreements. However, the Supreme Court has made clear that preemption applies only to state *substantive* law and that states have greater latitude to prescribe the procedural rules governing arbitration.¹³³ The Supreme Court attempted to explain this substance/procedure distinction in *Volt Information Sciences, Inc. v. Board of Trustees of Leland Stanford Junior University*.¹³⁴ In *Volt*, the Supreme Court affirmed a California court of appeals decision and upheld a statute that allowed parties to stay an arbitration proceeding pending related litigation between a party to the arbitration agreement and a third party not bound by it.¹³⁵ The

132. See *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).

133. *Hall St. Assocs. v. Mattel*, 552 U.S. 576 (2008); *Volt Info. Scis., Inc. v. Bd. of Trs. of Leland Stanford Junior Univ.*, 489 U.S. 468, 485 (1989).

134. 489 U.S. 468.

135. *Id.* at 470–71.

party seeking to compel arbitration argued that the California court's decision amounted to imposing involuntary waiver on that party and denying the party its federally guaranteed ability to compel arbitration. It also argued that the California court's decision ran afoul of the "national policy" to resolve cases that fall within the FAA with a "healthy regard for the federal policy favoring arbitration."¹³⁶

The Supreme Court rejected both arguments and held that the FAA did not preempt the state *procedural* law.¹³⁷ The court reasoned that the FAA does not grant a right to compel arbitration at any time; rather, "it confers only the right to obtain an order directing that 'arbitration proceed in the manner provided for in [the parties'] agreement."¹³⁸ The Court further stated that there "is no federal policy favoring arbitration *under a certain set of procedural rules.*"¹³⁹ Where the parties agreed to arbitrate in accordance with California law, a statute that merely specifies the rules under which the arbitration would occur does not violate Congress's purpose of enforcing arbitration agreements under their own terms.¹⁴⁰ In a footnote, the majority drew a distinction between the "substantive" provisions of the FAA, which are also applicable in state courts, and sections 3 and 4, which set out a number of procedural requirements that apply only to proceedings in federal courts.¹⁴¹

This substance/procedure distinction also played an important role in the Supreme Court's decision in *Doctor's Associates, Inc. v. Casarotto*,¹⁴² discussed above. In *Doctor's Associates*, the Supreme Court reversed the Montana Supreme Court after it upheld a state statute requiring that an arbitration clause be prominently displayed on the first page of the contract.¹⁴³ To buttress its conclusion, Montana Supreme Court had ostensibly relied on the Supreme Court's decision in *Volt*. In rejecting the Montana court's decision,

136. *Id.* at 475.

137. *Id.* at 474-76.

138. *Id.* at 474-75 (quoting 9 U.S.C. § 4).

139. *Id.* at 476 (emphasis added).

140. *Id.* at 478-79.

141. *See id.* at 477 n.5.

142. 517 U.S. 681 (1996).

143. *Id.* at 683.

the Supreme Court reasoned that the state court had misread *Volt*.¹⁴⁴ Because the statute in question in *Volt* affected only the efficient order of proceedings, rather than the enforceability of the agreement itself, the statute did not undermine the policy of the FAA. By contrast, the Montana statute was “antithetical” to those policies because it specifically limited the enforceability of the underlying agreement, rather than how the arbitration would proceed.¹⁴⁵

This substance/procedure distinction articulated in *Doctor’s Associates* remains a mystery in many respects. Subsequent decisions have provided little insight into the kinds of matters that may be contracted within the framework of the FAA.¹⁴⁶ In addition, the distinction between substance and procedure may be wholly academic and redundant anyway. Consider, for example, a state law provision that determines how arbitrators are chosen. As discussed in the preceding part, that provision may escape preemption because it does not restrict the enforceability of an arbitration agreement in contravention of § 2 of the FAA. This is also the type of statute that seems paradigmatically procedural and may be easily cabined accordingly. Next consider, however, a provision governing forum selection clauses in arbitration agreements. At the outset, mandating that a given clause be included in an agreement definitely seems to interfere with the agreement’s enforceability. On the other hand, states should be able to determine where and how arbitration will occur, in an effort merely to affect the “efficient order of proceedings.” In such a case, a court will likely look to the basic policy behind the FAA to determine whether such a provision affects substantive rights—applying a substantially similar analysis as they would have under § 2 of the FAA anyway.¹⁴⁷ As a result, statutes that

144. *Id.* at 688.

145. *Id.*

146. *But see* Hall St. Assocs. v. Mattel, 552 U.S. 576, 586 (2008) (mentioning, in dicta, that “many features of arbitration [may be chosen] by contract, including the way arbitrators are chosen, what their qualifications should be, which issues are arbitrable, along with procedure and choice of substantive law”).

147. *See, e.g.*, Manson v. Dain Bosworth, Inc., 623 N.W.2d 610 (Minn. Ct. App. 1998). In *Manson*, the Minnesota Court of Appeals upheld a statutory personal service requirement on the grounds that it was procedural rather than substantive. The court reasoned that the Supreme Court’s decision in *Volt* makes it clear that there is no federal policy to arbitrate under a certain set of procedural rules. *Id.* at 615 (citations omitted). The court cited a number of state cases reaching the same result. *Id.* Ultimately, the court concluded that “[t]he

are toward the less restrictive end of the spectrum will tend to be those procedural in nature, making the substance/procedure distinction unnecessary. Those more toward the middle, not clearly substantive or procedural, will be subject to much the same analysis as they would under § 2.

At the very least, the substance/procedure distinction does nothing to further the interests of either doctors or patients. Any meaningful provisions that would affect the balance of power between the parties would likely either restrict or remove restrictions to the enforceability of arbitration agreements. Accordingly, litigation will almost always require a § 2 analysis.¹⁴⁸ The practical result is that state statutes that are vulnerable to preemption will likely remain on the books due to judges, practitioners, and legislators continuing to struggle in an unnecessary haze until Congress or the Supreme Court hands down clear guidance on the substance/procedure issue.

B. No Voice for Preemption

Another factor that allows vulnerable statutes to remain on the books deals with practical litigation incentives. The traditional, ad hoc judicial approach to determining whether the FAA will preempt a state statute is insufficient in the health care arbitration context due to a glaring Catch-22¹⁴⁹ that faces practitioners in this area. As the

key issue in determining whether the FAA preempts a substantive state law is *whether the state law is an obstacle to the purposes and objectives of the FAA.*" *Id.* (emphasis added). The court further noted that the Supreme Court's decision in *Doctor's Associates* stands for the proposition that state laws that have been held to be preempted by the FAA are laws that undermine the private arbitration process by making it difficult to enforce the underlying agreement. *Id.* at 616 (citations omitted); *see also* *Keystone, Inc. v. Triad Sys. Corp.*, 971 P.2d 1240 (Mont. 1998) (distinguishing a statute that invalidated choice of forum provisions in contracts generally from *Casarotto* and reasoning that just because the statute in *Keystone* limits part of the enforceability of the agreement, it does not follow that it conflicts with the policy of the FAA). *But see* *Allen v. World Inspection Network Int'l, Inc.*, 911 A.2d 484 (N.J. Super. Ct. App. 2006) (holding that the FAA preempts state law invalidating the forum-election clause unless enforcement would be contrary to general principles of contract law).

148. Proponents of the substance/procedure distinction would counter this argument by maintaining that once a provision is deemed "procedural" that is the end of the analysis, there is no vast spectrum—or at least that provision is no longer plotted on it. Such a view is overly formalistic because any issue worth litigating will probably implicate important rights that a court engaged in arbitrary line drawing could construe as either substantive or procedural.

149. This problem represents a Catch-22 in the most fundamental sense. The term "Catch-22" originates from Joseph Heller's book of the same name, first published in 1961. It

policy and history surrounding the UHCMA's Arbitration Provisions clearly demonstrate, there is no voice advocating for FAA preemption. Obviously, a patient facing a motion to compel arbitration under the Utah law would never argue for preemption because, as discussed above, section 421 probably already contains greater patient safeguards than the FAA allows. However, a doctor seeking to compel arbitration for an agreement not in compliance with section 421 will quickly find that arguing for preemption is counterproductive. If section 421 is meant to be a statutory safe-harbor for physicians' arbitration agreements, representing a huge amount of work and lobbying resources by the health care industry, the last thing that a doctor would want is to have the statute invalidated. The vacuum created by preemption would subject providers to the unpredictability of the unconscionability, or some other judicially created, doctrine.¹⁵⁰ The resulting increase in litigation cost is exactly what the legislature sought to avoid by enacting section 421.

has come to mean, in everyday usage, a dilemma or no-win situation of any type. The true meaning from the book, however, is more subtle. In the book, *Catch-22* is a bureaucratic military rule that typifies the self-contradictory, circular logic that was the subject of Heller's satirical critique. Through the course of the book, Heller evokes provisions of *Catch-22* to illustrate different incarnations of these logical quandaries. At one point, the protagonist, a B-25 bombardier, examines how *Catch-22* could prevent a pilot from avoiding combat missions. *Catch-22* specified that concern for safety in the face of real and immediate danger was the process of a rational mind. If a pilot was crazy, he could be grounded; but as soon as he asked to be excused, he was no longer crazy and had to fly more missions. Hence, if he flew missions, he was crazy and did not have to; but if he did not want to he was sane and had to. JOSEPH HELLER, *CATCH-22*, at 52 (Simon & Schuster Classics 1999) (1961).

150. One author recently suggested that the FAA and the result in *Casarotto* has sparked renewed interest in unconscionability doctrine. See Sandra F. Gavin, *Unconscionability Found: A Look at Pre-Dispute Mandatory Arbitration Agreements 10 Years after Doctor's Associates, Inc. v. Casarotto*, 54 CLEV. ST. L. REV. 249 (2006). Gavin argues that "[t]he Supreme Court's utilization of the FAA over the past few decades as the vehicle for overcoming hostility toward the arbitration process may have generated the backlash taking place in state courts today." *Id.* at 270. Gavin embraces the use of unconscionability doctrine, which she characterizes as flexible and well suited for policing fairness. *Id.* However, she declines to take a position on whether courts are "inappropriately stretching the unconscionability defense." *Id.* at 271. Further, she recognizes that common law courts traditionally leave fairness of an agreement to the bargain of the contracting parties and that "the definition of unconscionability remains sketchy and elusive." *Id.* at 262 (quoting Susan A. Fitzgibbon, *Teaching Important Contracts Concepts: Teaching Unconscionability through Agreements to Arbitrate Employment Claims*, 44 ST. LOUIS U. L.J. 1401, 1405 (2000) (internal quotation marks omitted)).

The practical result is that only practitioners representing doctors whose agreements do not conform to section 421 would ever argue for preemption. Such a scenario would likely arise only where attorneys representing a given physician either do not fully understand section 421, or are simply careless in drafting the agreement. This will be unlikely in the future given that both health care providers and attorneys representing them have dedicated significant resources to complying with the state law, and by now, most, if not all, physicians who use these agreements have probably achieved compliance. In this case, too, the consequences of winning on the preemption argument are worse than losing because of the likelihood of increased future costs. Hence, this Catch-22 will likely cause the preemption question to go unanswered because it would require doctors to argue against their own safe harbor. The practical result is that even the state law provisions on the most restrictive end of the spectrum will go unchallenged. Thus, because appellate review is unlikely, ad hoc judicial action will only maintain the status quo: confusion and inconsistent results.

Some might argue that the problem is not the FAA, but the state legislatures that seek to blend arbitration enforcement with politically popular patients' rights. This Comment does not advance the legislative approaches, embodied by the UHCMA and similarly-crafted statutes from other states, as a perfect solution. Rather, it points to Utah's legislative experience as a viable instance of a state reaching a well-wrought political compromise and passing commensurate legislation. Although this might cut against the policy underlying the FAA on its face, it does no more violence to the enforceability of arbitration than ad hoc judicial determinations based on common-law contract defenses. At the very least, giving a green light to state statutes will help rectify the FAA confusion in this area, provide a safe harbor for physicians' arbitration agreements, and provide patients greater predictability than the common law alternatives. Frankly, federal law has little to lose because, without a voice to argue for preemption, the FAA is already failing to further the "national policy" in favor of arbitration.¹⁵¹

151. Other voices in the FAA debate urge that the FAA is inadequate for a different reason—that courts have extended the FAA too far in general. According to some, the "national policy" favoring arbitration has turned into judicial hostility to state legislative attempts to protect unsophisticated parties. Such a viewpoint is embodied in vivid language by

C. McCarran-Ferguson Act: An Answer to the Preemption Problem?

As preceding parts demonstrate, many questions remain as to which statutes should be preempted by the FAA. Further complicating matters, state courts have recently begun to add the McCarran-Ferguson Act (“MFA”) into the FAA preemption puzzle by using the MFA to “reverse preempt” the FAA, arguing that the MFA places their state statutes beyond the reach of FAA preemption. This subsection begins with a brief history of the MFA, an overview of its key provisions, and a review of two state court cases applying the MFA to health care arbitration statutes. It then critiques the courts’ use of the MFA in this context before highlighting why the MFA is a poor conceptual fit when applied by state courts to avoid FAA preemption of health care arbitration statutes.

Justice Trieweiler of the Montana Supreme Court. In special concurrence of a case where FAA preemption was at issue, Justice Trieweiler wrote:

In Montana, we are reasonably civilized and have a sophisticated system of justice which has evolved over time and which we continue to develop for the primary purpose of assuring fairness to those people who are subject to its authority.

.....

We have contract laws and tort laws. We have laws to protect our citizens from bad faith, fraud, unfair business practices, and oppression by the many large national corporations who control many aspects of their lives but with whom they have no bargaining power.

.....

These insidious erosions of state authority and the judicial process threaten to undermine the rule of law as we know it.

Nothing in our jurisprudence appears more intellectually detached from reality and arrogant than the lament of federal judges who see this system of imposed arbitration as “therapy for their crowded dockets.” These decisions have perverted the purpose of the FAA from one to accomplish judicial neutrality, to one of open hostility to any legislative effort to assure that unsophisticated parties to contracts of adhesion at least understand the rights they are giving up.

Casarotto v. Lombardi, 886 P.2d 931, 939–41 (Mont. 1994) (Trieweiler, J., concurring) (emphasis added).

1. History and basic provisions of the MFA

In 1869, the United States Supreme Court held that insurance was not “commerce” and therefore was not subject to federal Commerce Clause statutes.¹⁵² Later, in 1944, the Court reversed its stance: whereas no other commercial enterprise conducting business across state lines was completely beyond Congress’s Commerce Clause authority, the Court refused to “make an exception of the business of insurance.”¹⁵³ A year later, Congress passed the MFA to “alleviate the effect” of that decision on insurance companies.¹⁵⁴ The MFA states, in relevant part, that “[n]o Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance”¹⁵⁵ Thus, by reversing the Supreme Court’s inroads into state insurance regulation, Congress gave “support to the existing and future state systems for regulating and taxing the business of insurance.”¹⁵⁶

It is not entirely clear what constitutes the “business of insurance”; however, the Supreme Court has suggested that the following are included: fixing insurance rates; advertising and selling policies; licensing insurance companies and agents; and determining the types of policies issued.¹⁵⁷ Although the outer limits remain elusive, the Court has hinted that “other activities . . . [may] relate so closely to [a company’s] status as [a] reliable insurer[.]” that they should be included in the “business of insurance.”¹⁵⁸ Regardless of

152. Paul v. Virginia, 75 U.S. 168, 183 (1869).

153. United States v. Se. Underwriters Ass’n, 322 U.S. 533, 553 (1944).

154. Freier v. N.Y. Life Ins. Co., 679 F.2d 780, 782 (9th Cir. 1982); see also SEC v. Nat’l Secs., Inc., 393 U.S. 453, 458 (1969) (discussing the history of the MFA).

155. 15 U.S.C. § 1012(b) (2006).

156. *Nat’l Secs., Inc.*, 393 U.S. at 458 (quoting *Prudential Ins. Co. v. Benjamin*, 328 U.S. 408, 429 (1946)); see also *U.S. Dep’t of Treasury v. Fabe*, 508 U.S. 491, 508 (1993). *Fabe* clarified a statement from *National Securities* that the MFA attempted to “turn back the clock” to the status quo prior to *South-Eastern Underwriters*. *Id.* Rather than inviting a “detailed point-by-point comparison between the regime created by McCarran-Ferguson and the one that existed before,” the language in *National Securities* regarding “turning back the clock” referred specifically to restoring to the states their broad regulatory power in the insurance industry. *Id.*

157. See *Nat’l Secs., Inc.*, 393 U.S. at 460.

158. *Id.* (“Undoubtedly, other activities of insurance companies relate so closely to their status as reliable insurers that they too must be placed in the same class.”).

the exact limits of the MFA's terms, however, it is clear that it focuses on the insurance company's relationship with the policyholder. Hence, "[s]tatutes aimed at protecting or regulating this relationship, directly or indirectly are laws regulating the 'business of insurance.'"¹⁵⁹

2. State courts and the specter of reverse preemption

State courts have recently begun to grapple with the question of which laws regulate insurance for reverse preemption purposes in health care arbitrations. For example, in *In re Kepka*,¹⁶⁰ the Texas Court of Appeals held it improper to compel arbitration where a wife filed a wrongful death action after her husband died approximately sixteen days after being admitted to a nursing home.¹⁶¹ At the time he was admitted, the wife signed a number of documents, including an arbitration agreement.¹⁶² The wife argued that the trial court erred in compelling arbitration because the agreement did not comply with state requirements.¹⁶³ Specifically, the agreement did not contain a certain, statutorily required phrase in ten-point, bold-faced type.¹⁶⁴ The wife also argued that, although the agreement expressly provided that the FAA should apply, the McCarran-Ferguson Act "reverse preempts" the FAA, preventing it from preempting the state law.¹⁶⁵ The court agreed and held that the MFA reverse preempts federal law when: "(1) the federal statute does not specifically relate to the business of insurance, (2) the state law was enacted for the purpose of regulating the business of insurance, and

159. *Id.* (citation omitted); see also *Fabe*, 508 U.S. at 501.

160. 178 S.W.3d 279 (Tex. App. 2005). *In re Labatt Food Service, L.P.*, 279 S.W.3d 640, 647 (Tex. 2009), overruled *In re Kepka's* holding that a non-signatory beneficiary could not be bound by the decedent having signed an arbitration agreement. *In re Labatt Food Service* did not address the issues of preemption and reverse preemption; therefore, *In re Kepka* appears to remain good law on this point. *Id.* at 649.

161. *Id.* at 285.

162. *Id.* at 283.

163. *Id.* at 287.

164. *Id.* at 287-88.

165. *Id.* at 288.

(3) the federal statute operates to invalidate, impair, or supersede the state law.”¹⁶⁶

Looking to compel arbitration under the FAA, the *Kepka* defendant had argued that the portion of the conflicting Texas act covering arbitration should be examined separately from the rest of the act. According to the defendant, the MFA did not save the arbitration provisions from preemption because that portion of the Texas act aimed to regulate the relationship between health care providers and patients, rather than the relationship between the insurer and the insured.¹⁶⁷ *Kepka* acknowledged that there was some precedent for such a reading.¹⁶⁸ In *U.S. Department of Treasury v. Fabe*, the U.S. Supreme Court suggested that courts should look to discrete provisions in determining whether the MFA applied to state statutes.¹⁶⁹ As *Kepka* explained, *Fabe* held that under the MFA a given state statute could be “enacted ‘for the purpose of regulating the business of insurance’” “only ‘to the extent that’ the statute was aimed at protecting or regulating the relationship between the insurer and insured.”¹⁷⁰ Hence, to the extent that the state sought to regulate some other relationship, the MFA would not apply, and the conflicting federal law would preempt the state law.¹⁷¹

Nevertheless, the court rejected the defendant’s argument—and, implicitly, the guidance in *Fabe* concerning whether to examine state statutes in whole or in part—and refused to “read [the Texas act] in a vacuum for the purpose of determining whether it was enacted ‘for

166. *Id.* (quoting *Bodine v. Webb*, 992 S.W.2d 672, 677 (Tex. Ct. App. 1999) (internal quotation marks omitted). Although this standard has its roots in the actual language of 15 U.S.C. §1012(b), the practice of parsing that language into discrete elements did not originate in the Texas appellate courts. Rather, *Bodine* cited to *Munich American Reinsurance Co. v. Crawford*, a Fifth Circuit case arising in a different context than medical malpractice arbitration. 141 F.3d 585 (5th Cir. 1998). *Munich’s* complicated facts boil down to a dispute between two insurance companies (one of which was held in receivership by the state) over whether monies paid out under an umbrella insurance policy constituted salvage to which the other company was entitled under the contract. *Id.* at 587.

167. *See Kepka*, 178 S.W.3d at 289.

168. *Id.*

169. *See U.S. Dep’t of Treasury v. Fabe*, 507 U.S. 491, 508 (1993).

170. *Kepka*, 178 S.W.3d at 289 (quoting *Fabe*, 508 U.S. at 505, 508). *Fabe* declared, “We hold that the Ohio priority statute, to the extent that it regulates policyholders, is a law enacted for the purpose of regulating the business of insurance. To the extent that it is designed to further the interests of other creditors, however, it is not a law enacted for the purpose of regulating the business of insurance.” *Fabe*, 508 U.S. at 508.

171. *See Kepka*, 178 S.W.3d at 289.

the purpose of regulating the business of insurance.”¹⁷² Instead, the court considered the statute “as a whole, rather than just the portion of the act” that arguably conflicts with federal law.¹⁷³ The court cited twelve specific “findings and purposes” given by the Texas Legislature in the act to buttress its conclusion that the purpose of the *entire* statute was to decrease the cost of health care liability claims through modifying the insurance system.¹⁷⁴ The court also noted that the act’s stated purpose was to “improve and modify the system by which health care liability claims are determined.”¹⁷⁵ Thus, according to the *Kepka* court, because the *entire* Texas act aimed to indirectly regulate the cost of malpractice insurance through doctor/patient arbitration, the act triggered the MFA, reverse preempting the FAA’s preemption of the Texas act.¹⁷⁶ The practical result was that the defendant’s motion to compel arbitration under the FAA was defeated.

Another state case that provides an important comparison to *Kepka* in the reverse preemption discussion is *Allen v. Pacheco*.¹⁷⁷ In *Allen*, the Colorado Supreme Court refused to compel arbitration on facts similar to those in *Kepka*.¹⁷⁸ The state statute at question in *Allen* specifically mandated that health care arbitration be voluntary by stating that no insurer could require a health care provider to use arbitration agreements as a condition to providing medical malpractice insurance.¹⁷⁹ The court concluded that the state’s arbitration agreement requirements were enacted for the purpose of regulating the business of insurance because they “not only directly regulate[d] contracts between health insurance policyholders and

172. *Id.*

173. *Id.* Other than citing two circuit court cases, the court provided no rationale justifying this approach in light of *Fabe. Id.* (citing *Munich Am. Reinsurance Co. v. Crawford*, 141 F.3d 585, 590, 592 (5th Cir. 1998) and *Stephens v. Am. Int’l Ins.*, 66 F.3d 41, 45 (2d Cir. 1995)).

174. *See id.* at 289–91.

175. *Id.* at 290 (quoting Act of May 30, 1977, ch. 817, § 1.02, Tex. Gen. Laws 2039, 2039–41 (1977) (repealed 2003)) (internal quotation marks omitted).

176. *See id.* at 291–92.

177. 71 P.3d 375 (Colo. 2003).

178. *Id.* at 377–78 (holding that a wife was not required to submit to arbitration in a wrongful death suit brought on behalf of her deceased husband in part because the MFA reverse preempted the FAA).

179. *See* COLO. REV. STAT. ANN. § 13-64-403(1) (West 2005).

their insurers (in this case, HMOs), but also further[ed] the interests of these policyholders.”¹⁸⁰ The court reasoned that because HMOs have largely replaced traditional health care insurers, a relationship between the HMO medical service provider and the patient is a relationship between an insurer and an insured.¹⁸¹ As such, even though the Colorado statute applied to health care providers rather than exclusively to insurers, the statute was enacted for the purpose of regulating insurance. The court noted that “[a]s long as the statute is not one of general applicability, it is not necessary that the state statute *relate only to insurance* or that the statute be in the form of an insurance code.”¹⁸² Thus, the *Allen* court went a step beyond *Kepka* and seemed to conclude that, even if the *entire* statute was not passed for the purpose of regulating insurance, a given statute would trigger the MFA so long as at least some of its provisions regulated the relationship between insurers and the insured.

3. *How Kepka and Allen got it wrong*

Dissenting from the *Allen* majority, Colorado Supreme Court Justice Rebecca Kourlis provides a useful starting point in critiquing

180. *Allen*, 71 P.3d at 383 (footnote omitted).

181. *Id.* at 383 n.9.

182. *Id.* at 383 (emphasis added) (citing *Mut. Reinsurance Bureau v. Great Plains Mut. Ins. Co.*, 969 F.2d 931, 934 (10th Cir. 1992)). However, *Great Plains*, like *Munich American Reinsurance Co. v. Cranford*, 141 F.3d 585 (5th Cir. 1998), discussed above, *see supra* note 166, addressed the reverse preemption question in the context of reinsurance proceeds. *See Great Plains*, 969 F.2d at 932–33. Other courts have reached a similar result in the HMO context. *See, e.g.*, *Imbler v. PacifiCare of Cal., Inc.*, 126 Cal. Rptr. 2d 715 (Cal. Ct. App. 2002); *Smith v. PacifiCare Behavioral Health of Cal., Inc.*, 113 Cal. Rptr. 2d 140, 156–57 (Cal. Ct. App. 2001). *Imbler* came on the heels of *In re Erickson v. Aetna Health Plans of California, Inc.*, 84 Cal. Rptr. 2d 76 (Cal. Ct. App. 1999), where the court had held that the California statute at question in both *Imbler* and *Erickson* conflicted with the FAA. *See In re Erickson*, 84 Cal. Rptr. 2d at 78. However, *Erickson* did not address the MFA question. In *Imbler*, a California court of appeals affirmed the trial court’s denial of an HMO’s motion to compel arbitration where the health care plan failed to make certain disclosures required by state law. *Imbler*, 126 Cal. Rptr. 2d at 723–24. The HMO argued that the state statute did not apply because it was preempted by the FAA. *See id.* at 716. The court rejected the HMO’s argument and held that the FAA did not preempt the statute because the MFA operated to defeat preemption. *Id.* at 719. The court reasoned that the act, which regulated the actual language and disclosure requirements in an HMO’s service plan, meant both that the HMO was engaged in the “business of insurance” and that the act was passed for the purpose of regulating the business of insurance. *Id.* at 721–23. Hence, although cited with approval in *Allen*, the California statute in question in *Smith* and *Imbler* make those cases clearly distinguishable from *Allen*. *See Allen*, 71 P.3d at 383 n.9.

the MFA's application in FAA preemption cases. Justice Kourlis argued that the Colorado statute failed to meet both requirements necessary to trigger the MFA: the law neither implicated the "business of insurance" nor was it passed for that purpose.¹⁸³ Rather than regulating the insurance policy itself, the statute aimed to control medical malpractice actions.¹⁸⁴ Justice Kourlis further argued that because the Colorado act applied "generally to medical service providers and their patients, and not specifically to the relationship between insurers and their insureds, it would be a law of general application" and should not be subject to the MFA.¹⁸⁵ Thus, Justice Kourlis would have held that the *Allen* defendant could compel arbitration under the FAA because the FAA preempted the Colorado act.

Justice Kourlis next touched on a crucial point that may provide the key to correctly following *Fabe* in the health care arbitration context. According to Justice Kourlis, "it is the placement of the arbitration clause limitation language . . . that must be the pivotal factor . . ." ¹⁸⁶ Justice Kourlis rightly points out that where a court applies the MFA to a provision governing arbitration, the legislature's placement of the provision should manifest its intent to regulate only certain arbitration agreements that impact insurance.¹⁸⁷ Justice Kourlis believed that the Colorado act did not manifest such intent; rather, it sought to contain and limit malpractice awards, reduce malpractice insurance premiums, and stem the exodus of doctors from the profession.¹⁸⁸ Under *Fabe*, however, statutes aimed at protecting or regulating *the insurance relationship*, whether direct or indirect, regulate the business of insurance.¹⁸⁹ Justice Kourlis seems to have ignored this language in her critique of the *Allen* majority's decision to apply the MFA to the Colorado statute, even though she acknowledges that the Colorado legislature passed at

183. See *Allen*, 71 P.3d at 384 (Kourlis, J., dissenting).

184. See *id.* at 387.

185. *Id.* at 387–88.

186. *Id.* at 388.

187. See *id.*

188. See *id.*

189. See *U.S. Dep't of Treasury v. Fabe*, 508 U.S. 491, 501 (1993) (citing *SEC v. Nat'l Secs., Inc.*, 393 U.S. 453, 460 (1969)).

least certain provisions within the act to (indirectly) reduce malpractice insurance premiums.

As a result, Justice Kourlis ultimately misapplied *Fabe* by concluding that because some provisions did *not* regulate the relationship between insurers and insured, no provision in the statute could trigger the MFA. However, Justice Kourlis's mistake is no more obvious than that of the *Allen* majority. Both opinions seemed to acknowledge the *Fabe* decision by pointing to discrete provisions that supported their conclusion that the Colorado act did (majority) or did not (dissent) regulate the business of insurance. But rather than applying the MFA only to that discrete provision, both opinions used their conclusions regarding discrete provisions to decide whether to apply the MFA to the *entire* statute. This is not entirely faithful to *Fabe*, which instead commands that the MFA should apply *only* to the extent that a statute regulates the relationship between insurers and insured.¹⁹⁰ The *Allen* majority and dissent may have found some common ground had they identified provisions in the statute that they felt were actually passed to regulate insurance relationships, and then applied the MFA only to those parts.

Dissecting a given statute in this way is a crucial exercise for a court determining whether a statute or provision should fall under the MFA. Because *Fabe* would apply the MFA to statutes regulating insurance relationships "directly or indirectly,"¹⁹¹ *Fabe* raises the question to what degree a statute can indirectly regulate insurance before it no longer falls within MFA protection. While this question cries out for clarification, observers are left to hypothesize a host of scenarios in which state legislatures and courts could eviscerate the FAA or other preemption statutes by relating everything to insurance premiums, regardless of remoteness. In her *Allen* dissent, Justice Kourlis uses the example of state seat belt and helmet laws, arguing that these laws could potentially relate indirectly to insurance premiums under the *Allen* majority's broad interpretation.¹⁹² Although this is not the best example, as such laws generally already fall within the realm of the state's plenary police power, it is easy to see how state laws regulating everything from interstate drug

190. *See id.* at 508.

191. *Id.* at 501 (quoting *Nat'l Secs.*, 393 U.S. at 460) (internal quotations omitted).

192. *See Allen*, 71 P.3d at 388 (Kourlis, J., dissenting).

trafficking to long-haul freight limits can quickly relate back to health and liability insurance. For example, assume that State X decided to pass a law capping the length of long-haul tractor-trailers entering the state.¹⁹³ To support its policy, the legislature makes ten or twelve findings of fact concerning the danger presented by trucks over a certain length. Prompted by this legislative declaration, a state court might reason that, because of these dangers, insurance carriers in the state are forced to charge higher premiums when trucks exceed that length. This might lead the court to conclude that, by capping the length, the legislature meant to indirectly regulate the relationship between the insurance companies and their policyholders, the commercial trucking companies. Although this is an extreme example, it demonstrates how a court's interpretation of what might "indirectly" regulate the business of insurance could quickly expand the scope of the MFA, placing it at odds with a host of federal statutes and the Commerce Clause.¹⁹⁴ The danger of the MFA running amok is compounded when courts are unwilling to follow *Fabe's* mandate to consider statutory provisions that further differing interests separately and apply the MFA only to those provisions that further the interests of policyholders.

This quandary underscores the basic problem with the *Kepka* decision. Unlike both the *Allen* majority and dissent, which at least attempted to identify provisions that indicated that the Colorado statute was passed to regulate insurance relationships, the *Kepka*

193. For the purposes of this illustration, ignore the fact that this extreme example would patently violate the Dormant Commerce Clause doctrine. See, e.g., *Raymond Motor Transp., Inc. v. Rice*, 434 U.S. 429 (1978).

194. There is an interesting interaction between the Supreme Court and Congress on the cross-roads between the Commerce Clause, the FAA, and the MFA. Under *Allied-Bruce Terminex Cos. v. Dobson*, the Court concluded that Congress passed the FAA intending it to extend to the full reach of its Commerce Clause authority. See 513 U.S. 265, 276-77 (1995). It is doubtful that, at a time when federal power was expanding rapidly under the Commerce Clause, Congress intended to surrender its newly found power back to the states. Hence, in any given context, courts determining whether a statute was enacted for the purpose of regulating the business of insurance under the MFA will run up against the pervasive FAA. This Comment posits that this collision has already occurred in *Kepka* and *Allen*, and that either Congress or the Supreme Court needs to clarify the issue. As discussed in Part IV.B above, there is little incentive for parties to pursue appellate review in the health care arbitration context. This serves as support for the argument that Congress should remove this issue by exempting these agreements from the FAA and saving continued appellate review of the MFA for other, more logical contexts.

court summarily concluded that the *entire* Texas statute was passed to regulate insurance relationships.¹⁹⁵ While it is true that the *Kepka* court took notice of the legislature's findings that the Texas act was passed to answer skyrocketing malpractice premiums, it is doubtful that patient protection provisions in the arbitration statute were passed for this reason, or that these provisions furthered the interests of doctor/policyholders (or the "insured" to use the *Fabe* phraseology).¹⁹⁶

The extent to which a state law may indirectly regulate insurance and avoid preemption under the MFA is not the only ambiguity to arise out of the Supreme Court's decision in *Fabe* when applied to the health care arbitration context. As noted above, both the *Kepka* and *Allen* courts made reference to the *Fabe* majority's holding by reasoning that a state statute could be enacted for the purpose of regulating the business of insurance "to the extent" that it regulated policyholders. Although technically accurate, this characterization is only half of the story. As mentioned above, the *Fabe* majority's holding also stands for the proposition that, to the extent a law furthered the interests of *other* parties besides the insurer and the insured, it was *not* enacted for the purpose of regulating the business of insurance.¹⁹⁷ This latter interpretation is supported by the dissent in *Fabe*, led by Justice Kennedy, which sharply criticized the duality of the majority's "compromise holding."¹⁹⁸ The purpose of a given statute, argued Justice Kennedy, either "is the regulation of the business of insurance or is not."¹⁹⁹ Justice Kennedy reasoned that, read as a whole, the statute considered in *Fabe*, which covered insurance company insolvency, applied to all creditors to which money was owed, not just policyholders.²⁰⁰ Because the statute was "not limited to entities within the insurance industry," it did "not regulate the relationship between the insured and the insurer."²⁰¹

195. See *In re Kepka*, 178 S.W.3d 279, 291 (Tex. Ct. App. 2005).

196. See *id.* at 289–90.

197. See *U.S. Dep't of Treasury v. Fabe*, 508 U.S. 491, 508 (1993).

198. See *id.* at 517 (Kennedy, J., dissenting).

199. *Id.* at 518.

200. See *id.* at 517.

201. *Id.* ("The statute governs the rights of all creditors of insolvent insurance companies, including employees, general creditors, and stockholders, as well as government entities.").

Hence, in light of both the *Fabe* majority and dissenting opinions, the *Kepka* and *Allen* courts both misapplied *Fabe*, though in different ways. The *Kepka* court seemed to ultimately favor the *Fabe* dissent's "all-or-nothing" approach, but probably expanded the scope of the MFA further than the *Fabe* dissent would have been willing to go.²⁰² Because the Texas act in *Kepka*, and specifically the arbitration provisions, applied to patients as well as insurers and policyholders, Justice Kennedy would not have applied the MFA in *Kepka*. By contrast, the *Allen* majority at least paid lip service to the *Fabe* majority's decision to parse the statute into discrete segments, but then proceeded to apply their reasoning to the whole statute. Even Justice Kourlis missed the mark by mirroring Justice Kennedy's reasoning in his *Fabe* dissent and concluding that the Colorado act in *Allen* did not fall under the MFA because it applied to others outside the insurance relationship. Because these cases incorrectly applied *Fabe*, they fail to provide an example of how a court might properly dissect a health care arbitration statute and apply the MFA only to the extent that the provision was passed to regulate an insurance relationship. This raises the question of whether the MFA is, necessarily, too blunt an instrument for courts to use to defeat FAA preemption and allow state statutes to govern doctor/patient arbitration agreements.

4. Legislative intent and the MFA dilemma

Part of the state court confusion in the health care context lies in the complexity of prevailing MFA case law, and the fact that *Fabe* and its ilk were decided in the anti-trust context.²⁰³ A more important piece of the puzzle, however, concerns the underlying policy behind state health care arbitration statutes and what they are meant to do.

202. The *Kepka* court specifically rejected the defendant nursing home's reliance on *Union Labor Life Insurance Co. v. Pireno*, 458 U.S. 119, 129 (1982), and *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205, 210–14 (1979), the very cases that the *Fabe* dissent used to determine that the statute in that case did not regulate the business of insurance. See *In re Kepka*, 178 S.W.3d 279, 291 n.14 (Tex. Ct. App. 2005); *Fabe*, 508 U.S. at 511 (Kennedy, J., dissenting).

203. See *Fabe*, 508 U.S. at 510, 516–17 (Kennedy, J., dissenting) (“[T]he statutory question the majority considers with care is difficult . . .”).

Utah's health care arbitration statute provides a useful case study of general application. If the UHCMA was meant to further the interests of malpractice insurance policyholders (doctors) and regulate their relationship with the insurance companies, it would make sense that it would fall under the MFA's protection. However, UHCMA legislative history and case law demonstrate that the arbitration provisions blend the interests of doctors and patients in negotiating arbitration agreements, largely stepping into the shoes of common-law contracts defenses, such as unconscionability.²⁰⁴ Thus, at least some provisions are meant to further the patients' interest by ensuring that the patient is fully informed of the scope of the arbitration agreement before he or she signs it.

Generally speaking, if a court finds that a given provision in a state statute is meant to protect patients instead of policyholders, *Fabe* probably requires that such provisions be considered separately. This is true even if an arbitration provision is passed as part of an overall legislative scheme to reduce frivolous lawsuits and lower medical malpractice premiums by extension.²⁰⁵ This may seem like

204. See *supra* text accompanying notes 57–59 (discussing *Soriano v. Graul*, 186 P.3d 960 (Utah Ct. App. 2008)).

205. Recall that the *Kepka* court fell into this exact trap—concluding that the *entire* Texas act was passed to regulate the business of insurance based on the act's statement of legislative purpose. See *In re Kepka*, 178 S.W.3d 279, 289 (Tex. App. 2005). Ironically, at least one state district court judge in Utah has made the same mistake in analyzing the enforceability of arbitration agreements under the UHCMA. See *Sonnenburg v. Welling*, Civ. No. 070902669 (Utah D. Ct. Feb. 29, 2008) (ruling dismissing defendant's motion to compel arbitration) (on file with author). In *Sonnenburg*, the state district court judge concluded both that the FAA preempted the UHCMA and that the MFA reverse preempted the FAA, rendering an arbitration agreement that did not comply with the state law unenforceable. *Id.* at 9. The defendant in that case had argued that the FAA trumped the UHCMA, making even a non-compliant arbitration agreement enforceable. According to the defendant, the court should have read the arbitration provisions separately from the legislative findings. Defendant further argued that the arbitration provisions dealt with the doctor/patient relationship, not the relationship between the insurer and the insured. *Id.* at 7. The court acknowledged that “the arbitration portion of the Utah act deals with the relationship between patient and doctor, not insurer and insured.” *Id.* (citation omitted). Nevertheless, the court concluded that “it would be incorrect for the Court to extract the arbitration portion of the act from the reaches of the legislative intent placed upon the entire act.” *Id.* The court further reasoned that the legislative findings indicated the Utah Legislature's intent to indirectly regulate health care costs. *Id.* at 7–8. Thus, “the [MFA] reverse pre-empts the [FAA] because the purpose behind the [UHCMA] was, *in part*, to regulate the business of insurance.” *Id.* at 9 (emphasis added).

The above subsections demonstrate that the *Sonnenburg* court, like the court in *Kepka*, misapplied *Fabe*. *Fabe* demands that the court apply the MFA only to the extent that it regulates the interests of policyholders. As a result, the analysis that the *Sonnenburg* and *Kepka*

splitting hairs, but it is an important conceptual distinction because of the way that *Kepka*, *Allen*, and other similar cases have turned out. Had those courts correctly applied *Fabe*, they would have concluded that although their state's statute was passed to indirectly regulate insurance premiums, their arbitration provisions actually furthered the interests of patients, rather than doctors and their insurance companies. This conclusion would have led those courts to find that the FAA preempts their state statute and mandates arbitration. Instead, each time the court applies a statute that was, according to the court, passed to regulate an insurance relationship by indirectly lowering insurance premiums, it actually operates to defeat the doctor/policyholder's motion to compel arbitration through reverse preemption, thus countering the legislative purpose trumpeted by the court. These are outcome-driven decisions by courts recognizing that these statutes are meant to protect patients, just like judicially created contract defenses. Thus, the court's desire to work equity clouds its ability to correctly interpret health care arbitration statutes in light of *Fabe*. As a result, the courts are forced into the logical inconsistency of using the MFA—which was passed to protect the interests of policyholders—to tip the policy scale toward patients and defeat the doctor/policyholder's motion to compel arbitration.

Granted, there is a healthy debate over whether, and under what circumstances, arbitration actually benefits physicians.²⁰⁶ Regardless

courts should have conducted was the very inquiry that they both specifically rejected—parsing out the portions of the acts that did not further the interests of insureds and refusing to apply the MFA to those provisions. In addition, in the case of the UHCMA, the *Sonnenburg* court's analysis seemed to utterly overlook the vast amounts of legislative history demonstrating that portions of the UHCMA were passed to further patient rights. In fact, the portions of the UHCMA that make the act vulnerable to the FAA—those that restricted enforceability of arbitration agreements—are the very ones that the Utah Legislature passed to further the interests of patients, not doctor/policyholders. Thus, the MFA would not apply to those provisions, and even arbitration agreements that do not comply with the UHCMA should be enforceable under prevailing federal law.

206. See, e.g., DeVille *supra* note 6, at 334 (“Ironically, although the innovation is typically supported with enthusiasm by most medical audiences, it is by no means clear that arbitration is good for all physicians all the time.”). For an interesting, but ultimately inconclusive, empirical approach to the supposed benefits of arbitration, see Erik Moller, Elizabeth Rolph, & John E. Rolph, *Arbitration Agreements in Health Care: Myth and Reality*, 60 LAW & CONTEMP. PROBS. 153, 180 (1997) (“Our research does not permit us to draw any evaluative conclusions regarding outcomes when binding arbitration agreements are in place.

of arbitration's true merits, however, a given legislature that passes an arbitration statute in answer to the skyrocketing malpractice insurance premiums must have already found that arbitration helps decrease those costs.²⁰⁷ Thus, legislative intent becomes the court's double-edged sword by which the legislature's determination that malpractice arbitration decreases malpractice insurance premiums is the very thing that will ultimately defeat a doctor/policyholder's motion to compel arbitration under the FAA. This may not be so dangerous where the legislature anticipated and intended this result, or where courts correctly dissect their state statutes under *Fabe*. However, the danger of courts undermining legislative intent increases exponentially where courts, like *Kepka* and *Allen*, misapply *Fabe* and greatly expand the range of statutes that are passed "for the purpose of regulating the business of insurance."²⁰⁸

The ironic result of the interpretive problems discussed above is that, although the FAA's aim was to overcome judicial hostility to arbitration, the MFA continues to provide state courts a way to circumvent the FAA's main purpose. At the same time, state legislatures have proven effective laboratories to balance the complex interests of doctors and patients.²⁰⁹ A clear statement from Congress exempting state health care arbitration statutes from the FAA would give the green light to states to continue to enact fair and predictable statutes. It would also prevent state courts from applying the MFA too broadly, avoiding undue conflict between the FAA and the MFA. Congress advanced specific policy objectives in passing both these statutes. Where interpretive trends in the MFA threaten to swallow the FAA in the health care arbitration context, Congress, not state or federal courts, should be the body to draw a clear demarcation line between them.

Our survey results are inconclusive as to whether agreements lead to faster, less expensive, and/or more satisfying results or whether arbitrators show any biases toward defendants or plaintiffs.").

207. Recall too, the above discussion of the "findings and purposes" of the UHCMA. *See supra* Part II.B.1. This legislative pronouncement also obviates the stringent need to protect the "national policy" favoring arbitration under the FAA. If state legislatures have already found that arbitration will lower medical costs and insurance premiums, they have every incentive to promote their enforceability. At the same time, state legislatures are in a better position to balance the competing patients' rights, a task that has, up to this point, been fulfilled by state law judges through the unconscionability doctrine.

208. 15 U.S.C. § 1012(b) (2006).

209. *See supra* Part II.

V. CONCLUSION

In some ways, state health care arbitration statutes have stepped into the shoes of common-law patient protections, such as unconscionability. Utah's UHCMA is one example, demonstrating a compromise between patients' rights and statutory solutions to growing health care costs. However, the FAA threatens to preempt this and other statutes that restrict the enforceability of arbitration agreements. Nevertheless, the FAA already acknowledges some state law "grounds as exist at law or in equity for the revocation of [a] contract."²¹⁰ This Comment has demonstrated that states are willing and able to legislate in this area. Although Supreme Court case law views these statutes as hostile to the "national policy" favoring arbitration, without them, the courts will apply unpredictable common-law principles in an ad hoc manner to protect patients. Currently, murky Supreme Court case law and a lack of incentive for parties to invoke the FAA leave many legal questions unanswered. As such, some courts have resorted to the MFA to reverse preempt the FAA and save their state laws. This solution is inadequate. To the extent that these statutes regulate the relationship between doctors and patients, they do not regulate insurance, which is necessary to invoke the MFA. Thus, by sanctioning state statutes in this area, Congress will help further the "national policy" in favor of arbitration while still allowing state legislatures to provide courts a predictable statutory framework to protect important patients' rights as well.

*James C. Dunkelberger**

210. 9 U.S.C. § 2 (2006).

* J.D. candidate 2011, J. Reuben Clark Law School, Brigham Young University. Special thanks to my wife, Ashley, whose help and support made this piece possible. The Author would also like to thank Will Hains, Carla Crandall, and the other editors of the BYU Law Review for providing invaluable substantive and technical guidance.

