CONSUMER EXPECTATIONS AND ACCESS TO HEALTH CARE

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INTRODUCTION

Americans—some of them at least—enjoy a remarkable range of expectations about their health care. They have come to rely on free choice of physicians, on autonomy and the doctrine of informed consent to care, on the belief that they can get the best care money can buy, on the assumption that resources will be available to pay for that care, and perhaps even on the hope that death can be cheated for at least a little while. But these expectations are fragile for those who have them, and they are not shared by many others. As the 1992 presidential campaign gathers steam, polls indicate that even the affluent are worried about whether their relatively secure access to health care will continue and what they will do if it does not.[1] Other Americans—the more than thirty-one million who lack health insurance[2]—continue to have few if any expectations about health care at all.

Changes in American health care are certain to disappoint some expectations, modify others, and create entirely new ones. Some of these changes are already accelerating, as union contracts are renegotiated with diminished health benefits, as major insurers pull out of entire markets, and as states such as Oregon propose significant revisions in their Medicaid programs or seek more ambitiously to fund care for greater proportions of their residents.[3]

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[1] *See, e.g.*, Don Colburn & Richard Morin, *Americans Grade Their Health Care*, WASH. POST, Dec. 31, 1991, at H6 (discussing health care poll results in light of upcoming elections).

[2] *See, e.g.*, Emily Friedman, *The Uninsured: From Dilemma to Crisis*, 265 JAMA 2491, 2491 (1991) (noting that the number of Americans who lack public or private coverage is between 31 and 36 million).

[3] For a description of the Oregon proposals, see Charles J. Dougherty, *Setting Health Care Priorities: Oregon's Next Steps*, HASTINGS CENTER REP., Supp. May-June

If any of the proposals for national health policy bear fruit soon, further changes are likely.[4]

Expectations appear with remarkable frequency in discussions of the current state of American health policy; the contributions to the first section of this symposium are no exception.[5] Sometimes, expectations are regarded sympathetically. A standard argument for construing ERISA as strongly protective of the health benefits of retired workers, for example, is protecting the expectations of retirees.[6] More often today, however, high levels of expectations about health benefits are portrayed as unrealistic and uneconomical. From the automobile industry to public utilities, the high costs of health insurance are a standing recessionary theme.[7] Critics of

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1991, at 1.

[4] For a discussion of the moral issues raised by some of the proposals for universal health care, see CHANGING TO NATIONAL HEALTH CARE (Robert P. Huefner & Margaret P. Battin eds., 1992) [hereinafter NATIONAL HEALTH].

[5] *See, e.g.*, Robert Blank, *Regulatory Rationing: A Solution to Health Care Resource Allocation*, 140 U. PA. L. REV.—,—(1992) (noting that "the public has developed unrealistic expectations"). [ED. NOTE-PIN IS BEFORE N.14]

[6] Musto v. American Gen. Corp., 615 F. Supp. 1483 (M.D. Tenn. 1985), *rev'd*, 861 F.2d 897 (6th Cir. 1988), *cert. denied*, 490 U.S. 1020 (1989), provides a good example of this.

> It would be contrary to the spirit of ERISA to hold that rights promised welfare benefit plans are mere gratuities terminable at the will of the employer. . . . Congress has sought to fortify retirement income—not by mandating that individuals get more of it—but by seeking to assure that such income provide a reliable predictable source of financial support. Once an employee has rendered his years of service to the employer, his "sweat equity," and has taken retirement, the employee furnishes little to the employer that generates revenue . . . . The retirees have no economic leverage, hence no bargaining position to check modifications of benefits made solely in the interest of their former employer. To permit the enforcement of termination/modification clauses without a showing of good cause has the effect of reducing the status of hard earned welfare plan benefits to mere gratuities. Accurate financial forecasting or retirement planning is impossible because continuation of the benefits is subject to the discretion of an employer. The exercise of such discretion without a "for cause" standard cuts against Congress' intent to safeguard these retirement benefits.

Id. at 1496-97. The desire to protect expectations figured prominently in congressional debates leading to the Act's passage: "As part of [ERISA's] closely integrated regulatory system Congress included various safeguards to preclude abuse and 'to completely secure the rights and expectations brought into being by this landmark reform legislation.'" Ingersoll-Rand Co. v. McClendon, 111 S. Ct. 478, 482 (1990) (quoting S. REP. NO. 127, 93d Cong., 1st Sess. 36 (1973)).

[7] For example, public utilities have generally provided their employees and retirees with first dollar insurance coverage, passing the costs on to consumers by rate increases. Consumer groups now argue that rate increases should not automatically

American expenditures on technology and on intensive care at the end of life blame unrealistic expectations about the power of health care to conquer death.[8] British commentators have long contended that Americans expect too much from health care generally and technology in particular.[9]

Nonetheless, despite their salience in policy discussions, expectations have received little direct examination. This Article is an attempt to further discussion of the moral and legal significance of some of the American consumers' most important expectations about their health care. Do any of these expectations matter morally? If so, which ones matter, and why? Or, are all expectations about access to health care simply unrealistic in today's world of spiralling health costs? Are expectations about access given legal protection, by statute or the common law of contract? If so, do the legal protections correspond even roughly to the moral picture about expectations?

This Article begins with an outline of the variety of consumer expectations about health care. It then presents some basic elements of a moral theory of expectations, and applies the theory to several examples of expectations about the level of care that will be funded and about the continuation of current funding arrangements. Summarized briefly, the conclusion is that the strongest moral case can be made for expectations of continued access to moderate levels of care when they have been encouraged by employers or insurers. The Article then turns to an examination of the current state of legal protection for health care expectations. As the costs of meeting even modest expectations of workers or retirees continue to escalate, these expectations increasingly are disappointed. Plant closures and industrial bankruptcies illustrate the burdens imposed by retiree benefits on some employers, and the resulting fragility of those benefits.[10] Under ERISA in particu-

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fund such generous health benefits, particularly for future retirees. *See, e.g.*, Milt Freudenheim, *Utilities Want to Raise Rates To Meet Future Health Costs*, N.Y. TIMES, Jan. 7, 1992, at D1 (discussing consumer advocate opposition to utilities' use of rate increases to cover health costs).

[8] *See* PAUL T. MENZEL, STRONG MEDICINE: THE ETHICAL RATIONING OF HEALTH CARE 190-91 (1990).

[9] *See, e.g.*, John G. Francis & Leslie P. Francis, *Rationing of Health Care in Britain: An Ethical Critique of Public Policy-making*, *in* SHOULD MEDICAL CARE BE RATIONED BY AGE? 119, 125-26 (Timothy M. Smeeding ed., 1987) (noting American inclination toward excessive medical treatment using complex and expensive technology).

[10] *See, e.g.*, *In re* White Farm Equip. Co., 788 F.2d 1186, 1193-94 (6th Cir. 1986) (upholding employer's termination of retired employees' welfare benefits in context

lar, the Article then argues, benefit protection has been limited to written contractual specifications. The result is legal protection of contractually based expectations, even if they are quite generous, but not protection of other expectations for which there is arguable moral support. This discontinuity, the Article concludes, provides a rich source of arguments for discussion of universal health policy in the United States. On the one hand, failure to meet legitimate expectations should be a matter of public concern. On the other hand, if some current expectations are unreasonable, public dialogue can help provide both a justification for decisions not to meet these expectations, and a context that shapes these expectations in more reasonable directions.

I. EXPECTATIONS ABOUT HEALTH CARE

"Expectations" are beliefs about the future upon which people rely in structuring their lives. Many different kinds of expectations are characteristic of contemporary American health care. Although the term "expectations" appears frequently in discussions of physician-patient relationships and of access to health care, there has been little systematic study of the actual expectations of either patients or physicians. Some studies in the social psychology literature have focused on expectations as they affect particular physician-patient encounters. For example, Russell Jones has studied how patients' expectations about symptoms and diseases affect their decisions about whether to seek care,[11] and Peter Ditto and James Hilton have examined how physicians' expectations affect diagnostic decisions and how patients' expectations affect compliance with therapeutic recommendations.[12] These studies, however, do not consider the extent to which economic factors contribute to the decision to seek treatment or, more generally, the extent to which both physician and patient expectations are shaped by health care organization and funding. Consequently, the descriptions of expectations which follow are somewhat speculative. They are postulated as characteristic of the kinds of expectations that patients

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of bankruptcy negotiation).

[11] *See, e.g.*, Russell A. Jones, *Expectations and Delay in Seeking Medical Care*, 46 J. SOC. ISSUES 81, 84-91 (1990) (concluding that expectations about bodily states, symptoms, and diseases produce delay in seeking medical care).

[12] *See, e.g.*, Peter H. Ditto & James L. Hilton, *Expectancy Processes in the Health Care Interaction Sequence*, 46 J. SOC. ISSUES 97, 109-17 (1990) (analyzing how expectations affect patient/provider interaction).

and physicians are likely to have within the current American health care system. For the purposes of this Article, they can be viewed as hypotheses that warrant further empirical study.

First, patients have a variety of expectations about their relationships with physicians. For some patients, these might be called "autonomy expectations"—that is, expectations of care that responds to their choices.[13] For others, they are expectations of paternalistic care—that is, of care that is aimed at protecting their best interests. These expectations frequently arise from experience within the health care system—for example, through the establishment of a particular provider-patient relationship of an ongoing and relatively longstanding nature. Expectations about provider-patient relationships might include: that one will be able to continue to receive treatment from the same provider, that one will be able to choose other providers, or that one will be able to seek referrals to specialists. At least some expectations of continued care find legal support in the doctrine that physicians may not abandon their patients.[14] It is important to note the extent to which these expectations are rooted in experience with the current system of health care in the United States; by comparison, patients in the United Kingdom generally do not expect to be able to shop around for other general practitioners or to seek specialist care on their own.[15]

Patients may also have expectations of autonomy or paternalism about the extent and nature of shared decisionmaking within provider-patient relationships. As the doctrine of informed consent has gained wider currency, patients may expect to be informed about risks and alternatives to proposed care, and to be educated about the risks of not seeking care.[16] Patients who have gone to

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[13] *See* Grahame Feletti et al., *Patient Satisfaction with Primary-Care Consultations*, 9 J. BEHAV. MED. 389, 397-98 (1986) (attempting to correlate patient expectations with patient satisfaction).

[14] *See, e.g.*, Ricks v. Budge, 64 P.2d 208, 211-12 (Utah 1937) (outlining physicians' obligations with respect to continuing treatment and withdrawal).

[15] *See, e.g.*, THOMAS HALPER, THE MISFORTUNES OF OTHERS: END STAGE RENAL DISEASE IN THE UNITED KINGDOM 97-105 (1989) (discussing the "docility of the British patient").

[16] Legal obligations now accompany some of these expectations. *See, e.g.*, Canterbury v. Spence, 464 F.2d 772, 786-88 (D.C. Cir.) (holding physicians to a reasonable patient standard of informed consent), *cert. denied*, 409 U.S. 1064 (1972); Truman v. Thomas, 611 P.2d 902, 906-08 (Cal. 1980) (holding that the right of informed refusal requires disclosure of the risks of forgoing care). There are many discussions of the significance of these changes in the law of informed consent; for the suggestion that physicians should clarify expectations about informed consent,

the trouble and thought of executing advance directives or specifications about organ donation may expect that their wishes will be honored by providers and by family members.[17] At the same time, from a more traditional perspective, patients may expect caring and paternalism.[18] Many patients probably also expect confidentiality and undivided loyalty on the part of their health care providers.[19]

Another set of expectations that patients have might be termed "expectations of the likelihood of success." Patients may have expectations about what medical care will be provided and what that care can or cannot do for them. American health law has fostered expectations through written contracts, for example, a plastic surgeon who promised a beautiful nose to an aspiring actress,[20] or a surgeon who promised an easy cure for a peptic ulcer.[21] More frequently, expectations about what care can do remain unarticulated premises in the provider-patient encounter. Commentators often note that Americans expect a great deal from technology, in contrast with the British who remain far more skeptical about what technology can achieve.[22] Other patients may expect that nothing

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see, for example, Jerry A. Green, *Minimizing Malpractice Risks by Role Clarification: The Confusing Transition from Tort to Contract*, 109 ANNALS OF INTERNAL MED. 234, 235-36 (1988) (arguing that roles and responsibilities of both physician and patient should be clarified expressly to avoid later tort disputes).

[17] State statutes governing the creation of advance directives may provide that it is unprofessional conduct to fail to honor a directive. *See, e.g.*, UTAH CODE ANN. § 75-2-1112(3) (Supp. 1991) (stating that "[f]ailure of an attending physician . . . to comply with a directive . . . constitutes unprofessional conduct").

[18] Franz J. Ingelfinger's *Arrogance*, 303 NEW ENG. J. MED. 1507, 1509-10 (1980), laments the ways in which a medical ethic of autonomy appears to brush aside expectations of being cared for.

[19] Arguments that professionals have obligations of confidentiality frequently presume that clients will not feel free to seek fully effective advice unless confidentiality is assured. *See* Monroe H. Freedman, *Professional Responsibility of the Criminal Defense Lawyer: The Three Hardest Questions*, 64 MICH. L. REV. 1469, 1469-74 (1966). There appear to be no controlled studies, however, that have assessed the importance of confidentiality to consultation in either law or medicine. For a defense of confidentiality that does not presume clients' expectations, see Bruce M. Landesman, *Confidentiality and the Lawyer-Client Relationship*, *in* THE GOOD LAWYER: LAWYERS' ROLES AND LAWYERS' ETHICS 191 (David Luban ed., 1984).

[20] *See* Sullivan v. O'Connor, 296 N.E.2d 183, 184-85 (Mass. 1973).

[21] *See* Guilmet v. Campbell, 188 N.W.2d 601, 603 (Mich. 1971).

[22] *See, e.g.*, HALPER, *supra* note 15, at 101 ("Less likely to complain, the British patient may be more likely to accept . . . his illness . . . ."); *cf* RUDOLF KLEIN, THE POLITICS OF THE NATIONAL HEALTH SERVICE 133 (1983) ("[I]nternational comparisons do not suggest that greater expenditure automatically leads to better health . . . and it is at least arguable that the improvement in the health of the nation would be greater if extra resources were, for example, devoted to better housing."). One very interesting longitudinal study of five family practices in London suggests that patients

can be done for them and delay seeking care as a result; in some lower socioeconomic groups, for example, the tendency is to regard aches and pains as an ineluctable part of the aging process rather than as symptoms worthy of medical attention.[23]

Expectations about available medical treatments and likely outcomes come from a potpourri of sources: popular culture, gossip, magazines, self-help books, and other mass media. They also come from the medical profession itself, as new interventions such as coronary bypass surgery or, now, balloon angioplasty are heralded publicly as dramatic improvements in care. Expectations also come secondhand, as patients share information about what their different doctors have told them. As it becomes further developed and better known, the movement toward practice standards and consensus conferences, now largely motivated by concerns about quality and cost,[24] may extend patient expectations still further with respect to the forms of care they receive and likely outcomes.

Perhaps the most important set of patient expectations for purposes of this study are expectations about economic access to medical services. Patients have expectations about the extent to which their care will be paid for by insurance or other sources. In the United States, these expectations are largely employment-related. Generous health benefits are surely incentives to many

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both expected more than they got (only 57% of those who had expected physical examinations actually received them) and got more than they expected (48% of those who had not expected prescriptions were given them). *See* MARGOT JEFFERYS & HESSIE SACHS, RETHINKING GENERAL PRACTICE: DILEMMAS IN PRIMARY MEDICAL CARE 287 (1983).

[23] *See, e.g.*, Jones, *supra* note 11, at 85 (noting that many elderly people in low socioeconomic areas suffer from symptoms for which no help is sought because of the incorrect belief that the symptoms are merely part of the aging process).

[24] For discussion of practice standards, see, for example, Ellison C. Pierce, Jr., *The Development of Anesthesia Guidelines and Standards*, 16 QUALITY REV. BULL. 61-64 (1990) (discussing early and recent standards for anesthesiologists); Michele L. Robinson, *Medical Practice Standards: HCFA Joins the Fray*, HOSPITALS, Dec. 5, 1988, at 18 (1988) (discussing the Health Care Financing Administration's approach to medical practice standards). For discussion of consensus conferences, see, for example, Jacqueline Kosecoff et al., *Effects of the National Institutes of Health Consensus Development Program on Physician Practice*, 258 JAMA 2708-13 (1987) (concluding that the consensus development conference is an important educational tool the effect of which could be enhanced by focusing on practice areas that need improvement and by encouraging follow-up programs); Paul M. Wortman et al., *Do Consensus Conferences Work? A Process Evaluation of the NIH Consensus Development Program*, 13 J. HEALTH POL. POL'Y & L. 469, 469-98 (1988) (identifying problems and suggesting modifications of the NIH Consensus Development Program three-day conferences).

peoples' choices of employers or even occupations. For example, both job security and the relative stability of health benefits have been offered as important incentives to employment in the public sector. Job mobility is discouraged significantly when employees who have employment-based insurance must risk insurance exclusions when they shift to new employers.[25] Expectations of job-related insurance may start with employment contracts; but they may not be limited to explicit contractual terms. Benefits contracts, for example, typically extend for limited periods, one to three years at most. Nevertheless, many employees throughout the 1970s and early 1980s experienced almost automatic renewal or moderate changes in their benefits. These employees may have come to expect the continuation of their employment benefits in roughly the same form as long as their employment continued, although they had no written contractual rights to the continuation. Some employers have used this continued availability of benefits to encourage employee loyalty and longevity of service.[26]

Retirement benefits are another area in which expectations may extend beyond explicit contractual commitments. Promises to continue to pay health insurance premiums, particularly before Medicare eligibility begins, have been used as inducements for early retirement; a hotly-litigated issue has been the extent to which these promises can be modified in light of rising insurance costs.[27] The willingness to engage in hazardous occupations may provide other examples, especially if the employer (or other insurers, including

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[25] *See, e.g.*, Paul Cotton, *Preexisting Conditions 'Hold Americans Hostage' to Employers and Insurance*, 265 JAMA 2451-53 (1991) (quoting Blue Cross spokesperson Julie Boyle as stating that "[p]reexisting condition clauses 'cause a lot of people to hang onto jobs because they're scared that if they switch they will go uncovered for a period of time for the condition they have'").

[26] For example, beginning in 1939, National Life and Accident Insurance Company established insurance programs for its agents and employees. From the 1940s until the 1970s, National Life used "paid up" retirement medical insurance benefits as a significant tool for recruiting and retaining agents. When National Life was acquired by American General Corporation in 1982, however, the costs of maintaining retiree benefit levels appeared increasingly problematic. American General successfully relied on reserved rights of contractual modification to slash the retirees' "paid up" benefits. *See* Musto v. American Gen. Corp., 615 F. Supp. 1483, 1486 (M.D. Tenn. 1985), *rev'd*, 861 F.2d 897 (6th Cir. 1988), *cert. denied*, 490 U.S. 1020 (1989).

[27] *See, e.g., id.* at 1486 (upholding employer's termination and modification of retirement benefits to employees who had left active employment); Marjorie M. Kress, *Benefit Vesting in Employee Health Plans*, 24 TORT & INS. L.J. 88 (1988) (discussing ways to minimize benefit vesting claims).

society) makes promises about the availability of care in the case of injury. Sometimes these promises too are overtly contractual, as in examples of sports contracts that promise continued medical care for injured players.

Physicians likewise have expectations about medical care, expectations that interact with the expectations of their patients. Physicians' expectations are formed largely in training and in practice. On the level of interactions with patients, some physicians may expect to be largely in control of the relationship; others may expect to function with the patient as partner.[28] There may well be generational differences here. Some physicians may expect little beyond pay from patients in return for continuing the care-giving relationship, while others may, in certain circumstances, not even expect to collect their fees. Some physicians may expect to receive compliance from patients and to be able to dismiss or refer patients who do not follow their orders.[29]

Of crucial importance to this Article is the degree to which physicians expect the physician-patient relationship to be insulated from financial and other third party pressures. In certain practice settings, the expectation may be that treatment decisions are increasingly dictated by managerial policy.[30] In this and other ways, the intrusion of third party judgments into physicians' decisions about patient care may be perceived as disrupting

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[28] Jay Katz's study of communication between doctors and their patients is as much about physicians' expectations as it is about the expectations of patients. *See* JAY KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT (1984).

[29] American physicians can terminate relationships with their patients, provided they give the patients notice that is adequate enough to allow them to seek alternative care. *See, e.g.*, Payton v. Weaver, 182 Cal. Rptr. 225, 229 (Cal. App. 1982) (noting that physician who abandons a patient may do so only after having provided notice and ample opportunity to seek other medical care). Payton was a dialysis patient who continued to be disruptive and noncompliant despite frequent warnings. The case appears to be the only reported example in which the court countenanced cessation of care despite the recognition that the patient had been unable to find an alternative. In the end, the patient agreed to inpatient psychiatric treatment and had dialysis continued. It is more difficult in the United Kingdom for physicians to rearrange care for their patients; one study of family practice physicians in London suggests that occasionally referrals to specialists occur because general practitioners cannot "fire" patients, but need relief from some patients whom they find difficult, recalcitrant, or unresponsive. *See* JEFFERYS & SACHS, *supra* note 22, at 53.

[30] For a discussion of the possibility that public or corporate policy might constrain physician behavior, see, for example, Paul Campbell & Nancy M. Kane, *Physician-Management Relationships at HCA: A Case Study*, 15 J. HEALTH POL. POL'Y & L. 591, 601-04 (1990) (analyzing effect of corporate and public ownership of hospitals on the physician-patient relationship).

physicians' expectations about trust and independent judgment. At least part of physician resentment of the increase in malpractice litigation and of the need to justify care to third party payers may stem from physicians' sentiment that their judgment has come under fire in ways that are both unexpected and undeserved. Physicians surely also have expectations about important aspects of the working conditions they will face: the ability to arrange calls, the difficulties of running a small business, or the ability to maintain an independent practice with privileges at several hospitals.

Like patients, physicians also may have expectations about what medical care can accomplish. These expectations may play a major role in the kinds of innovative therapies they encourage patients to pursue—for example, bone marrow transplantation for advanced breast cancer.[31] Physicians' expectations of success, while rooted in technology and controlled studies, may outstrip what data are available.[32]

Physicians surely also have expectations about income levels. These expectations may have affected choices about practice specialties. Primary care specialists in general have lower projected incomes than surgical specialists; recent controversy about calculating physician reimbursement under Medicare by means of a "resource relative value scale" reflected reactions to the possibility of changes in this balance.[33]

Finally, just as few studies have examined patient and physician expectations independently of one another, there has been little study of the extent to which physicians' expectations are congruent with those of their patients.

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[31] *See, e.g.*, Adams v. Blue Cross/Blue Shield, 757 F. Supp. 661, 677 (D. Md. 1991) (holding that high dosage chemotherapy combined with autologous bone marrow transplant was not experimental treatment for breast cancer and was covered by health plan).

[32] A pathbreaking sociological study of physicians' expectations about care is RENEE C. FOX & JUDITH P. SWAZEY, THE COURAGE TO FAIL: A SOCIAL VIEW OF ORGAN TRANSPLANTS AND DIALYSIS (1974). Jay Katz's work also describes the difficulty physicians have in admitting uncertainty, even to themselves. *See* KATZ, *supra* note 28, at 165-206.

[33] *See, e.g.*, William C. Hsiao et al., *Estimating Physicians' Work for a Resource-Based Relative-Value Scale*, 319 NEW ENG. J. MED. 835, 835-41 (1988) (describing a resource based relative-value scale as an alternative to a payment system based on charges for physician services); William C. Hsiao et al., *Resource-Based Relative Values: An Overview*, 260 JAMA 2347, 2347-444 (1988) (discussing policy and development of resource-based relative value scales).

The argument of this Article is not that all, or even any, of these expectations have moral weight. Indeed, there are no doubt major conflicts among some of these expectations; not all of them can be realized consistently. Frustration with changes in the current system of American medical care may well reflect some of these conflicts; even affluent doctors and affluent patients cannot get all that they have come to expect. If for no other reason than likely political acceptance, however, it is important to consider which, if any, of these expectations have moral weight, and what kind of moral weight they have. Does any of this present panoply of expectations of physicians and patients matter morally? Is their disappointment morally problematic? Should they be taken into account in the analysis or design of changes in our system of health care? These are large issues and the discussion which follows only begins to investigate them.

II. THE MORAL WEIGHT OF EXPECTATIONS

This Section presents a brief account of why expectations might have moral significance. On many views of morality, individual autonomy is taken to have moral significance; and expectations are related to autonomy, in the following way. Part of what is involved in treating people autonomously is respecting their ability to make choices and undertake plans.[34] If expectations are ignored altogether, individuals will not have minimally stable contexts within which to plan, or minimal assurance that their plans will be taken seriously. The importance of planning does not mean that all expectations are significant, or that expectations matter conclusively in settling issues of social justice. As Robert Nozick pointed out in *Anarchy, State, and Utopia*, wishing does not make it morally so; the expectations of some are not traps that ensnare others whatever they do.[35] Expectations do not, can not, and should not redefine underlying realities. Nonetheless, if people are to be taken seriously as choosers and planners, it is important at least to open up the question of whether expectations matter morally under some circumstances, and why they do.

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[34] *See, e.g.*, TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 67-119 (3d ed. 1989) (discussing the principle of autonomy); JOHN RAWLS, A THEORY OF JUSTICE 513-20 (1971) (discussing autonomy and objectivity).

[35] *See* ROBERT NOZICK, ANARCHY, STATE, AND UTOPIA 268-71 (1974).

Here are some features of expectations that are relevant to morals. First of all, expectations are based on beliefs about the future ("base beliefs"). The more unreasonable are base beliefs, the less moral weight they carry. People should not be encouraged to build their houses on quicksand, and then rewarded when they do. Base beliefs might be unreasonable because they are known or suspected to be false, or because they are known to lack the kind of support that might reasonably be called upon in favor of that type of belief. For example, a belief in the efficacy of a therapeutic modality that has either no, or highly suspect, scientific support would be an unreasonable base belief.

One of the most difficult problems here is that the reasonableness of beliefs is dependent on context. That is, the reasonableness of a belief rests on the support that is available to a given person at a given time, rather than on the inherent truth or falsity of the belief. Thus, if well-designed studies have confirmed the efficacy of a therapy, it is reasonable for physicians to believe that the therapy is efficacious. If there are no confirming studies, or if new studies question earlier findings, these beliefs about efficacy diminish in reasonableness. Lay beliefs about the efficacy of therapy may be reasonable if they have been based on efforts to seek out appropriate expert advice, even when the advice is in turn not adequately supported. But lay beliefs about efficacy are not reasonable if they are based on desperate hopes for cures despite explicit advice that there is nothing more to be done.

Encouragement is a second feature that favors giving expectations some moral weight. Without the acknowledgement that it is sometimes reasonable to rely on assurances that expectations will be fulfilled, much planning would be undercut. Encouragement includes promising or leading someone on, but it also reaches to failures to disabuse someone of beliefs where a disclaimer would ordinarily be expected. For example, an employer can encourage an employee to believe that her employment will not be affected by her expensive health needs by reassuring her outright that she "will always have a job as long as he's in charge." Or, an employer can encourage an employee by failing to tell her that her job is in jeopardy in situations in which these concerns would normally be articulated (i.e. a review of employee benefits utilization that is specifically directed to issues of overutilization and its burdens for the employer). To take a similar pair of examples, some employers have encouraged employees contemplating retirement to count on

continued health insurance benefits.[36] Others have simply failed to disabuse employees of these expectations, even in response to inquiries.[37]

Like the reasonableness of belief, the reasonableness of reliance is context-dependent. Encouragement matters particularly when it comes from a privileged source such as an employer or a physician, a source on whom it is reasonable to rely with respect to the matter in question. We rely on experts when they recommend courses of action, employers when they make assurances of job security, and family members when they say they will help carry out our wishes.

In addition to the source, other features of the situation may also contribute to the reasonableness of reliance. The longer the encouragement persists, the more reasonable the reliance. Diversity of sources may also be a factor; some of the most persistent expectations about health care are encouraged by a wide range of different sources, often cumulatively: individual physicians, physicians' organizations, Office of Technology Assessment reports, employers, insurance companies, the Department of Health and Human Services or state health departments, the Center for Disease Control, gossip among neighbors, the popular press, and dozens more.

Encouragement raises complex issues of moral responsibility and legal liability. For example, should encouragers ever be viewed as morally responsible for the disappointment of the expectations they foster? If so, should responsibility be limited to primary encouragers or should others who have played supporting roles be called upon to help satisfy encouraged expectations? Should encouragement be the basis for legal liability only in the context of antecedent legal obligations (those created by statutory duties, employment contracts, or the common law of provider-patient relationships)? Or, should reliance interests more broadly be the basis of legal liability and, if so, where should limits be drawn? Is there an argument for assigning the government a special role with respect to encouragement, when expectations are generated from a wide range of sources, or are in effect culturally generated? The

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[36] *See, e.g.*, Musto v. American Gen. Corp., 861 F.2d 897, 910-14 (6th Cir. 1988) (upholding employer's termination and modification of retirement benefits to employees who had left active employment), *cert. denied*, 490 U.S. 1020 (1989).

[37] *See, e.g.*, Armistead v. Vernitron Corp., 944 F.2d 1287, 1290-92 (6th Cir. 1991) (holding unlawful employer's decision to deny health benefits to retirees even though they had assumed that the benefits would be available and had written inquiries to the employer stating this belief prior to their retirement).

concluding section of this Article suggests that the fragility of some reasonable expectations, the difficulty of assigning responsibility for their encouragement, and the frequent lack of resources even when lines of responsibility can be established, are important parts of the current case for publicly supported, universal health care in the United States.

Another feature that counts in favor of according expectations moral weight is their connection to the fabric of an individual's life, to the individual's sense of who she is and what her aims are. These expectations are likely to be both deeply felt and especially important to the realization of future goals. Physicians' expectations of being able to deliver good quality medical care, and of being able to act with integrity in the interests of their patients, are examples of expectations that are important to their conceptions of who they are and what they want to become. Similarly, patients' expectations that they will continue to receive care such as rehabilitation has an important impact on the exercise of capacities and the perceived quality of life.

The discussion to this point has ignored any connection between expectations and an underlying theory of moral rights or justice.[38] Some expectations are generated in reliance on conditions that are just; others under conditions of injustice. The expectations of white South Africans about continued protection of apartheid or the property expectations of a slave owner might be examples of expectations that are generated under conditions of such injustice, and with such understanding and complicity in that injustice that they bear no moral force whatsoever. However, it does not follow that we should give no moral weight to any expectations that arise under conditions of imperfect justice, although the injustice of a background situation may diminish the moral weight of the expectations it generates. Moreover, the desirability of correcting injustice is an argument for overriding expectations that stand in the way of movement towards a more just state of affairs.

Nonetheless, expectations that arise under conditions of less than perfect justice give rise to some of the most difficult moral dilemmas we have about the funding of health care today.[39] For example, consider the scenario in which health care benefits have been promised in exchange for early retirement, but keeping that

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[38] This point was suggested to me by Allen Buchanan.

[39] Rawls calls moral theory about situations of less than perfect justice "partial compliance" theory. *See* RAWLS, *supra* note 34, at 8.

promise conflicts with keeping promises to other workers or society in general by, for example, forcing the employer to forego investment in expensive pollution control equipment. Here, the promise provides a moral argument for the expectation; the expectation is probably also reasonable, encouraged, and relatively important to the individual's well-being, particularly if she is not yet eligible for Medicare or has health needs that are not well covered by Medicare. On the other hand, the retirement promises may have been improvident or far more generous than was justifiable on the basis of considerations of justice, such as the employee's prior contributions or fairness to other generations of employees. As the conclusion to this Article suggests, an argument for universal health care is that it is a compromise solution to this dilemma. Under proposals for universal care, retirees would not be totally dependent on their former employers for health care benefits, although they might get less generous benefits under a universal system than they had originally been promised.

As another illustration of the moral conflicts raised by background injustice, consider a young adult with expensive, chronic health needs, including anticipated eventual transplant surgery. His wealthy parents have been able to meet his needs to date, and plan also to pay for the transplant. Yet there is some question about the justice of the underlying distribution of wealth or about the parents' manner of acquiring their wealth. A "one-tier" system of universal health care, which did not pay for the transplant at issue because it had determined that other needs such as prenatal care were more pressing, and which did not allow for the private purchase of additional care, would disappoint the young man's expectation that his transplant will be paid for by his parents. There is real moral tension here. On the one hand, the expectation may be longstanding, encouraged, crucial to survival, and based on a conception of parental obligations. It may have played a role in the young man's plans about his future—for example, what kind of lifespan and capacities he has expected to enjoy. The expectations of a funded transplant may have seemed reasonable under the current mixture of American health policy. On the other hand, it might not have been reasonable for the young man to expect social policy to continue to permit him to be the recipient of his parents' largesse. And there are certainly arguments of justice both against allowing people to continue to benefit from certain forms of unjust wealth distribution and against a health care system that permits wide differences between what is publicly funded and what can be

purchased privately. These more general considerations of justice may outweigh the patient's expectations that his parents will be allowed to pay for continued care.

To see how complex this dilemma is, compare this scenario about the young man with two other related scenarios. The first variation is a scenario in which organs are sold to the highest bidder, and the young man expects to have a very good chance of getting an organ because his parents are quite wealthy. In this scenario, the considerations of justice are surely strong enough to outweigh the young man's expectations. The second variation is a scenario in which the young man's *parents* were suddenly to tell him that they would not pay for the transplant because they had decided their money would be better spent on a charitable contribution to prenatal care. Here, additional moral support is lent to the young man's expectations if parents have moral obligations to support their adult children who are in medical need.[40] His parents may also have encouraged him in very direct ways and there may have been no reason whatsoever for him to have guessed they were likely to change their minds about paying for his care. Although the reasons of abstract justice that favor prenatal care are just as strong as they were in the argument about the allocation of resources by society, there are no special reasons to think that the parents have obligations to ensure good prenatal care. But there are reasons to think that the parents have obligations to care for their son, and so in this case we might conclude that the son's expectations override the more general concern for social justice.

Even if one could argue that it would be morally problematic to disappoint certain expectations, it does not follow that we are locked in, morally, to the status quo. The need for change might be important enough to override the disappointed expectations. But the expectations might still bear some moral weight in how we shape the change. For example, the introduction of a system of universal health insurance might phase changes in gradually, grandfathering certain existing claims, or allowing a parallel voluntary system to continue. Changes might be introduced only

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[40] There has been a great deal of recent discussion about the moral significance of special relationships. *See, e.g.*, THOMAS NAGEL, THE VIEW FROM NOWHERE 165 (1986) ("Most people would acknowledge a noncontractual obligation to show special concern for [parents, children, spouses, siblings, fellow members of a community or even a nation]."). But there has been little discussion about the interrelationships between special relationships and expectations.

after extensive public discussion of which expectations should continue to be fulfilled, and which expectations are unrealistically high. The possibility of compensating those who are especially dislocated by changes might also be considered.[41]

To summarize, reasonableness, encouragement, longevity, integrity, and consistency with an underlying theory of rights and justice all provide support for the recognition of expectations. Conversely, unreasonableness, overt discouragement, transitoriness, relative lack of importance, and background injustice all count against according expectations any weight.

In light of these factors, a relatively strong moral case can be made for some of the expectations described in the preceding section. For example, consider an employee such as Robert Musto, who for years was encouraged to stay with National Life Insurance Company by promises of retirement insurance benefits.[42] If benefit levels are low or moderate in comparison to employer-provided health benefits generally, as they were in the *Musto* case, these expectations are arguably reasonable, even in today's context of decline. As announced selling points for employment, retiree benefits are employer-encouraged—despite unheralded disclaimers in the actual benefits contract that the employer reserves the right to make changes unilaterally. These expectations may well be longstanding and crucial to the employee enjoyment of a minimum quality of life. Moreover, if the expectations are moderate, they are consistent with background justice at least to the extent that they do not lay claim to an unfair share of social resources.

Or consider the nearly 120,000 retired coal mine workers and their families who are insured under a fund established as part of the settlement of the bitter national coal strike in 1946.[43] The fund is now over $100 million in debt.[44] The retired miners insist that part of what encouraged them to stay in the mines was the promise of retirement benefits. Yet at the present time, so many

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[41] *See* Leslie Pickering Francis, *Expectations and the Design of a Universal Health Care System*, *in* NATIONAL HEALTH, *supra* note 4, at 209, 220-30 (discussing proposals for universal health care).

[42] *See* Musto v. American Gen. Corp., 615 F. Supp. 1483, 1486-88 (M.D. Tenn. 1985), *rev'd*, 861 F.2d 897 (6th Cir. 1988), *cert. denied*, 490 U.S. 1020 (1989).

[43] *See* Keith White, *Gov. Caperton Urges Governors to Protect Miners Health Benefits*, GANNETT NEWS SERV., Feb. 2, 1992, *available in* LEXIS, Nexis Library, GNS File.

[44] *See* STAFF OF JOINT COMM. ON TAXATION, 102D CONG., 1ST SESS., BACKGROUND ON RETIRED COAL MINERS' HEALTH BENEFITS (JCX-18-91) (1991), *reprinted in* DAILY REP. EXECUTIVES (BNA), Sept. 25, 1991, at L-19, L-19.

companies have gone out of business and so many others are uneconomical that only twenty-five percent of mining companies are supporting the benefit fund for the remainder.[45] The retired miners' expectations of the continuation of at least moderate levels of benefits are surely reasonable, encouraged, integral to their lives, and consistent with background justice. Yet unless federal support is forthcoming, these expectations are unlikely to be fulfilled.[46]

Other expectations described in the earlier section may be less persuasive in comparison to these examples. Expectations that there is always some new therapy to be tried, and that health care can conquer death if therapeutic attempts are sufficiently persistent, are unreasonable. Expectations that employers will continue to fund benefits at current levels, despite loudly announced and persistent disclaimers rather than silent and unnoticed ones, are not encouraged. If these expectations have moral weight, it must rest on considerations of justice independent of encouraged reliance. Expectations of very high levels of benefits, particularly those that transfer wealth from already less affluent to more affluent sectors of society, are not consistent with background justice and lack moral weight on this account.

Of course, in the real world of employee benefits, things are not always as clear cut as these examples might suggest. Consider the story of Kathryn Reilly.[47] Mrs. Reilly and her husband wanted a biological child badly enough to seek out extensive infertility care. Mr. Reilly, a public school teacher, had Blue Cross coverage that excluded "[s]ervices and procedures which are experimental/investigative in nature . . . [and] any treatment . . . not yet recognized as accepted medical practice by Blue Cross."[48] In 1984, Mrs. Reilly underwent successful in vitro fertilization. Nearly a year later, Blue Cross denied her $3000 claim for the procedure on the ground that it was experimental in nature because it had less than a fifty percent success rate.[49] The Reillys argued that their expectations that the care would be funded were reasonable and encouraged under the Blue Cross agreement: in vitro fertilization had been

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[45] *See* Keith White, *Funds Shrinking for Miner Benefits*, GANNETT NEWS SERV., Sept. 25, 1991, *available in* LEXIS, Nexis Library, GNS File.

[46] *See* Marjorie Cortez, *Retired Miners Fear They'll Lose Health Benefits*, DESERET NEWS, Jan. 11, 1992, at B1, B2.

[47] *See* Reilly v. Blue Cross & Blue Shield United, 846 F.2d 416 (7th Cir.), *cert. denied*, 488 U.S. 856 (1988).

[48] *Id.* at 419.

[49] *See id.* at 422-23.

presented to them by their physicians as an accepted treatment for infertility, and Blue Cross had not said anything to indicate that they would deny the claim during the time the policy was in effect.[50] Blue Cross argued, on the other hand, that in vitro fertilization was not recognized as standard therapy, and that the Reillys had been encouraged only by their physicians, experts in infertility care, who wanted to further acceptance of the innovation.[51]

The Reillys' desires for a biological child were arguably central to their lives as they saw them. On the other hand, these desires would be viewed as less compelling if the goals of health care are taken to be relieving pain and preserving quality of life.[52] Finally, whether payment for in vitro fertilization is an unjust demand in a system that does not fund any health care for over thirty-one million people[53] is surely controversial. These kinds of disputes about the moral weight of expectations figure centrally in the legal cases that challenge denials of health care funding.

III. CURRENT LEGAL TRENDS AND THE LIMITED PROTECTION OF EXPECTATIONS

The topics discussed in this Section are important sources of contemporary legal development, but they are by no means the only areas of health care in which expectations receive limited legal protection. First, employer-provided health benefit plans are largely governed by the federal Employee Retirement Income Security Act of 1974 (ERISA).[54] ERISA protects expectations to the extent they are memorialized in written benefits contracts; it has effectively forestalled state statutory or common law efforts to extend the protection of expectations beyond contractual terms.[55] The result is that expectations about benefits that are otherwise reasonable, encouraged by unwritten employer assurances or perhaps by silence,

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[50] *See id.* at 420.

[51] *See id.* at 427 (Posner, J., concurring and dissenting) ("As it happens [the Reilly's] physicians are specialists in the treatment of fertility and naturally wanted to encourage the use of an exciting and promising treatment.").

[52] For example, the Oregon proposal categorizes in vitro fertilization as "services valuable to certain individuals," and assigns it a relatively low priority as a result. *See Oregon Basic Health Services Program*, *in* Dougherty, *supra* note 3, app. at 10.

[53] *See supra* note 2.

[54] Pub. L. No. 93-406, 88 Stat. 829 (1974) (codified as amended at 29 U.S.C. §§ 1001-1461 (1988 & Supp. I 1989)).

[55] *See infra* notes 68-82 and accompanying text.

important to peoples' lives, and consistent with background justice, receive little if any legal protection.

Second, job loss as a result of ill-health or expensive health care needs is another significant threat to expectations of continued health benefits. Under federal law, discharged employees enjoy an eighteen-month grace period during which they can continue group health benefits at their own expense.[56] However, these continuation rights do not protect employees against an employer's decision to cease to provide health benefits to any employees, or to reduce drastically the level of health benefits. Third, insurers' decisions to pull out of entire markets are another very important threat to the stability of health insurance. There is very little that can be done under current law to challenge these decisions. Thus employees who may have thought they could count on health benefits may find that in several important areas they cannot, and that the law gives them limited protection when these expectations are not met.

A. *ERISA*

The Employee Retirement Income Security Act of 1974 is a comprehensive federal effort to protect workers from underfunded, poorly managed, or illusory pension plans.[57] ERISA also governs employee welfare benefit plans—that is, benefit plans other than pensions, including health benefits.[58] Although ERISA sets out extensive standards for the vesting and funding of pension plans, it has no comparable substantive standards for welfare plans.[59] Indeed, courts have viewed Congress as explicitly intending through ERISA to grant employers wide flexibility in developing their non-pension benefit plans.[60] ERISA protection of employee health benefits rests solely on notice[61] and reporting requirements[62] and

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[56] *See infra* notes 130-35 and accompanying text.

[57] *See* 29 U.S.C. §§ 1001-1461 (1988 & Supp. I 1989).

[58] *See id.* § 1002(1).

[59] *See, e.g.*, Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 732 (1985) ("[ERISA] does not regulate the substantive content of welfare-benefit plans.").

[60] *See, e.g.*, Adams v. Avondale Indus., Inc., 905 F.2d 943, 947 (6th Cir.) ("Welfare benefit plan administrators . . . are explicitly exempted . . . from the obligations of the participation and vesting sections and the funding sections of the Act."), *cert. denied*, 111 S. Ct. 517 (1990); *In re* White Farm Equip. Co., 788 F.2d 1186, 1193 (6th Cir. 1986) ("Congress expressly exempted employee welfare benefit plans from stringent vesting, participation, and funding requirements.").

[61] *See* 29 U.S.C. § 1021(a) (1988 & Supp. I 1989).

[62] *See id.* § 1021(b).

on the requirement that the plan be administered by a designated fiduciary.[63] With respect to the creation of employee expectations, perhaps the most important of these ERISA requirements are that any health benefit plan be set out in a written instrument[64] and that employees be provided with periodic summaries of the plan's provisions. These summaries may recede into relatively distant reminders, however: they are required initially, with updates every five years thereafter if there have been plan changes, and republication every tenth year if there have been no changes.[65] ERISA also requires that employees be given notice of changes in the plan[66] and have access to the full written description of the plan if they so desire.[67]

Perhaps the most far-reaching consequence of ERISA for employee health benefits has been its pre-emption of state regulation of employee benefit plans, both pension plans and other employee welfare plans. Quite simply, ERISA preempts any state law that relates to employee benefit plans.[68] The United States Supreme Court has construed this preemption language expansively, to include any state regulation that "relates to" benefit plans in any way, rather than more narrowly to include only state regulation that might impinge on the core protective aims of ERISA.[69] Thus, common law tort and contract suits challenging refusals to pay benefits "relate to" benefit plans.[70] So do suits alleging that an employee was wrongfully discharged for utilizing employer-provided insurance benefits.[71] So do state statutes prohibiting insurers from requiring employees to make reimbursement when they receive third party repayment for claims.[72]

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[63] *See id.* § 1102(a).

[64] *See id.* § 1102(a)(1).

[65] *See id.* §§ 1021(a), 1024(b)(1).

[66] *See id.* § 1024(b)(1).

[67] *See id.* § 1024(b)(2).

[68] *See id.* § 1144(a).

[69] *See, e.g.*, FMC Corp. v. Holliday, 111 S. Ct. 403, 407 (1990) ("The pre-emption clause is conspicuous for its breadth. It establishes as an area of exclusive federal concern the subject of every state law that 'relates to' an employee benefit governed by ERISA." (citing 29 U.S.C. § 1144(a))).

[70] *See, e.g.*, Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 47 (1987) (holding that "[t]here is no dispute that the common law causes of action asserted in Dedeaux's complaint 'relate to' an employee benefit plan and therefore fall under ERISA[]").

[71] *See, e.g.*, Ingersoll-Rand Co. v. McClendon, 111 S. Ct. 478, 483 (1990) (finding that employee's discharge because of failure to contribute to a pension fund created a cause of action that related to an ERISA plan).

[72] *See, e.g., FMC Corp.*, 111 S. Ct. at 408-11 (1990) (holding that a Pennsylvania

Despite its preemption of state law relating to benefits plans, ERISA contains a "savings clause" which exempts state law that "regulates insurance" from ERISA preemption.[73] This "savings clause," has been construed broadly by the United States Supreme Court, in a challenge to state mandated-benefit laws.[74] Applying what it characterizes as a "common-sense" understanding of laws regulating insurance, the Court concluded that Massachusetts' mandated inclusion of minimum mental health benefits in insurance contracts was not preempted by ERISA, at least as applied to contracts purchased by employers for their employees in the general insurance market.[75] Subsequent cases quickly concluded that the common-sense understanding of insurance regulation did not extend beyond state regulation aimed specifically at insurance.[76] The insurance exemption does not save more general tort and contract doctrines that might be applied to insurance relationships, such as the availability of punitive damages for bad faith refusals to make good on contract claims.[77]

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antisubrogation law was preempted by ERISA).

[73] *See* 29 U.S.C. § 1144(b)(2)(A) (1988).

[74] *See* Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 740 (1985).

[75] *See id.* at 740-41.

[76] *See, e.g.*, Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 50 (1987) ("A common-sense view of the word 'regulates' would lend to the conclusion that in order to regulate insurance, a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry.").

[77] *See id.* at 47-57. For a particularly detailed recent application of *Pilot Life*, developing the distinction between general state law and laws regulating insurance, see International Resources, Inc. v. New York Life Ins. Co., 950 F.2d 294 (6th Cir. 1991). Larry Smith had purchased major medical insurance from Trans Pacific and its successor New York Life, under a multi-employer trust pooling the resources of small employers. As a result of an automobile accident, Smith's son became a mute quadriplegic requiring 24-hour nursing care. Some time later, New York Life canceled the group policy. Kentucky law forbids the cancellation of an insurance policy once liability has attached, *see id.* at 299; New York Life claimed that ERISA preempted the Kentucky prohibition, *see id.* The Sixth Circuit held that ERISA preempted any claims based on general Kentucky law: the Kentucky common law of contracts, any tort claims for bad faith claims denials, and any claims based on Kentucky statutes prohibiting unfair trade practices as incorporated into the insurance code. *See id.* at 299-300. One of Smith's claims did survive under the savings clause, however: the claim based on Kentucky statutes governing the terms of conversion policies issued by successor insurers was held to be a law directly regulating insurance under the savings clause. *See id.* at 300-01. Now ask: Should Larry Smith's ability to continue to receive insurance coverage for his son's catastrophic care depend on whether regulation of conversion policies is part of "insurance law," narrowly construed? Is this what Larry Smith might have thought about when he purchased the policies from Trans Pacific and New York Life?

One other crucial ERISA provision, the "deemer clause," extends the reach of preemption still further. Under the "deemer clause," benefit plans that are self-funded by employers are not deemed to be in the business of insurance for the "purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies."[78] The deemer clause, too, has been broadly construed; employer-funded plans are exempt not only from state regulation of the insurance business, but from any state regulation of insurance contracts.[79]

The results of the deemer clause—fully recognized by the Supreme Court[80]—are major disparities between the regulatory structure that applies to employer-funded benefit plans and the structure that applies to plans purchased for their employees by employers in the regular insurance market. The disparities are absolutely pivotal for the possibilities of reforming American health policy at the state level. Self-funded plans are not subject to state laws mandating benefits, whereas commercial insurance contracts are subject to mandates and may be notably more expensive as a result. It should not be surprising that by 1991 a significant proportion of larger employers had moved to self-insuring their employees' health plans, a move made even easier by the purchase of reinsurance for claims over a relatively modest amount such as $50,000.[81] ERISA's insulation of self-funded plans from state regulation has proved a major barrier to states' efforts to extend the scope of the health benefits available to their citizens.[82]

This general structure of ERISA preemption has had notable effects on litigation challenging employers' decisions that disappoint employees' expectations about health benefits. Evolving state common law doctrines have been cut off abruptly in favor of

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[78] *See* 29 U.S.C. § 1144(b)(2)(B) (1988).

[79] *See* FMC Corp. v. Holliday, 111 S. Ct. 403, 411 (1990); *Metropolitan Life*, 471 U.S. at 741.

[80] *See Metropolitan Life*, 471 U.S. at 747.

[81] Telephone Interview with Thomas Hartford, Staff Attorney, Blue Cross/Blue Shield of Utah (Feb. 26, 1992).

[82] *See* Henry Aaron, SERIOUS AND UNSTABLE CONDITION: FINANCING AMERICA'S HEALTH CARE 123 (1991); Robert Huefner, *Designing a Health Care System: Considering the Need to Know*, *in* NATIONAL HEALTH, *supra* note 4, at 251, 257. The notable exception is Hawaii, which has received ERISA exemption for programs in effect before ERISA. *See* Michael G. Pfefferkorn, Comment, *Federal Preemption of State Mandated Health Insurance Programs Under ERISA–The Hawaii Prepaid Health Care Act in Perspective*, 8 ST. LOUIS U. PUB. L. REV. 339 (1989).

ERISA's focus on explicit contractual language. These trends are apparent with respect to both the modification or cancellation of group benefit plans, and the denial of individual benefit claims. Their result is that expectations, no matter how morally persuasive, are increasingly not legally protected unless they are contractually specified.

1. Modification or Termination of Health Benefit Plans

As retiree health benefit plans have become increasingly expensive, and as traditional manufacturing industries have faced economic decline, pressures have mounted to modify or discontinue benefit plans for retirees, plans that may have existed for decades. Retiree benefits are not mandatory subjects of collective bargaining; unions representing the current generation of workers have understandably not been motivated to protect the retired generation whom they no longer represent. The result has been a series of cases challenging plan modifications or cancellations, particularly in the mid-western Sixth Circuit. The Sixth Circuit cases illustrate how ERISA preemption has moved legal analysis towards the rights established or reserved in the written benefit contract.

The Sixth Circuit cases began with the closure of Yard-Man's Jackson, Michigan, plant; the expiration of the collective bargaining agreement covering workers at the plant; and Yard-Man's decision to terminate retiree health insurance benefits at the end of the bargaining agreement.[83] The retirees contended that despite the plant closure they had been promised lifetime health benefits under the collective bargaining agreement.[84] The employer claimed that the bargaining agreement only promised retirement benefits equivalent to the benefits of active employees, benefits that had ended with the plant shutdown.[85] The Sixth Circuit applied traditional principles of contractual interpretation to contrast explicit durational language in the provisions applying to active workers with ambiguous language in the provisions applying to retirees, and to conclude thereby that the agreement did not intend to limit the retirees' benefits to the duration of the plant's operation.[86] The Sixth Circuit also pointed out that workers contem-

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[83] *See* Local 134, UAW v. Yard-Man, Inc., 716 F.2d 1476, 1478-79 (6th Cir. 1983), *cert. denied*, 465 U.S. 1007 (1984).

[84] *See id.* at 1480.

[85] *See id.* at 1480-81.

[86] *See id.* at 1480-81.

plating retirement would insist on lifetime benefits, because they could not always expect unions to negotiate for them, and because retiree benefits are "in a sense 'status' benefits which, as such, carry with them an inference that they continue so long as the prerequisite status is maintained."[87]

The *Yard-Man* decision was initially read as a broad charter for retiree rights under federal labor law.[88] But *Yard-Man* was not an ERISA case. Soon after *Yard-Man*, the Sixth Circuit faced the impact of ERISA preemption on retiree benefits.[89] White Farm Equipment Company, reorganizing in a bankruptcy proceeding, sought to reduce expenses by terminating the health benefits it had offered to its retirees.[90] To justify the cancellation, White Farm relied on a summary of the benefit plan, which had been given to employees and which reserved the right to change or discontinue the plan.[91] The employees sought to invoke a principle of Ohio common law that retiree benefits vested at retirement and could not be terminated thereafter.[92] The Sixth Circuit found that ERISA preempted Ohio law and clearly exempted retiree health benefits from any vesting requirement otherwise imposed by the state.[93] The White Farm retirees were thus forced to argue that the plan summary which they had been given was ambiguous and could be interpreted to establish vested rights to health benefits.[94]

In cases after *White Farm*, the Sixth Circuit applied ERISA to limit retirees to claims based on the interpretation of their written benefits contracts. For example, Robert Musto and other retired employees of National Life and Accident Insurance Company, had brought a class action challenging major reductions in their health

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[87] *Id.* at 1482.

[88] *See, e.g.*, Musto v. American Gen. Corp., 615 F. Supp. 1483, 1499 (M.D. Tenn. 1985) (holding that *Yard-man* requires that the terms of agreements "be construed to avoid nugatory and illusory promises," thus, "an express, unqualified grant of a right, rejected by an express unqualified reservation" constitutes an illusory right and is forbidden in the context of retiree benefits), *rev'd.*, 861 F.2d 897 (6th Cir. 1988), *cert. denied*, 490 U.S. 1020 (1989).

[89] *See, e.g., In re* White Farm Equip. Co., 788 F.2d 1186, 1187 (6th Cir. 1986) (examining the impact of ERISA on "an 'assignment and assumption' agreement" affecting retiree benefits).

[90] *See id.* at 1188.

[91] *See id.* at 1188-89.

[92] *See id.* at 1189.

[93] *See id.* at 1193.

[94] The documentary situation was actually quite complex: White Farm employees had been given several different summaries of their benefits and White Farm had not produced an overall document describing the plan. *See id.*

insurance benefits after National Life was acquired by American General Corporation.[95] Relying on *Yard-Man*, the Musto plaintiffs had succeeded in obtaining a preliminary injunction from the district court against the changes in the plan.[96] In reversing the district court, the Sixth Circuit, following *White Farm*, relied on language in the benefit policies reserving the right to change or terminate the plan.[97] Despite evidence that National Life had championed its retirement benefits to encourage employee loyalty, the Sixth Circuit refused to allow the plaintiffs to use evidence of oral representations to establish that National Life had reached additional contractual understandings that estopped them from modifying or terminating retiree health benefits.[98] ERISA's requirement of a written plan document, the court concluded, was designed to protect plan participants—employers as well as employees—against the vagaries of oral assurances.[99] *Musto* did not reach the issue of whether other written documents provided by the employer could be relied upon to modify the contractual agreement as found in the employer's description of the health plan.[100]

In its most recent cases applying ERISA preemption to the modification of benefits plans, the Sixth Circuit has in effect developed a federal version of the parol evidence rule of contracts. In *Armistead v. Vernitron Corporation*,[101] a group of employees took early retirement at the time of a plant closure, on the understanding that they were trading reduced pension benefits for the continuation of their health insurance. They sought to use evidence that their employer had specifically assured them in benefits seminars that they would receive the health benefits, to demonstrate that the apparent reservation of the right to amend benefits found in the written plan summary did not accurately reflect the parties' actual agreement.[102] The Sixth Circuit allowed the retirees to introduce the evidence extrinsic to the written instrument on the traditional contract theory that parol evidence is admissible to reform mistaken

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[95] *See* Musto v. American Gen. Corp., 615 F. Supp. 1483 (M.D. Tenn. 1985), *rev'd.*, 861 F.2d 897 (6th Cir. 1988), *cert. denied*, 490 U.S. 1020 (1989).

[96] *See id.* at 1498-99, 1505-06; *Musto*, 861 F.2d at 906-07.

[97] *See Musto*, 861 F.2d at 907.

[98] *See id.* at 909-10.

[99] *See id.* at 910.

[100] *See id.* at 907.

[101] 944 F.2d 1287 (6th Cir. 1991)

[102] *See id.* at 1298.

contractual writings.[103] In addition, the Sixth Circuit allowed the retirees to contend alternatively that Vernitron was estopped from asserting its contractual rights because of the assurances made by its benefits representatives.[104] But the court in *Armistead* did not allow the plaintiffs to use oral evidence to *modify* the contractual agreement. *Armistead* was a remarkably sympathetic case for the plaintiffs on the facts; they had asked specifically whether their health benefits would continue in exchange for their reduced pensions, and had been assured that they would. These facts allowed the Sixth Circuit to apply the doctrine of reformation, harkening back to *Yard-Man* themes of protecting retirees' expectations; but its interpretation of ERISA has limited the use of oral assurances to the situations in which extrinsic evidence may be introduced to show that a contract was not really what the writing makes it seem, and to preempt broader state law theories of reliance or good faith. The upshot, therefore, is that employers can ensure that they are legally free to amend or terminate benefit plans by careful drafting of the written instruments that set out the plans. The Sixth Circuit has not been alone in refusing to allow assurances extrinsic to the written benefits contract to be used to modify the contractual understanding.[105]

2. ERISA Preemption and Individual Claims

A second important regulatory feature of ERISA as it applies to employee welfare plans is that it holds plan administrators to the standards of fiduciaries.[106] Fiduciary standards apply to decisions interpreting benefit plans; they are not a back door way to include substantive guarantees in insurance plans.[107] However, ERISA's

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[103] *See id.*

[104] *See id.* at 1300.

[105] *See, e.g.*, Alday v. Container Corp. of Am., 906 F.2d 660, 666 (11th Cir. 1990) (refusing to refer to extrinsic communications between the parties' to determine the parties' intent), *cert. denied*, 111 S. Ct. 675 (1991); Cefalu v. B.F. Goodrich Co., 871 F.2d 1290, 1297 (5th Cir. 1989) (holding that oral agreements cannot form the basis of a cause of action under ERISA); Central States, S.E. & S.W. Areas Pension Fund v. Gerber Truck Serv., Inc., 870 F.2d 1148, 1154 (7th Cir. 1989) (en banc) (holding that oral understandings between the union and the employer that contradict a written pension plan will not be given effect by the court); Moore v. Metropolitan Life Ins. Co., 856 F.2d 488, 492 (2d Cir. 1988) (holding that absent proof of fraud an ERISA plan cannot be amended by parol evidence).

[106] *See* 29 U.S.C. §§ 1101-1114 (1988 & Supp. I 1989).

[107] *See* Nazay v. Miller, 949 F.2d 1323, 1331 (3d Cir. 1991) (determining that the employer may insist on precertification for admission as part of a managed care plan

fiduciary requirements may subject plan administrators to relatively strict judicial scrutiny of decisions to deny benefit claims. In *Firestone Tire & Rubber Co. v. Bruch*,[108] the United States Supreme Court held that because of the fiduciary obligations of plan administrators, actions challenging denials of benefits based on plan interpretations must receive *de novo* judicial review.[109] When the plan administrator exercises discretionary authority, however, benefit denials are to be reviewed on the more deferential arbitrary and capricious standard.[110]

The *Firestone* decision means that the extent of judicial scrutiny of decisions to deny benefits will depend on the way in which the benefits agreement structures the decisionmaking authority of the plan administrator. For example, the requirement that a plan pay for "medically necessary treatment" will subject claims denials to *de novo* judicial review; but the requirement that a plan pay for "medically necessary treatment as determined by the plan administrator" will subject denials to review on the more deferential arbitrary and capricious standard.[111] The Eleventh Circuit concluded—somewhat reluctantly, it appeared—that this result is necessary if employers or insurers are to be given the benefit of their bargains.[112]

The extent of discretion conferred on plan administrators has been especially pivotal in cases challenging decisions to deny benefits on the ground that the proposed treatment was experimental. In Maryland, for example, several patients with advanced breast cancer sought coverage from their Blue Cross plans for high dose

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and holding that decisions about plan benefits are the employer's prerogative and not subject to review on the arbitrary and capricious standard that applies to the decisions of fiduciaries managing ERISA plans); Adams v. Avondale Indus., Inc., 905 F.2d 943, 949 (6th Cir. 1990) (quoting Musto v. American Gen. Corp., 861 F.2d, 897, 912 (6th Cir. 1988), *cert. denied*, 490 U.S. 1020 (1989), which held that fiduciary standards do not apply to plan modifications), *cert. denied*, 111 S. Ct. 817 (1990).

[108] 489 U.S. 101 (1989).

[109] *See id.* at 108, 110.

[110] *See id.* at 111.

[111] *See, e.g.*, Brown v. Blue Cross & Blue Shield, 898 F.2d 1556, 1559 (11th Cir. 1990) (citing Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989) for the proposition that there should be *de novo* judicial review of an ERISA benefits denial decision "'unless the benefit plan gives the administrator or fiduciary discretionary authority'"), *cert. denied*, 111 S. Ct. 712 (1991); Adams v. Blue Cross/Blue Shield, 757 F. Supp. 661, 666 (D. Md. 1991) (noting that *de novo* judicial review is inappropriate when specific plan language vests discretionary power in the plan administrator).

[112] *See Brown*, 898 F.2d at 1563.

chemotherapy and autologous bone marrow transplantation.[113] Their insurance contracts excluded coverage for "'experimental and investigative'" treatments, defined as "'any treatment . . . not generally acknowledged as accepted medical practice by the suitable medical specialty practicing in Maryland, as decided by us.'"[114] Blue Cross's decision to deny coverage for bone marrow transplantation in breast cancer patients was based on its own evaluation of the scientific evidence, not on the opinions of the Maryland oncological community.[115] Blue Cross argued that, under the contractual definition of experimental treatment, it had been given discretion to decide when a treatment was experimental and, thus, its decision should be reviewed only on the deferential arbitrary and capricious standard.[116] The district court disagreed, finding the contractual language ambiguous and concluding that ambiguous language should trigger more searching judicial review because ERISA fiduciary standards are intended to protect employees.[117] However, had the contractual language "demonstrate[d] on its face a clear and unequivocal intent to vest the plan administrator with discretionary authority," the court would have concluded that it was limited to review on the arbitrary and capricious standard.[118]

The arbitrary and capricious standard does not leave plan administrators entirely unscrutinized, however. Courts following *Firestone* have found some room to tighten even deferential scrutiny when the plan administrator's interests conflict with the interests of the beneficiary. For example, the Eleventh Circuit has developed case law shifting the burden of proof to the fiduciary to show that its decision was not self-interested, when the fiduciary stands to profit financially from the benefits denial.[119] And in the *Reilly* case described above,[120] the Seventh Circuit held that there were material issues of fact about whether the Blue Cross decision to deny coverage for *in vitro* fertilization because of its less than fifty percent success rate had been arbitrary.[121] Thus, an insurer or

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[113] *See Adams*, 757 F. Supp. at 662-63.

[114] *Id.* at 663 (quoting Blue Cross benefit plan).

[115] *See id.*

[116] *See id.*

[117] *See id.* at 667.

[118] *Id.* at 666.

[119] *See, e.g.*, Brown v. Blue Cross & Blue Shield, 898 F.2d 1556, 1565 (11th Cir. 1990) (noting that without such burden shifting the plan beneficiaries would be left unprotected).

[120] *See supra* notes 47-51 and accompanying text.

[121] *See* Reilly v. Blue Cross & Blue Shield United, 846 F.2d 416, 423-24 (7th Cir.

employer can craft plan language to ensure relatively deferential review of decisions to deny claims, although its decisions may not be entirely insulated from scrutiny.

B. *Job Loss*

Another strategy that employers have sought to use when the costs of health benefits rise precipitously is to seek to discharge particularly expensive employees. Employees do enjoy some federal statutory protection from dismissals caused by health needs, but they are limited. ERISA prohibits discharges in retaliation for exercising rights under benefit plans.[122] Thus an employee cannot be fired because his multiple sclerosis might prove expensive for his employer's benefit plan.[123] The fact that a discharge deprives an employee of the opportunity to enjoy continued benefits, however, is insufficient by itself to support a retaliatory discharge claim.[124] In addition, under ERISA employers remain free to discharge employees for health difficulties that result in missed work or otherwise affect job performance.

The recent Americans with Disabilities Act (ADA)[125] may provide employees with some protection against job loss resulting from health needs. The ADA requires employers to make reasonable accommodations for employees with disabilities, although not to the extent of imposing undue hardships such as significant expense in light of the employer's financial resources.[126] Whether an ill employee can be discharged because of absenteeism will thus turn on the degree of hardship imposed on the employer. Under the ADA, it is also prohibited to discriminate by subjecting employees to differential fringe benefit contracts because of their disabilities.[127] But the ADA does not guarantee that employees with high health care expenses will be able to find or continue employment-based insurance. Employers are permitted to establish insurance plans that underwrite risks in a manner consistent with

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1988). *Reilly* antedated *Firestone*, but applied the arbitrary and capricious standard to plan language that conferred discretion on Blue Cross. *See id.* at 419.

[122] *See* 29 U.S.C. § 1140 (1988).

[123] *See* Folz v. Marriott Corp., 594 F. Supp. 1007, 1014-15 (W.D. Mo. 1984).

[124] *See* Turner v. Schering-Plough Corp., 901 F.2d 335, 346-47 (3d Cir. 1990).

[125] Pub. L. No. 101-336, 104 Stat. 327 (1990) (codified at 42 U.S.C.A. §§ 12101-12213 (Pamphlet 1992)).

[126] *See* 42 U.S.C.A. § 12111(9), (10).

[127] *See id.* § 12112(b)(2).

state law.[128] Employers may also establish benefit plans that are not regulated by state law—that is, self-insured plans regulated under ERISA—so long as they are bona fide.[129] As litigation under the ADA develops, it remains to be seen how much leeway employers will be given to curtail potentially expensive coverage. Preexisting condition exclusions, exclusions of certain types of coverage such as mental health benefits, and high copayments structured to share costs, all seem to be strategies that are likely to meet the standards of the ADA, so long as they apply to all employees within a group, despite their differential impact on employees with expensive health needs.

An additional federal protection for employees discharged as a result of health needs is the limited right to continue participation in the employer's group health plan. Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA),[130] employers may elect to continue their benefits at a level just above the employer's group cost if they have been subject to a "qualifying event"—most importantly, job loss for reasons other than gross misconduct.[131] But this COBRA protection is very limited. Participation is at the employee's own expense,[132] an expense that may be difficult to meet for employees who have lost their jobs because of health needs. COBRA rights extend for only eighteen months for discharged employees, and for thirty-six months for beneficiaries who qualify because of divorce or death.[133] If the employer modifies the plan it provides for continuing employees, COBRA beneficiaries' benefits will be likewise modified. If the employer ceases to provide health benefits at all, COBRA continuation rights also end.[134] The idea of COBRA is to allow discharged employees to receive insurance more cheaply, because they continue to participate in the risk pool of their employer's group plan. The employer can avoid the costs of risk pooling with a COBRA beneficiary, however, by changing the plan to exclude the expensive

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[128] *See id.* § 12201(c)(1)-(2).

[129] *See id.* § 12201(c)(3).

[130] Pub. L. No. 99-272, 100 Stat. 82 (1986) (relevant sections codified in scattered sections of 29 U.S.C.).

[131] *See* 29 U.S.C. § 1163 (1988).

[132] *See id.* § 1164(1).

[133] *See id.* § 1162(2)(A). For a more optimistic view of COBRA, see Thomas H. Somers, *COBRA: An Incremental Approach to National Health Insurance*, 5 J. CONTEMP. HEALTH L. & POL'Y 141, 152-54 (1989).

[134] *See* 29 U.S.C. § 1162(1), (2)(B) (1988).

kind of coverage, so long as the employer is willing to impose the same exclusion on all employees until the COBRA continuation rights expire.[135]

C. *Loss of Group Insurance*

Employer-provided benefits are the principal source of health insurance for working Americans, but they are by no means the only source. Individually purchased insurance, more affordable when obtained through group plans, is an important source of insurance for the self-employed or those who work for smaller employers. New York is a leading example of how this kind of coverage is presently in jeopardy. Empire Blue Cross and Blue Shield recently dropped group coverage for members of professional and trade associations in New York.[136] Empire claimed that it had been caught in a vicious cycle: as costs—and rates—rose, the healthier members of covered groups sought cheaper coverage elsewhere.[137] Empire was thus left providing group coverage for the most expensive members of these groups. As an illustration, nearly two thousand members of the New York State Bar had dropped the Blue Cross plan as premiums rose.[138] The decision by Empire to drop group coverage affected 100,000 group members.[139] Some groups, such as the Bar, have replaced the Empire coverage, but with policies that require health screening and thus do not help members with already-apparent health care needs.[140]

The most likely alternative for members of the dropped groups is to buy individual coverage. By statute, Empire Blue Cross is required to accept individual applicants; but it may impose far higher rates and reduced coverage.[141] Some group members who lost coverage estimate that their individual policies now cost over $10,000 per year.[142] The withdrawn group coverage had been offered on a periodic basis; group members did not have enforceable legal rights to its continuation. Nonetheless, as policies were

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[135] *See id.* (stating that only coverage identical to that of similarly situated beneficiaries need be provided).

[136] *See* Milt Freudenheim, *Associations' Coverage Cut by Blue Cross*, N.Y. TIMES, June 13, 1991, at D1.

[137] *See id.*

[138] *See id.* at D8.

[139] *See id.* at D1.

[140] *See id.* at D8.

[141] *See id.* at D1, D8.

[142] *See id.* at D1.

renewed year after year, policy holders may have come to count on their availability. Job decisions—such as whether to remain in solo practice—may have been importantly influenced by the presence of the apparently reliable coverage. Now, for members of these groups with apparent health needs, insurance coverage is unobtainable or very expensive indeed.

CONCLUSION

Legal protection of expectations about the funding of health care has thus tended towards a focus on written guarantees. Under ERISA, retirees will not be protected against changes in their health benefits if the employer has been careful to draft a termination clause into the plan (and has not engaged in conduct sufficiently encouraging to make it seem that the writing does not reflect the actual deal). Decisions to deny benefits claimed under a health plan will receive more deferential judicial scrutiny if the plan has been drafted to confer discretion on the plan administrator. Although employees cannot be fired in retaliation for using their health benefits, they can be dismissed for absenteeism due to illness (unless reasonable accommodation is possible as required by the ADA); COBRA then permits them to continue any group insurance for eighteen months at their own expense, an allowance that may be beyond their financial reach and in any event is quite limited. Insurers remain free to pull out of entire markets which they find uneconomical, although Blue Cross plans in some states continue to be obligated to provide individuals with community-rated coverage—quite likely a very expensive option. Thus, today's employees, together with yesterday's retirees, are experiencing a great deal of instability and finding limited legal protection for their health benefits.

Now, what should we make of these changes from the point of view of expectations? Do they disappoint expectations in ways that raise moral concerns? Or, are legal developments roughly congruent with protection of those expectations that are the most compelling morally—expectations that are reasonable, encouraged, longstanding, integral to the lives of those who have them, and consistent with background justice? Defenders of the current tendency to focus on the nature of actual agreements might argue that current law is actually sorting out fairly well those expectations that should matter from those that should not.

Take the retirees in the Sixth Circuit, for example. Their expectations are likely to be longstanding and central to their lives. But questions may surely be raised about whether they are consistent with background justice, reasonable, or encouraged. Whether they are consistent with background justice will depend on the extent to which they shift resources to those who do not need or deserve them. Some plans may indeed extend remarkably generous benefits to sectors of the population that are already relatively well insured by Medicare; other plans, however, may extend far more modest benefits to retirees before and after Medicare eligibility. Some employers may have made retirees quite well aware of the likelihood that benefits would be changed, in which case expectations of continuation would not have been reasonable or encouraged. Other employers, however, may have made the stability of benefits a real selling point to their employees, while carefully retaining termination rights by drafting appropriate language into the benefits contract.

Or consider decisions about whether particular kinds of therapy are or are not covered under an employee benefit plan. Perhaps employers are right to insist that decisions to deny benefits should be given highly deferential review when they have drafted the plan to reserve discretion to the plan administrator. It is not reasonable or just, employers might argue, for employees to expect health plans to cover all claims, regardless of the expense or the unproved efficacy of the therapy. Nor are employees encouraged to believe that they will receive coverage for any therapy recommended by their physicians, if they are clearly told that coverage denials are within the discretion of their insurers. An example might be employees offered a clear choice between insurance plans that allow them to select physicians but reserve the right to deny claims at the insurer's discretion, and plans that limit the choice of providers but guarantee the payment of claims.[143] On the other hand, many

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[143] An example of such a choice was apparently present in the case of Sarchett v. Blue Shield, 729 P.2d 267 (Cal. 1987):

> Plaintiff argues, however, even if the policy is not ambiguous upon close reading, it should still be construed in light of the "reasonable expectation of the insured." The subscriber under a Blue Shield policy, he contends, would reasonably expect to be covered for hospitalization recommended by the treating physician. We do not question this description of the subscriber's expectations, but we doubt that it arises from any belief that Blue Shield will cover all treatment recommended by a physician, however unreasonable the recommendation. Instead, the subscriber expects

employees may not have been told, or do not understand, the import of plan language that reserves discretion to the plan administrator.

Finally, perhaps it is not reasonable for employees to think that their health needs will not affect their jobs, or, that the market where they purchase health insurance will remain stable. Perhaps they should be realistic and recognize that their employer has the right to discharge them unless they have bargained otherwise, at least within the limits set by the ADA. There are certainly contexts in which employees have not been encouraged to count on stable jobs. Similarly, it might be argued, providers of group coverage such as Blue Cross have made no promises about what kinds of policies will remain economically viable; those who had counted on continued coverage were unreasonably optimistic and certainly unencouraged. Some Blue Cross plans are required to provide community-rated coverage to individuals, and COBRA continuation rights remain—exceptions, it might be argued, that prove the rule, because they have resulted from public policy decisions to make some coverage available at least to those who can afford it. In short, it might be concluded, people simply must come to understand that in a market economy, change is highly likely; bargained contracts are the mechanism that is available to ensure stability.

But these arguments miss many of the morally important features of expectations about health care benefits. In the first place, explicit contract language may not reflect the actual forms of encouragement that have grown up over time. Some employees, to be sure, will have understood quite clearly what benefits they could count on, and what benefits they could not. But other employees, as illustrated by many of the cases discussed above, have not been told clearly what they have and what the law will protect. Employ-

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> coverage because he trusts that his physician has recommended a reasonable treatment consistent with good medical practice. Consequently we believe the subscriber's expectations can be best fulfilled not by giving his physician an unreviewable power to determine coverage, but by construing the policy language liberally, so that uncertainties about the reasonableness of treatment will be resolved in favor of coverage.
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> . . . .
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> . . . Sarchett had a choice between the Blue Shield plan, which offered him unlimited selection of physicians but provided for retrospective review, and alternative plans which would require him to choose from among a limited list of physicians but guaranteed payment.

Id. at 273-74 (citations omitted).

ees are caught in a halfway world, in which historically shaped expectations conflict with present reality.

Of course, over time the significance of contract language could become quite well understood. New histories could be created, histories in which employees expect little if any continuation of their health benefits, except what is congruent with contractual language or required by statute. Now, suppose people did come to understand the limits of their benefits contracts and the nature of the legal world in which these contracts are litigated. The expectations which they had been encouraged to have would then be congruent with what would be protected legally. But these expectations might also be very limited; depending on how contracts are drafted, people might have no expectations of stability at all. Then the moral question to ask is whether it would be desirable to create a world of such uncertainty. Would a world in which no one had legitimate expectations to health insurance because they had been carefully informed about reserved termination rights in their benefits contracts be a morally diminished world? It would be a world of realism, but it would also be a world of great fear about the economic consequences of illness.

Moreover, explicit encouragement is only one morally relevant feature of expectations. The current legal focus on the written language of benefits contracts deflects us from other morally relevant features of expectations. For example, consider the funding of new therapeutic modalities. As described above, plaintiffs' success in challenging claims denials has turned on whether there is language in the benefits contract that supports limited or more extensive judicial review. But it is surely also important to ask whether it is reasonable for the plaintiffs' to expect to receive the therapy in light of current medical knowledge about its efficacy. It may also be important to ask whether the care is integral to the patients' lives; the Maryland breast cancer patients seeking funding for bone marrow transplantation, for example, were women in their thirties, with young children, who could not have been said to have lived out the course of their lives. There are also major issues of background justice about the funding of experimental care; the oncology community, for example, is now deeply concerned that if insurers deny claims for clinical trials or new

therapeutic modalities, progress in treating cancer will slow down significantly.[144]

This is not to say that these other features of expectations make them all morally compelling. But it is to say that there are important moral issues raised by expectations which go beyond whether they are provided for by current contractual language. These issues are not being attended to by law or by public discussion. Public discussion of which expectations matter, and of how the costs of fulfilling them might be shared, would expand the moral debate. It might also have the consequence of fostering expectations that both are more reasonable and are more legitimate on other moral grounds. Accountability for expectations is thus another important piece of the argument for public responsibility for health policy in the United States in the 1990s.

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[144] *See* William B. Farrar, *Clinical Trials: Access and Reimbursement*, 67 CANCER 1779, 1782 (1991).