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Retirees at Risk: The Precarious Promise of Post-Employment Health Benefits

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INTRODUCTION

The American conception of retirement has received a number of significantly jarring assaults in recent years.[1] Employers have increasingly shifted the investment risk of funding retirement to their employees by switching from so-called "traditional" defined benefit plans that promise retirees a predictable paycheck for life to defined contribution arrangements that provide no such assurances.[2] Other employers have frozen their traditional pension plans or otherwise terminated their employees' ability to accumulate further credits toward retirement.[3] Even President George W. Bush added to the general anxiety about income in retirement by an extended campaign in 2005 that suggested that the federal government's venerable program for funding retirement—Social Security—was hopelessly outmoded and headed toward bankruptcy.[4]

This Article examines a source of retirement anxiety that has received far less attention but is of paramount importance for prospective and current retirees alike—namely, health insurance in retirement. Indeed, the presence of retiree health insurance is one of the most significant factors determining when people choose to leave the compensated workforce,[5] especially if declining health is one

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1. *See generally* Patricia E. Dilley, *Hope We Die Before We Get Old: The Attack on Retirement*, 12 ELDER L.J. 245 (2004).

2. *See* Richard L. Kaplan, *Enron, Pension Policy, and Social Security Privatization*, 46 ARIZ. L. REV. 53 (2004). *See generally* JACOB S. HACKER, THE GREAT RISK SHIFT (2006); ALICIA H. MUNNELL ET AL., WHY HAVE SOME STATES INTRODUCED DEFINED CONTRIBUTION PLANS? (2008), *available at* http://crr.bc.edu/images/stories/Briefs/slp_3.pdf; EDWARD A. ZELINSKY, THE ORIGINS OF THE OWNERSHIP SOCIETY: HOW THE DEFINED CONTRIBUTION PARADIGM CHANGED AMERICA (2007).

3. *See, e.g.*, Steven D. Jones, *Pensions Likely To Stay Dying Breed*, WALL ST. J., Aug. 29, 2006, at C3; Ellen E. Schultz, Charles Forelle & Theo Francis, *IBM To Freeze Pension Program in '08*, WALL ST. J., Jan. 6, 2006, at A3; Ellen E. Schultz, Charles Forelle & Theo Francis, *Forecast: More Pension Freezes*, WALL ST. J., Jan. 12, 2006, at C1; John D. Stoll, *GM To Freeze Pension Plans of White-Collar Workers*, WALL ST. J., Mar. 8, 2006, at A10.

4. Address Before a Joint Session of the Congress on the State of the Union, 41 WEEKLY COMP. PRES. DOC. 126, 128 (Feb. 2, 2005); *see also* Richard L. Kaplan, *The Security of Social Security Benefits and the President's Proposal*, ELDERLAW REP., Apr. 2005, at 1.

5. *See* Paul Fronstin, *Retirement Patterns and Employee Benefits: Do Benefits Matter?*, 39 GERONTOLOGIST 37 (1999); *see also* David M. Blau & Donna B. Gilleskie, *Retiree Health Insurance and Labor Force Behavior of Older Men in the 1990s*, 83 REV. ECON. & STAT. 64 (2001); Jeannette Rogowski & Lynn Karoly, *Health Insurance and Retirement Behavior: Evidence from the Health and Retirement Survey*, 19 J. HEALTH ECON. 529 (2000); Erin Strumpf, Presentation at 12th Annual National Research Service Award (NRSA) Trainees Research Conference The Decline in Employer-Sponsored Health Insurance for Retirees and Its Impact on Older Americans (June 24, 2006), *available at* http://www.ahrq.gov/fund/training/strumpftxt.htm.

of the reasons that they are considering retirement.[6] As an important recent study concluded, without such insurance, "current employees will have strong financial incentives to work longer and retire later."[7] Such incentives might therefore impact employment prospects for younger workers if older workers delay their retirement. Thus, this issue is enormously important to anyone connected to the U.S. workplace, regardless of age.

Since 1965, the federal government has operated a health insurance program called Medicare[8] that specifically covers older Americans.[9] This program, however, has major gaps in its service coverage, ranging from specified deductibles for hospital admissions to 20% co-payment obligations regarding doctors' fees and the like.[10] In 2003, Congress undertook a determined effort to patch Medicare's most glaring coverage gap—namely, prescription medications—in its highly publicized and roundly criticized Medicare Prescription Drug, Improvement, and Modernization Act.[11] Notwithstanding this legislation, a prominent financial services company predicts that the typical retired couple will incur over $215,000 of medical expenses not covered by Medicare,[12] and that estimate does not even consider the cost of long-term care in

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6. *See* RUTH HELMAN ET AL., EBRI 2008 RECENT RETIREES SURVEY: REPORT OF FINDINGS 5-6 (Employee Benefit Research Inst., Issue Brief No. 319, 2008), *available at* http://www.ebri.org/pdf/briefspdf/EBRI_IB_07-2008.pdf (among surveyed engineers and technicians in the aerospace and defense industries, 46% cited health as an extremely or very important factor in their retirement decision, and 69% indicated that the availability of health insurance was similarly important in determining their "ability to afford retirement").

7. THE KAISER FAMILY FOUND. & HEWITT ASSOCS., RETIREE HEALTH BENEFITS EXAMINED: FINDINGS FROM THE KAISER/HEWITT 2006 SURVEY ON RETIREE HEALTH BENEFITS 34 (2006) [hereinafter KAISER/HEWITT SURVEY], *available at* http://www.kff.org/medicare/upload/7587.pdf; *see also* U.S. GOV'T ACCOUNTABILITY OFFICE, RETIREMENT DECISIONS: FEDERAL POLICIES OFFER MIXED SIGNALS ABOUT WHEN TO RETIRE 32 (2007), *available at* http://www.gao.gov/cgi-bin/getrpt?GAO-07-753 (noting that "workers who have access to health insurance in retirement are substantially more likely to retire before becoming eligible for Medicare at age 65 than those without such access"). This study found that men with access to pre-Medicare health insurance were 86% more likely to retire before age sixty-five, and women were 139% more likely. *Id.*

8. 42 U.S.C. § 1395 (2000). *See generally* LAWRENCE A. FROLIK & RICHARD L. KAPLAN, ELDER LAW IN A NUTSHELL 64-95, 103-08 (4th ed. 2006) (explaining the major features of Medicare).

9. 42 U.S.C. § 426(a)(1) (2000).

10. *See* FROLIK & KAPLAN, *supra* note 8, at 64-82.

11. Pub. L. No. 108-173, 117 Stat. 2066 (2003). *See generally* FROLIK & KAPLAN, *supra* note 8, at 85-91 (explaining the major features of Medicare's prescription drug benefit).

12. *See* News Release, *Fidelity Investments Estimates $215,000 Needed To Cover Retiree Health Care Costs*, March 27, 2007, *available at* http://content.members.fidelity.com/Inside_Fidelity/fullStory/1,,7448,00.html; *see also* PAUL FRONSTIN, SAVINGS NEEDED TO FUND HEALTH INSURANCE AND HEALTH CARE EXPENSES IN RETIREMENT 13 (Employee Benefit Research Inst., Issue Brief No. 295, 2006), *available at* http://www.ebri.org/pdf/briefspdf/EBRI_IB_07-2

an assisted living facility or a nursing home.[13]

To address the numerous gaps in Medicare, many employers have for some time provided supplementary health benefits to their retirees.[14] Such retiree health benefits preceded the 2003 Medicare enactment regarding prescription drugs by several decades and continue to provide important coverage.[15] Retiree health benefits are especially important for those who retire before reaching age sixty-five, generally the qualifying age for Medicare. For these pre-Medicare retirees, employer-provided health insurance may be their only protection from financial disaster. These so-called "early" retirees often find obtaining quality individual health insurance forbiddingly expensive, if not completely impossible, due to pre-existing medical conditions and other underwriting criteria.[16]

Yet despite their importance, retiree health benefits for both pre-Medicare and Medicare-eligible retirees have been under persistent assault on several fronts. Some employers have initiated or substantially raised the monthly premiums that they charge retirees for health benefits,[17] without regard to these retirees' often-fixed pension income—effectively reducing these retirees' spendable retirement income by considerable amounts.[18] Indeed, one recent report found that median premium contributions by retirees had more than quadrupled over the past decade.[19] Moreover, a recent survey of employers with at least 1000 employees found that 80% of such employers plan to increase further the contributions required of retirees.[20] Some companies have increased

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0061.pdf [hereinafter FRONSTIN, Issue Brief No. 295] (calculating that $295,000 would be needed for a sixty-five-year-old couple retiring in 2006 who live to average life expectancies). For an extended simulation effort to determine the funds needed for health care costs in retirement, see PAUL FRONSTIN, SAVINGS NEEDED TO FUND HEALTH INSURANCE AND HEALTH CARE EXPENSES IN RETIREMENT: FINDINGS FROM A SIMULATION MODEL (Employee Benefit Research Inst., Issue Brief No. 317, 2008), *available at* http://www.ebri.org/pdf/briefspdf/EBRI_IB_05-20081.pdf.

13. *See generally* Richard L. Kaplan, *Retirement Planning's Greatest Gap: Funding Long-Term Care*, 11 LEWIS & CLARK L. REV. 407 (2007) (examining the nature and cost of long-term care, particularly when such care is provided in an institutional setting).

14. *See* MADELON LUBIN FINKEL & HIRSCH S. RUCHLIN, THE HEALTH CARE BENEFITS OF RETIREES 1 (1991).

15. *See id.* at 62.

16. *See infra* text accompanying notes 337-340.

17. *See* KAISER/HEWITT SURVEY, *supra* note 7, at 19-21.

18. *See, e.g.*, Robert L. Rose, *Firms' Attempts To Cut Health Benefits Break Calm of Retirement*, WALL ST. J., Feb. 24, 1993, at A1; Ellen E. Schultz, *Companies Transform Retiree-Medical Plans into Source of Profits*, WALL ST. J., Oct. 25, 2000, at A1.

19. RICHARD W. JOHNSON, WHAT HAPPENS TO HEALTH BENEFITS AFTER RETIREMENT? 4 (2007), *available at* http://crr.bc.edu/images/stories/Briefs/wob_7.pdf.

20. KAISER/HEWITT SURVEY, *supra* note 7, at 21. In addition, 40% of employers are very or somewhat likely to increase retirees' cost-sharing requirements, and 30% are very or somewhat likely to raise the limit on retirees' out-of-pocket expenses. *Id.*

retirees' cost-sharing obligations or applicable limits on out-of-pocket expenditures,[21] while others have capped their contributions to the cost of these plans,[22] leaving retirees to bear the full cost of future medical inflation. Still other employers have terminated their retiree health benefits outright,[23] leaving the affected retirees—especially pre-Medicare retirees[24]—exposed to the financial hardships of a major illness or accident. As employers struggle in the current economic crisis, these trends are likely to accelerate further.

This Article begins by tracing the decline in retiree health insurance coverage over the past several decades and setting forth some of the reasons for this dramatic decline. The Article then analyzes the legal posture of retirees who have lost the health benefits that they expected to have in retirement. Finding surprisingly little legal relief for these retirees' dashed expectations, the Article then considers various self-help options currently available to retirees before examining a major public policy alternative—namely, expanding Medicare eligibility to cover retirees younger than sixty-five years of age.

I. DECLINING SCOPE OF RETIREE HEALTH COVERAGE

Retiree health benefits originated as an extension of employer-provided health insurance for employees, a phenomenon that itself began largely as an employer response to wage controls imposed by Congress during World War II[25] and was later canonized by a tax law provision that excluded such insurance from employees' taxable income.[26] The pervasiveness of industrial unions during this period further contributed to the expansion of various employer-provided job benefits, most especially health insurance.[27] As an outgrowth of this

21. *See id.* at 19; *see also* U.S. GEN. ACCOUNTING OFFICE, RETIREE HEALTH BENEFITS: EMPLOYER-SPONSORED BENEFITS MAY BE VULNERABLE TO FURTHER EROSION 10 (2001).

22. KAISER/HEWITT SURVEY, *supra* note 7, at 13-14 (among employers with at least 1000 employees and that offer retiree health benefits, 46% have caps on their plans for pre-Medicare retirees and 50% have caps for Medicare-eligible retirees); *see also* PAUL FRONSTIN, THE IMPACT OF THE EROSION OF RETIREE HEALTH BENEFITS ON WORKERS AND RETIREES 6 (Employee Benefit Research Inst., Issue Brief No. 279, 2005), *available at* http://www.ebri.org/pdf/briefspdf/0305ib.pdf.

23. *See* FRONSTIN, Issue Brief No. 295, *supra* note 12, at 9, 11.

24. *See* AARP PUB. POL'Y INST., DATA DIGEST: HEALTH COVERAGE AMONG 50- TO 64-YEAR-OLDS 3 (2007), *available at* http://assets.aarp.org/rgcenter/health/ dd155_coverage.pdf (reporting that the number of retirees aged fifty to sixty-four without health insurance increased more than 25% between 2000 and 2005).

25. *See History of Health Insurance Benefits*, FACTS FROM EBRI (Employee Benefit Research Inst., Washington, D.C.), Mar. 2002, at 1, *available at* http://www.ebri.org/publications/facts/index.cfm?fa=0302fact.

26. I.R.C. § 106 (2008).

27. *See* Thomas C. Buchmueller, John Dinardo & Robert G. Valletta, *Union Effects on Health*

phenomenon, employers agreed to maintain such health insurance after their workers retired, an especially valuable benefit during the period prior to the enactment of Medicare.[28] Employers were generally amenable to providing these benefits, because health care costs were not expensive, life expectancy was rather limited, and no actual expenditures were required until many years into the future.[29] As Americans began living longer in retirement, however, these benefits became much more expensive at the same time that they became more valuable to covered retirees.

But far more than general retirement trends was at play here. First, the cost of health care has increased in recent years, often dwarfing increases in general inflation.[30] Second, exogenous events, particularly pronouncements from accounting regulators, have forced employers to project *and report* the anticipated future expense of their retiree health benefit obligations. This Part considers both of these factors.

A. Rising Cost of Health Care

Health care costs consume an ever-increasing share of this country's gross domestic product[31] and are a perennial source of anxiety for many Americans.[32] Health care reform proposals of varying scope have been a central issue in U.S. presidential election campaigns since the implosion of President Clinton's 1993 proposal,[33] focusing particularly on the plight of those Americans who have no

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Insurance Provision and Coverage in the United States, 55 INDUS. & LAB. REL. REV. 610 (2002).

28. *See generally* THEODORE R. MARMOR, THE POLITICS OF MEDICARE (2d ed. 2000) (discussing the historical and political context in which Medicare developed).

29. *See generally* FINKEL & RUCHLIN, *supra* note 14, at 62; G. Lawrence Atkins, *The Employer Role in Financing Health Care for Retirees*, *in* PROVIDING HEALTH CARE BENEFITS IN RETIREMENT 100, 108 (Judith F. Mazo, Anna M. Rappaport & Sylvester J. Schieber eds., 1994) [hereinafter PROVIDING HEALTH CARE].

30. Professor Gruber has recently concluded that "the rapid rise in health care costs has been driven by quality-improving technological change." Jonathan Gruber, *Covering the Uninsured in the United States*, 46 J. ECON. LITERATURE 571, 603 (2008); *see also* Paul Krugman & Robin Wells, *The Health Care Crisis and What To Do About It*, N.Y. REV. OF BOOKS, Mar. 23, 2006, *available at* http://www.nybooks.com/articles/18802 (agreeing that "new medical technology" is the principal factor driving health care costs higher).

31. *See* Krugman & Wells, *supra* note 30 (noting that the percent of U.S. gross domestic product spent on health care rose from 5.2% in 1960 to 16% in 2004).

32. *See, e.g.*, GARY CLAXTON ET AL., EMPLOYER HEALTH BENEFITS: 2006 ANNUAL SURVEY 1 (2006), *available at* http://www.kff.org/insurance/7527/upload/7527.pdf; Sudeep Reddy, *Census Income Report Feeds Health-Care Debate*, WALL ST. J., Aug. 29, 2007, at A3.

33. Health Security Act of 1993, H.R. 3600, S. 1757, 103d Cong. (1993). *See generally* THEDA SKOCPOL, BOOMERANG: CLINTON'S HEALTH SECURITY EFFORT AND THE TURN AGAINST GOVERNMENT IN U.S. POLITICS (1996).

health insurance. And in 2007, Michael Moore's controversial movie, *Sicko*,[34] tapped into the concerns and financial fears harbored by even those Americans who have health insurance.

Employers, for their part, have been trying to assert control over the ever-burgeoning cost of the health insurance that they provide to their employees. Some companies have increased employees' monthly premiums, co-payments, deductibles, and other cost-sharing mechanisms, and some employers have reduced service coverage or ceased providing health insurance to their employees altogether. Certain employers, however, have taken a different approach, instituting so-called "wellness" programs that seek to implement preventative approaches, including lifestyle changes like regular exercise, smoking cessation, and weight loss regimens.[35] Others have lowered or even eliminated the employee cost of prescription medications to ensure that these pharmaceuticals are taken regularly and that expensive hospitalization episodes are thereby prevented.[36] The latest attempt by policymakers to make employees more responsible for their own health care costs and perhaps more cost-conscious in this regard is the introduction of Health Savings Accounts.[37] These arrangements pair a pre-tax account from which an employee can spend as she chooses on "qualified medical expenses"[38] with a high-deductible health insurance policy that covers catastrophic expenses.[39]

In the context of these conflicting trends, there has been a decline in employees with employment-based health insurance. According to recent data from the Employee Benefit Research Institute, only 64.2% of Americans aged eighteen to sixty-four years have some form of employer-provided health insurance, a number that has declined from 69.3% as recently as 2000.[40] This trend has persisted despite the presence of an unlimited income tax exclusion that

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34. SICKO (The Weinstein Company 2007).

35. *See, e.g.*, Howard M. Leichter, *"Evil Habits" and "Personal Choices": Assigning Responsibility for Health in the 20th Century*, 81 MILBANK Q. 603, 609 (2003); Kris Maher, *Companies are Closing Doors on Job Applicants Who Smoke*, WALL ST. J., Dec. 21, 2004, at B6.

36. *See* Vanessa Fuhrmans, *A Radical Prescription*, WALL ST. J., May 10, 2004, at R3.

37. *See* I.R.C. § 223 (2008). *See generally* Richard L. Kaplan, *Who's Afraid of Personal Responsibility? Health Savings Accounts and the Future of American Health Care*, 36 MCGEORGE L. REV. 535 (2005); Amy B. Monahan, *The Promise and Peril of Ownership Society Health Care Policy*, 80 TUL. L. REV. 777 (2006).

38. I.R.C. § 223(d)(2)(A) (2008).

39. *Id.* § 223(c)(2). *See infra* Subsection III.A.3 (outlining more information on Health Savings Accounts).

40. PAUL FRONSTIN, SOURCES OF HEALTH INSURANCE AND CHARACTERISTICS OF THE UNINSURED: ANALYSIS OF THE MARCH 2007 CURRENT POPULATION SURVEY 7 (Employee Benefit Research Inst., Issue Brief No. 310, 2007), *available at* http://www.ebri.org/pdf/briefspdf/EBRI_IB_10a-20071.pdf.

applies to such insurance,[41] a reality that suggests that the tax law may not be the *deus ex machina* that virtually all would-be health reformers seem to think it is.[42] That is, health reformers from all points on the political spectrum seem to believe that changing the current tax treatment of employer-provided health insurance is essential public policy,[43] without noting that despite the current law's alleged generosity, the prevalence of employer-provided health insurance continues to decline.

In any case, retiree health coverage is particularly vulnerable. Employers who diminish or terminate their coverage of employees' health care costs risk losing employees to employers who provide better benefits. Affected workers who do not leave, moreover, might complain, reduce their output in protest, or even organize a debilitating strike against their employer if they are represented by a labor union. But retirees faced with similar cutbacks enjoy no such leverage over their former employers. Accordingly, when employers consider various strategies to lower their costs of providing health insurance, the first group to be targeted is often former employees who are now retired.[44]

This last point is particularly salient in light of the changing composition of the American workplace. Manufacturing jobs represent an ever-diminishing share of U.S. employment in favor of financial services, retail, and other service industries.[45] Yet, manufacturing companies—especially firms in large-scale industries like automobiles and steel—are much more likely to offer retiree

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41. I.R.C. § 106 (2008).

42. *See* Holman W. Jenkins, *The Biggest Secret in Health Care*, WALL ST. J., Feb. 7, 2007, at A14 (noting that analysts across the political spectrum believe that changing the tax exclusion for health insurance premiums is an essential element of health care reform).

43. *See, e.g.*, 2008 PRESIDENTIAL CANDIDATE HEALTH CARE PROPOSALS: SIDE-BY-SIDE SUMMARY, *available at* http://www.health08.org/sidebyside.cfm; CONG. RESEARCH SERV., TAX BENEFITS FOR HEALTH INSURANCE AND EXPENSES: OVERVIEW OF CURRENT LAW AND LEGISLATION (2007), *available at* http://opencrs.cdt.org/rpts/RL33505_20070720.pdf; PAUL FRONSTIN & DALLAS SALISBURY, HEALTH INSURANCE AND TAXES: CAN CHANGING THE TAX TREATMENT OF HEALTH INSURANCE FIX OUR HEALTH CARE SYSTEM? (Employee Benefit Research Inst., Issue Brief No. 309, 2007), *available at* http://www.ebri.org/pdf/briefspdf/EBRI_ IB_09-20071.pdf; Joseph R. Antos, *Is There a Right Way To Promote Health Insurance Through the Tax System?*, 59 NAT'L TAX J. 477 (2006); Len Burman et al., *An Evaluation of the President's Health Insurance Proposal*, 114 TAX NOTES 1013 (2007); Jason Furman, *Two Wrongs Do Not Make a Right*, 59 NAT'L TAX J. 491 (2006).

44. *See* Susan E. Cancelosi, *Revisiting Employer Prescription Drug Plans for Medicare-Eligible Retirees in the Medicare Part D Era*, 6 HOUS. J. HEALTH L. & POL'Y 85, 104 (2005) ("[P]rotecting employee health as a means to enhance productivity and reduce absenteeism obviously does not extend to retirees who, by definition, no longer contribute actively to the workplace.").

45. Regina T. Jefferson, *Rethinking the Risk of Defined Contribution Plans*, 4 FLA. TAX REV. 607, 683 (2000).

health benefits in any form than new economic powerhouses like Wal-Mart and Google.[46] Those old-line industries, moreover, have reduced their U.S. workforces to such an extent that their number of current employees is often dwarfed by their number of retirees.[47] These reduced payrolls, in turn, make it even more attractive from an employer's standpoint to slash health care coverage for retirees. In other words, not only are health care costs higher and rising faster on a per-person basis for retirees than for current employees,[48] there are also more retirees—in some cases, many more retirees—than current employees.[49] These pressures provided the backdrop for General Motors' dramatic decision in mid-2008 to eliminate retiree health benefits for its non-unionized Medicare-eligible retirees.[50] Only one year earlier, the company had shifted all responsibility for health care costs of its unionized retirees to a new union-controlled entity in exchange for a one-time transfer of funds.[51] The point is that the rising cost of health care has combined with larger trends affecting the composition of the American workplace to seriously imperil the provision of retiree health benefits.

B. Accounting Disclosure Requirements

Compounding these cost-reduction tendencies in the face of rising health care costs, the Financial Accounting Standards Board (FASB) began requiring nongovernmental employers to disclose the projected cost of future retiree health benefits. FASB's fateful Statement No. 106, entitled "Employers' Accounting for Postretirement Benefits Other Than Pensions," first effective in 1992,[52]

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46. *See* CLAXTON ET AL., *supra* note 32, at 134 (noting disparity in retiree health benefit availability by industry); FINKEL & RUCHLIN, *supra* note 14, at 65-66 (same).

47. *See* Anna M. Rappaport & Carol H. Malone, *Adequacy of Employer-Sponsored Retiree Health Benefit Programs*, *in* PROVIDING HEALTH CARE, *supra* note 29, at 59-61 (noting that the ratio of retirees to current workers is three to one); Jeffrey Zaslow & Gregory L. White, *For GM Retirees, It Feels Less Like 'Generous Motors,'* WALL ST. J., Feb. 21, 2003, at A1 ("GM's 460,000 retirees and surviving spouses now outnumber active employees in the U.S. nearly 3 to 1.").

48. *See* HEWITT ASSOCIATES, TIAA-CREF INST., THE RETIREE HEALTH CARE CHALLENGE 2 (2006), *available at* http://www.tiaa-crefinstitute.org/pdf/research/dvds_books/110106.pdf.

49. *See id.* at 3 (retiree health care costs represent 29% of total health care costs among large employers offering such benefits).

50. *See* Bill Vlasic, *With Warning, G.M. Takes Wide Cost Cuts*, N.Y. TIMES, July 16, 2008, at C1 (noting that this elimination of benefits "was unexpected").

51. *See* Jeffrey McCracken & John D. Stoll, *UAW, GM Near Historic Deal on Retiree Health Costs*, WALL ST. J., Sept. 22, 2007, at A3; Jyoti Thottam, *GM's Get-Well Plan*, TIME, Oct. 1, 2007, *available at* http://www.time.com/time/magazine/article/0,9171,1663838-1,00.html; *see also* John D. Stoll, *UAW Weighs Health-Care Trust*, WALL ST. J., July 20, 2007, at A8.

52. FIN. ACCOUNTING STANDARDS BD., EMPLOYERS' ACCOUNTING FOR POSTRETIREMENT BENEFITS OTHER THAN PENSIONS: STATEMENT OF FINANCIAL ACCOUNTING STANDARDS NO. 106 (1990), *available at* http://www.fasb.org/pdf/fas106.pdf.

represented a sharp break with prior practices because most companies do not pre-fund retiree health benefits.[53] In contrast to the typical practice of making annual cash outlays to pay future pension obligations, companies generally pay retiree health care costs as the retirees receive this care, with few financial assets set aside in advance.[54] FASB Statement No. 106 required employers to acknowledge the substantial drain on future profits that they had undertaken with respect to both current and prospective retirees. As one analyst explained,

> The rationale was that retiree medical benefits are a form of deferred compensation for current employees, and the future benefits should be reported as they are earned. The underlying theory was that if an employer is going to hold out these benefits to employees in trade for their work, the obligation of paying for them down the line has to be recognized at the time the work earning the benefit is done and the obligation incurred.[55]

From a financial accounting perspective, in other words, incurred costs—including future health care expenses of current employees—should be reflected in an employer's financial results when that employer assumes responsibility for those costs. Notwithstanding the theoretical correctness of this approach, the result was a major increase in the annual cost reported by employers for their operations, in some cases, as much as five to ten times the cost on a pay-as-you-go basis.[56]

Faced with these financial statement disclosures, many companies felt considerable pressure to reduce the extent of their obligations, and many firms initiated cost-reduction strategies to that end.[57] The impact was calamitous for retirees. Among employers with at least 200 employees, the share of such employers who offer any type of retiree benefits dropped from 66% in 1988 to 35% in 2006.[58] Even larger employers—namely, those with at least 1000

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53. *See* KAISER/HEWITT SURVEY, *supra* note 7, at 12 (75% of retiree health benefit plans are not pre-funded). Even among employers with 20,000 or more employees, 60% of such plans are not pre-funded. *Id.*

54. *See* FINKEL & RUCHLIN, *supra* note 14, at 66.

55. Sylvester S. Schieber, *The Outlook of Retiree Health Benefits*, TIAA-CREF RES. DIALOGUE, Sept. 2004, at 3, *available at* http://www.tiaa-crefinstitute.org/pdf/research/research_dialogue/81.pdf.

56. Deborah J. Chollet, *Is Retiree Health Insurance Crowding Out Retiree Cash Benefits?*, *in* PROVIDING HEALTH CARE, *supra* note 29, at 17, 20. *See generally* Rappaport & Malone, *supra* note 47, at 72-74 (cost impact of the FASB pronouncement).

57. *See* FRONSTIN, *supra* note 22, at 8; TIAA-CREF INST., *supra* note 48, at 3-4; CONG. RESEARCH SERV., HEALTH INSURANCE COVERAGE FOR RETIREES 12 (2006), *available at* http://opencrs.cdt.org/rpts/RL32944_20060328.pdf; *see also* U.S. GEN. ACCOUNTING OFFICE, *supra* note 21, at 10.

58. KAISER/HEWITT SURVEY, *supra* note 7, at 1. Among all private sector employers, the proportion offering retiree health benefits has declined from 20-22% in 1997 to 13% in 2002. *See*

employees—have diminished their offerings of retiree health benefits steadily, as this chart shows:[59]

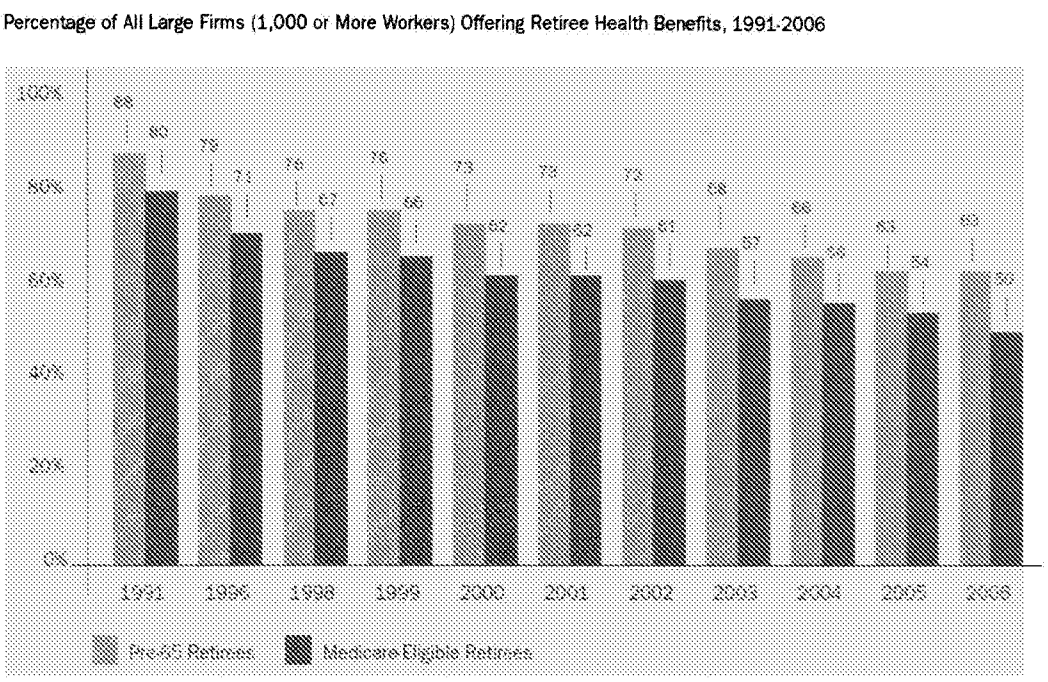

FIGURE 1: Trends in Employer Retiree Health Coverage (1991-2006)
Source: HEWITT ASSOCIATES, TIAA-CREF INST., THE RETIREE-HEALTH CARE CHALLENGE 2 (2006), *available at* http://www.tiaa-crefinstitute.org/research/articles/docs/110106.pdf (reprinted with permission).

Note that pre-Medicare retirees have always fared better than Medicare-eligible retirees, but the trend line for both groups is nevertheless declining.[60] Note further that among these employers, approximately one in six requires their retirees to pay the *entire* cost of provided health benefits.[61]

This erosion of retiree health benefits, moreover, has fallen unevenly across America's retired population. Younger retirees, women, and those without a post-college education are more likely to be affected.[62] A comprehensive survey involving approximately twenty-six and thirty-one million retirees in 1997 and 2002, respectively,[63] found that female retirees were three times as likely as male

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FRONSTIN, *supra* note 22, at 4.

59. Reprinted with permission from HEWITT ASSOCIATES, *supra* note 48, at 6.

60. Of these employers, 85% offer health benefits to both pre-Medicare and Medicare-eligible retirees, while 14% offer benefits only to pre-Medicare retirees. KAISER/HEWITT SURVEY, *supra* note 7, at 4.

61. *Id.* at 15; *see, e.g.*, Amy Merrick, *Sears Is To Make Additional Cuts to Retirees' Medical Benefits*, WALL ST. J., Sept. 23, 2005, at A2.

62. *See* FRONSTIN, *supra* note 22, at 12-13.

63. *Id.* at 12.

retirees to lose retiree health benefits during the period examined.[64] Non-unionized retired workers were also three times as likely as unionized retired workers to see such a decline.[65] Thus, the general decline of unionization in the American workplace further undermines the provision of retiree health benefits.[66]

As bad as this situation is, newly effective accounting pronouncements are likely to exacerbate it. In 2006, the FASB promulgated Statement No. 158, which requires that the net obligation for retiree health benefits be shown on the face of the financial statements themselves, rather than being buried in the voluminous notes that typically accompany financial statements.[67] This change was deemed necessary by the FASB, because "presenting such information only in the notes made it more difficult for users of financial statements to assess an employer's financial position and ability to satisfy postretirement benefit obligations."[68] As a result, public and privately-held companies, as well as nongovernmental not-for-profit organizations, are now required to highlight the expected cost of retiree health benefits beginning with fiscal years that end after June 15, 2007, and in some cases even earlier.[69] Such heightened disclosure is likely to increase existing pressures on employers to lower the cost of these benefits by reducing their scope of coverage.

A similar pattern may develop in the governmental sector where retiree health benefits are even more common. Fully forty-eight of the fifty states and more than half of all municipalities currently provide such benefits.[70] Nearly all governmental employers pay the cost of these benefits out of current budgetary receipts with no provision for future expenditures.[71] But this pay-as-you-go approach is being challenged by Statement No. 45 of the Governmental Accounting Standards Board (GASB), entitled "Accounting and Financial

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64. *Id.*

65. *Id.* at 14-15.

66. *See* Buchmueller, Dinardo & Valletta, *supra* note 27, at 626.

67. FIN. ACCOUNTING STANDARDS BD., EMPLOYERS' ACCOUNTING FOR DEFINED BENEFIT PENSION AND OTHER POSTRETIREMENT PLANS: STATEMENT OF FINANCIAL ACCOUNTING STANDARDS NO. 158 (2006), *available at* http://www.fasb.org/pdf/ fas158.pdf; *see* HEWITT ASSOCIATES, *supra* note 48, at 4.

68. FIN. ACCOUNTING STANDARDS BD., *supra* note 67, at Summary (unnumbered second page).

69. *Id.* paras. 12-14, at 7.

70. Janice Revell, *The Great State Health-Care Giveaway*, FORTUNE, May 2, 2005, at 43, 44; *see also* Judith F. Mazo, *Introduction to Retiree Health Benefits*, *in* PROVIDING HEALTH CARE, *supra* note 29, at 9, 11 (noting the "traditional pattern of public employers offering richer benefits than much of the private sector in return for lower cash compensation"); *The Other Benefits Mess*, KIPLINGER'S PERS. FIN. MAG., Sept. 2007, at 17 (82% of public-sector employers provide retiree health benefits).

71. *See, e.g.*, David Denholm, *States Nearing Crisis in Retiree Benefits*, HEALTH CARE NEWS, July 2007, at 15; Chris Edwards & Jagadeesh Gokhale, *A $2 Trillion Fiscal Hole*, WALL ST. J., Oct. 12, 2006, at A18.

Reporting by Employers for Postemployment Benefits Other Than Pensions."[72] This Statement deals with "other post-employment benefits," which principally includes health care benefits, but can also encompass dental care, vision care, and life insurance.[73]

GASB Statement No. 45 requires state and local governments to estimate the projected cost of their other post-employment benefits[74] and to record as a current-year expense the amount that would be needed to fund this projected cost over the next thirty years.[75] Although the affected governments need not actually transfer cash equal to this expense, they must disclose the amount of this obligation.[76] Substantially similar to FASB Statement No. 106, GASB Statement No. 45 applies to all governmental entities for fiscal years after December 15, 2008.[77] While its implementation is only now upon us, and it is impossible to predict what changes these disclosures will precipitate, a re-examination of retiree health care benefits is likely. Some analysts have already described the employers covered by GASB Statement No. 45 as "shocked, simply shocked" by the required revelations,[78] and the taxpayers who must fund these retiree health care benefits may be similarly surprised by the extent of the future tax obligations that they have unwittingly assumed. To citizens who themselves have lost—or perhaps never even had—employer-provided retiree health care benefits, efforts to reduce these promised benefits may look extremely appealing.[79] As was the case with private sector employers, state and local government employers may find that the new GASB accounting rules provide an impetus—or "cover" perhaps—to reduce retiree health care benefits that were already under pressure from rising health inflation trends, increasing retiree-to-employee ratios, and tax revenue shortfalls.[80]

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72. GOVERNMENTAL ACCOUNTING STANDARDS BD., ACCOUNTING AND FINANCIAL REPORTING BY EMPLOYERS FOR POSTEMPLOYMENT BENEFITS OTHER THAN PENSIONS: STATEMENT NO. 45 OF THE GOVERNMENTAL ACCOUNTING STANDARDS BOARD (2004) [hereinafter GASB NO. 45].

73. *Id.* para. 7, at 3.

74. *Id.* paras. 19-20, at 13-14.

75. *Id.* para. 13(f)(1), at 9-10.

76. *See* Ronald Kramer & Mark Casciari, *Government* [sic] *Accounting Standards Board (GASB) Statement No. 45 Makes Public Employers Revisit Retiree Health Insurance*, 37 URB. LAW. 427, 430 (2005).

77. GASB NO. 45, *supra* note 72, para. 36, at 35.

78. *See* Revell, *supra* note 70, at 44.

79. *See generally* Stan Wisniewski & Lorel Wisniewski, *State Government Retiree Health Benefits: Current Status and Potential Impact of New Accounting Standards*, AARP PUB. POL'Y INST. 19-25 (2004), *available at* http://assets.aarp.org/rgcenter/health/2004_08_benefits.pdf. Regarding possible state constitutional constraints on reducing governmental retirees' health benefits, see Kramer & Casciari, *supra* note 76, at 443-46.

80. *See* Schieber, *supra* note 55, at 9; *see also* Robert L. Clark, *Financing Retiree Health Care: Assessing GASB 45 Estimates of Liabilities*, CENTER FOR STATE & LOCAL GOVERNMENT

II. LEGAL RECOURSE WHEN BENEFITS ARE REDUCED OR TERMINATED

The Employee Retirement Income Security Act of 1974, better known as ERISA, provides statutory protections for employee benefits generally, including retiree health benefits.[81] This federal law regulates employer-provided pension plans and welfare plans to protect employees' future interests, while encouraging employer development of retiree benefit plans.[82] Pension plans are essentially future installment income plans paid to employees,[83] while welfare plans are maintained to provide employees with "medical, surgical, or hospital care or benefits . . . ."[84] Although ERISA does not require employers to provide employee benefit plans, an employer that chooses to do so becomes subject to its requirements.[85]

ERISA medical plans are subject principally to 1) reporting and disclosure requirements, 2) fiduciary rules, and 3) enforcement and remedial measures.[86] With respect to reporting and disclosure requirements, ERISA requires the plan administrator to file a fully comprehensive description of the plan with the U.S. Secretary of Labor and to furnish plan participants and beneficiaries with a summary plan description that is "written in a manner . . . to be understood by the average plan participant, and . . . sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights . . . under the plan."[87]

Regarding fiduciary responsibilities, ERISA requires that every employee

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EXCELLENCE ISSUE BRIEF 4 (2008), *available at* http://www.slge.org/ (follow the "Financing Retiree Health Care: Assessing GASB 45 Estimates of Liabilities" hyperlink at left) ("[M]ost plans covering state and local government employees and retirees are amended regularly in an effort to reduce cost increases.").

81. Employee Retirement Income Security Act of 1974 (ERISA), Pub. L. No. 93-406, 88 Stat. 829 (codified as amended in scattered sections of 5, 18, 26, 29, and 42 U.S.C.).

82. *See* 29 U.S.C. § 1001b(c) (2000). Congressional adoption of ERISA was meant to balance competing goals of employee benefit protection and reasonable standards for employers. *See also* Melissa Elaine Stover, *Maintaining ERISA's Balance: The Fundamental Business Decision v. The Affirmative Fiduciary Duty To Disclose Proposed Changes*, 58 WASH. & LEE L. REV. 689, 690 & nn.1-2 (2001).

83. 29 U.S.C. § 1002(2)(A) (2000) (Pension plans "provide retirement income to employees, or result . . in a deferral of income by employees for periods extending to the termination of . . . employment or beyond.").

84. *Id.* § 1002(1). In this Article, the phrases "welfare plan," "medical plan," and "health care plan" are used interchangeably to refer to post-retirement health care arrangements.

85. For a comprehensive overview of ERISA, see JOHN H. LANGBEIN, SUSAN J. STABILE & BRUCE A. WOLK, PENSION AND EMPLOYEE BENEFIT LAW (4th ed. 2006).

86. 29 U.S.C. §§ 1021-1031, 1101-1114, 1131-1147 (2000) (applying to welfare benefit plans).

87. *Id.* §§ 1021(f)(4), 1022(a), 1024(b).

benefit plan "be established and maintained pursuant to a written instrument" and that every plan "provide a procedure for amending such plan . . . "[88] To protect the interests of employees and beneficiaries, ERISA imposes the common law duties of a trustee on the fiduciaries of the employee benefit plan.[89] A legal person is a fiduciary with respect to a benefits plan if that person exercises control over plan management, renders investment advice, or maintains discretionary authority over the plan's execution.[90] Corporate benefit administrators, therefore, undertake fiduciary obligations to plan participants by disseminating and managing benefit plans within the employer company. However, these duties attach only when the employer actually functions as a fiduciary rather than as a self-interested business entity.[91] The Supreme Court formulated the so-called "two hats"[92] doctrine to create a threshold when an employer's fiduciary duties attach, stating that an employer is subject to fiduciary liability under ERISA only when performing one of the statutorily defined functions.[93] Ultimately, an employer's actions determine its fiduciary status, not simply its position.

With respect to enforcement and remedial measures, ERISA provides that participants and beneficiaries have a cause of action for violations of the reporting and disclosure requirements or the fiduciary responsibilities created by this statute.[94] A participant or beneficiary also has a cause of action to protect contractually defined benefits.[95] Moreover, a participant or beneficiary has a cause of action against any person who discharges "or discriminate[s] against a participant or beneficiary for exercising any right . . . under the employee benefit plan . . . for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan."[96]

In the interest of national uniformity, Congress federalized the law of employee benefit plans, except for a few areas such as state regulation of insurers.[97] Rights and remedies under ERISA are largely limited to reporting, disclosures, and fiduciary responsibilities. In effect, ERISA pre-empted the more

88. *Id.* §§ 1102(a)(1), (b)(3).

89. *Id.* § 1104.

90. *See id.* § 1002(21)(A).

91. Varity Corp. v. Howe, 516 U.S. 489 (1996).

92. *See* Stover, *supra* note 82, at 715-17 (2001). The concept is entitled "two hats" because the company's actor can wear either a "fiduciary" hat when acting as benefits plan administrator or "business entity" hat when acting in the interests of the business.

93. *Id.* at 698, 717-19 (noting that employer is only subject to ERISA fiduciary duties when wearing its "fiduciary hat" as functionally defined).

94. 29 U.S.C. §§ 1132(a)(1)(A), (3), (4) (2000).

95. *Id.* § 1132(a)(1)(B).

96. *Id.* § 1140.

97. *Id.* § 1144(b)(2)(A).

comprehensive rights and remedies that might have been available under state law. Courts have, on occasion, supplemented ERISA with federal common law.[98]

This Part begins by examining the employer's right under ERISA to change health benefit plans. It then discusses the extent to which this right is limited because an employee's rights have vested and cannot be unilaterally altered by the employer—both in a unionized context and in a non-unionized setting. This Part next considers claims that employers have breached fiduciary duties in changing retiree health benefits. Finally, this Part analyzes claims of estoppel—namely, that the employer's prior actions bar subsequent changes that might otherwise be allowed.

A. Employer's Right To Change Health Benefit Plans

ERISA clearly allows employers to change health benefit plans, as the Supreme Court held in *Curtiss-Wright v. Schoonejongen*.[99] As long as an employer retains the right to do so, that employer is "generally free under ERISA, for any reason at any time, to adopt, modify, or terminate [its] welfare plan."[100] Moreover, ERISA does not specify any vesting guarantees for welfare plans, unlike its stipulated mandatory vesting requirements for pension plans.[101] In the benefits context, vesting means that an employee has attained an unalterable right to a particular provision. Thus, while pension benefits cannot be changed if they have vested according to ERISA's guidelines, health care benefits have no such statutory protection.

ERISA's silence regarding the vesting of health care benefits has spawned extensive litigation and nuanced jurisprudential hopscotch over whether vesting of welfare benefits can occur in the absence of explicit and unambiguous contractual language in a company's benefits plan agreement. These cases have arisen both in the organized labor context, where benefit plans are formulated through negotiated collective bargaining agreements, and in individual employee benefit plans that are unilaterally written and instituted by the employer. As will be seen shortly, in neither context are retirees automatically vested in welfare benefit plans; rather, they must prove by a preponderance of the evidence that their former employer intended for the retiree health benefits to be vested.[102] But extrinsic evidence about the intent of the parties is considered only when the retirement plan language is ambiguous due to conflicting clauses or multiple

98. *See, e.g.*, PM Group Life Ins. Co. v. Western Growers Assurance Trust, 953 F.2d 543 (9th Cir. 1992).

99. 514 U.S. 73 (1995).

100. *Id.* at 78.

101. 29 U.S.C. §§ 1051-1061, 1081-1086 (2000).

102. Howe v. Varity Corp., 896 F.2d 1107, 1109 (8th Cir. 1990); *see also* McMunn v. Pirelli Tire LLC, 161 F. Supp. 2d 97, 122 (D. Conn. 2001).

plausible interpretations or is otherwise silent as to an employer's intent that the benefits vest.[103] In the absence of such situations, the plan documents stand on their own.

Although vesting claims are contractual disputes that focus on an employer's failure to honor allegedly vested health care benefits, an employer's fiduciary conduct in benefits communications can also come under legal scrutiny. Employer representatives potentially breach their ERISA-mandated fiduciary duty by making false statements to employees, and these statements can lead to employee claims for misrepresentation and estoppel. Employers may breach their fiduciary duties when their representatives make material misrepresentations either intentionally or negligently, depending on the judicial circuit. Estoppel claims may arise from employers' making false representations that their retirees detrimentally relied upon in making their retirement choices.

For example, the Seventh Circuit's decision in *Vallone v. CNA Financial Corp.*[104] provides an apt starting point for considering retirees' legal claims in lost benefits cases, because it included retiree claims on all three legal theories: contract breach regarding vesting, breach of fiduciary duty, and estoppel. Michael Vallone and two fellow employees at Continental Insurance Company accepted an early retirement package in 1991 that included a provision of "lifetime" welfare benefits known as the Health Care Allowance (HCA).[105] This provision of lifetime HCA benefits was reiterated both orally and in writing to the early retirees.[106] Eight years later, CNA Financial Corporation, the plan's employer-administrator that had acquired Continental Insurance, notified Mr. Vallone and the other early-retirees that their HCAs were being terminated.[107] CNA's basis for retiree benefits termination was a contractual clause that reserved the employer's right to change or amend the plan.[108]

In a class action, Vallone brought suit against CNA on three substantive issues: 1) breach of contract under ERISA for not honoring the alleged lifetime nature of HCA benefits (i.e., a vesting argument), 2) breach of its ERISA

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103. Helen M. Kemp, *The Employer Giveth and Taketh Away: Retiree Health Benefits Under ERISA-Governed Health Plans*, THE BRIEF (Am. Bar Ass'n, Chi., Ill.), Spring 2005, at 16, 18 (discussing employer-employee disputes over benefit vesting).

104. 375 F.3d 623 (7th Cir. 2004).

105. *Id.* at 626.

106. *Id.*

107. *Id.*

108. *Id.* at 634 (holding that reservation of rights allows stripping of "lifetime" benefits because contractual silence as to vesting presumes non-vested benefit status; also noting that "in the perhaps beady eyes of the law, the 'lifetime' nature of a welfare benefit does not operate to vest that benefit if the employer reserved the right to amend or terminate the benefit, given 'what it takes to overcome the presumption that welfare benefits do not vest'") (quoting Diehl v. Twin Disc, 102 F.3d 301 (7th Cir. 1996)).

fiduciary duty by providing informational misrepresentations as plan administrator, and 3) promissory estoppel for the retirees' reasonable reliance on the employer's misrepresentations.[109] The Seventh Circuit affirmed the district court's summary judgment for CNA on all claims.[110] First, the court found that the employer's reservation clause was sufficiently unambiguous as to CNA's intentions to not vest welfare benefits in its standard retirement plans, and the early retirement package constituted simply a modification to the existing plan rather than an entirely new plan.[111] Second, the court held that the employer did not breach its fiduciary duty to the plaintiffs, because CNA's representatives did not intentionally deceive the early retirees when they made material misrepresentations about their benefits.[112] Lastly, the retirees could not show a knowing misrepresentation of fact on CNA's behalf to prevail on an estoppel claim; plaintiffs, moreover, did not substantiate their reasonable reliance on CNA's purported misrepresentations.[113] The *Vallone* plaintiffs thus failed to prevail on any of their three legal theories. This case illustrates well that retirees are not likely to prevail on legal challenges to employers who modify the terms of post-retirement welfare plans.

B. Vesting Claims

As a general matter, health benefits plans are reduced to the written terms of the ERISA-governed benefit plan document. While ERISA allows employers a right to amend benefit plans, employers may relinquish this right by affirmatively contracting with their employees for vesting of the employees' welfare benefits, including health care coverage in retirement.[114] To this end, retirees who want to protect their benefits must invariably argue that the benefit plan language included an employer commitment to vest and that such vesting was impervious to future employer modification; stated differently, retirees must prove that the employer promised to vest benefits and that the duration of that promise was unlimited within a retiree's lifetime. It is the employees' burden to prove these facts in order to overcome the *Curtiss-Wright* rule that employers are free to modify benefit plans where they have reserved the right to do so. As will be seen below, employee-retirees have significant difficulty prevailing on such claims, whether in a unionized or non-unionized setting.

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109. *Id.* at 626-27.

110. *Id.* at 626.

111. *Id.* at 634-35.

112. *Id.* at 640-642 (endorsing the intentional deception standard necessary for breach of fiduciary duty and stating that a "breach of fiduciary duty exists if fiduciaries 'mislead plan participants or misrepresent the terms or administration of a plan'") (quoting Anweiler v. American Elec. Power Serv. Corp., 3 F.3d 986, 991 (7th Cir. 1993)).

113. *Id.* at 639-40.

114. *See* Kemp, *supra* note 103, at 18.

1. The Unionized Workplace

In a union context, the Collective Bargaining Agreement (CBA) governs benefit plans and provides the basis for deciding the parties' intent and scope of vested benefits. The written document describing the terms of the collectively bargained benefits is called a Summary Plan Description, or SPD, which is the statutorily mandated vehicle by which employees are informed of their coverage.[115] SPDs usually contain clauses reserving an employer's right to amend benefit plans at a later time, but other language in the document often suggests that the benefits are unequivocally vested for the employees' lifetimes. These conflicting provisions therefore give rise to litigation when employers later amend plans, and retirees object by claiming that their benefits are vested for life. In such cases of contractual ambiguity, the rules of contract interpretation require the court to assess the intent of the parties.

a. Inter-Circuit Disagreement over Inferring an Employer's Intent to Vest Benefits

The most controversial and widely cited federal case regarding contractual ambiguity and intent of the parties regarding benefits in a union setting is *UAW v. Yard-Man, Inc.*[116] This case is well-known for the Sixth Circuit's groundbreaking "*Yard-Man* inference" that silence as to benefits' duration suggests an employer's intent to vest.[117] Although the United Automobile Workers (UAW) and the company agreed to provide retiree welfare benefits in a 1974 CBA, the company terminated these benefits after the CBA's three-year term expired.[118] Viewing the retiree benefit provision language stating that the company "will provide insurance benefits equal to the active group" as reasonably ambiguous regarding the benefits' duration, the Sixth Circuit allowed extrinsic evidence to be considered under the rules of contract interpretation.[119]

The court, inferring into the situational context the relative bargaining positions of the parties, ruled that retiree health benefits extended beyond the

115. *See* 29 U.S.C. §§ 1022(a), 1102 (2000).

116. 716 F.2d 1476 (6th Cir. 1983).

117. *See* Jason Blumberg, Comment, *Bringing Back the Yard-Man Inference*, 4 U. PA. J. LAB. & EMP. L. 195, 201 (2001).

118. 716 F.2d at 1478.

119. *Id.* at 1480 (internal quotation marks omitted). UAW interpreted the phrase as a characterization of the nature of the benefits (i.e., what benefits they were promised), while the company read it as tying retirees' benefits to those of active employees who were to be terminated at the end of the CBA due to plant closing and the cessation of an active work force. *See* Douglas Sondgeroth, Note, *High Hopes: Why Courts Should Fulfill Expectations of Lifetime Retiree Health Benefits in Ambiguous Collective Bargaining Agreements*, 42 B.C. L. REV. 1215, 1231-32 (2001) (explaining and defending the *Yard-Man* inference).

expiration of the CBA. It reasoned that retiree benefits were akin to status benefits that "carry with them an *inference* that they continue so long as the prerequisite status is maintained. Thus, when the parties contract for benefits which accrue upon achievement of retiree status, there is an *inference* that the parties likely intended those benefits to continue as long as the beneficiary remains a retiree."[120] Retirees had a justified expectation of future welfare benefits, the court found, because retirement benefits are "typically understood as a form of delayed compensation or reward for past services" that would not likely "be left to the contingencies of future negotiations."[121] In other words, the retiree health benefits had already accrued to retirees in exchange for previously sacrificed wages and were not subject to later agreements.[122] Having inferred these points and considered all factors, the Sixth Circuit decided that the specific benefits clause vested retiree benefits interminably and ultimately trumped the routine three-year duration clause pronounced for the CBA as a whole. Because the agreement contained specific duration clauses for other less significant benefits, the generalized duration clause could not defeat the specialized benefits language into which the court read an intent to vest.

Two trends have been evident in the jurisprudential wake of *Yard-Man*. First, and far more conventional than controversial, the Sixth Circuit's application of the interpretive canon that the "specific controls the general" found accord among other circuits that later adopted *Yard-Man*'s distinction between specific and general duration clauses. In *United Steelworkers of America v. Connors Steel Co.*,[123] for example, the Eleventh Circuit confronted the issue of whether retiree health benefits terminated at the expiration of the CBA. The agreement provided that retirees "shall not have such coverage terminated or reduced . . . so long as the individual remains retired from the company . . . notwithstanding the expiration of this agreement."[124] As in *Yard-Man*, the court held that a specific duration clause overrides a general duration clause. Because contract interpretation is highly factual, courts have sometimes found that the language of the agreement unambiguously provided retirees lifetime benefits that did not end with the expiration of the CBA.[125]

Second, the *Yard-Man* inference spawned chaos among the circuit courts as to its validity, force, and effect, although some commentators have pointed to limiting language in the opinion to say that the Sixth Circuit's approach was not

120. 716 F.2d at 1482 (emphasis added).

121. *Id.*

122. Sondgeroth, *supra* note 119, at 1232 (explaining the Sixth Circuit's rationale for the *Yard-Man* inference).

123. 855 F.2d 1499 (11th Cir. 1988).

124. *Id.* at 1505.

125. *See, e.g.*, Diehl v. Twin Disc, Inc., 102 F.3d 301 (7th Cir. 1996); Policy v. Power Pressed Steel Co., 770 F.2d 609 (6th Cir. 1985).

nearly as radical as it has been interpreted by other courts.[126] The Sixth Circuit itself incorrectly applied its own precedent in *Policy v. Powell Pressed Steel Co.*[127] by decreeing that "normally retiree benefits are vested," which substantially overstates the thrust of *Yard-Man*.[128] But it subsequently corrected its mistake in *In re White Farm Equipment Co.*,[129] by overruling a federal district court that had found under the federal common law of ERISA that welfare benefits vest automatically on retirement and are nonterminable, despite plain language in the plan authorizing such termination[130]: "[W]e find that . . . ERISA, though silent on this issue, counsels against . . . an absolute rule effectively requiring mandatory vesting at retirement of retiree welfare benefits . . . . [W]e discern no basis for finding mandatory vesting in ERISA of retiree welfare benefits."[131]

Other circuits generally agree with *In re White Farm Equipment Co.* that retiree benefits do not automatically vest absent affirmative language to that effect. The Third Circuit has found that "[retiree] welfare benefits do not automatically vest as a matter of law,"[132] while the Eighth Circuit has said that "Congress explicitly exempted welfare benefits from ERISA's vesting requirements. It, therefore, seems illogical to infer an intent to vest welfare benefits in every situation where an employee is eligible to receive them on the day he retires."[133] Similarly, the Second Circuit persuasively argued that:

> [Congress rejected] [a]utomatic vesting . because the costs of such plans are subject to fluctuating and unpredictable variables. Actuarial decisions concerning [pensions] are based on fairly stable data, and vesting is appropriate. In contrast, medical insurance must take account of inflation, changes in medical practice and technology, and increases in the costs of treatment independent of inflation. These unstable variables prevent accurate predictions of future needs and costs.[134]

Still, significant disagreement among circuits has developed since *Yard-Man* regarding the degree of importance that should be attached to the inference of vesting when a contract is ambiguous. Some circuits deem the inference a strong

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126. *See, e.g.*, Blumberg, *supra* note 117, at 202 (arguing that the *Yard-Man* inference is only one of many factors to consider, and although the Sixth Circuit made this abundantly clear, some future courts have applied the inference too broadly).

127. 770 F.2d 609 (6th Cir. 1985).

128. *Id.* at 613-14.

129. 788 F.2d 1186 (6th Cir. 1986).

130. *Id.* at 1190.

131. *Id.* at 1192-93.

132. Molnar v. Wibbelt, 789 F.2d 244, 250 (3d Cir. 1986).

133. Anderson v. Alpha Portland Industries, Inc., 836 F.2d 1512, 1517 (8th Cir. 1988).

134. Moore v. Metropolitan Life Ins. Co., 856 F.2d 488, 492 (2d Cir. 1988).

factor in ascertaining the intent of the parties to a CBA,[135] while others consider it only selectively. For instance, the Fifth Circuit limits application of the vesting inference to those instances in which retirees have no voice in negotiating a new CBA.[136] By contrast, a vesting inference has no place in the Seventh Circuit, which has ruled that there is a presumption against vesting beyond the duration of a CBA if the agreement is silent on the issue, unless retirees can show by objective evidence that the agreement is latently ambiguous.[137] This ruling is compelling for two reasons. First, the union negotiates the terms of the agreement, so it is highly unlikely that the union was naïve about the risks of having ambiguity or silence on an issue. Second, and perhaps more importantly, the ruling treats CBAs and unbargained-for ERISA plans consistently in this regard.

b. Recent Union Cases Show Employers' Diligence in Avoiding Contractual Ambiguity and Precluding the Possibility of an Intent-to-Vest Inference

Despite the significant disagreement among circuit courts regarding an employer's intent to vest benefits, this issue is becoming less significant as courts generally find benefit plans straightforward enough, or sufficiently unambiguous, to preclude the consideration of extrinsic evidence. Furthermore, the decline in union density, changed economic circumstances, and shifting composition of the workforce have weakened the bargaining power of unions to safeguard the benefits interests of their members.[138] The chronological sampling below of recent Courts of Appeals cases demonstrates that retirees have routinely been unsuccessful on claims of vested benefits and contract breach against their employers.

i) Hughes v. 3M Retiree Medical Plan (2002)[139]

A married couple sued their former employer and its retiree medical plan in response to the employer's changes to their medical benefits after they had retired. The employer implemented a revised retiree plan that included

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135. *See* Golden v. Kelsey-Hayes Co., 73 F.3d 648, 654 (6th Cir. 1996); Keffer v. H.K. Porter Co., 872 F.2d 60, 64 (4th Cir. 1989); United Steelworkers v. Textron, Inc., 836 F.2d 6, 9 (1st Cir. 1987).

136. *See* Int'l Ass'n of Machinists v. Masonite Corp., 122 F.3d 228, 231-32 (5th Cir. 1997); United Paperworkers Int'l Union v. Champion Int'l Corp., 908 F.2d 1252, 1261 n.12 (5th Cir. 1990); Int'l Ass'n of Machinists v. Masonite Corp., 122 F.3d 228, 231-32 (5th Cir. 1997).

137. Rossetto v. Pabst Brewing Co., Inc., 217 F.3d 539, 544, 547 (7th Cir. 2000).

138. *See* Maria O'Brien Hylton, *The Changing World of Employee Benefits*, 79 CHI.-KENT L. REV. 625, 627-28 (2004).

139. 281 F.3d 786 (8th Cir. 2002).

"additional cost sharing by retirees"; however, plaintiffs contended that the "Your Benefits" booklet given to them by the company following the 1991 union-employer CBA contained vesting language stating that "[i]f you retire with 15 years of pension service regardless of when you were hired, you and your spouse will receive medical benefits for your lifetime at company expense."[140]

The Eighth Circuit found that the benefits booklet cited by plaintiffs was not the correct SPD, as the booklet referred participants over age sixty-five to a separate "Med-Supp Plan" brochure that governed plaintiffs' plan and contained no language even remotely suggestive of vesting.[141] Regardless of which booklet was appropriate, both documents—"Med-Supp Plan" or "Your Benefits"—contained reservation clauses stating that while the company intended to continue the plan indefinitely, it reserved the right to amend or discontinue benefits.[142] These reservation-of-rights clauses sufficed for 3M to unilaterally alter retiree benefits long after the CBA was ratified. Interestingly, whereas the "Your Benefits" booklet for workers under age sixty-five read that the company "reserves the right to amend or discontinue . . . subject to collective bargaining as required,"[143] the Med-Supp Plan's reservation clause concluded with "reserves the right to change or discontinue it if necessary."[144] Although not mentioned in the opinion, it seems that retirees are more at risk than are current employees, since the employer could alter their plan "if necessary" rather than "subject to collective bargaining as required," the standard applicable to current employees.

ii) UAW v. Rockford Powertrain, Inc. (2003)[145]

Former union member retirees, surviving spouses of retirees, and their local union sued their former employer, Rockford Powertrain, Inc. (RPI), after RPI cut welfare benefits midway through the term of the instant CBA.[146] RPI had acquired the manufacturing plant of the retirees' previous employer in 1988, assumed the existing CBA, and thereafter re-negotiated subsequent CBAs periodically with the UAW.[147] Although the latest CBA was to apply through 2001, RPI announced benefit cuts in late 1999 that would 1) reduce medical insurance coverage by increasing retirees' share of premiums and 2) fully terminate life insurance benefits across its active and retired workforce.[148] Citing recessionary economic pressures, RPI terminated all health benefits for active

140. *Id.* at 789.
141. *Id.* at 792.
142. *Id.* at 792-93.
143. *Id.* at 789.
144. *Id.* at 792.
145. 350 F.3d 698 (7th Cir. 2003).
146. *Id.* at 700.
147. *Id.*
148. *Id.* at 701-02.

employees and retirees the following year.[149]

Although all SPDs published by RPI included a reservation-of-rights clause in the "Future of Plans" section of the plan description,[150] plaintiffs alleged that their health benefits had fully vested based on language found in other sections of the document covering post-retirement health and life-insurance benefits. A clause in the retiree health benefits section, which the court dubbed the "lifetime benefits provision," read that "health coverage is continued . . . until death . . . [and if] you die after retirement, health coverage may be continued for your spouse."[151] However, this language contradicted what the court characterized as a "plan termination clause" found elsewhere in the same section saying that "in the event this group plan is terminated, coverage for you and your dependents will end immediately."[152] The potential ambiguity of the plan, plaintiffs argued, was further buttressed by silence on both of these matters—vesting and termination—in the post-retirement life insurance benefits section.[153]

The Seventh Circuit, citing its own precedent and that of the Supreme Court, explained that welfare benefits do not vest automatically, but rather are subject to employer modification, amendment, or termination under ERISA when the employer has not contractually "cede[d] its freedom" to do so.[154] Accordingly, the court would adhere to "federal principles of contract construction, meaning that [it would] give contract terms their 'ordinary and popular' sense and avoid resort to extrinsic evidence when faced with unambiguous language."[155] In applying such principles and keying on the canon of interpreting potentially conflicting language to be in agreement with a document's integrated whole the court determined that the contractual language of the reservation-of-rights, "lifetime benefits," and "plan termination" clauses did not create ambiguity as to RPI's intent to vest benefits.[156] While RPI intended to provide lifetime welfare coverage for its retirees when it wrote the plans, such coverage was subject to the employer's will.[157] Thus, although the SPD purportedly conferred lifetime benefits on its employees, the employer's right to modify and its explicit

149. *Id.* at 702.

150. RPI's reservation of rights clause in all SPDs read, "[a]lthough the company expects and intends to continue the plan indefinitely, it reserves the right to modify, amend, suspend or terminate them at any time." *Id.* at 701.

151. *Id.* (internal quotation marks omitted) (citing potentially contradictory contractual provisions).

152. *Id.* (internal quotation marks omitted).

153. *Id.*

154. *Id.* at 702 (citing Inter-Modal Rail Employees Ass'n v. Atchison, Topeka & Santa Fe Ry. Co., 520 U.S. 510, 515 (1997); Diehl v. Twin Disc, Inc., 102 F.3d 301, 305 (7th Cir. 1996)).

155. *Id.* at 702-03 (quoting *Diehl*, 102 F.3d at 306).

156. *Id.* at 703.

157. *Id.* (citing Abbruscato v. Empire Blue Cross & Blue Shield, 274 F.3d 90, 99 (2d Cir. 2001); In re Unisys Corp. Retiree Med. Benefit "ERISA" Litig., 58 F.3d 896, 904 (3d Cir. 1995)).

affirmation of such ability in the reservation-of-rights clause could not be read as promising *vested* healthcare benefits. Moreover, because the current union-RPI CBA did not specifically discuss terms of post-retirement welfare benefits, but instead incorporated the terms of an overall insurance agreement for all benefits-related issues that included a reservation-of-rights clause, RPI was contractually empowered to terminate benefits in the middle of the CBA's term rather than waiting until its expiration.[158]

iii) McCoy v. Meridian Automotive Systems, Inc. (2004)[159]

The Sixth Circuit, perhaps in homage to the liberality it expounded in *Yard-Man*, has recently been more lenient toward the plight of retirees losing their health benefits. In this case, the Sixth Circuit upheld a lower court's injunction against an employer's attempt to slash retirees' health coverage based on the theory that the retirees' welfare benefits were directly tied to vested pension benefits granted in the CBA.[160] In so deciding, the court cited *Yard-Man* principles to set the analytical stage—namely, that 1) parties to a CBA may contract for benefits that continue beyond the life of the agreement, 2) the rules of contract interpretation apply to view provisions as part of an integrated whole, and 3) extrinsic evidence is to be considered only when ambiguity remains from such a reading.[161]

In following these rules and applying post-*Yard-Man* cases, the court resolved two overarching issues in the retirees' favor. First, it determined that the language in the "Supplemental Agreement" between the employer and UAW was sufficiently clear in tying together eligibilities for health benefits and pensions.[162] Second, and more importantly, the Sixth Circuit allowed the Supplemental Agreement to be considered in the proceeding because of its incorporation into

158. *Id.* at 705 ("RPI's unilateral reduction, and later termination, of post-retirement benefits was not an impermissible mid-term unilateral change because the text of the plan—and by incorporation, the text of the CBA—reserved RPI's right to alter the specific terms of insurance.").

159. 390 F.3d 417 (6th Cir. 2004).

160. *Id.* at 420-22.

161. *Id.* at 421-22.

162. *Id.* at 422. The Supplemental Agreement stated that "[t]he Company shall contribute the full premium or subscription charge for Health Care . . . coverages continued in accordance with Article III, Section 5, for: (i) a retired employee (including any eligible dependents) provided such retired employee is eligible for benefits under Article II of the Company's Hourly-Rate Employees Pension Plan. . . . The Health Care . . . coverages an employee has under this Article at the time of retirement . . . shall be continued thereafter provided that suitable arrangements for continuation can be made with the Carrier(s)." *Id.* at 419. Furthermore, "the Supplemental Agreement similarly tied retirees' spouses' medical benefits to pension benefits." *Id.*; *see also* Golden v. Kelsey-Hayes Co., 73 F.3d 648 (6th Cir. 1996).

the CBA by reference.[163] In other words, the CBA language alluded to the Supplemental Agreement on the subject of pension plans and insurance programs, and thus the Supplemental Agreement provided intrinsic—rather than extrinsic—evidence about the contractual intent of the parties.[164]

Finally, in distinguishing the force and effect of the employer's reservation-of-rights clause from its anti-employer injunction, the Sixth Circuit held that this clause operated simply to "alert [future retirees] that the company may discontinue the retirement benefits of employees *who have yet to retire* when the agreement ends."[165] Thus, the Sixth Circuit has favored employees a bit more recently but only where the contractual language strongly links health benefits and vested pension benefits.[166]

iv) Cherry v. Auburn Gear, Inc. (2006)[167]

Three years after its stark treatment of union-employer disputes over welfare benefits in *Rockford Powertrain*,[168] the Seventh Circuit confronted a more determined union litigant. In this case, the retirees' former employer instituted various changes over the preceding two decades that increased retiree co-payments and charged monthly premiums. These changes culminated with Auburn Gear's notification in 2002 of its intention to terminate retiree benefits outright, and the union responded by having its active employees strike immediately.[169]

Ruling against the retirees, the court progressed through the same contract principles as in previous cases to arrive at its decision. Reviving its language from earlier decisions, it admitted that "this story does not have a happy ending":

> We are mindful of the burden placed upon retired individuals with fixed income who now must bear an unexpected increase in healthcare costs. "However, we are bound to determine only whether a legally sufficient agreement between the parties exists to support plaintiffs' claim." If a union "want[s] to assure that employer-paid health benefits for the workers they represent are vested[,] they will have to insist on explicit language to this

163. *McCoy*, 390 F.3d at 423-24.

164. *See id.* at 419.

165. *Id.* at 425.

166. *See* Noe v. PolyOne Corp., 520 F.3d 548 (6th Cir. 2008) (noting the critical linkage of retiree health benefits to pension plan benefits); Yolton v. El Paso Tenn. Pipeline Co., 435 F.3d 571 (6th Cir. 2006).

167. 441 F.3d 476 (7th Cir. 2006).

168. UAW v. Rockford Powertrain, Inc., 350 F.3d 698 (7th Cir. 2003); *see also* Barnett v. Ameren Corp., 436 F.3d 830 (7th Cir. 2006) (holding that retiree health benefits do not vest unless there is an unambiguous indication in the agreement that they do).

169. 441 F.3d at 479-81.

effect." In this case, Union failed to obtain the necessary contractual language.

> The distinction between lifetime benefits and vested benefits is "a legal distinction that understandably escaped" many of the retirees. "It is difficult to imagine that someone without legal training would be able to fully comprehend a reservation of rights clause and how the court would interpret such a clause." To avoid this information gap, Union representatives must be mindful of their responsibility to deliver the benefits they have promised and not guarantee benefits they have failed to obtain through explicit contractual language.
>
> The contractual language at issue in this case was clear: "lifetime" benefits extended only so long as the collectively bargained insurance agreement remained in effect.[170]

Thus, the Seventh Circuit has been consistently unsympathetic to retiree efforts to protect their evaporating health care benefits, as the law of ERISA and contractual principles weigh heavily against retirees.

v) Coffin v. Bowater Inc. (2007)[171]

Finally, the First Circuit joined this parade by allowing a subsequent benefit plan adoption to unilaterally abrogate the health care benefits that retirees possessed under a predecessor arrangement. In a convoluted situation involving a subsidiary's acquisition and subsequent disposition, Bowater Inc. argued that such transactions automatically terminate a parent company's health benefit obligations to that subsidiary's retirees. On this point, the court held for the retirees, noting that "parent companies tend to terminate ERISA plans when selling a subsidiary, [but] there is nothing automatic about this correlation."[172] Such companies, according to the court, must satisfy certain procedural requirements in ERISA that "alert employees that the parent was terminating responsibility for its welfare benefits upon the sale of the subsidiary."[173]

The First Circuit then noted the applicable requirements:

> [A]n ERISA plan amendment must be in writing; it must be executed by a party authorized to amend the plan; the language of the amendment must clearly alert the parties that the plan is being amended; and the amendment must meet any other requirements laid out for such amendments in the plan's governing documents.[174]

These requirements, the court observed, were not met by the stock purchase

170. *Id.* at 486 (citations omitted).

171. 501 F.3d 80 (1st Cir. 2007).

172. *Id.* at 88.

173. *Id.*

174. *Id.* at 91-92.

agreement that Bowater executed when it sold the relevant subsidiary.[175]

The retirees' victory, however, was short-lived. In 2003, Bowater established a "unified plan to replace the various plans under which its employees received health and welfare benefits."[176] This "unified plan" excluded Mr. Coffin and the other retiree-plaintiffs, and the plan's explicit declaration that it "supersedes and replaces any program document defining the terms of or describing a Benefit Program that is not incorporated and made part of the Plan" meant that the retirees' benefits were no more.[177]

2. The Non-Unionized Workplace

In contrast to the Sixth Circuit and selected other circuits' cases that may follow *Yard-Man* in a union context, courts historically do not recognize a presumption or inference of vesting of benefits in unbargained-for welfare plans, nor are they inclined to distinguish between general and specific duration clauses. As such, courts interpreting contracts are less friendly to retirees with unbargained-for retiree health benefit plans. For example, in the 1995 case of *In re Unisys Corp. Retiree Medical Benefit "ERISA" Litigation*,[178] the Third Circuit considered whether an employer could unilaterally reduce retiree health benefits where the plan described the duration of benefits as "lifetime" and "rest of your life," while at the same time expressly reserving the employer's right to terminate or change benefits under the plan for any reason.[179] Absent any consideration of a vesting inference, the court reconciled the arguably inconsistent language by reasoning that "the promise made to [the Unisys] retirees was a qualified one: the promise was that retiree medical benefits were for life provided the company chose not to terminate the plans, pursuant to clauses that preserved the company's right to end them at any time or for any reason."[180] In other words, even "vested" retiree health benefits are conditional upon an employer's continued willingness to provide such benefits—a rather nuanced interpretation, to say the least, of what "vested" benefits represent.

Similarly, in *Sprague v. General Motors*,[181] retirees challenged General Motors' (GM) ability to unilaterally terminate retiree welfare benefits as reserved in the plan document, but in contradiction to a subsequent SPD that promised lifetime benefits without alluding to GM's right to terminate. The Sixth Circuit held that the plan terms and the SPD were not inconsistent, because the plans and

175. *Id.* at 91.

176. *Id.* at 92.

177. *Id.* at 93.

178. 58 F.3d 896 (3d Cir. 1995).

179. *Id.* at 904.

180. *Id.* at 904 n.12.

181. 133 F.3d 388 (6th Cir. 1998).

the SPDs unambiguously reserved GM's right to amend or terminate the plan. In addressing whether omissions in a SPD about vesting of medical benefits could create an ambiguity between the plan and SPD, the court answered in the negative because "Congress did not require [disclosure of] such information for *welfare* plans; neither did the Department of Labor in its ERISA reporting and disclosure regulations."[182] The court addressed the issue of whether there is a presumption of vesting by stating,

> To vest benefits is to render them forever unalterable. Because vesting of welfare plan benefits is not required by law, an employer's commitment to vest such benefits is not to be inferred lightly; the intent to vest must be found in the plan documents and must be stated in clear and express language.[183]

The Sixth Circuit ultimately reasoned that GM had made a qualified promise to provide lifetime retiree health benefits, a promise that held true as long as the company did not change its mind. Such an interpretation renders whatever benefits retirees continue to receive a mere gratuity, a product of GM's forbearance, or perhaps its generosity.

The following is a sampling of recent cases of non-union retiree vesting claims that underscore the legally precarious position of retirees with regard to post-employment health benefits.

a. Abbruscato v. Empire Blue Cross & Blue Shield (2001)[184] *and Devlin v. Empire Blue Cross & Blue Shield (2001)*[185]

Plaintiff-retirees left employment either through the ordinary course of business or through early retirement severance packages between 1989 and 1998.[186] Both cases involved the same fact pattern, except that the *Devlin* retirees based their claims on pre-1987 SPDs, while the *Abbruscato* retirees focused on benefit plan descriptions from 1987 and beyond. The key difference between the two cases was that a newly written employee handbook ("Your Handbook") introduced in 1987 was the first version to include a reservation-of-rights clause. This handbook provided that "the company expects and intends to continue the Plans in your Benefits Program indefinitely, but reserves its right to end each of the Plans, if necessary. The company also reserves its right to amend each of the Plans at any time."[187]

Those plaintiffs accepting early retirement packages received written

182. *Id.* at 402.

183. *Id.* at 400.

184. 274 F.3d 90 (2d Cir. 2001).

185. 274 F.3d 76 (2d Cir. 2001).

186. *Abbruscato*, 274 F.3d at 93.

187. *Id.* at 94.

materials that described the specialized terms of their incentive-laden departures, and both plans contained reservation-of-rights language concerning the benefits.[188] Furthermore, the early retirement packages included a "Separation Agreement and General Release" in which the employer "reserve[d] the right to change or eliminate, at any time, these retiree medical and life insurance benefits" and asserted that "the agreement constituted the sole and complete understanding between the parties."[189] Thus, there were three categories of plaintiffs across these two cases: 1) pre-1987 SPD regular retirees in *Devlin* whose plan lacked a reservation-of-rights clause, 2) "Your Handbook" regular retirees from 1987 forward who were subject to a reservation-of-rights clause, and 3) early retirees whose plans also contained a reservation-of-rights clause.

As to the early retirees, the *Abbruscato* court found that there were intrinsic grounds in the plans to create ambiguity about the meaning of "lifetime" benefits and overturned the lower court's summary judgment for Empire.[190] The Second Circuit deemed the eligibility formulas to conflict with the generalized reservation-of-rights clauses found elsewhere in the plans. The purported reservation clauses could be "interpreted to mean that Empire merely reserved the right to change the program for those individuals who have not already retired under the terms described, not the right to alter the described benefits for those individuals who had retired under those terms."[191]

By contrast, the same court found no such ambiguity that would allow the "Your Handbook" regular retirees to pursue their benefit claims against Empire. Instead, the Second Circuit ruled that a generalized reservation-of-rights clause plus termination language about a specific benefit provided a clear message to retirees about the nonvesting nature of their benefits.[192] One commentator's reading of *Abbruscato's* holding explained that "employees cannot reasonably believe that their benefits are vested if the same document that promises lifetime benefits also clearly informs employees that those benefits are subject to change."[193]

Finally, the court upheld the motion of the pre-1987 SPD plaintiffs in *Devlin* by ruling that there was adequate written language in the SPDs "'*capable of reasonably being interpreted* as creating a promise' to survive an employer's summary judgment motion."[194] Since the pre-1987 SPDs lacked a reservation-of-rights clause, and certain other sentences read that "retired employees, after

188. *Id.* at 94-95.

189. *Id.* at 95.

190. *Id.* at 98.

191. *Id.*

192. *Id.* at 99.

193. Kemp, *supra* note 103, at 19.

194. *Devlin*, 274 F.3d 76, 84 (2d Cir. 2001) (quoting Am. Fed'n of Grain Millers v. Int'l Multifoods Corp., 116 F.3d 976, 980 (2d Cir. 1997)).

[meeting a condition precedent] *will be insured*" and that life insurance benefits "will remain at [the annual salary] level *for the remainder of their lives*," there were reasonable grounds to interpret an intent to vest life insurance benefits.[195]

Setting aside their intricacies, the two *Empire* cases demonstrate that the evidentiary burden on retirees makes it difficult to even withstand an employer's summary judgment motion, let alone defeat an employer's benefits-slashing. The *Empire* retirees required either 1) an absence of an employer reservation-of-rights clause (in the case of pre-1987 plaintiffs), or 2) an SPD containing a generalized reservation-of-rights clause coupled with a specific clause that was sufficiently ambiguous in order to proceed. Thus, a generalized reservation-of-rights clause, standing alone, is apparently sufficient to sustain an employer's motion for summary judgment.

b. Stearns v. NCR Corp. (2002)[196]

A group of early retirees brought suit against their former employer for reducing health benefits granted to them in their severance package.[197] The plaintiffs accepted an Enhanced Retirement Program package in 1993 that provided, inter alia, a better health care package than was currently offered under the company's standard medical plan.[198] Six years later, the company instituted sweeping changes, including higher premiums, increased deductibles and co-payments, and cancellation of the company's Medicare supplement plan.[199] Plaintiff Stearns represented the retiree class, arguing that NCR's purported reservation-of-rights provision in the Plan Amendment subsection of the group benefits plan was invalid.

The Eighth Circuit ruled for the employer, citing its precedent from *Hughes v. 3M Retiree Medical Plan*[200] that an unambiguous reservation-of-rights provision is sufficient to defeat a claim that retirement welfare plan benefits are vested.[201] Explaining the framework of contract analysis, the court said that extrinsic evidence could only be considered in cases of facial ambiguity or conflict with other plan provisions.[202] Finding neither situation, the Eighth Circuit held that NCR could terminate benefits according to the reservation-of-rights clause.

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195. *Id.* at 84-85 (internal quotation marks removed).

196. 297 F.3d 706 (8th Cir. 2002).

197. *Id.* at 708.

198. *Id.*

199. *Id.* at 709.

200. 281 F.3d 786 (8th Cir. 2002).

201. *Stearns*, 297 F.3d at 712.

202. *Id.*

c. Bland v. Fiatallis North America, Inc. (2005)[203]

In this case, there was no reservation-of-rights clause. The plaintiff-retirees protested their employer's "onion solution" to gradually peel away layers of retiree benefits over time, and initiated suit on grounds that the contract language was ambiguous and subject to extrinsic evidence of an intent to vest.[204] The Seventh Circuit recognized that although health benefits do not vest automatically, they may be so triggered by an affirmative contractual promise by the employer.[205] While the court noted that a contract that is silent about vesting holds a presumption that the employer did not intend to grant vested benefits, this presumption is defeated by what Judge Richard Posner called "any positive indication of ambiguity, [or] something to make you scratch your head."[206] The Seventh Circuit was made to scratch its proverbial head in this case, as plaintiff-retirees pointed to multiple instances of "life-time" language in the plan documents, even though there was no explicit promise to vest nor any reservation of a right to modify benefits.[207] Ultimately, in the absence of contrary evidence where the language was ambiguous, the Seventh Circuit determined that "lifetime" within the plan documents was used as a durational term that equated to "good for life unless revoked or modified."[208] Accordingly, it reversed the lower court's granting of summary judgment for the employer and remanded the case to decide the scope of vested benefits that were ostensibly promised by the employer.

d. Boubolis v. Transport Workers Union of America (2006)[209]

In an interesting twist on the typical fact situation, this case presents an employee union as the benefits-slashing employer. The plaintiff-retirees were former New York City Transit Authority workers who became staff employees of the local union chapter, Local 100, of the Transport Workers Union of America.[210] The retirees alleged that they were given assurances at various junctures during their employment with Local 100 that they would have "lifetime health insurance coverage" under Local 100's plan, which provided better health benefits than those available to them as former employees of the Transit Authority.[211] Accordingly, when new union leadership of Local 100 terminated

203. 401 F.3d 779 (7th Cir. 2005).
204. *Id.* at 781-82.
205. *Id.* at 783-84.
206. *Id.* at 784.
207. *Id.* at 785.
208. *Id.* at 786.
209. 442 F.3d 55 (2d Cir. 2006).
210. *Id.* at 58.
211. *Id.*

the health care benefits of all retirees who were otherwise eligible for health insurance coverage from another employer, these retirees sued to enforce their right to be covered by Local 100's plan rather than the inferior Transit Authority plan.[212]

The retirees first argued that their health benefits were "lifetime" in nature because, although the SPD lacked explicit vesting language, it listed only two conditions—ceasing employment and death—by which benefits could terminate.[213] Because they were already retired, plaintiffs reasoned that they could lose their benefits only upon death; i.e., the end of their lifetime.[214] Unfortunately for the retirees, the Second Circuit rejected this argument based on the widely held rule that the absence of vesting language does not create a promise to vest by the employer. The SPD therefore did not, on its own, vest lifetime health care benefits in the retirees.[215]

Boubolis shows that even the unions that bargain with employers and pursue litigation in the interests of their employees can have an alter-ego as a self-interested employer or business entity. In this situation, the union engaged in the same sort of objectionable action that it would normally oppose on behalf of its members. By cutting retiree benefits and breaking its promise, regardless of whether the retirees had available insurance coverage from another source, the union maligned and disenfranchised its retirees exactly as employers have done in the ERISA-related vesting cases. And as in the vast majority of other benefits cases, the employer is legally allowed to do so under the courts' interpretation of ERISA.[216]

Because retirees' vesting arguments are rarely successful in either the union or the non-union context, plaintiffs invariably allege that the employer's actions breached its fiduciary duties. It is this type of action—breach of the fiduciary duty—to which we now turn.

C. Breach of Fiduciary Duty Claims

Because ERISA mandates that employers acting as benefit plan administrators are performing fiduciary functions, the oral representations that are made by human resources personnel and other benefits-related personnel in a company often come under scrutiny in cases of benefits-stripping. That is, when

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212. *Id.*

213. *Id.* at 61.

214. *Id.*

215. *Id.*

216. *See, e.g.*, Balestracci v. NSTAR Electric & Gas Corp., 449 F.3d 224 (1st Cir. 2006) (affirming summary judgment for the employer due to the SPD's reservation of the right to terminate "lifetime" dental benefits, even though informal summaries provided to early retirees did not disclose this right).

employees have been told one thing about their expected benefits, but the company later does the opposite, it is possible that the employer breached its fiduciary duties of disclosure, care, and loyalty to the employee-beneficiaries (and future retirees). Such factual scenarios are especially common in cases of early retirement plans where employees, after having been assured that no sweetened severance packages would be forthcoming, depart the company before an enhanced package is unveiled shortly thereafter. As the case law in this area points out, plaintiffs who are seeking restitution for lost benefits must meet two significant evidentiary hurdles. First, they must show that an employer's misrepresentative communication was material. Second, they must substantiate the requisite scienter, or intent threshold, underlying the employer's material misrepresentation, a standard that varies from circuit to circuit. Stated somewhat differently, employees must prove that the company made a significant—rather than trivial—misrepresentation that was either intentionally fraudulent or merely negligent, depending on the circuit involved.

These hurdles originate from the Supreme Court's landmark decision in *Varity Corp. v. Howe*,[217] the first case to recognize an actionable claim for breach of fiduciary duty under ERISA. In that case, corporate management affirmatively advised and purposefully induced employees to switch their benefit plans from the parent company to an insolvent shell-company subsidiary in a dubious cost-cutting scheme.[218] The Supreme Court held that the employer's misconduct violated its ERISA fiduciary duties,[219] yet it left open the questions of 1) what constitutes a material misrepresentation, and 2) whether deceitful intent by the employer is required to make an employee's fiduciary breach claim actionable. These issues were addressed recently by the Seventh Circuit in *Beach v. Commonwealth Edison Co.*[220] and *Vallone v. CNA Financial Corp.*[221]

1. When Are an Employer's Oral Misrepresentations "Material"?

Beach involved an employee who retired six weeks prior to the announcement of a voluntary separation package amid adamant company assurances that no such plan would be offered anytime soon.[222] The Seventh Circuit ruled on behalf of the employer that, inter alia, the verbal misrepresentations made by the company's representatives to the plaintiff were not material, because the early retirement package that was eventually offered was not sufficiently developed when the misrepresentations were made. In other

217. 516 U.S. 489 (1996).

218. *Id.* at 493-94.

219. *Id.* at 506-07.

220. 382 F.3d 656 (7th Cir. 2004).

221. 375 F.3d 623 (7th Cir. 2004).

222. *Beach*, 382 F.3d at 657.

words, what turned out to be a misrepresentation (e.g., "a new early retirement plan won't be offered") may not have been so at the time it was made, because the alternative plan had not yet achieved sufficient managerial ratification. Mr. Beach failed to show that the formative stages of the voluntary separation package were already underway and that its disclosure to employees would have been material to his retirement decision.[223]

The standard used in *Beach* to determine whether a fiduciary breach has been committed is known as the Serious Consideration Doctrine.[224] Under this standard, "a duty of accurate disclosure begins when 1) a specific proposal 2) is being discussed for purposes of implementation 3) by senior management with the authority to implement the change . . . . At that point, details of the amendment become material; until then, there is only speculation."[225]

The Seventh Circuit found that the employer's misrepresentations were not material and that the employer had no duty to disclose managerial speculation regarding possible benefits plan changes.[226] In endorsing the Serious Consideration Doctrine, the court concluded that the certainty of the deal's structure is the touchstone for triggering disclosure to employees.[227] The court also warned that absent a Serious Consideration Doctrine threshold, high-level executives might ostracize benefits counselors to avoid the risk of confidential strategies being prematurely shared with employees.[228] Such action would render human resources personnel useless and might breed rumor circulation and mistrust among employees within the company.[229]

Beach's endorsement of the Serious Consideration Doctrine finds significant support in the First, Fourth, Sixth, Eighth, Ninth, Tenth, and Eleventh Circuits.[230] The Second and Fifth Circuits, however, have departed from the Serious Consideration Doctrine's rigidity, holding that materiality of information is not solely a function of the employer's internal deliberations.[231] Instead, these

223. *Id.*

224. *Id.* at 659-60.

225. *Id.* at 659 (internal citations omitted).

226. *Id.* at 660-61.

227. *Id.* at 659-60.

228. *Id.* at 660 ("Giving firms a duty to forecast accurately would just induce employers to tell the human resources staff to say nothing at all.").

229. *Id.*

230. *Id.*; *see, e.g.*, Mathews v. Chevron Corp., 362 F.3d 1172, 1180-82 (9th Cir. 2004); Bins v. Exxon Co. U.S.A., 220 F.3d 1042, 1048 (9th Cir. 2000) (en banc); McAuley v. Int'l Bus. Mach. Corp., 165 F.3d 1038, 1043 (6th Cir. 1999); Vartanian v. Monsanto Co., 131 F.3d 264, 272 (1st Cir. 1997); Hockett v. Sun Co., Inc., 109 F.3d 1515, 1522-23 (10th Cir. 1997); Wilson v. Sw. Bell Tel. Co., 55 F.3d 399, 405 (8th Cir. 1995); Elmore v. Cone Mills Corp., 23 F.3d 855, 861 (4th Cir. 1994) (stating that a plan "must actually be in existence; the mere decision to create an employee benefit plan is not actionable"); Barnes v. Lacy, 927 F.2d 539, 544 (11th Cir. 1991).

231. *See* Martinez v. Schlumberger, Ltd., 338 F.3d 407, 411-12 (5th Cir. 2003); Ballone v.

Circuits have fashioned what I will call the "Expansive Materiality" standard, which essentially equates to a totality of the circumstances test.[232] This standard focuses on the materiality of the information—that is, the material impact that such information may have on an employee's retirement decision—and takes into account the employer's "serious consideration" factors as just a few of many variables that are part of the decision-making process. According to these Circuits, the Serious Consideration Doctrine has a fatal flaw in its operation: a "free zone for lying" may arise in which a benefits administrator could knowingly deny or mislead employees simply because plan changes had not achieved sufficient internal ratification.[233]

In *Ballone v. Eastman Kodak Co.*,[234] the Second Circuit ruled that the materiality of Kodak's misrepresentations was not solely predicated upon the Serious Consideration Doctrine's three-pronged test. Rather, the materiality inquiry should be whether an employer's misrepresentation was substantially likely to mislead a reasonable employee in making an adequately informed retirement decision.[235] To assess such materiality, the court held that variables beyond the Serious Consideration Doctrine, such as the egregiousness of the misrepresentation and the availability of contrary extrinsic evidence, should be weighed.[236] The Fifth Circuit's *Martinez v. Schlumberger, Ltd.*[237] decision further refined the Expansive Materiality Test, holding that the key to assessing materiality was whether a reasonable person would have considered the misrepresentation important in his early-retirement decision.[238] In that regard, the court held that an employer's statement that it had not made a decision whether "to roll out an enhanced benefits plan in the future . . could not have been material or misleading until [that employer] had actually decided to implement such a plan."[239]

Disagreement among the circuits between the Serious Consideration Doctrine and the Expansive Materiality Test highlights the varying evidentiary burdens incumbent upon employee-retiree plaintiffs to substantiate a claim that an employer breached its fiduciary duty. While materiality has different meanings in different courts, it is evident that proving materiality is a particularly

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Eastman Kodak Co., 109 F.3d 117, 122-23 (2d Cir. 1997).

232. *See* sources cited *supra* note 231.

233. *See* Beach v. Commonwealth Edison, 388 F.3d 1133, 1135 (7th Cir. 2004) (Ripple, J., dissenting); *Martinez*, 338 F.3d at 428.

234. 109 F.3d 117 (2d Cir. 1997).

235. *Id.* at 122-23.

236. *Id.* at 125 (stating that materiality of false assurances could be assessed by factors independent of the Serious Consideration Doctrine).

237. 338 F.3d 407, 428 (5th Cir. 2003) (adopting *Ballone*'s materiality approach).

238. *Id.* (the overarching question is the impact on employee's retirement decision).

239. *Id.* at 431.

challenging burden faced by employee-retirees. Moreover, as discussed below, even if the materiality threshold is met, plaintiffs must then prove that the employer's actions were intentional or negligent.

2. Need To Prove Negligence or Fraudulent Intent

ERISA imposes on fiduciaries a duty of loyalty and a prudent-man duty of care.[240] Assessing these duties, the Supreme Court in *Varity* held that lying to employees in the context of benefits administration violates the fiduciary obligation.[241] Accordingly, the easy case of intentional deceit, or disinformation, by employers was uniformly adopted by the federal bench as a violation of ERISA.[242] But what happens when a fiduciary is not lying, but rather unintentionally conveys a material misrepresentation whose falsity is unknown by him? Must there be deceptive intent, or "scienter,"[243] in an employer's actions to allow a fiduciary breach claim? On this issue, the federal circuits are divided.[244]

In *Vallone v. CNA Financial Corp.*,[245] the Seventh Circuit upheld the employer's termination of early-retirees' "lifetime" welfare benefits based on a contractual reservation-of-rights provision. The court held that, under *Varity* and other Seventh Circuit precedents, "an employer must have set out to disadvantage or deceive its employees . . . in order for a breach of fiduciary duty" claim to succeed.[246] Thus, unless an employer engages in intentional misconduct, or disinformation, employees lose out under current law;[247] breach of the fiduciary duty arises only through intentional wrongdoing.[248]

In contrast to the Seventh Circuit, some have argued "[t]he Second, Third, and Sixth Circuits have interpreted *Varity* as permitting claims against a fiduciary even in the absence of . . . intentional misconduct so long as materially

240. 29 U.S.C. § 1104(a) (2000).

241. Varity Corp. v. Howe, 516 U.S. 489, 506 (1996).

242. *See* WILBER H. BOIES & NANCY G. ROSS, COMMUNICATING WITH EMPLOYEES ABOUT BENEFITS: A CENTRAL ISSUE IN ERISA ADMINISTRATION AND LITIGATION 522 (Practising Law Inst. 2001) (describing and analyzing standards used by appellate courts).

243. BLACK'S LAW DICTIONARY 1373 (8th ed. 2004) ("A degree of knowledge that makes a person legally responsible for the consequences of his or her act or omission . A mental state consisting in an intent to deceive, manipulate, or defraud.").

244. *See* Beach v. Commonwealth Edison Co., 382 F.3d 656, 668-69 (7th Cir. 2004) (Ripple, J., dissenting) (illustrating that disagreement exists regarding the scienter requirement).

245. 375 F.3d 623, 626 (7th Cir. 2004).

246. *Id.* at 642 (endorsing intentional deception standard necessary for breach of fiduciary duty).

247. Appellant's Petition for Writ of Certiorari to the Seventh Circuit, *Vallone*, 375 F.3d (No. 04-502), 2004 WL 2326794.

248. 375 F.3d at 640 (7th Cir. 2004) (citing Varity Corp. v. Howe, 516 U.S. 489, 506 (1996)).

misleading information was provided by the fiduciary."[249] If inadvertently incorrect information, or "misinformation," was conveyed, a claim for fiduciary breach is possible as long as the information provided was materially misleading.[250] The key is that an employee's subjective evaluation of the information matters as much as the actual truth of the information provided. If misinformation is conveyed to an employee who internalizes and acts on it, a breach claim can be levied.[251]

According to the Second, Third, and Sixth Circuits, as well as Judge Ripple's dissent in the *Beach* case, "importing the intent to deceive requirement . . . into this type of ERISA fiduciary case lacks any grounding."[252] Rather, unintentional misrepresentations suffice as actionable grounds for breach of the fiduciary duty on several bases. First, per Congressional intent and *Varity*'s decree, ERISA duties have greater force than their common law trust pedigree and are more onerous than simply avoiding fraud.[253] Second, analogizing ERISA duties to agency law's apparent authority doctrine suggests that a beneficiary's reasonable reliance is important in assessing fiduciary liability, whereas a fiduciary's subjective intent is irrelevant.[254] Third, while ERISA's trust law roots make no mention of scienter, they do indicate duties to inform and not misinform beneficiaries; a trustee must convey to its beneficiary all material facts related to a transaction that the "trustee knows or should know."[255] Thus, reckless misinformation may be actionable when an employer should have known better.[256]

In contrast to its sister courts, the Seventh Circuit endorses a strict "disinformation" standard for breach of the ERISA fiduciary duty, a standard whose turnkey issue is employer intent.[257] The Seventh Circuit applied this scienter requirement in *Vallone*, eviscerating retirees' breach claim by showing

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249. Appellant's Petition for Writ of Certiorari to the Seventh Circuit, *supra* note 247, at *1.

250. *Id.*

251. *Id.*

252. Beach, 382 F. 3d at 668 (Ripple, J., dissenting) (denouncing Seventh Circuit's endorsement in dicta of employer scienter requirement).

253. Varity Corp. v. Howe, 516 U.S. 489, 497 (1996) (noting that the legislative intent in enacting ERISA was in part to enhance the common law of trusts).

254. RESTATEMENT (THIRD) OF AGENCY § 2.03 (Tentative Draft No. 2, 2001) (apparent authority doctrine); *see also Beach*, 382 F.3d at 669-70 (Ripple, J., dissenting). The apparent authority doctrine is especially poignant because it imposes liability on a corporation that otherwise might circumvent its ERISA obligations by erecting a "Chinese wall" between its plan administrator—a fiduciary—and its human resources counselors who may have non-fiduciary status.

255. RESTATEMENT (SECOND) OF TRUSTS § 173 cmt. d (1959).

256. *See* Beach v. Commonwealth Edison Co., 382 F.3d 656, 669 (7th Cir. 2004) (Ripple, J., dissenting).

257. *See* Vallone v. CNA Fin. Corp., 375 F.3d 623, 640-41 (7th Cir. 2004).

that there was no evidence of purposeful deception akin to *Varity*'s "campaign of disinformation."[258]

The *Vallone* court justified its "disinformation" approach on grounds of allegiance to *Varity*'s scienter requirement and the need to avoid excessive burdens on employers in their duty of care.[259] First, the "disinformation" theory asserts that future changed circumstances that are unanticipated at the time of a fiduciary-beneficiary communication cannot provide grounds for fiduciary liability.[260] A fiduciary that believes its actions serve the best interests of its beneficiaries cannot, by definition, be in breach of ERISA's § 1004(a)(1) duty of loyalty.[261] Second, by distinguishing ERISA's duty of loyalty from its duty of care, and showing that the duty of care is not breached by negligence in a corporate fiduciary context, the court denounces negligence as too low a liability standard for ERISA plan administration.[262] Finally, the Seventh Circuit took a holistic view of ERISA's duty of care provision by saying that a fiduciary's overall diligence in benefits plan management overrides any discrete instances of oral advice.[263] Thus, the court essentially subjugated the importance of a benefits administrator's communications to his investment and management activities.[264]

To summarize, *Varity* stands for the undeniable proposition that employer deceit violates ERISA. An employer-fiduciary may not actively lie to employees if and when it chooses to communicate with them, whether through a nonfiduciary agent or by its own accord. Beyond this insidious intent that ERISA condemns outright, the *Varity* court strongly implied that materiality of information is the touchstone for substantiating breach of fiduciary duty. How this materiality should be judged forms the basis of the present circuit split over the Serious Consideration Doctrine versus the Expansive Materiality Test. Furthermore, either the negligence or intent characterizing an employer's misrepresentation is integral to courts' upholding breach of fiduciary duty claims. Viewing these requirements holistically, their inconsistent judicial interpretations, and the significant evidentiary burdens faced by employees, it is fair to say that fiduciary breach actions are exceedingly difficult for employee-retirees to maintain against their employers. As a result, retirees often resort to

258. *Id.* at 641 (Count III for Breach of Fiduciary Duty fails).

259. *Id.* at 640-43 (explaining rejection of negligence standard and adoption of intent requirement).

260. *See id.* at 641-42; Frahm v. Equitable Life Assurance Society, 137 F.3d 955, 960 (7th Cir. 1998) (duty of loyalty is unequal to clairvoyance).

261. *See Frahm*, 137 F.3d at 959 (fiduciaries not engaged in *Varity*-type deceit, but rather acted loyally in what they believed to be beneficiaries' best interests).

262. *Id.*

263. *Id.* at 960 (overall management of the plan, and specifically asset management, is targeted by the duty of care).

264. *Id.* at 959-61.

estoppel claims alleging their reasonable reliance on employer misrepresentations that detrimentally impacted their retirement decision-making.

D. Estoppel Claims

Estoppel claims provide the last legal avenue for retirees seeking protection or restoration of their lost health care benefits. Estoppel theories posit that the defendant made a false representation that the plaintiff relied upon to the plaintiff's detriment. In the context of the retiree benefits, the hypothetical employer falsely stated orally and informally (equitable estoppel under common law) or in a quasi-contractual writing (promissory estoppel under ERISA), and beyond the terms of the SPD, that benefits were indefinite or interminable and that this statement induced the retiree to take reasonable action that ultimately damaged his interests. In analyzing the relevant case law in this area, the distinction between promissory and equitable estoppel is inconsequential.

Across retiree health benefit cases, all circuits require the plaintiffs to establish the basic elements of estoppel to prevail on an estoppel claim.[265] While the various circuits differ slightly in describing these elements,[266] the fundamental components are 1) a material misrepresentation, 2) reasonable and detrimental reliance upon the representation, and 3) extraordinary and extreme circumstances.[267] Plaintiffs have experienced daunting obstacles in proving the requisite "material" (or "knowing") nature of the employer's misrepresentation, the "reasonableness" of their own actions in reliance, and the "extraordinariness" of the factual circumstances surrounding their cases.

1. Material Misrepresentation

As with fiduciary claims, the material misrepresentation element of estoppel claims is particularly difficult for retirees to substantiate due to the onerous evidentiary requirements. For a misrepresentation to be material, courts generally require that the employer-administrator knowingly provided false information to the employee-retirees. Scienter thus becomes an issue, as "knowing misrepresentation" apparently has fraudulent undertones, meaning that plaintiffs must prove that the employer *purposely* misled the plaintiffs. The *Vallone* court,

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265. Kemp, *supra* note 103, at 23.

266. As an example of courts differing in explaining their estoppel test, the Seventh Circuit requires 1) a knowing misrepresentation 2) in writing 3) reasonably relied upon 4) to the plaintiff's detriment, which the court limits to a "narrow scope" of cases justified by extreme circumstances. Vallone v. CNA Financial, 375 F.3d 623, 639 (7th Cir. 2004), while the Second Circuit explains it as 1) a promise 2) relied upon 3) causing injury 4) resulting in injustice if not enforced, and it also requires "extraordinary circumstances," Devlin v. Empire Blue Cross & Blue Shield, 274 F.3d 76, 85-86 (2d Cir. 2001).

267. Kemp, *supra* note 103, at 23.

for example, seized upon the employer's lack of deceitful intent in finding against the retirees. The Seventh Circuit there said that

> the plaintiffs have not shown a knowing misrepresentation of fact. Although "[r]epresentations about plans and intentions could be false if, at the time the statements were made, the speaker actually had a different intention," the district court found that, at the time the VSRP was offered, [the company] had no intention of terminating the "lifetime" HCA benefit.[268]

The Second Circuit has also referred to the evidentiary need to show employer fraud in an estoppel claim. In *Moore v. Metropolitan Life Insurance Co.*,[269] the court had to decide whether nonplan documents and oral communications legitimately modified the terms of the welfare plan. The plan and SPD both mentioned the employer's power to amend or terminate retiree health benefits, but the employer's informational programs and filmstrips did not. The court commented that "absent a showing tantamount to proof of fraud, an ERISA welfare plan is not subject to amendment as a result of informal communications between an employer and plan beneficiaries."[270] The court further explained that:

> Congress intended that plan documents and the SPDs exclusively govern an employer's obligations under ERISA plans . . . . Were all communications between an employer and plan beneficiaries to be considered along with the SPDs as establishing the terms of a welfare plan, the plan documents and the SPDs would establish merely a floor for an employer's future obligations. Predictability as to the extent of future obligations would be lost, and, consequently, substantial disincentives for even offering such plans would be created.[271]

Thus, in addition to finding employer behavior bordering on fraud to constitute "knowing misrepresentation" in the estoppel context, courts also look to the written plan documents and SPDs as powerful defensive shields against estoppel claims.

2. Reasonability of Reliance

Even if plaintiff-retirees overcome the material misrepresentation challenge, they must prove the reasonable reliance element of estoppel. Courts have

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268. *Vallone*, 375 F.3d at 639 (7th Cir. 2004) (quoting Frahm v. Equitable Life Assurance Soc'y, 137 F.3d 955, 961 (7th Cir. 1998)) (holding that the employer's statement was not a knowing misrepresentation).

269. 856 F.2d 488 (2d Cir. 1988).

270. *Id.* at 492.

271. *Id.*

concluded that if reservation-of-rights clauses and other written plan provisions indicate an employer's right to modify or limit benefits, it is not objectively reasonable for the plaintiffs to rely on *any* alleged statements to the contrary. The Third Circuit explained this rationale in *In re Unisys Corp. Retiree Medical Benefit "ERISA" Litigation*,[272] where an unambiguous reservation-of-rights clause in the SPD eviscerated the reasonableness of plaintiff-retirees' reliance on a benefits administrator's oral interpretation of the plan that conflicted with the SPD.[273] In an earlier case, *Frahm v. Equitable Life Assurance Society of the United States*,[274] the Seventh Circuit similarly observed that "[i]n federal law, a person cannot rely on an oral statement, when he has in hand written materials disclosing the truth."[275]

Even among courts that go beyond the bounds of ERISA-based estoppel, there is often little relief for retirees. For example, the Eleventh Circuit recognizes a very narrow common law doctrine of equitable estoppel that requires 1) ambiguous written provisions, coupled with 2) informal interpretations of the ambiguous provisions made by the benefits provider, but even then, an unambiguous benefits plan defeats retirees' estoppel claims.[276] Lastly, the reliance aspect clearly requires that an employee-retiree act *subsequent* to an employer's alleged misrepresentation, rather than before it. In the case of *UAW v. Rockford Powertrain, Inc.*,[277] the Seventh Circuit concluded that it was impossible for the plaintiffs to have relied on their employer's statements in making their retirement decision, because "plaintiffs admit[ted] in their brief that the statements at issue were made 'during exit interviews after the retirees made their decisions to retire.'"[278]

3. Extraordinary Circumstances

The final prerequisite to successful estoppel claims is showing the "extraordinary circumstances" context of the employer-retiree dispute. The Seventh Circuit has commented that, "[a]s a guideline for the boundaries of ERISA estoppel, [the court has] emphasized the 'narrow scope' of estoppel

272. 58 F.3d 896 (3d Cir. 1995).

273. *Id.* at 907-08 (unambiguous reservation-of-rights clause means plaintiffs' reliance on contrary statements was unreasonable).

274. 137 F.3d 955 (7th Cir. 1998).

275. *Id.* at 961; *see also* Vallone v. CNA Fin. Corp., 375 F.3d 623, 640 (7th Cir. 2004) (plaintiff's reliance not reasonable).

276. *See, e.g.*, Jones v. Am. Gen. Life & Accident Ins. Co., 370 F.3d 1065, 1069-71 (11th Cir. 2004). "[A]n ERISA plaintiff can only succeed . . . if he can establish that the plan at issue is at least ambiguous with respect to the relevant benefits for which he claims entitlement." *Id.* at 1170.

277. 350 F.3d 698 (7th Cir. 2003).

278. *Id.* at 705-06.

claims and [has] noted that 'only extreme circumstances' justify such claims."[279] While the standard to constitute extraordinary circumstances is apparently an assessment of all the facts, it seems clear nonetheless that courts are hesitant to find such circumstances. In *Devlin v. Transportation Communications International Union*,[280] an employer unexpectedly amended the retirees' welfare plan by replacing free medical coverage with monthly premiums, contradicting previous informal company statements, letters, and sworn affidavits.[281] Nevertheless, the Second Circuit refused to find "extraordinary circumstances," because it found "no evidence to suggest that employers sought the retirement of any of the [employees] or that the promise of free, lifetime health benefits was used to intentionally induce any particular behavior on the [employees'] part."[282]

Accordingly, the Second Circuit has grafted a fraudulent or deceptive inducement element onto its "extraordinary circumstances" evaluation process. Using this yardstick, the court found extraordinary circumstances present in the two *Empire Blue Cross & Blue Shield* cases (*Devlin* and *Abbruscato*).[283] Based on management depositions in these cases, the Second Circuit determined that the employer had used promises of full benefits to initially garner and subsequently retain qualified employees for many years:

> [A] trier of fact could reasonably conclude that Empire intentionally promised lifetime life insurance benefits to lure (and retain) employees away from other firms paying higher salaries and then denied those benefits after the employees were of an age where they could neither make up the salary difference or obtain alternative benefits at a reasonable cost.[284]

Thus, for the nonearly retirees who sued the employer in *Devlin*, their long years of service were seen by the court as legitimately reasonable reliance on a promise that was ultimately broken by the employer. Furthermore, in *Abbruscato*, the Second Circuit found that a benefit accrued to the employer by the employees accepting early retirement:

> [A]ppellants . . . have presumably conferred a benefit on Empire, and prevented it from having to resort to salary reductions, layoffs or firings during those years. A trier of fact could reasonably find that Empire intentionally induced

279. *Vallone*, 375 F.3d at 639 (citing Sandstrom v. Cultor Food Science, 214 F.3d 795, 797 (7th Cir. 2000)).

280. 173 F.3d 94 (2d Cir. 1999).

281. *See* Kemp, *supra* note 103, at 23.

282. 173 F.3d at 102; *see also* Kemp, *supra* note 103, at 23.

283. For a refresher on non-union vesting cases, see Subsection II(B)(2), *supra*. Abbruscato and Devlin (whose cases are often referred to by the second-named plaintiff, Kunkel, to distinguish them from *Devlin v. Transport Communications International Union*) were both plaintiffs against Empire Blue Cross and Blue Shield.

284. Devlin v. Empire Blue Cross & Blue Shield, 274 F.3d 76, 86-87 (2d Cir. 2001).

> appellants to accept the offer to retire in order to avoid having to take these less desirable steps.[285]

The Second Circuit's experience shows that the extraordinary circumstances element has a high threshold and probably requires improper inducements proffered by an employer to prospective retirees. Even these cases, moreover, merely allowed estoppel claims to survive motions for summary judgment.

To summarize, estoppel claims in retiree benefits cases are exceedingly difficult to substantiate because of the significant evidentiary requirements. To win, retirees must prove that 1) an employer intentionally deceived retirees in making misstatements about their benefits, 2) the plan documents were sufficiently vague or ambiguous to cause reliance on inconsistent oral statements, and 3) extraordinary circumstances were present. And because estoppel claims are the last legal claim that is routinely alleged in retiree benefits cases, it appears that current law provides little recourse to retirees whose post-employment health benefits have been substantially reduced or terminated.

E. Summary

To recapitulate briefly, ERISA generally allows employers to change retiree health benefit plans at any time. Retirees have the burden of proving that their former employer intended their benefits to "vest," thereby making them unalterable, and plan documents are given great deference in establishing the "vested" status of the benefits in question. Where plan documents are ambiguous, different circuit courts apply different inferences, at least in a unionized context. The majority of those courts, however, find that retiree health benefits do not vest unless there is specific language in the plan documents to that effect, which is rarely the case.

In a non-unionized context, no circuit court infers vesting. Rather, vesting must be stated in unambiguous plan document language. But a generalized reservation by an employer of the right to change a plan's terms is usually sufficient to defeat claims by retirees that their benefits have vested. As a consequence, what are labeled "lifetime" retiree health benefits are more accurately described as lasting only as long as the former employer chooses to provide them.

Retirees' claims that employers have been less than truthful have proven difficult to sustain as breaches of the employers' fiduciary duty to their employees. To win such claims, retirees must clear two separate hurdles: first, that the former employer's representatives made material misrepresentations; and second, that the former employer either knew of those misrepresentations, or should have known about them, depending upon which judicial circuit the case

285. Abbruscato v. Empire Blue Cross & Blue Shield, 274 F.3d 90, 101-02 (2d Cir. 2001).

involves.

Finally, retirees have tried to claim that they relied to their detriment on an employer's false assurances of future health benefits. But courts have held that presentations to prospective retirees need not mention an employer's right to change benefits, as long as the plan documents themselves contain such references. Small wonder, then, that even retirees who feel genuinely deceived are unable to prove the elements that estoppel claims demand.

III. POSSIBLE APPROACHES FOR RETIREES WHO HAVE LOST HEALTH BENEFITS

For retirees who have lost most or all of their post-employment health benefits, the available options depend entirely on whether the retiree in question is eligible for Medicare, which generally requires that the retiree be at least sixty-five years old.[286] The Medicare-eligible retiree is entitled to Medicare Part A coverage of most hospital expenditures,[287] some nursing home[288] and home health care expenses,[289] and the cost of hospice care.[290] In addition, Medicare-eligible retirees have available the full panoply of health insurance alternatives that retirees who never had employer-provided post-employment health benefits can access. These alternatives include the following:

1) Medicare Part B, which covers physicians' fees, ambulance charges, and most outpatient medical tests and procedures;[291]

2) Medicare Part D prescription drug benefit plans;[292]

3) Private supplemental insurance, generally known as "Medigap" insurance, which covers most of the deductibles and co-payment obligations under Medicare's hospital and physician coverages;[293]

4) Medicare Part C managed care plans that incorporate many, if not most, of the benefits under Medicare Parts B and D, plus Medigap insurance.[294]

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286. 42 U.S.C. § 1395c(1) (2000).

287. *See* FROLIK & KAPLAN, *supra* note 8, at 66-68.

288. *See id.* at 68-71.

289. *See id.* at 71-73.

290. *See id.* at 73-75.

291. *See generally id.* at 75-78 (explaining Medicare Part B coverage).

292. *See generally id.* at 85-91 (explaining Medicare Part D prescription drug benefit plans).

293. *See generally id.* at 95-103 (explaining private Medigap insurance coverage and options).

294. *See generally id.* at 103-07 (explaining Medicare managed care plans).

To be sure, these alternatives may be quite difficult to sort out. The Medicare Part D prescription drug plans, in particular, vary considerably from state to state and change annually in terms of medications, dosage amounts, and dosage frequencies covered—an unnecessarily baffling array of options that far surpass all other pharmaceutical arrangements in terms of their complexity.[295] Similarly, Part C managed care plans provide comprehensive coverage but generally limit access to specific doctors, hospitals, pharmacies, and drugs, or allow wider access to health care providers but on less attractive financial terms.[296]

In many cases, the cost of these various alternatives is likely to exceed what the Medicare-eligible retirees would have paid under their former employers' retiree health benefit plans. For example, Medicare Part B costs $96.40 per month in 2009,[297] and this amount is adjusted annually.[298] Upper-income retirees, in fact, pay higher amounts depending upon the level of their income as computed for federal income tax purposes.[299] Monthly premiums for Medicare Part D plans vary widely depending upon the scope of their covered pharmaceutical formulary and their own set of deductibles and co-payment obligations for generic and name-brand medications.[300] Medigap policies are standardized into twelve different benefit packages, and premiums vary by state but are generally higher for more comprehensive benefit arrangements.[301] Finally, Medicare managed care plans, currently dubbed "Medicare Advantage,"[302] exhibit considerable price variation depending upon their

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295. *See* Richard L. Kaplan, *The Medicare Drug Benefit: A Prescription for Confusion*, 1 NAT'L ACAD. ELDER L. ATT'YS J. 167, 186 (2005); Medicare, Prescription Drug Coverage, http://www.medicare.gov/pdphome.asp (last visited Apr. 20, 2009); *see also* Jane Zhang, *Expect Changes In Drug Co-Pays For Medicare*, WALL ST. J., Nov. 4, 2008, at D1 (describing the most recent batch of annual changes in prescription drug plans confronting Medicare enrollees).

296. *See* 2007 MEDICARE HANDBOOK 7-1 to -50 (Judith A. Stein & Alfred J. Chiplin, Jr. eds., 2007).

297. *See* Medicare Part B Monthly Premiums in 2009, http://questions.medicare.gov/cgibin/medicare.cfg/php/enduser/popup_adp.php?p_sid=undefined&p_lva=undefined&p_li=undefined&p_faqid=2099&p_created=1221840031&p _sp=undefined (last visited Mar. 31, 2009).

298. 42 U.S.C. § 1395r(a) (2000).

299. *See generally* Richard L. Kaplan, *Means-Testing Medicare: Retiree Pain for Little Governmental Gain*, J. RETIREMENT PLAN., May-June 2006, at 22. In 2009, premiums are higher for married couples with more than $170,000 of income. Medicare Part B Monthly Premiums in 2009, *supra* note 297.

300. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE & YOU 2009, at 55-56 (2008), *available at* http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf.

301. *See generally* CTRS. FOR MEDICARE & MEDICAID SERVS., 2009 CHOOSING A MEDIGAP POLICY: A GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE (2008), *available at* http://www.medicare.gov/Publications/Pubs/pdf/02110.pdf.

302. 42 U.S.C.A. § 1395w-21 (West 2009).

restrictiveness in terms of access to providers and the nature of any additional services that they might include, such as wellness classes and vision care.

These choices may well be much more perplexing and complicated than the employer-provided retiree health benefit packages that Medicare-eligible retirees previously had, but at least these choices are available. The optional components of Medicare—Part B, managed care plans under Part C, and prescription drug plans under Part D—are all available without regard to a prospective enrollee's medical profile. Even Medigap insurance, a private product, cannot be denied for pre-existing medical conditions if an applicant applies for coverage prior to or during the first six months of his or her enrollment in Medicare Part B.[303] Having to navigate this unholy mess certainly adds to the anxiety and confusion that these retirees face, but they are no worse off than Medicare-eligible retirees who never had any retiree health benefits from a former employer.

Pre-Medicare retirees, by contrast, *are* distinctly worse off, and it is to their situation that this section now turns. Their situation is especially problematic given the high range of medical expenditures that this group incurs. The Centers for Medicare and Medicaid Services found that people aged fifty-five to sixty-four years spent an average of nearly $7800 per person on health care spending in 2004,[304] the most recent year for which data are available. Moreover, this figure—as high at it is—masks the uneven distribution of health care costs across this age cohort. A study using 2002 figures found that among persons aged fifty-five to sixty-four years, nearly half of the entire group's health care costs were incurred by the 7% of this group with the highest medical expenses.[305] Clearly, pre-Medicare retirees have a particular need for health insurance. In this section, we first examine currently available options, and then we analyze a proposal to expand Medicare to younger retirees.

A. Current Options for Pre-Medicare Retirees

Retirees who are not yet eligible for Medicare have several options depending on their individual circumstances. One such option is health insurance through a working spouse. This option requires that 1) the retiree is currently married, 2) the retiree's spouse is employed, 3) the spouse's employer offers health insurance to its employees and their dependents, 4) the spouse is eligible for this insurance according to the employer's criteria of hours worked and length

303. *Id.* § 1395ss(s)(2)(A) (2000).

304. Ctrs. for Medicare & Medicaid Servs., Total Personal Health Care Per Capita Spending, By Age Group, Calendar Years, 1987, 1996, 1999, 2002, 2004, at 2, http://www.cms.hhs.gov/NationalHealthExpendData/downloads/2004-age-tables.pdf (last visited Apr. 20, 2009).

305. *See* JOHN HOLAHAN, KAISER COMM'N ON MEDICAID & THE UNINSURED, HEALTH INSURANCE COVERAGE OF THE NEAR ELDERLY 35 (2004), *available at* http://www.kff.org/uninsured/ upload/Health-Insurance-Coverage-of-the-Near-Elderly-Report.pdf.

of employment,[306] and 5) the premiums associated with adding the retiree as a spouse fit within the couple's budget. Only if *all* five of these requirements are met is this alternative feasible.[307]

A second option is obtaining Medicare as a disabled person prior to reaching age sixty-five.[308] Someone who receives Social Security disability payments for twenty-four months is eligible for Medicare, regardless of age.[309] Qualifying for such benefits, however, is not easy. The putative disabled person must be unable to perform "*any* substantial gainful activity by reason of any medically determinable physical or mental impairment."[310] The process of meeting this standard involves various medical examinations and vocational tests to assess an individual's possible employability.[311] Moreover, an inability to perform "substantial gainful activity" must be expected to last at least one year or result in the death of that person.[312] In addition, the person's status as "disabled" is reviewed periodically until he or she reaches Social Security's full "retirement age."[313] The qualification process is beset with delays, uncertainty, and successive layers of administrative appeals.[314] In any case, the "successful" applicant must still cover his or her own medical costs during the requisite twenty-four month period before Medicare eligibility is established.[315]

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306. *See* JEFFREY D. MAMORSKY, EMPLOYEE BENEFITS HANDBOOK § 43.09[1] (3d ed. 1992).

307. Among persons aged fifty-five to sixty-four years, active employees as well as retirees, approximately 18% receive health insurance through their spouse. This estimate was derived by authors from CARMEN DENAVAS-WALT, BERNADETTE D. PROCTOR & JESSICA C. SMITH, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2007, at 69 (2008), *available at* http://www.census.gov/prod/2008pubs/p60-235.pdf; *see also* Richard W. Johnson, *When Should Medicare Coverage Begin?*, NAT'L ACAD. OF SOC. INS., Dec. 2003, at 2, *available at* http://www.nasi.org/usr_doc/nasiBrief_risk6_03.pdf (presenting a comparable estimate of 16% using 1998 data).

308. Among persons aged fifty-five to sixty-four years, active employees and retirees, 9.5% are enrolled in Medicare. DENAVAS-WALT, PROCTOR & SMITH, *supra* note 307, at 69.

309. 42 U.S.C. §§ 426(b)(2)(A)(i), 1395c(2) (2000).

310. *Id.* § 416(i)(1)(A) (emphasis added). A person is presumed to be disabled if he or she earns less than an annually adjusted amount, which in 2009 was $980 per month. 20 C.F.R. § 404.1574 (2008); Social Security Online, Automatic Increases in Recent Years, http://www.ssa.gov/ OACT/COLA/autoAdj.html (last accessed Mar. 31, 2009).

311. *See* 42 U.S.C. § 423(d)(5)(A), (B), (f). *See generally* CHARLES T. HALL, SOCIAL SECURITY DISABILITY PRACTICE (2007); 1-3 BARBARA SAMUELS, SOCIAL SECURITY DISABILITY CLAIMS (2d ed. 1994).

312. 42 U.S.C. § 416(i)(1)(A) (2000).

313. *Id.* § 416(i)(2)(D). A person's full "retirement age" under Social Security is determined by that person's year of birth. *See id.* § 416(*l*)(1).

314. *See* 20 C.F.R.§ 404.1520 (2008). *See generally* FROLIK & KAPLAN, *supra* note 8, at 323-25 (describing appeals procedures).

315. There is no waiting period for individuals with amyotrophic lateral sclerosis. 42 U.S.C. § 426(h) (2000).

Three more generally applicable options for retirees who are not yet eligible for Medicare include the following: 1) continue their former employer's health insurance under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA),[316] 2) purchase health insurance in the individual market, or 3) utilize a health savings account after retirement. As this section will show, none of these three options adequately addresses the problem of early retirees who have lost their employer-sponsored retiree health benefits.

1. Continuation Coverage

COBRA allows former employees, including early retirees,[317] to continue the health insurance they had through their former employer for up to eighteen months after termination of employment.[318] Many early retirees, of course, face a gap of much more than eighteen months between the date of their retirement and their sixty-fifth birthday.[319] This time period is extended until a retiree's death if that retiree's former employer terminates its health insurance coverage through a Chapter 11 bankruptcy organization.[320] There is no such extension for a Chapter 7 bankruptcy liquidation, however.

In any case, COBRA insurance is not always affordable. Retirees must pay the entire cost of this insurance without the employer subsidy that they typically received when they were actively employed.[321] As a result, the monthly cost for a former employee might be as much as five times the cost that a current employee would pay.[322] Such a cost increase is especially difficult for a person who is not currently employed.[323] Perhaps it is not terribly surprising, then, that the most

316. Pub. L. No. 99-272, § 10002(a), 100 Stat. 82, 227-31 (1986) (codified at 29 U.S.C. §§ 1161-1168).

317. *See* 29 U.S.C. § 1167(2) (2000); MAMORSKY, *supra* note 306, § 36.05[2][d].

318. 29 U.S.C. §§ 1161(a), 1162(1), 1162(2)(A)(i), 1163(2) (2000). The COBRA period is 36 months for the spouse of a current employee who becomes entitled to Medicare. *Id.* §§ 1162(2)(A)(iv), 1163(4).

319. *See* 42 U.S.C. § 426(a)(1) (2000).

320. 29 U.S.C. §§ 1162(2)(A)(iii), 1163(6) (2000); *see also* JEFFREY D. MAMORSKY, HEALTH CARE BENEFITS LAW § 7.03[6] (2008).

321. 29 U.S.C. §§ 1162(3)(A), 1164(1) (2000); *see also* Employee Benefits Security Administration, FAQs About COBRA Continuation Health Coverage, *available at* http://www.dol.gov/ebsa/faqs/faq_consumer_cobra.html. Recent national data on the cost of employer-provided health insurance appear in BETH LEVIN CRIMMEL & JOHN P. SOMMERS, EMPLOYER-SPONSORED HEALTH INSURANCE FOR LARGE EMPLOYERS IN THE PRIVATE SECTOR, BY INDUSTRY CLASSIFICATION, 2006 (Medical Expenditure Panel Survey, Statistical Brief No. 211, 2008), *available at* http://www.meps.ahrq.gov/mepsweb/data_files/publications/st211/stat211.pdf.

322. FIDELITY WORKPLACE SERVS., RETIREE HEALTH CARE COSTS: ADDRESSING THE GROWING GAP 17 (2002).

323. *See generally* FAMILIES USA, SQUEEZED! CAUGHT BETWEEN UNEMPLOYMENT BENEFITS

recent study of this program found that only 9% of individuals eligible for COBRA continuation coverage actually obtain such insurance.[324] On the other hand, at least this insurance is available without medical underwriting.

These twin problems of COBRA—namely, a limited coverage period and high premium costs—were both addressed in the very beginning of President Barack Obama's administration. His signature economic stimulus legislation, appropriately designated as House Bill 1,[325] provided that persons who lost their employer-provided health insurance after attaining age fifty-five could extend their COBRA coverage until they reached the Medicare eligibility age of sixty-five years.[326] This Bill also provided that the cost of this coverage would be subsidized by the federal government to the extent of 65%, with the individual retiree being responsible for the remaining 35%.[327] This COBRA provision would apply, however, only to persons who were involuntarily terminated from employment between September 1, 2008 and December 31, 2009.[328] Although this provision passed the House of Representatives, the Conference Committee that produced the final version of the American Recovery and Reinvestment Act of 2009[329] further limited its applicability to workers who were within nine months of becoming age-eligible for Medicare.[330]

In any case, the Health Insurance Portability and Accountability Act of 1996[331] allows persons who previously had group health insurance coverage to obtain individual coverage without being declined for medical reasons.[332] But this statute puts no limits on the price of such coverage. As the Government Accounting Office concluded in a study of insurance policies issued under this statute, these policies "may be cost prohibitive to many retirees."[333]

AND HEALTH CARE COSTS (2009), *available at* http://www.familiesusa.org/assets/pdfs/cobra-2009.pdf.

324. MICHELLE DOTY ET AL., MAINTAINING HEALTH INSURANCE DURING A RECESSION: LIKELY COBRA ELIGIBILITY 3 (Commonwealth Fund Issue Brief 3, 2009), *available at* http://www.commonwealthfund.org/usr_doc/Doty_maintainighltinsrecessionCOBRA_1225_ib.pdf?section=4039.

325. American Recovery and Reinvestment Act of 2009, H.R.1, 111th Cong. (engrossed as agreed to or passed by the House of Representatives, Jan. 28, 2009).

326. *Id.* § 3002(b)(1)-(3).

327. *Id.* § 3002(a)(1).

328. *Id.* § 3002(a)(3)(A), (C).

329. American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, 123 Stat. 115.

330. *See id.* § 3001(a)(2)(A)(i), (ii)(I).

331. Pub. L. No. 104-191, 110 Stat. 1936 (1996) (codified as amended in scattered sections of 26, 29, and 42 U.S.C.).

332. I.R.C. § 9802(a)(1) (2008); 29 U.S.C. § 1182(a)(1) (2000). States have the option of establishing high risk pools. *See generally* MAMORSKY, *supra* note 320, § 16.04.

333. U.S. GOV'T ACCOUNTING OFFICE, RETIREE HEALTH BENEFITS: EMPLOYER-SPONSORED BENEFITS MAY BE VULNERABLE TO FURTHER EROSION 19 (2001), *available at*

2. Individual Insurance Market

Retirees who try to purchase health insurance in the individual insurance market face a major obstacle: medical underwriting.[334] Unless state laws require insurance companies to accept all applicants (so-called "guaranteed issue"),[335] private insurers are free to accept or reject whomever they choose. Some states require that insurers apply the same rates to all accepted applicants (so-called "community rating"),[336] but most states allow insurers to price accepted applicants differentially. As a result, a pre-Medicare retiree may be unable to obtain any health insurance in the individual market, much less quality coverage, or to afford whatever health insurance that he or she can obtain.[337] This situation is radically different from the pre-retirement context where the person was part of an employer-based group that included younger and presumably healthier co-workers who effectively subsidized their older colleagues.[338]

To put the matter in the bluntest terms, many people simply take their employer-provided health insurance for granted until they try to replace it outside the workplace environment. For example, a 2004 study published by the Kaiser Family Foundation found that middle-income persons aged fifty-five to sixty-four years who claimed to be in "good" health were twice as likely to have no health insurance as those whose self-reported health status was "excellent" or "very good."[339] It is often the case that retirees in this age group have developed some medical history that diminishes their prospects of securing health insurance.[340]

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http://www.gao.gov/new.items/d01374.pdf.

334. *See* Sarah Rubenstein, *Health Insurers Often Reject 'Near Elderly,'* WALL ST. J., Nov. 16, 2004, at B1; *see also* COUNCIL OF ECON. ADVISORS, REACHING THE UNINSURED: ALTERNATIVE APPROACHES TO EXPANDING HEALTH INSURANCE ACCESS 2-3 (2000).

335. *See* COUNCIL FOR AFFORDABLE HEALTH INS., 2007 STATE LEGISLATORS GUIDE TO HEALTH INSURANCE SOLUTIONS AND GLOSSARY 18-19 (2007), *available at* http://www.cahi.org/cahi_contents/resources/pdf/2007Stateleg.pdf.

336. *See id.* at 11-12.

337. As to the difficulties affecting the individual insurance market generally, including misleading advertising, high rejection rates that rise with an applicant's age, and high nonrenewal rates for those who incur covered expenses, see FAMILIES USA, EMPTY PROMISE: SEARCHING FOR HEALTH INSURANCE IN AN UNFAIR MARKET (2008), *available at* http://www.familiesusa.org/assets/pdfs/play-fair-empty-promise-1.pdf.

338. *See* Paul B. Grant, *Commentary*, *in* PROVIDING HEALTH CARE, *supra* note 29, at 93, 95 (noting that the cost of insuring a sixty-year-old employee may be as much as four times the cost of insuring a twenty-five-year-old); David A. Hyman & Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 YALE J. HEALTH POL'Y L. & ETHICS 23, 31-33 (2001).

339. HOLAHAN, *supra* note 305, at 16-17.

340. *See* Chad Terhume, *Employers Turn to Alternative For Insuring Staff*, WALL ST. J., July 30, 2007, at A1 (noting that "about a quarter of people 55 to 64 get rejected for individual

To be sure, thirty-four states operate some sort of high-risk insurance pool, but sixteen states have none.[341] Moreover, the high-risk insurance pools that do exist often place limits on their coverage of pre-existing conditions, impose waiting periods on such coverage, or exclude these conditions from coverage entirely.[342] Even with these limitations, these policies may be unaffordable.[343]

AARP, the older persons advocacy group, has tried to respond to this problem by offering health insurance specifically to persons aged fifty to sixty-four years.[344] This plan intentionally has more lenient underwriting criteria; for example, it looks back only five years when someone applies for coverage in considering pre-existing medical conditions.[345] Nevertheless, it rejects some applicants and raises prices for others.[346] But the point remains that the individual insurance market is fraught with uncertainty,[347] a prospect that is especially troubling for early retirees as they enter a phase in their lives when increased health care utilization is more likely than not.

3. Health Savings Accounts

A third alternative utilizes the health savings account (HSA) mechanism that Congress first created in 2003.[348] These accounts are combined with a high-deductible insurance policy that covers the cost of accidents and extended illness.[349] The central idea is that early retirees may save pre-tax dollars in an HSA and then use funds in that account to cover health care costs that are not covered by the associated insurance policy.[350] Among the categories of

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coverage"); *see also* FAMILIES USA, *supra* note 323, at 3 (nothing that "those with health problems are likely to find that no insurer will sell them a policy that will cover their pre-existing conditions at any price").

341. Terhume, *supra* note 340.

342. *See* AMANDA MCCLOSKEY & RACHEL KLEIN, FAMILIES USA, TOO FEW OPTIONS: THE INSURANCE STATUS OF WIDOWED OR DIVORCED OLDER WOMEN 17 (2001), *available at* http://www.communityvoices.org/Uploads/om3gfk55hhzyvrn00n4 nerbf_20020828085202.pdf.

343. *Id.*; *see also* Catherine Chou, *Insuring Medically Uninsurable Individuals: An Examination of Different State Approaches*, 27 J. LEGAL MED. 443, 448-49 (2006).

344. AARP, AARP Health Products & Services, http://www.aarphealthcare.com/products/default.aspx (last visited Apr. 20, 2009).

345. *See* Rubenstein, *supra* note 334.

346. *See id.*

347. *See* Rappaport & Malone, *supra* note 47, at 86 ("Virtually no market exists for individual coverage for retirees not yet eligible for Medicare.").

348. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 1201(a), 117 Stat. 2066, 2469 (codified as amended at I.R.C. § 223). *See generally* Kaplan, *supra* note 37.

349. I.R.C. § 223(c)(1)(A)(i) (2008).

350. Kaplan, *supra* note 37, at 549.

"qualified medical expenses" that can be paid with tax-free withdrawals from an HSA[351] are premiums on COBRA continuation insurance policies,[352] as well as premiums on Medicare Part B coverage[353] once the retiree becomes eligible for that program.

To qualify, the early retiree must have a health insurance policy that meets the definition of "high-deductible."[354] Such a policy must have an annual deductible before coverage starts of at least $1150 for self-only coverage or $2300 for family coverage.[355] These limits pertain to calendar year 2009 and are adjusted annually for inflation.[356] Certain medical expenses may be covered by a "high-deductible" policy before the annual deductible is satisfied, but those expenses relate to "preventive care,"[357] a category that generally includes periodic medical examinations, diagnostic procedures, and various screening tests.[358] Pharmaceuticals may not, however, be covered until the policy's deductible has been met. Accordingly, a qualifying "high-deductible" insurance policy can expose the typical early retiree to considerable out-of-pocket medical expenses.

In any case, there is no guarantee that an early retiree will be able to obtain the "high-deductible" insurance policy that an HSA requires. Such policies are subject to the same medical underwriting limitations, including possible unavailability due to an applicant's pre-existing conditions, that characterize the individual insurance market generally. Consequently, the HSA alternative is less promising than it might appear due to the necessity of securing a "high-deductible" insurance policy.

But if an early retiree manages to secure such a policy, the appeal of the HSA alternative then depends principally upon two independent factors: one, how much is put into the account; and two, how much is withdrawn.[359] The owner of an HSA can make pre-tax contributions of an annually adjusted amount.[360] In 2009, the maximum annual contribution is $3000 for self-only coverage and $5950 for family coverage.[361] Persons who are at least fifty-five years old, moreover, are allowed to make additional "catch up" contributions of

351. I.R.C. § 223(d)(2), (f)(1).

352. *Id.* § 223(d)(2)(C)(i).

353. *Id.* § 223(d)(2)(C)(iv).

354. *See id.* § 223(c)(2).

355. Rev. Proc. 2008-29 § 2, 2008-22 I.R.B. 1039.

356. I.R.C. § 223(c)(2)(A)(i), (g)(1) (2008).

357. *Id.* § 223(c)(2)(C).

358. I.R.S. Notice 2004-23, 2004-1 C.B. 725.

359. Of less consequence is the investment return earned by the funds in the HSA.

360. *See* I.R.C. § 223(a) (2008).

361. Rev. Proc. 2008-29 § 2, 2008-22 I.R.B. 1039.

$1000 per year in 2009.[362] Funds in an HSA accumulate free of income tax,[363] and any balance that is unspent at year's end simply rolls forward.[364] Thus, the optimum strategy is to contribute the maximum amount allowable each year *and* to minimize withdrawals from the HSA.[365] In other words, even permissible withdrawals for "qualified medical expenses" should be kept to a minimum to preserve the funds accumulated in the HSA. Suffice it to say, few early retirees are able to meet both of these conditions without suffering some degree of financial hardship.

Even if an early retiree obtains a qualifying "high-deductible" health insurance policy, funds the associated HSA at the maximum levels allowed, and minimizes withdrawals, what might result? The answer depends on the rate of return that the HSA's investments yield, the extent to which those withdrawals are minimized, and the number of years during which this arrangement is maintained. A simulation prepared by the Employee Benefit Research Institute assumed a 5% annual rate of return and maximum annual contributions, including "catch up" contributions.[366] According to their results, as modified for current contribution levels, a fifty-five-year-old retiree with self-only coverage would have the following balances in his or her HSA after ten years (i.e., at age sixty-five),[367] depending upon the percentage of year-end account balance that is left untouched:

Rollover Percentage	Account Balance[368]
50	$10,473
75	$20,393
90	$35,691
100	$54,966

362. I.R.C. § 223(b)(3)(B) (2008).

363. *Id.* § 223(e)(1).

364. *See* Sarah Lueck, *Medicare Law Reaches the Under-65 Set, Too*, WALL ST. J., Dec. 16, 2003, at D1.

365. *See* Sarah Rubenstein, *How to Manage a Health Savings Account To Cover Your Medical Bills in Retirement*, WALL ST. J., Dec. 20, 2006, at D1.

366. FRONSTIN, Issue Brief No. 295, *supra* note 12, at 17.

367. A retiree who is entitled to Medicare benefits may not contribute to an HSA. I.R.C. § 223(b)(7) (2008).

368. Adapted by authors from FRONSTIN, Issue Brief No. 295, *supra* note 12, at 17, and Paul Fronstin, *Savings for Health Care Expenses in Retirement: The Use of Health Savings Accounts*, EBRI NOTES, August 2008, at 12, *available at* http://www.ebri.org/pdf/notespdf/EBRI_Notes_08b-20081.pdf. Maximum contributions to HSAs (excluding catch up contributions) are assumed to increase at a 2.8% annual rate of inflation. *See* Bd. of Trs. of the Fed. Hosp. Ins. & Fed. Supplementary Med. Ins. Trust Funds, 2008 Annual Report at 7, *available at* http://www.cms.hhs.gov/reportstrustfunds/downloads/tr2008.pdf.

Thus, even in the most optimistic scenario—the 100% rollover, with no withdrawals—the HSA would accumulate only $54,966 after ten years of maximum contributions. Moreover, the extent to which HSA funds are utilized for "qualified medical expenses" during the ten-year period makes a huge difference in the final result. As the results above show, the difference between the 50% and 100% rollover situation is not merely twice as much available at the end of the period, but 5.25 times as much.[369] Furthermore, the possibility of maximizing HSA balance by contributing at maximum levels at a younger age than fifty-five is precluded by the fact that most people would not be eligible for an HSA while employed because their employer-provided health insurance is more comprehensive than a "high deductible" policy. Accordingly, the alternative of a "high deductible" insurance policy coupled with an HSA has limited potential for addressing an early retiree's health care costs in most circumstances.[370]

To summarize, continuation coverage under COBRA is limited to eighteen months and can be very expensive. It is available, however, to early retirees without the need to satisfy medical underwriting criteria. Such criteria can be a large, and often insurmountable, barrier for early retirees who seek health insurance in the individual policy market. Even retirees who are able to secure such insurance, moreover, may find that they must accept high-deductible policies to keep the premiums affordable. Given that reality, some early retirees may want to establish an HSA to cover out-of-pocket medical expenses. But such an account is unlikely to generate significant funds except under rather trying conditions of limited withdrawals. In short, the existing options for pre-Medicare retirees who have lost their employer-provided post-employment health benefits are less than appealing.[371]

B. Extending Medicare to Early Retirees

In light of the above discussion, this Section considers the alternative approach of simply extending Medicare coverage to early retirees. Persons under age sixty-five are already eligible if they have received disability payments under

369. $54,966 ÷ $10,473 = 5.25.

370. *See* George Wagoner et al., *Risk-Sharing in Retiree Medical Benefits*, *in* RESTRUCTURING RETIREMENT RISKS 136, 154, 156 (David Blitzstein, Olivia S. Mitchell & Stephen P. Utkus eds., 2006) (using a simulation to show the inadequacy of HSAs to meet most estimates of projected health care costs in retirement).

371. *See* EDWIN PARK & ROBERT GREENSTEIN, CTR. ON BUDGET & POLICY PRIORITIES, NEW RETIREMENT MEDICAL ACCOUNT PROPOSAL WOULD CREATE LUCRATIVE TAX SHELTER AND SWELL DEFICITS, BUT DO LITTLE TO HELP LOW- AND MODERATE-INCOME SENIORS (2004), http://www.cbpp.org/4-19-04health.pdf (discussing a retiree medical benefit account proposal that was never introduced as legislation).

the Social Security program for twenty-four months.[372] The policy question, therefore, is whether retirees who are not disabled should be allowed to join the Medicare program prior to reaching age sixty-five.

In point of fact, President Bill Clinton actually made such a proposal more than a decade ago.[373] On January 6, 1998, he put forward a budget-neutral plan for retirees who were at least sixty-two years old to buy into Medicare at an actuarially full cost.[374] And retirees who were at least fifty-five years old would, under this proposal, be able to extend their COBRA coverage until they were eligible for Medicare.[375]

President Clinton's proposal did not, however, receive much serious attention. Within two weeks of introducing this proposal, the Monica Lewinsky scandal broke,[376] and official Washington became obsessed with the political ramifications of that matter. The idea of extending Medicare has remained salient nevertheless, and some version of President Clinton's proposal has been introduced in every subsequent Congress.[377] The latest iteration is Senate Bill 3710, the Medicare Early Access Act of 2008.[378] Proposed by such prominent Senators as Jay Rockefeller and John Kerry, among others, this Bill provides that individuals who are at least fifty-five years old may enroll in Medicare if they are not eligible for Medicaid, the federal employees' health benefit program, TRICARE, active duty military health care, or any other group health plan.[379] For this purpose, eligibility for a group health plan through a COBRA continuation provision would be disregarded.[380]

1. Eligibility Criteria

To qualify for this proposed "early access" Medicare, an individual would

372. 42 U.S.C. § 426(b) (2000).

373. *See* Press Release, Dep't of Health & Human Servs., President Clinton Announces New Proposal to Provide Americans Age 55 to 65 Improved Access to Health Insurance (Jan. 6, 1998), *available at* http://www.hhs.gov/news/press/1998pres/980106.html.

374. *Id.*

375. *Id.*

376. *See* James Bennet, *Defending Himself*, N.Y. TIMES, Jan. 22, 1998, at A1.

377. *See* S. 3747, 109th Cong. (2006); H.R. 2072, 109th Cong. (2005); H.R. 5218, 108th Cong. (2004); H.R. 4357, 108th Cong. (2004); S. 1935, 108th Cong. (2003); H.R. 3189, 108th Cong. (2003); S. 2679, 107th Cong. (2002); H.R. 4684, 107th Cong. (2002); S. 623, 107th Cong. (2001); H.R. 1255, 107th Cong. (2001); H.R. 803, 107th Cong. (2001); S. 2918, 106th Cong. (2000); H.R. 4938, 106th Cong. (2000); H.R. 3529, 106th Cong. (2000); H.R. 2228, 106th Cong. (1999); S. 202, 106th Cong. (1999); S. 10, 106th Cong. (1999); H.R. 4799, 105th Cong. (1998); S. 1789, 105th Cong. (1998); H.R. 3470, 105th Cong. (1998).

378. S. 3710, 110th Cong. (2008).

379. *Id.* § 101(a)(2).

380. *Id.*

otherwise need to be be eligible for Medicare benefits.[381] This criterion would require a person to be eligible for retirement benefits under the federal government's Social Security program.[382] In general terms, such a person must have earned at least forty "quarters of coverage" in employment that was subject to the Social Security payroll tax.[383] Most employment in the United States so qualifies, but there are some exceptions, including employment in most state and local government service and student employment at the college or university in which a student is enrolled.[384] A person earns a "quarter of coverage" by earning a stipulated amount that is adjusted annually for inflation.[385] Work in 2009 required earnings of $1090 to count as a "quarter of coverage."[386] Alternatively, a person can qualify for Medicare if his or her spouse meets the work requirement,[387] and a divorced spouse of an eligible worker can qualify as long as their marriage lasted at least ten years.[388]

In any case, the proposed legislation would require an enrollee to remain in the program.[389] That is, a person who enrolled in "early access" Medicare and then terminated his or her enrollment (except upon reaching age sixty-five) could not subsequently re-enroll in the program.[390] An exception would be made, however, for someone who enrolled in a group health plan or other federal health insurance program and then lost eligibility for that program.[391] But potential enrollees would not be required to exhaust their rights to COBRA continuation coverage before accessing Medicare early.[392]

2. Financing Aspects

Early access Medicare would not be cost-free by any means, but it would be available to all eligible applicants without regard to their medical history or current health profile. As noted previously, that feature would be a major benefit of this program. Enrollees would be assessed a premium that was calculated in an

381. *Id.*

382. 42 U.S.C. §§ 426(a)(2)(A), 1395c (2000).

383. *Id.* § 414(a)(2) (2000).

384. *See generally* FROLIK & KAPLAN, *supra* note 8, at 285-87 (explaining the scope of covered employment under Social Security).

385. 42 U.S.C. § 413(d)(2) (2000).

386. Social Security Online, Automatic Increases in Recent Years, http://www.ssa.gov/OACT/COLA/autoAdj.html (last visited Mar. 31, 2009).

387. 42 U.S.C. § 402(b)(1), (c)(1) (2000).

388. *Id.*; *id.* § 416(d)(1) (2000).

389. S. 3710, 110th Cong. § 101(a)(2) (2008) (at Sec. 1860E-1(b)(2)).

390. *Id.*

391. *Id.*

392. *Id.* (at Sec. 1860E-1(b)(2)(B)).

effort to make the early access program self-sustaining.[393] This program would have its own "trust fund"[394] to ensure that the financial condition of the existing Medicare program would not be affected by the introduction of early access Medicare. The U.S. Secretary of Health and Human Services would calculate the national "average annual per capita amount,"[395] and enrollees would be responsible for 25% of this cost.[396] The proposed legislation would allow persons with existing employer-provided retiree health benefits to choose early access Medicare instead of those benefits[397] and suggests—but does not require—that the former employer in such circumstances might pay the enrollee's 25% cost obligation.[398]

To ensure that this program will be affordable to the broadest swath of potential enrollees, the remaining 75% of the cost would come from a federal income tax credit.[399] This tax credit would be "refundable,"[400] so that enrollees with limited or no income tax liability would nevertheless benefit from it. Moreover, this tax credit would be in the form of an "advance payment,"[401] meaning that an enrollee would not be required to wait until after he or she files a tax return to receive the financial benefit from the credit. This rather convoluted financing mechanism results in the early access Medicare program's cost being borne 25% by the enrollee (or possibly the enrollee's former employer) and 75% by general tax revenues of the federal government. This 25–75 ratio, by the way, is the same cost allocation that applies generally to persons who enroll in Medicare Part B[402] to get coverage of doctors' fees, diagnostic tests, and other outpatient services. To reduce the financial impact on the federal government, the means-testing mechanism that currently applies to Medicare Part B could be applied to this program as well.[403] It should be noted, however, that none of the early access Medicare proposals that have been put forward contain this particular feature.

Without the 75% subsidy, an early access program would impose no

393. *See id.* (at Sec. 1860E-3(b)(1)).

394. *Id.* (at Sec. 1860E-4(a)(1)); *id.* (at Sec. 1860E-6).

395. *Id.* (at Sec. 1860E-4(b)(1)).

396. *Id.* (at Sec. 1860E-5(b)(2)).

397. *Id.* (at Sec. 1860E-5(a)).

398. *Id.* (at Sec. 1860E-5(b)).

399. *Id.* § 201(a) (at Sec. 36A(a)).

400. *Id.* § 201(a).

401. *Id.* § 201(b).

402. 2009 MEDICARE HANDBOOK § 6.02[C][1], at 6-10 (Judith A. Stein & Alfred J. Chiplin, Jr. eds., 2009).

403. *See* 42 U.S.C.A. § 1395r(i) (West Supp. 2008) (describing the means testing of Part B). *See generally* FROLIK & KAPLAN, *supra* note 8, at 60-61 (explaining the surcharge for Medicare Part B imposed on higher-income enrollees). For an analysis of the implementation problems involved in means-testing Medicare, see Kaplan, *supra* note 299, at 22.

significant costs on the federal government. Although none of the legislative proposals made since President Clinton's 1998 announcement has been the focus of a Congressional Budget Office (CBO) cost study, the CBO very recently issued a "budget options" report[404] that included a variant of early access Medicare among its 115 health care proposals.[405] The option discussed in this Report would cover only persons age sixty-two through sixty-four,[406] rather than the larger group that the legislative proposals considered above would cover—namely, persons age fifty-five to sixty-four. The CBO report stated that if the government would "set a premium that would cover the costs of the program's participants during the buy-in years . . . the program would not require *any* new outlays."[407]

The CBO report contends that an early buy-in option for Medicare would be very expensive, because it would induce additional Social Security beneficiaries to file for early retirement benefits under that program.[408] But early retirement benefits under Social Security are actuarially reduced so that over the lifetime of early-claiming beneficiaries, the government's outlays for Social Security are essentially equivalent.[409] That is, early claimants of Social Security retirement benefits receive more money at younger ages than do beneficiaries who wait until their "full retirement age" to start receiving benefits,[410] but they receive less money after that point. Inducing early claimants under Social Security, therefore, does not increase total lifetime government expenditures for the affected beneficiaries. There will certainly be an increase in near-term government outlays, which is what the CBO report highlighted, but that is strictly a timing phenomenon and does *not* increase Social Security's overall expenditures. As the CBO report itself acknowledges, "the effects on [Social Security] outlays should be minimal, because earlier retirement results in lower annual benefits."[411]

If the government chooses to subsidize the early access Medicare program, however, there will obviously be an increase in government expenditures. Precisely how much that increase will be depends upon three distinct factors: 1) the cost of the program per enrollee, 2) the number of persons who participate in

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404. 1 CONG. BUDGET OFFICE, BUDGET OPTIONS (2008), *available at* http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf [hereinafter CBO REPORT].

405. *Id.* at 1, 39-40.

406. *Id.* at 39.

407. *Id.* (emphasis added).

408. *See id.*

409. *See* C. EUGENE STEUERLE & JON M. BAKIJA, RETOOLING SOCIAL SECURITY FOR THE 21ST CENTURY 221 (1994) ("The actuarial reduction for early retirement roughly offsets the extra benefits one receives before age 65.").

410. *See* FROLIK & KAPLAN, *supra* note 8, at 289-91 (explaining the computation of "early" Social Security retirement benefits).

411. CBO REPORT, *supra* note 404, at 39-40.

the program, and 3) the degree of premium subsidization that the government provides. On the first factor, the CBO estimated the annual premium cost as $7600 for calendar year 2011,[412] but this amount includes a 5% "administrative fee" that would be imposed in addition to the actual programmatic cost.[413] The real projected cost, in other words, would be $7238 per participant,[414] which seems reasonable given the targeted age group's incidence of chronic medical conditions.[415]

Even this figure is somewhat inflated, however, because of three separate factors. First, the program considered by the CBO would cover only persons over age sixty-one, rather than the larger age cohort of fifty-five to sixty-four-year-olds that the legislative proposals cover. Bringing the younger segment of this age cohort—that is, persons aged fifty-five to sixty-one—into the program would *lower* the per-person cost, because health care costs tend to rise as a person ages.[416] Thus, the per-person cost of a program for fifty-five to sixty-four-year-olds would be less expensive than the amount estimated by the CBO for a program that applies only to sixty-two to sixty-four-year-olds.

Second, the program described by the CBO would be voluntary, so persons anticipating higher expenditures would be more likely to enroll. As the CBO report itself notes, "The premium for the buy-in program would be *higher* than if the entire eligible population was enrolled because the program would be likely to experience adverse selection . . . ."[417] To be sure, any nonmandatory health insurance program is subject to this phenomenon, including the legislative proposals analyzed earlier, but it raises the per-person cost nonetheless.

Finally, the CBO did not consider the budgetary *benefit* of providing health insurance to persons who would otherwise enroll in Medicare at age sixty-five, but in worse health. The CBO report acknowledges that "improvements in health status [of pre-Medicare enrollees] . . could reduce Medicare's spending for those individuals after they turned 65."[418] Indeed, an important study in the *New England Journal of Medicine* found that the cost of extending health insurance coverage to pre-Medicare adults would be partially offset by reduced Medicare expenditures when those persons later enrolled in that program,[419] especially for

412. *Id.* at 39.

413. *Id.*

414. Premium cost of $7600 ÷ 1.05 = $7238.

415. *See* Jonathan Gruber, *Health Insurance and the Labor Market*, *in* 1A HANDBOOK OF HEALTH ECONOMICS 645, 675 (Anthony J. Culyer & Joseph P. Newhouse eds., 2000) (chart of chronic conditions by age cohort).

416. *See* Ctrs. for Medicare & Medicaid Servs., *supra* note 304, at 2.

417. CBO REPORT, *supra* note 404, at 39 (emphasis added).

418. *Id.* at 40.

419. J. Michael Williams et al., *Use of Health Services by Previously Uninsured Medicare Beneficiaries*, 357 NEW ENG. J. MED. 143, 151 (2007).

persons with cardiovascular disease or diabetes.[420] On the other hand, the CBO cautioned that "such improvements in health status might also reduce the number of people who died before turning 65, which would increase outlays for Medicare."[421]

As for the number of people who would enroll in the program, the CBO report estimated this number as 300,000,[422] assuming no premium subsidy would be offered. But the number of enrollees will undoubtedly increase if younger-age persons are eligible, and even more so if the government provides a substantial premium subsidy, as the legislative proposals considered previously provide. The degree of premium subsidy, in other words, is a budget variable that Congress can use to adjust the scope of the program. That is, if the subsidy is low, either in dollar terms or as a percentage of the premium cost, then fewer eligible retirees are likely to participate. But if the subsidy is large, then more eligible retirees will probably participate, thereby raising associated program costs.

Notwithstanding these uncertainties, what would a subsidized early access Medicare program cost? Using the CBO's per-person estimate of $7600 (which includes administrative expenses), a 75% subsidy translates into a governmental cost of $5700 per enrollee. The most likely retirees who would enroll in this program are those who are either uninsured presently or who have individually issued health insurance policies. According to the most recent Census Bureau data, the number of fifty-five to sixty-four-year-olds in these two categories is 7,248,000.[423] Multiplying the $5700 per-person cost by this population produces a projected government outlay of over $41 billion.[424]

This estimate, however, is subject to several major caveats. It is undoubtedly inflated because it is based on the CBO's per-person cost, which ignores the lower per-person cost that would be obtained if retirees under age sixty-two were included in the program. The estimate is also inflated because it ignores the offsetting benefits of providing better access to health care for pre-Medicare retirees. It is further inflated because it assumes that every retiree who is eligible for the program will choose to enroll in it. But many low-income retirees will not be able to afford the 25% portion of the premium cost that enrollees themselves must pay. To the extent that there will be nonparticipating retirees, therefore, the

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420. *Id.*; *see also* Jack Hadley & Timothy Waidmann, *Health Insurance and Health at Age 65: Implications for Medical Care Spending on New Medicare Beneficiaries*, 41 HEALTH SERVICES RES. 429 (2006) (extending health coverage to persons aged fifty-five to sixty-four could offset some of the cost of that coverage with improved health at age sixty-five).

421. CBO REPORT, *supra* note 404, at 40.

422. *Id.*

423. Among fifty-five to sixty-four-year-olds, 4,011,000 had no health insurance and 3,237,000 had individual coverage in 2007. *See* DENAVAS-WALT, PROCTOR & SMITH, *supra* note 307, at 69.

424. $5700 × 7,248,000 = $41,313,600,000.

early access program will cost less than the $41 billion estimate derived above. On the other hand, the program's cost will exceed this estimate if employers continue to abandon their existing retiree health benefit arrangements, thereby increasing the number of early retirees without adequate health insurance.

Whatever the cost of this program may be, the question of whether the government should extend the social safety net to pre-Medicare retirees is ultimately a normative matter for the political process to resolve. As noted in Part II of this Article, many early retirees believed for decades that their future health care costs would be covered. They placed their faith in the promises of retiree health benefits that their employers made as part of their compensation packages. Had these retirees realized just how ephemeral those promises were, they might have sought other employment or at least higher wages in lieu of retiree health benefits. But now, it is too late for them to pursue those alternatives.

Perhaps the government should have warned prospective retirees to discount employer assurances as meaningless inducements subject to cancellation at a corporate whim, or at least subject to the unknowable vagaries of future economic conditions. Alternatively, Congress could have provided more effective tax incentives for employers to prefund retiree health benefits,[425] complete with a government agency guarantee in case of employer bankruptcy,[426] akin to the elaborate structure created by ERISA to give pensions the reliability they currently have. When that statute was enacted, the focus was on pensions because they were already significant obligations. The unanticipated increase in the value of retiree health benefits, however, makes these benefits equally worthy of legal protection. But even if Congress acted along these lines tomorrow, such an enactment would provide no benefit for the generation of current and near-term prospective retirees whose health benefits have been curtailed or eliminated outright.

Instead, the courts eviscerated retirees' reasonable expectations by focusing on obscure clauses in impenetrable plan documents without regard to the retirees' level of education, the length of those documents, or the content of employer-provided "general" information. Only long after the fact have retirees learned that employer promises of future health benefits are not what they seemed. Throughout the course of the litigation analyzed previously in this Article, Congress provided no relief—either prospective or remedial—to the innocent victims of these employment benefit "interpretations." Having allowed this state

425. *See* CONG. RESEARCH SERV., EMPLOYER-SPONSORED RETIREE HEALTH INSURANCE: AN ENDANGERED BENEFIT? 10 (2006) (on file with the Journal) ("The tax code in general does not provide as favorable a tax treatment for prefunding of retiree health benefits as for pension benefits."); EMPLOYEE BENEFIT RESEARCH INST., FUNDAMENTALS OF EMPLOYEE BENEFIT PROGRAMS 268 (6th ed. 2009).

426. *See* FROLIK & KAPLAN, *supra* note 8, at 361 (explaining the function of the Pension Benefit Guaranty Corporation and the scope of its protection).

of affairs to develop, it falls to the government to address these retirees' claims of broken promises.

Extending access to Medicare would advance the original premise of the program—namely, to provide health insurance when private insurers are unwilling to do so.[427] Moreover, this extension accords with the sentiments of a substantial majority of Americans regarding access to health care generally. A September 2007 survey conducted by the Harris Poll organization posed the following question: "To what extent do you personally agree or disagree with the following statement . . . 'It is the government's duty to ensure that all Americans have adequate healthcare coverage'?"[428] Nearly two-thirds of the survey respondents agreed with this statement, including almost half of all self-identified Republicans.[429] Thus, expanding Medicare to cover "early" retirees would accord with people's general conception of the proper role of government regarding health care.

3. Possible Impact on Existing Retiree Health Benefit Plans

One extremely important caveat regarding a proposed extension of Medicare to "early" retirees involves existing employer-provided retiree health plans—namely, would the availability of such a government-subsidized program further encourage employers to drop or substantially curtail their current retiree health benefit arrangements?[430] If so, many of the affected retirees would actually be worse off financially. For the most part, employer-provided retiree health benefit plans are easier to understand, more comprehensive, and less expensive than the current Medicare program with its separate components for physicians' fees, prescription drugs, and Medigap coverage.[431] Consequently, extending Medicare availability to "early" retirees might be resisted by individuals who fear that their

427. *See* Marilyn Moon, *Retiree Health Care: Individuals Picking Up Bigger Tab*, TIAA-CREF INST. TRENDS & ISSUES, July 2005, at 3, *available at* http://www.tiaa-crefinstitute.org/pdf/research/trends_issues/tr070105.pdf; *see also* FINKEL & RUCHLIN, *supra* note 14, at 62 ("[H]ealth insurance for the elderly person was generally unavailable as a commercial product before 1965.").

428. *WSJ.com/Harris Interactive Survey Finds That Senator Hillary Clinton Most Trusted on Healthcare Policy Issues, but Trust is Declining*, HEALTH CARE POLL, Oct. 4, 2007, at 5, http://www.harrisinteractive.com/news/newsletters/wsjhealthnews/HI_WSJ_HealthCarePoll_2007_v06_i16.pdf.

429. *Id.* at 6.

430. *See* Rappaport & Malone, *supra* note 47, at 86 (stating that "it seems likely that many employers would no longer sponsor retiree health benefit coverage" if Medicare's eligibility age were reduced).

431. *See supra* text accompanying notes 287-298; *see also* JOHNSON, *supra* note 19, at 4 (reporting that monthly premiums for Medigap coverage in 2004 were more than double the median monthly retiree contribution in employer-sponsored retiree benefit plans).

former employers will use this new development as an excuse to alter or abandon their present retiree health benefit obligations.

This specific issue of Medicare substitution or "crowd out" was raised during the extensive negotiations that took place when a prescription drug benefit for Medicare was being considered in 2003. With employers eager to rid themselves of retiree health benefit plans anyway, many retirees and policymakers were extremely concerned that a new government-funded alternative for prescription drugs would only make matters worse for persons who currently had retiree health benefits.[432] After all, the cost of prescription medications accounts for almost two-thirds of the expense of a typical employer-sponsored retiree health benefits plan.[433] The political imperative, therefore, was "first, do no harm," a requirement that almost derailed the Medicare prescription drug bill's very enactment.[434]

In the end, Congress added an incentive in the form of a federal subsidy equal to 28% of an employer's annual cost of providing prescription medications of more than $295 and less than $6000 (in 2009) per person.[435] In effect, employers that offer qualifying drug coverage can receive an annual federal subsidy of as much as $1597 (in 2009) per covered retiree.[436] This subsidy, moreover, is free of federal income tax,[437] and does not reduce the employer's allowable federal income tax deduction for the cost of this expense.[438] That deduction is equivalent to a further federal subsidy of as much as 35%, depending upon the employer's tax bracket.[439] But even employers who face no current federal income obligation—such as charitable organizations, state and local governments, and profit-seeking enterprises with significant tax loss carryforwards[440]—can benefit from the 28% federal subsidy.

The critical question, of course, is whether this federal subsidy, perhaps

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432. *See* Patricia Barry, *Anxiety Zone: Will the New Medicare Law Encourage Employers To Drop or Keep Their Retiree Drug Plans?*, AARP BULLETIN, Feb. 2005, at 14; FRONSTIN, *supra* note 22, at 8, 10; Frank B. McArdle et al., *Large Firms' Retiree Health Benefits Before Medicare Reform: 2003 Survey Results*, HEALTH AFFAIRS, Jan. 2004, at w4-7 *available at* http://content.healthaffairs.org/webexclusives/index.dtl?year=2004.

433. *See* Schieber, *supra* note 55, at 10.

434. *See* Laurie McGinley et al., *A Guide to Who Wins and Loses in Medicare Bill*, WALL ST. J., Nov. 18, 2003, at B1.

435. 42 U.S.C. § 1395w-132(a)(3)(A), (B) (2000); Memorandum from Abby L. Block & Paul Spitalnic to All Medicare Advantage Orgs., Prescription Drug Plan Sponsors, and Other Interested Parties 33 (Apr. 7, 2008), *available at* http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2009.pdf.

436. $6000 - $295 = $5705 × 28% = $1,597.40.

437. I.R.C. § 139A (2008).

438. *Id.* § 162(a)(1).

439. *Id.* § 11(b)(1) (specifying the corporate income tax rate structure).

440. *See id.* § 172.

combined with the income tax deduction, is sufficient to forestall reductions in employer-provided retiree health benefits. Medicare's prescription drug benefit first became available in 2006,[441] so the results of this natural experiment are still too tentative for a definitive assessment, but early returns are encouraging. Kaiser/Hewitt surveyed private-sector employers with at least 1000 employees who offered retiree health benefits in 2006.[442] Of this group, only 8% of employers terminated their drug coverage for Medicare-eligible retirees.[443] Fully 82% of employers surveyed offered prescription drug coverage that qualified for the tax-free subsidy, and the remainder created a supplement or other type of drug coverage.[444] To be sure, this group of employers is a rarefied collection, but they comprise 22% of all Fortune 500 companies and are the most likely to offer retiree health benefits generally.[445] This group indicated, moreover, that they planned to maintain their existing arrangements for the near future,[446] but there is obviously no way to know for certain whether that will, in fact, be the case. Thus, although Medicare's drug benefit might lead to further reductions in retiree health benefits, the evidence available thus far suggests that the financial incentives created to forestall such reductions have done so. Perhaps, similar financial incentives for employers could be added to an early access Medicare program to prevent or minimize reductions of employer-sponsored retiree health benefit plans.

4. Potential Impact on Retirement Decisions

As noted at the outset of this Article,[447] the availability of health insurance is often a major factor in timing one's retirement. Indeed, one analyst has observed that "[p]ension and retiree health benefits also have been used to encourage and enable older workers to retire, to create openings for younger workers, and to increase overall productivity."[448] This phenomenon, however, is not an unbridled societal good. As the same analyst notes, when early retirement is facilitated, "able-bodied workers are removed prematurely from the workplace, the tax base is reduced, and the demand for public benefits is consequently increased."[449] The essential question, therefore, is whether and to what extent early access to

441. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 101(a)(2), 117 Stat. 2066, 2071 (2003) (codified as amended at 42 U.S.C. § 1395w-101(a)(2)).

442. KAISER/HEWITT SURVEY, *supra* note 7, at 2.

443. *Id.* at 24.

444. *Id.*

445. *Id.* at 2.

446. *Id.* at 25.

447. *See supra* note 5 and accompanying text.

448. Atkins, *supra* note 29, at 100, 109.

449. *Id.* at 120.

Medicare would precipitate retirements that would not otherwise take place.

A comprehensive examination of continuation health insurance among men aged fifty-five to sixty-four years suggests that the impact on induced retirement is rather small.[450] The researchers looked at actual data and concluded that "one year of [continuation health] coverage raised the probability of being retired by about 1.1 percentage points."[451] Furthermore, such coverage apparently "provide[d] insurance coverage for individuals who would have retired in the absence of [such coverage] even though they would not have been covered by employer-provided health insurance."[452] These authors admit, however, that continuation health coverage is more expensive than retiree health insurance and severely time-limited.[453] Such insurance, in contrast, would be more likely to affect retirement timing decisions, depending on the scope of its coverage.[454]

A different study created a simulation model to examine this issue theoretically.[455] According to the model-builders, the impact of lowering Medicare's eligibility age to sixty-two "would raise retirement rates for both men and women by 7%," a result that they characterized as "small."[456] The Medicare early access proposal that they considered, however, did not apply to persons younger than age sixty-two, so it is possible that the increase in retirement rates might be larger if the eligibility age were fifty-five years instead. On the other hand, the authors noted that "[t]he retirement effects of an expansion of the Medicare program would be *even smaller* if near-elderly adults could obtain Medicare coverage only by buying into the program and paying substantial premiums."[457] Accordingly, if induced premature retirement is a major concern of policymakers, they could adjust the effective cost-sharing ratio and make it less generous than the 25-75 split that the current proposals envision.[458] While hardly a perfect solution, such a trade-off might balance the need of older retirees

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450. *See* Jonathan Gruber & Brigitte C. Madrian, *Health Insurance and Early Retirement: Evidence from the Availability of Continuation Coverage*, *in* ADVANCES IN THE ECONOMICS OF AGING 115 (David A. Wise ed., 1996).

451. *Id.* at 140.

452. *Id.*

453. *Id.* at 141.

454. *See* Janet Currie & Brigitte C. Madrian, *Health, Health Insurance and the Labor Market*, *in* 3C HANDBOOK OF LABOR ECONOMICS 3309, 3379 (Orley Ashenfelter & David Card eds., 1999).

455. *See* Richard W. Johnson, Amy J. Davidoff & Kevin Perese, *Health Insurance Costs and Early Retirement Decisions*, 56 INDUS. & LAB. REL. REV. 716 (2003).

456. *Id.* at 726; *see also* Melissa A. Boyle & Joanna N. Lahey, *Health Insurance and the Labor Supply Decisions of Older Workers: Evidence from the U.S. Department of Veteran Affairs* (Ctr. for Ret. Research at Boston Coll., Working Paper No. 2007-23, 2007), *available at* http://www.bc.edu/crr (expansion of the Veterans Affairs health care system's coverage led to "a 2.3% increase in the probability that a treated individual reports being retired").

457. Johnson, *supra* note 455, at 726 (emphasis added).

458. *See supra* text accompanying notes 396-402.

for some sort of reliable health insurance with society's desire to limit unintended early retirements.

At bottom, of course, the timing of any individual's withdrawal from regular employment is determined by many factors—both financial and nonfinancial. And some particularly salient factors, such as overall health status,[459] are largely beyond the control of the prospective retiree. Nonetheless, the potential impact of early access to Medicare on retirement, at least at the proverbial margin, cannot be ignored.

CONCLUSION

The United States is presently in the midst of an unprecedented expansion of its older population. The numbers of Americans in the "early" retiree cohort of age fifty-five to sixty-four years and the "typical" retiree cohort of age sixty-five and older are expected to increase dramatically, as Figure 2 indicates:[460]

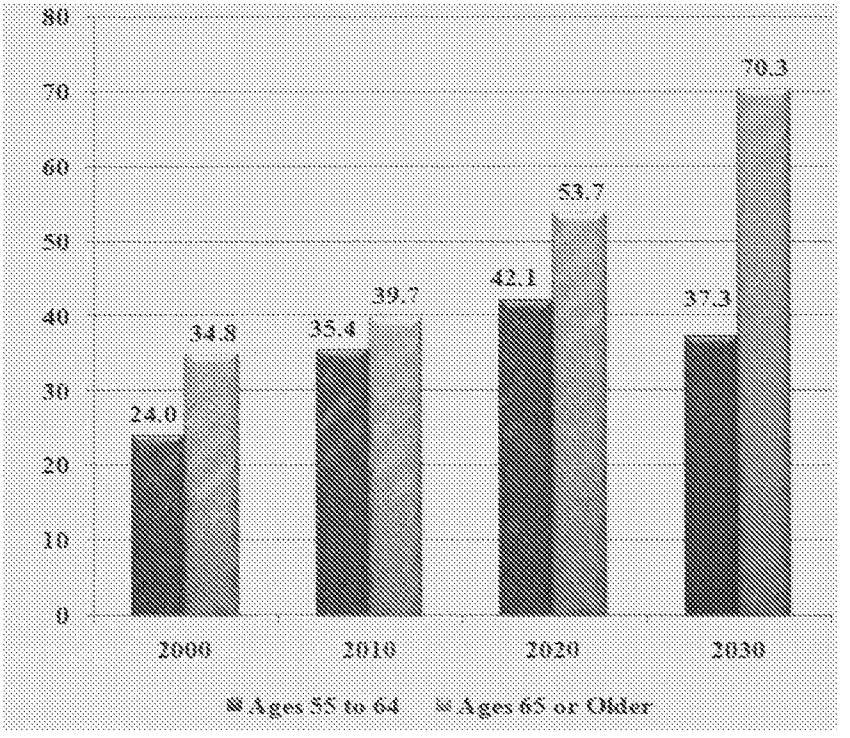

FIGURE 2: Projected Population (in Millions)
Source: U.S. Census Bureau, "Projections of the Total Resident Population by 5-Year Age Groups and Sex with Special Age Categories: Middle Series," selected years 2000 to 2030, January 2000.

For these two cohorts, employer-provided health insurance is an essential

459. *See* Johnson, *supra* note 455, at 726.

460. U.S. GEN. ACCOUNTING OFFICE, *supra* note 21, at 18.

pillar of their anticipated retirement, and especially so for the pre-sixty-five group that generally cannot yet enroll in Medicare.

But the status of post-employment health benefits is already precarious and likely to become even more precarious in the future. Premium increases and benefit cutbacks, as well as outright plan terminations, have become commonplace throughout the private sector and may start appearing among public sector employers as well due to newly effective accounting disclosure requirements. An important study of retiree health benefits concluded that "[t]hese benefits should be viewed not as a gift but as a form of deferred compensation which cannot be abrogated by the employer."[461] This Article has demonstrated, however, that such abrogation is widespread and that legal recourse has limited effect. Barring unusually restrictive contract language, employers have been allowed to alter and even end retiree health benefits that had been part of their firm's culture, literally, for generations.[462]

Into this abyss, Medicare appears as a distinctly "second best" solution. Age-eligible retirees are almost always worse off with Medicare's disjointed multi-faceted programs than they were under their former employer's retiree health benefit plan.[463] Like the old Catskills complaint about the food tasting terrible and the portions being small, Medicare generally offers less coordination of benefits, more complexity, and higher cost.

Retirees who are not yet age-eligible for Medicare, however, are in even worse straits. Beyond limited continuation coverage, such retirees must try to secure health insurance in the individual market, but there is a very high likelihood that such coverage will be expensive, unaffordable, or unobtainable. Health savings accounts have limited appeal to these retirees, as such accounts must be accompanied by a "high-deductible" health insurance policy that may or may not be available, depending upon medical underwriting criteria.

For this group, early access to Medicare is likely to be the better approach. Cost considerations, possible crowd out of existing retiree health benefits, and some impact on induced early retirement are certainly important issues to address. But the essential feature of extending Medicare's universal health coverage to persons younger than age sixty-five is an idea whose urgency has only increased since it was first introduced a decade ago. Further delay is

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461. FINKEL & RUCHLIN, *supra* note 14, at 118.

462. *See, e.g.*, Vanessa Fuhrmans & Theo Francis, *Retiree Benefits Take Another Hit*, WALL ST. J., July 16, 2008, at D1 ("Even those who are in or near retirement shouldn't count on keeping the company coverage they have built up.").

463. *See* DALE YAMAMOTO, TRICIA NEUMAN & MICHELLE KITCHMAN STROLLO, HOW DOES THE BENEFIT VALUE OF MEDICARE COMPARE TO THE BENEFIT VALUE OF TYPICAL LARGE EMPLOYER PLANS? 3 (Kaiser Family Found., Medicare Issue Brief, 2008), *available at* http://www.kff.org/medicare/upload/7768.pdf (finding that even with the new prescription drug benefit, Medicare's benefit value is lower than the typical large employer plan by more than $1500).

increasingly untenable and unwarranted.

The political climate for resolving this problem may, in fact, be at hand. President Obama has declared that health care reform is an essential component of the more general economic recovery effort, stating that reforming health care is "not something that we can sort of put off because we're in an emergency. This is part of the emergency."[464] Insuring the uninsured will likely be a major part of this initiative, and the ranks of the uninsured include many early retirees.

Moreover, the chair of the Senate Finance Committee, which has jurisdiction over the Medicare program, included early access to Medicare as part of his "Call to Action: Health Reform 2009" white paper.[465] This document is a high-concept proposal with few specifics, but it explains that persons aged fifty-five to sixty-four years "face greater risk of illness than their younger counterparts . . . [but] have fewer and fewer affordable insurance options."[466] The document proposes that "Medicare would charge enrollees electing the buy-in option an annual premium . . . [such] that the total costs for the buy-in population would be budget neutral,"[467] asserting that "this option would not create new costs for the Medicare program or for taxpayers."[468] Perhaps under the new administration, retirees younger than age sixty-five will finally see change they can believe in.

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464. Transcript of Obama's Health Care Briefing, Dec. 11, 2008, http://www.nytimes.com/2008/12/11/us/politics/11text-obama.html?emc=etal (last visited Apr. 20, 2009); *see also* Jonathan Gruber, *Universal Health Insurance Coverage or Economic Relief—A False Choice*, 360 NEW ENG. J. MED. 437, 439 (2009) (noting that "universal health coverage for our citizens, can improve both individual health and the economy's health, both today and in the long run").

465. MAX BAUCUS, CALL TO ACTION: HEALTH REFORM 2009, at 21-22 (2008), *available at* http://finance.senate.gov/healthreform2009/finalwhitepaper.pdf.

466. *Id.* at 21.

467. *Id.* at 21-22.

468. *Id.* at 22.

Stemming the Tide of Law Student Depression: What Law Schools Need To Learn from the Science of Positive Psychology

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INTRODUCTION

In a country where the depression rate is ten times higher today than it was in 1960,[1] lawyers sit at the unenviable zenith of depressed professionals. Of all professionals in the United States, lawyers suffer from the highest rate of depression after adjusting for socio-demographic factors, and they are 3.6 times more likely to suffer from major depressive disorder than the rest of the employed population.[2] Lawyers are also at a greater risk for heart disease, alcoholism and drug use than the general population.[3] In one sample of practicing lawyers, researchers found that 70% were likely to develop alcohol-related problems over the course of their lifetime, compared to just 13.7% of the general population; of these same lawyers, 20% to 35% were "clinically distressed," as opposed to only 2% of the general population.[4] With such disproportionate levels of unhappiness, it is not surprising that the profession itself is suffering. Alcoholism or chemical dependency is the cause of the majority of lawyer discipline cases in the United States,[5] and a growing disaffection with the practice of law pushes 40,000 lawyers to leave the profession every year.[6]

Unfortunately, these problems afflict not only practicing lawyers, but law students as well. While there has been less research on law students than on lawyers, a growing body of literature shows that they too exhibit signs of psychological distress,[7] including elevated levels of depression, stress, and

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1. *See* MARTIN E.P. SELIGMAN, AUTHENTIC HAPPINESS 117 (2002).

2. *See* William W. Eaton et al., *Occupations and the Prevalence of Major Depressive Disorder*, 32 J. OCCUPATIONAL MED. 1079, 1083 (1990).

3. *See, e.g.*, Martin E.P. Seligman, Paul R. Verkuil & Terry H. Kang, *Why Lawyers Are Unhappy*, 10 DEAKIN L. REV. 49, 53 (2005).

4. Connie J.A. Beck, Bruce D. Sales & G. Andrew H. Benjamin, *Lawyer Distress: Alcohol-Related Problems and Other Psychological Concerns Among a Sample of Practicing Lawyers*, 10 J.L. & HEALTH 1, 51 (1995).

5. *See, e.g.*, Rick B. Allan, *Alcoholism, Drug Abuse and Lawyers: Are We Ready To Address the Denial?*, 31 CREIGHTON L. REV. 265, 268 (1997).

6. *See* Diana Nelson Jones, *Legally Unhappy: Experts Worry About Growing Tide of Lawyers Abandoning Careers*, PITTSBURGH POST-GAZETTE, May 4, 2005, at E1. For comparison purposes, according to the ABA, there were 1,162,124 active attorneys in the United States at the beginning of 2008. American Bar Association, National Lawyer Population by State (2008), http://www.abanet.org/marketresearch/2008_NATL_LAWYER_by_State.pdf. By way of additional comparison, according to the ABA, the total of J.D.s and LL.B.s awarded for the 2007-2008 school year was 43,518. American Bar Association, Enrollment and Degrees Awarded, 1963-2007, http://www.abanet.org/legaled/statistics/charts/stats%20-%201.pdf (last visited Apr. 1, 2009).

7. In this paper we use the phrase "psychological distress" as an umbrella term to signify the presence of symptoms related to depression, stress, and anxiety.

anxiety.[8] One study found that 44% of law students meet the criteria for clinically significant levels of psychological distress.[9] Law students also report significantly higher levels of alcohol and drug use than college and high school graduates of the same age, and their alcohol use increases between their second and third year of law school.[10] Moreover, these problems seem unique to law students and are not generalizable to other overworked populations of graduate students. For instance, one study showed that compared to medical students in a similarly demanding academic situation, law students have significantly higher levels of stress, stress symptoms, and alcohol abuse.[11]

Contrary to the popular belief that life settles down after the first year of law school, student stress levels appear to increase as the years pass,[12] and levels of depression and anxiety are still significantly elevated two years after graduation.[13] We also know that the problems law students suffer are tied directly to the law school experience. Before they enter law school, students show no signs of elevated psychological distress compared to the general population, but just six months into school, their negative symptom levels increase dramatically.[14] The research seems to suggest that law school is to blame for the alarmingly elevated levels of student distress.[15]

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8. *See, e.g.*, G. Andrew H. Benjamin et al., *The Role of Legal Education in Producing Psychological Distress Among Law Students and Lawyers*, 1986 AM. B. FOUND. RES. J. 225; Susan Daicoff, *Lawyer Know Thyself: A Review of Empirical Research on Attorney Attributes Bearing on Professionalism*, 46 AM. U. L. REV. 1337, 1407 (1997); Matthew M. Dammeyer & Narina Nunez, *Anxiety and Depression Among Law Students: Current Knowledge and Future Directions*, 23 LAW & HUM. BEHAV. 55 (1999); Gerald F. Hess, *Heads and Hearts: The Teaching and Learning Environment in Law School*, 52 J. LEGAL EDUC. 75 (2002); Stephen B. Shanfield & G. Andrew H. Benjamin, *Psychiatric Distress in Law Students*, 35 J. LEGAL EDUC. 65 (1985); Kennon M. Sheldon & Lawrence S. Krieger, *Does Legal Education Have Undermining Effects on Law Students? Evaluating Changes in Motivation, Values, and Well-Being*, 22 BEHAV. SCI. & L. 261 (2004) [hereinafter Sheldon & Krieger, *Does Legal Education Have Undermining Effects*]; Kennon M. Sheldon & Lawrence S. Krieger, *Understanding the Negative Effects of Legal Education on Law Students: A Longitudinal Test of Self-Determination Theory*, 33 PERSONALITY & SOC. PSYCHOL. BULL. 883 (2007) [hereinafter Sheldon & Krieger, *Understanding the Negative Effects*].

9. Lynda L. Murdoch, Psychological Distress and Substance Abuse in Law Students: The Role of Moral Orientation and Interpersonal Style 87 (Nov. 2002) (unpublished Ph.D. dissertation, Simon Fraser University) (on file with authors).

10. *See* Hess, *supra* note 8, at 79; Murdoch, *supra* note 9, at 95-97.

11. Marilyn Heins, Shirley N. Fahey & Roger C. Henderson, *Law Students and Medical Students: A Comparison of Perceived Stress*, 33 J. LEGAL EDUC. 511, 511–14 (1983).

12. Nancy J. Soonpaa, *Stress in Law Students: A Comparative Study of First-Year, Second-Year, and Third-Year Students*, 36 CONN. L. REV. 353, 377-78 (2004).

13. Benjamin et al., *supra* note 8, at 245.

14. *Id.* at 240.

15. David R. Culp, *Law School: A Mortuary for Poets and Moral Reason*, 16 CAMPBELL L. REV. 61 (1994); Daicoff, *supra* note 8, at 1380; Barbara Glesner Fines, *Competition and the Curve*,

Law students themselves are becoming aware of how widespread the problem is. The Law Student Division of the American Bar Association recently initiated a Law Student Mental Health Initiative, and it has designated March 27 as "National Mental Health Day" at law schools across the country.[16] The Chair of the Law Student Division has urged law schools "to sponsor educational programs and events that teach and foster breaking the stigma associated with severe depression and anxiety amongst law students and lawyers."[17] The Association of American Law Schools (AALS) has begun to recognize the importance of these issues as well. In 2006, AALS created a new section, the Section on Balance in Legal Education, to address mental health concerns; this Section presented a program on law student well-being at the most recent AALS Annual Meeting.[18]

Psychologists, lawyers, and scholars have suggested many different ways law school could be a causal factor in student unhappiness. Some researchers have focused on the fierce competition for grades and the singular emphasis on achievement.[19] Researchers also cite the use of the Socratic method in the classroom and the faculty's emphasis on linear thinking at the expense of student creativity and personal values.[20] Others have found that law school fosters certain personality traits in its students that can lead to unhappiness, such as defensiveness and pessimism.[21] Finally, studies have shown that as the school year progresses, students' intrinsic motivation decreases, as does their contact with social support networks.[22]

Given the growing body of literature on law student distress, how have law

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65 UMKC L. REV. 879 (1997); B.A. Glesner, *Fear and Loathing in the Law Schools*, 23 CONN. L. REV. 627 (1991); Hess, *supra* note 8, at 77–78; Ann L. Iijima, *Lessons Learned: Legal Education and Law Student Dysfunction*, 48 J. LEGAL EDUC. 524, 526–27 (1998).

16. American Bar Association, Law Student Mental Health Initiative, http://www.abanet.org/lsd/mentalhealth/home.html (last visited Apr. 30, 2009).

17. *Id.*

18. *See* AALS Section Events, Educating Lawyers and Best Practices for Legal Education: A Mandate to Humanize the Law School Experience, https://memberaccess.aals.org/eWeb/DynamicPage.aspx?webcode=SesDetails&ses_key=67f14eb2-ca05-4a6a-bb9f-4270d482bbdf (last visited Apr. 30, 2009).

19. *See* Culp, *supra* note 15, at 69; Hess, *supra* note 8, at 78.

20. *See* Culp, *supra* note 15, at 62; Daicoff, *supra* note 8, at 1381; Hess, *supra* note 8, at 81; Lawrence S. Krieger, *What We're Not Telling Law Students—and Lawyers—that They Really Need To Know: Some Thoughts-in-Action Toward Revitalizing the Profession from Its Roots*, 13 J.L. & HEALTH 1, 25-26 (1998).

21. *See* Daicoff, *supra* note 8, at 1380; Jason M. Satterfield, John Monahan & Martin E.P. Seligman, *Law School Performance Predicted by Explanatory Style*, 15 BEHAV. SCI. & L. 95, 103-104 (1997); Seligman et al., *supra* note 3, at 54–56.

22. *See* Iijima, *supra* note 15, at 526–28; Sheldon & Krieger, *Does Legal Education Have Undermining Effects*, *supra* note 8, at 275–76.

schools responded? For the most part, they have evinced an awareness of the problem and responded with limited programs to assist law students in distress. Almost universally, however, these programs are reactive; they respond to students' requests for help by directing severely distressed students to a mental health counselor in the student assistance program (SAP) at the university of which the law school is a part.[23] These programs offer help to those most in need of counseling and assistance, but they suffer from two significant limitations. First, as we discuss in more detail in Part II, the SAPs are primarily designed to provide assistance only when a student is severely distressed; they offer little help in warding off the distress before it reaches a crisis. Second, if law student distress is as prevalent as the studies indicate, SAPs can offer help to only a small percentage of the students who suffer from significant levels of stress and depression.[24] SAP programs are designed to provide counseling when students come to seek assistance, and only a small percentage of students who are stressed do so.[25]

SAPs are an important, but limited, first step in responding to the high levels of stress and depression in law schools. The question remains, then: what else can be done to aid students in distress or, even better, prevent the problems before they begin? As discussed in greater depth in Part III below, scholars have suggested a number of possible solutions, including restructuring the law school curriculum to provide a greater emphasis on practical skills and less focus on abstract legal theory, altering or eliminating the traditional Socratic method, reducing the size of law school classes, and changing the way in which students are graded.[26]

For reasons that we develop more fully in Part III of this Article, these proposals all have significant limitations or problems. The proposed curricular changes would be controversial because many would regard them as pedagogically unsound, even if psychologically less stressful. Moreover, a curricular shift to more practical and practice-oriented classes runs counter to the increasing trend toward theoretical and interdisciplinary classes. Thus, even if these proposals were good ideas (which they may well be), they would face some stiff opposition from law school faculties. The challenge law schools face is to come up with innovative approaches to the problem of law student distress that do not require a complete overhaul of the law school curriculum.

Fortunately, the relatively new field of positive psychology may provide some useful solutions to the problem where the traditional approaches of clinical psychology and the proposals for curricular reform fail.[27] The principal tenet of

23. *See infra* notes 89–112 and accompanying text.

24. *See, e.g.*, *infra* note 96 and accompanying text.

25. *Id.*

26. *See infra* notes 134–155 and accompanying text.

27. The current body of psychological research on student distress mirrors the larger field of

positive psychology is that to understand the human condition, we should study not only mental illness and distress but also the conditions that lead to optimal functioning.[28] With this goal in mind, positive psychology focuses its research on the study of "positive emotions, positive character traits, and enabling institutions."[29] Positive psychologists are quick to emphasize that their research is designed to supplement and not to replace traditional psychological research on the causes of psychological suffering.[30] Rather, it is intended to explore areas that have been neglected by traditional psychology. Although positive psychology researchers were not the first persons to think about what makes for a full and happy life, "the value of the overarching term *positive psychology* lies in its uniting of what had been scattered and disparate lines of theory and research about what makes life most worth living."[31]

Positive psychology aims to move from a disease model, where the focus is solely on fixing what is wrong with people, to a health model, where the focus is on building positive traits and skills that foster optimal functioning. In terms of law student well-being, this means that we have an obligation to study not only those students who become depressed, but also those who manage to thrive in law school. Law schools should ask the question: in the face of overwhelming stress and the high risk for depression, why do some law students remain happy? This altered focus does not mean that we can now neglect the depressed law students in favor of those who are happy; in fact, finding relief for the distressed law student population is still our chief priority. But by switching our focus to the study of those students who thrive during law school, we can start identifying what characteristics buffer certain law students against depression. Thus, this Article's focus on positive psychology aims to explore not only how schools might reduce the current levels of student distress, but also how they can build in preventative measures that will foster optimal psychological functioning for future classes of law students. In the end, a greater understanding of the individual and societal conditions that lead to optimal levels of well-being will

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psychology, especially clinical psychology, in that it focuses only on mental illness—not on the full spectrum of human experience. *See* Shelly L. Gable & Jonathan Haidt, *What (and Why) Is Positive Psychology?*, 9 REV. GEN. PSYCHOL. 103, 105–07 (2005).

28. *Id.* at 104.

29. Martin E.P. Seligman et al., *Positive Psychology Progress: Empirical Validation of Interventions*, 60 AM. PSYCHOLOGIST 410, 410 (2005).

30. *Id.* As two researchers described it,

> positive psychology does *not* imply that the rest of psychology is negative, although it is understandable that the name may imply that to some people. In fact, the large majority of the gross academic product of psychology is neutral, focusing on neither well-being nor distress. Positive psychology grew largely from the recognition of an imbalance in clinical psychology, in which most research does indeed focus on mental illness.

Gable & Haidt, *supra* note 27, at 104.

31. Seligman et al., *supra* note 29, at 410.

actually better prepare law schools to meet the needs of those who are suffering.[32]

The potential benefits of positive psychology in the field of law student well-being have already been suggested by some scholars with varying degrees of reference to the psychology literature. For instance, several articles on law student well-being do not mention positive psychology by name, but do provide advice on how to find "the good life" in the field of law.[33] Recently, a few psychologists have contributed more directly to this line of inquiry by examining specific characteristics of happy and unhappy law students.[34] Their focus so far has been on the changes in motivation and values of law students. Their findings suggest that intrinsically motivated activities cultivate greater fulfillment in law school and that decreases in community service values are correlated with decreases in subjective well-being.[35] Studies have also shown that law students have an increased ability to cope with the stress of looking for a job when they have higher levels of intrinsic motivation and internal attributions for success.[36]

This research is helpful, yet it singles out just a few of the potentially numerous personal characteristics that may differentiate the happy law students from the depressed ones. In their study of attorney discontent, Seligman, Verkuil, and Kang address this vast potential for study through the lens of positive psychology: "Law schools are themselves a potential breeding ground for lawyer demoralization and that makes them—as well as law firms—candidates for reform. In these ways the relationship between positive psychology and law becomes a subject worthy of further study in the legal academy, as well as in the profession at large."[37]

This Article aims to respond to this call for action by exploring some of the ways in which the research of positive psychologists may help in reducing law student distress. The positive psychology literature offers a number of methodologies that law schools might utilize to help insulate their students from

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32. *Id.*

33. Tim Kasser, *Personal Aspirations, the "Good Life" and the Law*, 10 DEAKIN L. REV. 33, 34 (2005); *see, e.g.*, James J. Alfini & Joseph N. Van Vooren, *Is There a Solution to the Problem of Lawyer Stress? The Law School Perspective*, 10 J.L. & HEALTH 61, 61–67 (1995); Krieger, *supra* note 20, at 48; Patrick J. Schiltz, *On Being a Happy, Healthy, and Ethical Member of an Unhappy, Unhealthy, and Unethical Profession*, 52 VAND. L. REV. 871, 920-51 (1999).

34. *See* Antonia Abbey, Christine Dunkel-Schetter & Philip Brickman, *Handling the Stress of Looking for a Job in Law School: The Relationship Between Intrinsic Motivation, Internal Attributions, Relations with Others, and Happiness*, 4 BASIC & APPLIED SOC. PSYCHOL. 263 (1983); Sheldon & Krieger, *Understanding the Negative Effects*, *supra* note 8.

35. Abbey et al., *supra* note 34.

36. *Id.* Someone who is intrinsically motivated pursues activities for their own internal reasons—because the activities are worthwhile in and of themselves—and not for external reasons, like recognition or financial gain.

37. Seligman et al., *supra* note 3, at 54.

stress and depression. Although a complete solution to the problem of law student distress will require much additional research, there are currently enough reliable empirical studies to suggest several promising paths for law schools to explore.

In addition, this Article provides the results of a modest empirical study designed to test, in the law school context, one of the principal tenets of positive psychology research, that the identification and utilization of certain personal strengths buffers individuals against stress and depression and allows them to function at optimal levels. A growing body of research conducted outside of law student populations has suggested that concentrating on one's strengths improves life satisfaction.[38] Focusing on enhancing these strengths has been associated with numerous positive outcomes in the workplace, including increased employee engagement and well-being.[39] Research shows that at workplaces where employees believe they have the "opportunity to do what [they] do best," there are significantly higher rates of loyalty and employee retention[40] and also greater annual employee productivity.[41]

Using the strengths-based approach of positive psychology as the foundation for our study, we hypothesized that the law students who used their top strengths more often in daily life would be the ones to report higher levels of well-being. This was indeed the case: students who found ways to use their top strengths were less likely to suffer from depression and stress and more likely to report satisfaction with life.[42] Although our study was only correlational, when viewed in light of previous research that shows a focus on strengths can actively improve life satisfaction and lower depression levels in the general population,[43] it may suggest that a focus on personal strengths can act as a buffer against psychological distress in law school.

We discuss the issues described above in four principal Parts. In Part I, we review the literature on law student distress to present an accurate image of the

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38. ALEX LINLEY, AVERAGE TO A+: REALISING STRENGTHS IN YOURSELF AND OTHERS 154 (2008).

39. *See, e.g.*, MARCUS BUCKINGHAM & DONALD O. CLIFTON, NOW, DISCOVER YOUR STRENGTHS 5 (2001); Timothy D. Hodges & Donald O. Clifton, *Strengths-Based Development in Practice*, *in* POSITIVE PSYCHOLOGY IN PRACTICE 256, 262–65 (P. Alex Linley & Stephen Joseph eds., 2004).

40. BUCKINGHAM & CLIFTON, *supra* note 39, at 5; James K. Harter, Frank L. Schmidt & Theodore L. Hayes, *Business-Unit-Level Relationship Between Employee Satisfaction, Employee Engagement, and Business Outcomes: A Meta-Analysis*, 87 J. APPLIED PSYCHOL. 268, 273-274 (2002).

41. Julie Connelly, *All Together Now*, GALLUP MGMT. J., Mar. 15, 2002, http://gmj.gallup.com/content/763/All-Together-Now.aspx.

42. *See infra* pp. 411-412.

43. Seligman et al., *supra* note 29, at 419.

extent of stress and depression among law students. In Part II, we present the results of an informal survey of law schools to identify what they are currently doing to respond to issues of student well-being. Our investigations show that although every law school surveyed had access to a university counseling service for seriously troubled law students, very few had significant preventative programs designed to forestall the development of mental health issues among law students. In Part III, we identify the various suggestions scholars have offered to address law student distress and discuss the potential of these solutions as well as the problems associated with the suggestions. Finally, in Part IV, we discuss the relatively new discipline of positive psychology and how law schools might begin to utilize the work of positive psychology researchers to protect students from the stress and depression which affects so many. In particular, we identify three strands of positive psychology research that might be especially helpful in this regard: learned optimism, the "broaden-and-build" theory of positive emotions, and strengths theory. In this Part we also present the results of our own empirical research and offer suggestions on how law schools might incorporate what we learned into positive psychology programs for their students.

I. THE RESEARCH ON LAW STUDENT DISTRESS

A growing body of research shows that law students have an unusually high level of distress, even when compared to students in other stressful professional programs. In 1957, the first of these studies showed that first-year law students experienced higher levels of anxiety than first-year medical students.[44] Moreover, the greater levels of anxiety continued throughout law school to the time of graduation.[45] Subsequent articles reached similar conclusions, but these were largely anecdotal or did not use tested and verified survey instruments.[46] In 1979, James M. Hedegard conducted an empirically valid, longitudinal study of students at the J. Reuben Clark Law School at Brigham Young University.[47] Students were tested during the law school's orientation week and then again two

44. *See* Leonard D. Eron & Robert S. Redmount, *The Effect of Legal Education on Attitudes*, 9 J. LEGAL EDUC. 431, 435-36 (1957).

45. *Id.*

46. *See, e.g.*, Phyllis W. Beck & David Burns, *Anxiety and Depression in Law Students: Cognitive Intervention*, 30 J. LEGAL EDUC. 270 (1979); Lawrence Silver, *Anxiety and the First Semester of Law School*, 1968 WIS. L. REV. 1201; Alan A. Stone, *Legal Education on the Couch*, 85 HARV. L. REV. 392 (1971); James B. Taylor, *Law School Stress and the "Déformation Professionelle,"* 27 J. LEGAL EDUC. 251 (1975); Andrew S. Watson, *The Quest for Professional Competence: Psychological Aspects of Legal Education*, 37 U. CIN. L. REV. 93 (1968).

47. James M. Hedegard, *The Impact of Legal Education: An In-Depth Examination of Career-Relevant Interests, Attitudes and Personality Traits Among First-Year Law Students*, 1979 AM. B. FOUND. RES. J. 791.

weeks before the end of the second semester.[48] The study found "increases in feelings of psychological distress, internal conflict, [and] anxiety" from the first test to the second.[49] In addition, the study showed that the scores were significantly higher than predicted based on the scores for BYU undergraduates.[50]

Further studies over the next two decades confirmed and expanded on these findings.[51] One examination of law students and medical students in their first and third years of school found that depression levels were significantly higher among law students than medical students.[52] This study found that third-year law students reported even higher rates of depression than first-year law students.[53] Another comparative study found that law students experienced significantly more academic and fear-of-failing stress than medical students,[54] disproving the authors' original hypothesis that medical students would be more stressed.[55] Researchers also found that law students experienced much higher anxiety rates than undergraduate students[56] and that law students exhibited significantly higher levels of stress and depression than the population at large.[57]

One of the largest studies on law student distress was conducted in 1986 by Andrew Benjamin and fellow researchers at the University of Arizona Law School.[58] The authors studied 320 students and alumni from the law school, and they used five separate instruments to measure the demographic information and

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48. *Id.* at 809.

49. *Id.* at 835.

50. *Id.* at 836-37. Scores were elevated somewhat compared to undergraduates even at the start of law school, but were higher by the end of the first year. *Id.*

51. One positive note is that at least one study has found that "law students commit suicide significantly less frequently than [their] age-matched peers." M.J. Hamilton et al., *Thirty-Five Law Student Suicides*, 11 J. PSYCHIATRY & L. 335, 342 (1983).

52. Robert Kellner, Roger J. Wiggins & Dorothy Pathak, *Distress in Medical and Law Students*, 27 COMPREHENSIVE PSYCHIATRY 220, 221-22 (1986).

53. *Id.* at 222.

54. Heins et al., *supra* note 11, at 519.

55. *Id.* at 522. For yet another study that found the distress of law students to be much greater than that of medical students, see Shanfield & Benjamin, *supra* note 8, at 68-70. In this study, the researchers attributed the higher levels of distress among law students to differences in the learning environments between law school and medical school. They noted that while medical school has smaller classes and offers students more individual attention, law school classes are less personal and professors are more distant. In short, they concluded, "[l]aw school appears to be less nurturant of students than medical school." *Id.* at 69.

56. Roseanna McCleary & Evan L. Zucker, *Higher Trait- and State-Anxiety in Female Law Students than Male Law Students*, 68 PSYCHOL. REP. 1075, 1077 (1991).

57. Shanfield & Benjamin, *supra* note 8, at 69, 74 tbl.1.

58. G. Andrew H. Benjamin et al., *The Role of Legal Education in Producing Psychological Distress Among Law Students and Lawyers*, 11 AM. B. FOUND. RES. J. 225 (1986).

psychological status of the students at different time intervals.[59] The researchers found that prior to entering law school, students reported scores within the normal range, but during their first year, law students' average scores increased significantly, indicating elevated levels of psychological distress.[60] The researchers also found that the "increase in symptoms of law students continued as they progressed through the three years of the program."[61] Depending on the symptom (which included, among others, depression, anxiety, hostility, obsessive compulsive behavior, and interpersonal sensitivity), 20% to 40% of the study group demonstrated significant symptom elevations.[62] The researchers' bottom line was grim:

> Before law school, subjects develop symptom responses similar to the normal population. This comparison suggests that prospective law students have not acquired unique or excessive symptoms that set them apart from people in general. During law school, however, symptom levels are elevated significantly when compared with the normal population. Elevations of symptom levels significantly increase for law students during the first to third years of law school.[63]

Interestingly, the researchers found no correlation between symptom levels and a number of factors that one might have expected to influence student distress. For example, the research found no significant relations between symptom levels and age, undergraduate grade point average, law school grade point average, hours devoted to undergraduate studies, or hours devoted to law school studies.[64] The researchers concluded that the "pattern of results suggests that certain aspects of legal education produce uncommonly elevated psychological distress levels among significant numbers of law students and recently graduated alumni."[65]

The problem of law student distress encompasses not only elevated levels of stress and depression but increased substance abuse as well. In 1993, the Association of American Law Schools Special Committee on Problems of

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59. *Id.* at 228.

60. *Id.* at 240.

61. *Id.* at 241.

62. *Id.* at 246.

63. *Id.*

64. *Id.*

65. *Id.* at 247. The University of Arizona researchers suggested a number of possible causes for the significant levels of student distress found in their study. Here, however, they were much less definite about the reliability of their observations. Their tentative hypotheses included: "excessive workloads and time management problems," "chronically high student-faculty ratios, leading to limited interactions," and "unbalanced development of student interpersonal skills." *Id.* at 248-50.

Substance Abuse in the Law Schools[66] found that American law school students showed a higher regular use of alcohol and certain psychedelic drugs than high school and college graduates of the same age.[67] The survey also found that 11.7% of law students had abused alcohol since enrolling.[68] The survey provided evidence that this substance abuse increases in degree and frequency throughout the three years of law school, especially in the case of alcohol; third-year students reported significantly higher alcohol usage than first- and second-year students.[69] Based on their surveys, the Committee concluded that "some of the data must be viewed as extremely disturbing and indicative of a continuing problem that demands attention."[70] The report went on to conclude that a significant portion of law students seem to be using substances to relieve stress and that these patterns may only worsen as these individuals enter pressurized careers in the field of law.[71]

In 1999, two psychologists reviewed the empirical literature on law student distress and made these conclusions:

> 1) "Anxiety and depression are typically higher among law students than the general population, regardless of which measure was used . "
>
> 2) "Contrary to some anecdotal reports, anxiety and depression were not limited to first-year students, as symptom measures were as high or higher for third-year students."
>
> 3) "In every published study, law students tended to report higher levels of depression and anxiety than those reported by medical students."[72]

Krieger of Florida State University Law School has been the leading writer on this subject over the past five years. His work with psychologist Kennon Sheldon has explored the anecdotal literature and provided substantial new empirical research confirming the extent of the problem of law student distress. In 2002, Krieger observed, "tales of law student and lawyer depression, overwork, dissatisfaction, alcohol abuse, and general distress are legion, and many of us see, more clearly than we would like, the undoing of our students' collective energy, enthusiasm, and engagement after only a few months of law

66. SPECIAL COMM. ON PROBLEMS OF SUBSTANCE ABUSE IN THE LAW SCHS., ASS'N OF AM. LAW SCHS., REPORT (1993), *available at* http://www.aals.org/documents/substanceabusereport.pdf.

67. *Id.* at 8.

68. *Id.* at 10.

69. *Id.* at 12.

70. *Id.* at 11.

71. *Id.* at 12.

72. Dammeyer & Nunez, *supra* note 8, at 67.

school."[73]

In Sheldon and Krieger's first major empirical work, the authors conducted two studies of law students that were designed to determine the extent of law student distress to see how these problems might be solved.[74] The study took a longitudinal approach in measuring law students at a medium-sized public law school on their first day of law school and subsequently over the course of the spring of their first year and the fall of their second and third years.[75] An undergraduate comparison sample consisted of students in an upper division psychology course at a different public university.[76] The researchers used three different study instruments to measure mood,[77] life satisfaction,[78] and depression.[79] They also measured physical health by asking participants to rate eighteen different physical symptoms ("such as runny nose/sore throat, insomnia, and headaches").[80] The researchers then created an aggregate subjective well-being score for each participant by combining all of these survey results.[81]

The results of the study confirmed two important points about law student distress. First, a comparison of the law students at the beginning of their law school career with the undergraduate students showed no significant problems among the law students. In fact, the entering law students reported higher levels of positive affect and life satisfaction than the undergraduates. The researchers noted that "the most important thing to take from these analyses is that the law students appeared quite happy and healthy at the beginning of their career, with relatively intrinsic and prosocial values."[82] Thus, the study suggested that "consistent with earlier research . . . any later distress among the law students is

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73. Lawrence S. Krieger, *Institutional Denial About the Dark Side of Law School, and Fresh Empirical Guidance for Constructively Breaking the Silence*, 52 J. LEGAL EDUC. 112, 113 (2002).

74. *Id.* at 112.

75. Sheldon & Krieger, *Does Legal Education Have Undermining Effects*, *supra* note 8, at 267.

76. *Id.*

77. Mood was measured with the Positive and Negative Affect Schedule (PANAS). This measures the quantity and degree of positive and negative emotions an individual is currently feeling. *See* David Watson, Lee Anna Clark & Auke Tellegen, *Development and Validation of Brief Measures of Positive and Negative Affect: The PANAS Scales*, 54 J. PERSONALITY & SOC. PSYCHOL. 1063 (1988).

78. Life Satisfaction was measured with the Satisfaction with Life Scale. *See* Ed Diener et al., *The Satisfaction with Life Scale*, 49 J. PERSONALITY ASSESSMENT 71 (1985).

79. Depression was measured using the Beck Depression Inventory. *See* AARON T. BECK, COGNITIVE THERAPY AND THE EMOTIONAL DISORDERS (1976).

80. Sheldon & Krieger, *Does Legal Education Have Undermining Effects*, *supra* note 8, at 268.

81. *Id.*

82. *Id.* at 271.

not an effect of pre-existing distress or problematic personality traits."[83]

Second, the study showed that, over the course of the first year of law school, the study participants "experienced large reductions in positive affect, life satisfaction, and overall [subjective well-being], and large increases in negative affect, depression, and physical symptoms."[84] Looking at the data from the second and third years of law school, the researchers found that the declines in subjective well-being remained constant, with the levels remaining unchanged in both the second and third years.[85]

A second study by these researchers, this time at a private, urban law school, showed a similar decline in law student well-being during the first year, supporting the proposition that the problems observed in the first study may be generalized to other law schools.[86] Based on the two studies, Sheldon and Krieger concluded:

> Past scholarly commentaries and previous studies paint a bleak picture of the effects of legal education on the well-being of law students. Our data from two very diverse law schools confirms these negative reports. If these experiences are common in American law schools, as anecdotal reports and other studies indicate, it would suggest that various problems reported in the legal profession, such as depression, excessive commercialism and image-consciousness, and lack of ethical and moral behavior, may have significant roots in the law-school experience.[87]

In 2007, Sheldon and Krieger reported an enlarged and extended version of their previous work, which also showed that at the two different law schools studied, subjective well-being declined over the students' time in law school.[88] This study is the most extensive investigation of law student well-being published to date in two respects. First, it contains study results for classes of students at two separate law schools that differ in significant ways. Second, it reports on data for law student distress longitudinally over the entire law school career of the students studied. It essentially confirms all of the conclusions of Sheldon and Krieger's first study and underscores the need for law schools to take a serious look at what they can do to mitigate the problem of law student distress.

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83. *Id.*

84. *Id.* at 272.

85. *Id.* at 274.

86. *Id.* at 276.

87. *Id.* at 283.

88. Sheldon & Krieger, *Understanding the Negative Effects*, *supra* note 8, at 889. This study involved a different sample group from a subsequent year's class at the first law school. In addition, the authors gathered additional data from the third year of the law students at the second law school who had been included in the earlier study. *Id.* at 887.

II. WHAT LAW SCHOOLS ARE DOING ABOUT LAW STUDENT DISTRESS

Given the well-documented problems of law student distress discussed in the previous section, it is important to examine possible ways in which law schools can respond to the problem. In this section of the paper we examine the current law school programs for dealing with law student distress.

To get some idea of how law schools have been responding to this issue, we surveyed the websites of the top seventy-five law schools as ranked by *U.S. News & World Report* in 2008.[89] In surveying the websites we looked for information regarding the following possible sources of assistance for law students: 1) whether there was any on-site counseling at the law school; 2) whether the website contained any information about referrals to the undergraduate or main university counseling center or services available through student health insurance; 3) whether the website contained any information regarding the local lawyer assistance program that virtually all bar associations now maintain for lawyers who have psychological or substance abuse problems;[90] and 4) whether the website contained any information about proactive programs or materials designed to help students avoid stress, depression, and other problems affecting student well-being. We supplemented these surveys with calls to the student affairs offices at each law school to determine if the information on the website was complete or if there were additional programs or resources not listed.

Most of the law schools surveyed have no on-site counseling available at the law school itself and refer law students to the university counseling or health center.[91] There are a few exceptions: Washington University in St. Louis School of Law, which states that it has a licensed professional counselor on staff at the law school; Georgetown, which retains three professional counselors for its campus; the University of Washington School of Law, which states that it has a mental health professional on call; and Loyola Law School (Los Angeles), where

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89. *Schools of Law: The Top 100 Schools*, U.S. NEWS & WORLD REP., Apr. 7, 2008, at 46-47. For the schools and the pages of their websites that contain information regarding mental health programs, see *infra* Appendix C.

90. The ABA's website maintains contact information for lawyer assistance programs offered by state bar associations. *See* American Bar Association, Commission on Lawyer Assistance Programs, Directory of CoLAP Programs, http://www.abanet.org/legalservices/colap/lapdirectory.html (last visited Apr. 30, 2009). The vast majority of state bars allow law students to take advantage of these programs, but there are some exceptions. Of the thirty-two states and the District of Columbia in which the top seventy-five law schools are located, only three restrict use of the program to members of the bar: Arizona, California, and Oklahoma. In the state of Washington, only third-year law students may use the program. Telephone Interviews by Matthew Albanese with State Bar Representatives (Feb. 18, 2009) (notes on file with the authors).

91. Several of the law schools stressed that university counseling centers were nearby and easily accessible to law students. Additionally, it was mentioned that law students seemed to prefer off-site counseling in order to preserve anonymity.

a licensed counselor is available on site through the Office of Student Affairs. At eight law schools, counselors hold office hours at certain scheduled times of the week on the law school campus or are available exclusively to law students at the university counseling center.[92] Additionally, while many law school websites state that counseling is available through the Office of the Dean of Students or Dean of Student Affairs, most schools (via telephone interviews) stated that this counseling takes the form of an initial assessment, after which deans may refer students to the appropriate resource, usually the university counseling center.[93]

Sixty-two of the seventy-five law schools have information on their websites concerning referral to the main university's counseling center for services that are either covered by the student health insurance plan or student activity fees or are free of charge. These references typically provide a description of the counseling and mental health services available along with lists of possible student concerns. While the majority of law school deans stated in phone interviews that they provide students with information regarding the local lawyers assistance program (usually at orientation), only fifteen provide such information on their websites.[94]

This survey suggests that law schools are genuinely aware of the need that many students will have for psychological or mental health counseling and that the university generally provides such counseling. These programs are available to students who seek out help, many of whom can benefit from individual therapy.[95] It is unlikely, however, that counseling will reach the great majority of students who experience psychological distress. At George Washington

92. These law schools are Chicago-Kent College of Law, Cornell Law School, George Mason University School of Law, George Washington University Law School, Ohio State University Moritz College of Law, Seton Hall University School of Law, University of Alabama School of Law, and the University of Missouri School of Law. Brooklyn Law School does not offer on-site counseling, but its website does list three mental health professionals with whom students can consult. *See* Brooklyn Law School, Student Health, Mental Health Consultation, http://www.brooklaw.edu/studenthealth/mentalhealth.php (last visited Apr. 1, 2009).

93. This practice is understandable, as most deans stated they are not mental health professionals. However, the depth and length of counseling may vary depending on the nature of the student's problem and the training of the particular dean. At Villanova, for example, the Assistant Dean for Student Affairs is also a licensed counselor.

94. American University Washington College of Law, Boston College Law School, Boston University School of Law, Brooklyn Law School, Chicago-Kent College of Law, Florida State University College of Law, Georgetown University Law Center, Harvard Law School, Indiana University Maurer School of Law (available in the online version of the student handbook), Seton Hall University School of Law, Temple University Beasley School of Law, University of California Hastings College of the Law, University of Miami School of Law, University of Minnesota Law School, and Villanova University School of Law.

95. *See* Phyllis W. Beck & David Burns, *Anxiety and Depression in Law Students: Cognitive Intervention*, 30 J. LEGAL EDUC. 270, 270-73 (1979).

University Law School, for example, only sixty law students utilized the university counseling services during the past year.[96] Our own study of George Washington University law students and previous empirical research indicate that far more than sixty law students likely experienced significant problems with stress and depression over this period.[97] Moreover, counseling services, while certainly necessary, address the problem only once a student is already fairly seriously distressed; they do nothing to head off the development of psychological issues in the first place. Finally, at least one study has found that law students are significantly less likely than medical students to seek out psychological help.[98] Thus, counseling alone seems insufficient to address the problem of law student distress.

To determine whether law schools have developed any programs for dealing proactively with the problem of law student distress, we surveyed the law schools' websites to try to identify specific programs or resources devoted to such prophylactic mental health resources. Of the seventy-five law schools we surveyed, only a handful had any indications on their websites of programs or materials of this type.[99] In addition, we made telephone calls to the various Offices of Student Life or Student Affairs, which confirmed the results of the website survey that indicated most law schools have not developed formal programs to deal with student distress in a preventative way. We list below some steps that law schools have taken to address proactively the problems of student distress.

Some of the most popular measures include advertising wellness activities hosted by the law school and university, including athletic and spiritual offerings. Columbia Law School runs a "Wellness Wednesday" program,[100] and Georgetown Law offers various services designed to "promote a positive

96. Interview with Renee DeVigne, Dean of Student Affairs, George Washington Univ. Law Sch., in Wash., D.C. (Dec. 1, 2008).

97. For the results of our own empirical study of George Washington University law students, see *infra* text accompanying notes 316–344. *See also* the empirical research cited *supra* notes 47, 54, 57, 58, 73 & 88.

98. *See* Heins et al., *supra* note 11, at 520–21.

99. Examples of such sites include Harvard Law School's "Wellness@Law" webpage, which provides online links to resources that are designed to offer information about how to maintain "healthy living" and promote wellness, Harvard Law School, Wellness@Law, http://www.law.harvard.edu/current/student-services/wellness/index.html (last visited Apr. 1, 2009), and the wellness section of Cornell Law School's website, which recognizes "that teaching habits which foster good health and effective time and stress management skills is a critical part of legal education," Cornell University Law School, Student Resources, http://www.lawschool.cornell.edu/studentlife/resources.cfm (last visited Apr. 1, 2009).

100. *See* Columbia Law School, Health and Wellness Programs, http://www.law.columbia.edu/current_student/student_service/Health_and_Well (last visited Apr. 1, 2009).

lifestyle," including relaxation techniques, counseling, and campus ministries.[101] At Fordham Law School, free weekly mindfulness and yoga classes are offered to students and faculty as a way to "release some of the tension that is a natural part of studying and working at a law school."[102] The University of Miami School of Law instituted its First Annual Wellness Week in the fall of 2007 in order "to promote positive choices about work-life balance and provide resources that support [the] ability to make these choices."[103]

Several law schools also distribute literature to incoming students about the potential hurdles in law school and techniques to deal with stress. Through its "Humanizing Law School" webpage, Florida State University College of Law maintains several articles by Professor Lawrence Krieger that deal with issues from grades and teaching techniques to depression and career satisfaction, to give students "some perspectives and advice about the issues of health and life/career satisfaction as a law student and lawyer."[104] At the University of Maryland, the Assistant Dean for Student Affairs distributes Professor Krieger's pamphlet on student stress[105] and discusses it when she meets with all first-year law students in small groups for lunch.[106]

Perhaps most advanced in its efforts to prevent law student distress, Vanderbilt University Law School has actually incorporated an optional non-credit course called "Supportive Practices" into its first-year curriculum.[107] About thirty students meet one hour per week during the first semester and are taught strategies for dealing with issues like stress, anxiety, and setting realistic

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101. *See* Georgetown Law, Center for Wellness Promotion, http://www.law.georgetown.edu/wellness/ (last visited Apr. 1, 2009).

102. *See* Fordham Law, Wellness, http://law.fordham.edu/ihtml/sa-2wellness.ihtml?id=1433 (last visited Apr. 1, 2009).

103. University of Miami School of Law, Wellness Initiatives, http://www.law.miami.edu/dos/ds_05.php?op=5 (last visited Apr. 1, 2009).

104. Florida State University College of Law, Student Resources, http://www.law.fsu.edu/academic_programs/humanizing_lawschool/studentresources.html (last visited Apr. 1, 2009); *see also* Florida State University College of Law, Resources for Teachers & Administrators, http://www.law.fsu.edu/academic_programs/humanizing_lawschool/teacherresources.html (last visited Apr. 1, 2009). The law school notes that the division between student and teacher resources is "not absolute" and that students or faculty may "find helpful information in either area." Florida State University College of Law, Humanizing Law School, http://www.law.fsu.edu/academic_programs/humanizing_lawschool/humanizing_lawschool.html (last visited Apr. 23, 2009).

105. LAWRENCE S. KRIEGER, THE HIDDEN SOURCES OF LAW SCHOOL STRESS (2005), *available at* http://www.law.fsu.edu/academic_programs/humanizing_lawschool/images/ep.pdf.

106. Telephone Interview with Dawna Cobb, Assistant Dean for Student Affairs, Univ. of Md. Sch. of Law (June 9, 2008).

107. Telephone Interview with Julie Sandine, Assistant Dean for Student Affairs, Vanderbilt Univ. Law Sch. (June 12, 2008).

performance expectations; various works of Professor Krieger are utilized.[108] The course extends five weeks into the second semester in order to cover the period when first-semester grades are released.[109] The law school has added a second "Supportive Practices" class to accommodate a large number of requests from students.[110]

Vanderbilt's approach appears to be unique. Most law schools seek to promote mental health and alleviate distress among the student body through a combination of the following methods: holding "wellness" events sporadically or at specific times, such as before exam period or during the release of grades; establishing peer mentoring or counseling programs; encouraging students to participate in sports, student groups, or community activities; providing academic counseling and informational events (under the assumption that well-informed students are less likely to experience stress or anxiety); informing students of the available personal and emotional counseling resources and distributing related materials and literature; and letting students know that there is always someone available to talk.[111] Law school deans stated that these methods have met with varying success. Indeed, the success of a program at one school may vary from year to year, with student participation cited as the most common (and unpredictable) variable affecting that success.[112]

As this discussion suggests, law schools are only beginning to think proactively about ways to forestall student mental distress. It is possible that our research may not have captured all that the law schools, or the universities, are doing to help students deal with stress, depression, and other forms of law school distress. Nevertheless, our review of law school websites, supplemented by our calls to the offices of the deans of student affairs, provides a fair indication that the main focus of law schools is to help students by providing counseling service for those who are seriously distressed rather than through the provision of proactive programs designed to ward off law student distress. Law schools have not yet responded to the need for major action to prevent the development of stress and depression among their students.

III. THE CAUSES OF LAW STUDENT DISTRESS

Before we can suggest how law schools may be able to address law student

108. *Id.*

109. *Id.*

110. *Id.*

111. These approaches have been compiled from phone interviews with deans at the various law schools.

112. According to deans and directors of student affairs, low participation in a program resulted from any number of familiar reasons on the part of law students: time constraints, apathy, dubiety that a program would really help, and fear of the stigma of seeking help.

distress in a proactive way, we must first address the question of what it is about the law school experience in particular that may be causing such a problem. In this Part we examine the literature on law student distress in order to assess the solutions that have been proposed to deal with this problem. Unfortunately, the current literature suffers from two significant problems. First, while we are beginning to see significant empirical data on the kinds and levels of law student distress, there has been little empirical research on the causes of the problem. Second, many discussions of the law school environment and its relation to law student well-being are parts of larger critiques of how law is taught and how the substance of what is taught should be changed. In these critiques, the issue of law student distress is simply a subsidiary argument for change.

A common target of critics looking for the source of law school stress is the Socratic method and other teaching styles that put pressure on students to perform in front of their peers.[113] Krieger argues that the use of the Socratic method of case analysis "can leave even strong students with a baseline sense of incompetence if emphasized to the exclusion of the many other skills that students know will be necessary for law practice."[114] Even worse, the Socratic method can invite daily feelings of anxiety and fear for law students, especially when the technique is used harshly by aggressive professors.[115] Stephen Halpern, a political science professor who went to law school, charges law school pedagogy with engendering "psychological insecurity" and inhibiting "curiosity and genuine intellectual interest . . . . In such an environment independent and critical thinking by students is unlikely."[116]

Criticisms of the Socratic method have come from professors seeking to remake the legal educational experience[117] and from students who found the experience to deaden creativity.[118] Other objections have focused upon the impact of the Socratic method on students' personal lives and relationships.[119] Some writers complain that the Socratic method exalts "criticism over imagination,"[120] while others have argued that "impressionistic studies of law school have identified a narrowing of interests toward the analytic skills used by

113. *See* Culp, *supra* note 15, at 62; Hess, *supra* note 8, at 81; Krieger, *supra* note 20, at 25.

114. Krieger, *supra* note 20, at 25.

115. *Id.*

116. Stephen Halpern, *On the Politics and Pathology of Legal Education*, 32 J. LEGAL EDUC. 383, 389 (1982).

117. *See* Paul N. Savoy, *Toward a New Politics of Legal Education*, 79 YALE L.J. 444, 460 (1970).

118. Robert Stevens, *Law School and Law Students*, 59 VA. L. REV. 551, 610–11 (1973).

119. *See* Anthony J. Mohr & Katherine J. Rodgers, *Legal Education: Some Student Reflections*, 25 J. LEGAL EDUC. 403, 412-13 (1973).

120. Howard S. Erlanger & Douglas A. Klegon, *Socialization Effects of Professional School*, 13 LAW & SOC'Y REV. 11, 14 (1978).

practitioners and away from a broader concern with social values and creative use of intelligence."[121] Psychologists also question the use of the Socratic method—Andrew Watson noted that "since most professorial responses are questions, they are perceived as never-ending demands, and hoped-for relief never comes into sight. Such a technique runs counter to all learning theory."[122] To date, however, there appears to be no empirical research that supports the conclusion that the Socratic method is to blame for law student distress.[123]

Commentators have criticized not only the method of teaching, but also the substance of what is taught in law schools. We also have (with one major exception discussed below)[124] little empirical research on this issue and instead have only a good deal of anecdotal commentary and polemical advocacy. For example, in their recent book on the legal profession,[125] Jean Stefancic and Richard Delgado argue that lawyer discontent begins in law school and has two elements: "A conceptual dimension, concerned with how they understand what they do, and a phenomenological one that embraces the felt experience of law and lawyering."[126] These problems are caused by legal formalism, which is "associated with a form of education that emphasizes doctrines and cases and minimizes external factors, such as justice, social policy, and politics. It imagines law as an autonomous discipline existing apart from others; it is not at all interdisciplinary."[127] Stefancic and Delgado find the source of lawyers' unhappiness in law school and the hyper-competitive environment that students face there.[128]

The authors argue that law students are afflicted by a range of mental health problems because of the inconsistencies and sterility of legal formalism.[129] The authors also cite as causes of law student distress the demands of large and growing law firms for students to be trained to suit their needs and the insistence of the ABA's MacCrate Report on the need for more practical legal education.[130]

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121. Thomas A. Willging & Thomas G. Dunn, *The Moral Development of the Law Student: Theory and Data on Legal Education*, 31 J. LEGAL EDUC. 306, 338 (1981).

122. Watson, *supra* note 46, at 123.

123. *See* Dammeyer & Nunez, *supra* note 8, at 71.

124. *See* discussion *infra* notes 139-144 and accompanying text.

125. *See* JEAN STEFANCIC & RICHARD DELGADO, HOW LAWYERS LOSE THEIR WAY: A PROFESSION FAILS ITS CREATIVE MINDS (2005).

126. *Id.* at 29.

127. *Id.* at 35.

128. *Id.* at 63.

129. *Id.* at 63-64.

130. *See* AM. BAR ASSOC., SECTION OF LEGAL EDUC. & ADMISSIONS TO THE BAR, LEGAL EDUCATION AND PROFESSIONAL DEVELOPMENT—AN EDUCATIONAL CONTINUUM (1992), *available at* http://www.abanet.org/legaled/publications/onlinepubs/maccrate.html. This report is often called the "MacCrate Report," referring to Robert MacCrate, the Chair of the Task Force that published the report.

Finally, the authors complain that the widely-discussed critiques of judges like Judge Harry Edwards stating that law schools are becoming too detached from the practice of law have exacerbated the problem.[131] All of these factors contribute, the authors contend, to cynicism and depression among law students.[132]

It is far from clear, however, that legal education demands a formalistic approach, much less that this approach is a significant cause of law student distress. As Theresa Beiner has noted, non-formalism involving extra-legal knowledge plays a significant role in legal education and even in the practice of law, so law schools are hardly bastions of a purely formal legal approach.[133] Moreover, other commentators take the opposite approach from Stefancic and Delgado and argue that it is precisely the increasingly abstract and theoretical approach of modern law schools that exacerbates the decline of law students' subjective well-being. For example, Sheldon and Krieger argue that

> law schools traditionally emphasize theoretical scholarship and the teaching of legal theory, and many hire and reward faculty primarily based on scholarly potential and production. Our findings suggest that schools will benefit from reevaluating faculty priorities regarding such issues and from considering carefully the effect of their teaching methods and practices on students. Changes toward employing faculty with more teaching and lawyering (including public service) experience, offering a balance of practical skills training, or providing more training and rewards for teaching excellence might also ultimately enhance students' sense of autonomy and engagement.[134]

The anecdotal criticisms of both the Socratic method and the substance of what is taught in law schools do not offer much in the way of a clear solution to the problem of law student distress. On the whole, they lack a solid empirical foundation, and many of them seem to be vehicles for larger political statements. Moreover, as a practical matter, it is unlikely that law schools will abandon the use of the Socratic method. As David Culp has noted, the practice of Socratic techniques today is virtually the same as it was in the 1970s, or, for that matter, as it was in the 1870s.[135]

There also appears to be good reason for retaining the Socratic method, at least in the first year and basic courses. The recent Carnegie Commission Report

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131. *See* Harry T. Edwards, *The Growing Disjunction Between Legal Education and the Legal Profession*, 91 MICH. L. REV. 34, 58 (1992).

132. STEFANCIC & DELGADO, *supra* note 125, at 44-45.

133. Theresa M. Beiner, *Insights into the Woes of a Profession*, 20 GEO. J. LEGAL ETHICS 101, 119 (2007) (reviewing STEFANCIC & DELGADO, *supra* note 125).

134. Sheldon & Krieger, *Understanding the Negative Effects*, *supra* note 8, at 894–95.

135. Culp, *supra* note 15, at 72.

on Legal Education[136] praises the Socratic method as the "signature pedagogy" of the legal education process, which should remain the cornerstone of legal education.[137] Although the Commission offers plenty of recommendations for how best to implement the Socratic method, the report's bottom line is decidedly positive. The report compares the Socratic method to "a master artisan guiding a roomful of novices through the early stages of learning a craft. . . . Only through question and answer can instructors make their thought processes explicit, observable, and available for imitation by students."[138]

Perhaps the problem lies not in the teaching method, but in the substance of what is taught in law schools. As mentioned above, there is one recent survey that identifies the substance of what law schools teach as a major cause of student alienation. Elizabeth Mertz, an anthropologist, law professor, and Senior Fellow at the American Bar Foundation, has published the results of a study of first-year contracts classes at eight different law schools.[139] Mertz studied classes taught by professors with widely varying backgrounds and teaching styles.[140] She found that in all of the classes students were taught to "think like lawyers" by discounting their own moral values, setting aside their own feelings of empathy and compassion, and substituting a strictly analytical and strategic mode of thinking.[141] Based upon her observations, Mertz concludes that law school has the "goal of changing people's values"[142] and encouraging students to unmoor themselves from moral reasoning.[143] The result of this approach, according to Mertz, is that students lose their sense of self and become analytically and emotionally detached.[144]

If Mertz's analysis is correct, it is not difficult to see why law school education could lead to stress, depression, and a loss of individual identity. Krieger finds Mertz's research to be a compelling explanation for the sources of law school stress[145] and argues that the consequences of legal education are "desocializing pressures on student personality" that destroy subjective well-being and contribute to ethical and interpersonal problems in the legal

136. *See* WILLIAM M. SULLIVAN ET AL., EDUCATING LAWYERS: PREPARATION FOR THE PROFESSION OF LAW (2007).

137. *Id.* at 23, 74-75.

138. *Id.* at 62-63.

139. *See* ELIZABETH MERTZ, THE LANGUAGE OF LAW SCHOOL: LEARNING TO "THINK LIKE A LAWYER" 4 (2007).

140. *Id.* at 94.

141. *Id.* at 6, 95.

142. *Id.* at 1 (quoting SHIRLEY BRICE HEATH, WAYS WITH WORDS: LANGUAGE, LIFE, AND WORK IN COMMUNITIES AND CLASSROOMS 367-68 (1983)).

143. *Id.* at 1, 6.

144. *Id.* at 99.

145. Lawrence S. Krieger, *Human Nature as a New Guiding Philosophy*, 47 WASHBURN L.J. 247, 266-67 (2008).

profession.[146] The most discouraging aspect of Mertz's study was the ubiquity of the problems she observed and the extent to which her findings were independent of teaching style. Even if we were certain that Mertz had located a key source of stress and depression, it would not be an easy matter to change the substance of what is taught in every law school. Nor would it necessarily be in the best interests of legal education and the training of prospective lawyers to make radical alterations to the substance of the legal curriculum.

Even if law professors learn how to implement the Socratic method as sensitively and carefully as one might hope, and even if they work to humanize legal education, a number of additional stress factors remain in law students' daily lives. Many commentators have pointed out the problems stemming from the fierce competition for grades and the heavy workload borne by those who struggle to achieve them.[147] David Culp has argued that the "competition and fear of the almighty evaluator, the grade, cripple creative functioning in the classroom."[148] Krieger, in writing to law students about possible sources of stress, acknowledged that

> [y]our entire class shares the pressure to be in that exclusive Top Ten Percent (and to be invited to law review), and you all know that ninety percent of you cannot succeed in this endeavor. . . . If you allow these concerns to dominate your thinking, your studies are fraught with anxiety and unease about your worth, your future, and your job prospects. It is as if your whole life is riding on your grades. And this persistent insecurity in turn can create much more stress, by causing you to overwork and abandon your life balance.[149]

Gerald Hess echoed this concern when he wrote in 2002 that because "[g]rades and class rank are significant gatekeepers to the reward system during and after law school—law review membership, research or teaching-assistant positions, internships and jobs," competition for them creates enormous stress, fear, and for many, "a profound loss of self-esteem."[150] Although one might expect grade pressures to affect medical students and undergraduates as well, there may be something unique (although, as yet unidentified) about the law school environment that makes these pressures more severe.

Added to the stress of intense competition is the related stress created by a heavy workload. As Hess notes, "[t]he workload overwhelms many law students. They have little time for sleep, relaxation, and relationships with friends and family. The demands of the first year cause many of them physical and

146. *Id.* at 269-70.

147. *See* Culp, *supra* note 15, at 70-72; Daicoff, *supra* note 8, 1389; Fines, *supra* note 15, at 884; Hess, *supra* note 8, at 78.

148. Culp, *supra* note 15, at 71.

149. KRIEGER, *supra* note 105, at 3.

150. Hess, *supra* note 8, at 78.

psychological exhaustion."[151] Stephen Halpern has also argued that excessive workload is a major cause of law student distress:

> It is not uncommon for the workload to be such that it is physically impossible to complete assignments on time. For the many highly motivated first-year students this can lead to a near constant state of anxiety. Physical and psychological exhaustion are, I think, programmed into the first year The student is stripped naked, so to speak, so that he may be remade a lawyer. The underlying dynamic, I suspect, parallels the highly structured, controlling, emotionally intense initiatory rites used by the church or the military in the indoctrination of their neophytes.[152]

The problem with solving these potential causes of law school stress and depression is that they are very difficult to remedy directly. For example, although some commentators have suggested that there should be a reduced use of traditional grading methods in order to decrease competition,[153] it seems unlikely that most law schools will abandon traditional grading methods. Legal educators, law students, and those who hire students directly out of law school all seem to agree that some form of grading system is necessary in order to sort candidates for hiring.[154] Yale Law School may be able to ensure its graduates obtain job offers without traditional grades, but few other law schools are able to emulate Yale's model.[155] As long as law school remains graded and law students compete for select jobs, it will be difficult to eliminate these factors as causes of stress.

The empirical studies of law student distress offer a somewhat better substantiated analysis of the causes of distress, but even they tend to rely heavily on the anecdotal literature in identifying causal factors. For example, the study by Benjamin and fellow researchers at the University of Arizona concluded that "the results of the study do show that many [students] do feel overwhelmed by the workload."[156] The researchers also found that "the time management issue, as

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151. *Id.*

152. Stephen C. Halpern, *On the Politics and Pathology of Legal Education*, 32 J. LEGAL EDUC. 383, 388-89 (1982).

153. *See, e.g.*, Fines, *supra* note 15; Hess, *supra* note 8, at 79.

154. In a discussion before a recent moot court final argument at George Washington University Law School, Justice Scalia and two distinguished circuit judges agreed that the abandonment of grades was not a realistic possibility for the vast majority of law schools. Justice Antonin Scalia, Judge Marsha Berzon & Judge Jeffrey Sutton, Question and Answer Session Before the Final Round of the 59th Annual Jacob Burns Van Vleck Constitutional Law Moot Court Competition at the George Washington University Law School (Jan. 22, 2009).

155. Harvard has recently abandoned letter grades (joining Stanford and Berkeley), but there is no indication that this is a trend that is catching on at other law schools, particularly those outside of the traditional "top ten" schools.

156. Benjamin et al., *supra* note 8, at 248.

shown by the current study, also affects other law students and alumni long after the first year of law school ends."[157] The authors of the study, however, do not have any strong empirical evidence that the workload is what causes high levels of stress and depression among law students. Given that a number of studies show law students' distress to be much higher than that of medical students, despite similarly heavy workloads, it is unlikely that the quantity of work in law school is the main problem.

The Benjamin study notes that the high student-faculty ratio and the low frequency of student-teacher interactions could also be a cause of student distress.[158] The researchers also suggest that "unbalanced development of student interpersonal skills is the last category of suspect contributors that could lead to impaired psychological well-being."[159] With respect to each of these issues, however, the researchers' support comes mainly from the anecdotal literature on law student distress and not from their own empirical research.

In Sheldon and Krieger's first study, published in 2004,[160] the focus was principally upon identifying the extent of law student distress, rather than clearly identifying the causes of that distress. The authors did conclude, however, that although the answer to the question of what causes law student distress is complicated, the data they obtained suggests that a shift in motivation and values may be part of the equation.[161] For instance, they found that over the course of their first year in law school, students move away from an emphasis on community service values and move toward a focus on appearance and image.[162] Students also experience a shift in motivation from internal to external; that is, they report pursuing goals less for their own enjoyment and more to meet the expectations of others.[163] Although the authors did find some correlation between changes in motivation and subjective well-being, they admitted that causality could not be determined.[164]

Sheldon and Krieger's second study[165] made more of an effort to correlate the decline in law students' mental health with factors that might be ameliorated in order to improve law students' well-being. This study evaluated whether self-determination theory could provide insights into the causes and possible cures for the declines in law student subjective well-being.[166] Self-determination theory is

157. *Id.* at 249.

158. *Id.*

159. *Id.* at 250.

160. *See* Sheldon & Krieger, *Does Legal Education Have Undermining Effects*, *supra* note 8.

161. *Id.*

162. *Id.*

163. *Id.* at 280–81.

164. *Id.* at 281.

165. Sheldon & Krieger, *Understanding the Negative Effects*, *supra* note 8.

166. *Id.* at 884, 894.

concerned with human motivation and the degree to which people's actions are determined by free choice and inner beliefs (intrinsic motivation) or by outside forces and external rewards (extrinsic motivation).[167] For intrinsic motivation to be present in subordinate individuals like law students, authority figures must provide "autonomy support." In this context, autonomy support in law school would have three important characteristics: 1) "choice provision," in which students are presented with as much choice as possible; 2) "meaningful rationale," in which students are helped to understand the situations where they have no choice; and 3) "perspective taking," in which students feel that their point of view is valued and considered by their school's professors and administrators.[168]

Sheldon and Krieger postulated that satisfaction of these psychological needs that form the basis of self-determination theory would be correlated with improved subjective well-being and negatively correlated with measures of student distress such as depression. Based upon their survey results, Sheldon and Krieger concluded that "autonomy support predicted . . . higher subjective well-being relative to baseline, better graded performance controlling for undergraduate GPA and more self-determined motivation to pursue the upcoming legal career."[169] Those students who rated faculty within their program as more controlling experienced declining psychological need satisfaction.[170]

What then are the implications of Sheldon and Krieger's conclusion for law schools? The authors suggest that

> to maximize the learning and emotional adjustment of its graduates, law schools need to focus on enhancing their students' feelings of autonomy. Why? Because such feelings can have trickle-down effects, predicting changes in students' basic need satisfaction and consequent psychological well-being, effects that may also carry forward into the legal career.[171]

Exactly how to accomplish this change, however, is a vexing problem. The

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167. As Sheldon and Krieger describe:

> This theory, and its 30-year empirical research tradition, focuses on the contextual and personality factors that cause positive and negative motivation, with corresponding positive and negative performance and subjective well-being (SWB) outcomes. Because the theoretical focus of [self-determination theory] is related to many of the above propositions and critiques, we hope that applying this theory might shed new light on the law school conundrum, as well as suggesting concrete ways to ameliorate the various problems.

Sheldon & Krieger, *Does Legal Education Have Undermining Effects*, *supra* note 8, at 263.

168. Sheldon & Krieger, *Understanding the Negative Effects*, *supra* note 8, at 884.

169. *Id.*

170. *Id.* at 893.

171. *Id.* at 894.

authors propose that law schools should reconsider their emphasis on theoretical scholarship and teaching of legal theory as well as their hiring and promotion practices that currently emphasize "scholarly potential and production."[172] That prescription, however, as previously noted runs directly against the prevailing opinion in the legal academy, and it would be a difficult prescription for any law school to adopt. The authors' additional suggestion that "employing faculty with more teaching and lawyering (including public service) experience, offering a balance of practical skills training, or providing more training and rewards for teaching excellence" similarly bucks the trend in law school hiring and curricula development.[173]

Thus, it seems clear that a solution to the problem of law student distress is unlikely to come from a major restructuring of law school teaching methods or the relationship between law students and their professors. It is not that these subjects do not deserve attention or that improvements in these areas would not be welcomed by law students. Rather, the practical problems with achieving major changes in these areas seem insurmountable. Instead, the solution to law student distress seems much more likely to be found in programs that help students create buffers against stress and depression that will help them to resist the difficult environment of law school, regardless of the specific causes.

One example of such a program was reported by researchers Richard Sheehy and John Horan.[174] These researchers developed a stress inoculation training program for first-year law students. As described by the researchers, stress inoculation training typically involves three phases:

> First, participants are *educated* about the sources of their stress, including, for example, its relationship to irrational thinking and possible ways to reduce it at both the physiological and psychological levels. Next, *coping skills* directed toward specific stressors are fostered. These include, for example, relaxation techniques and cognitive restructuring. (Here, we tailored the coping skills to the individual stressors identified in the law school experience, i.e., competition, lack of feedback, instructional methods, value conflicts, and myths.) The final *application* phase involves exposure to real or simulated situations for practice in using the coping skills.[175]

The study involved twenty-two students who participated in stress inoculation training. Participants met with counselors for weekly sessions of ninety minutes each. The first session focused on the education phase of the training; the students were told about the possible sources of stress and anxiety

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172. *Id.*

173. *Id.*

174. *See* Richard Sheehy & John J. Horan, *Effects of Stress Inoculation Training for 1st-Year Law Students*, 11 INT'L J. STRESS MGMT. 41 (2004).

175. *Id.* at 44.

and given information on breathing exercises. The next two sessions dealt with the coping skills training and included homework assignments to help them practice the techniques. In the fourth and final session, the students reviewed the previous sessions and engaged in role-playing to test the application of the newly-learned skills.[176]

The researchers found that all participants in the study showed declines in stress and anxiety and that they exhibited significantly lower stress and anxiety levels than the control group of students, who received no special training at all.[177] Also, more than half of the students in the stress inoculation training reported significant improvements in their predicted class rank. The bottom line, according to the researchers, was that the "study had the support of the law school administration, and was thus easily implemented . . . . If other schools incorporated the principles of [stress inoculation training] into their curricula and other programs, perhaps both students and graduates would experience less occupational stress as well as improved academic and professional success."[178]

We think that these researchers are on the right track, and we believe that the science of positive psychology can provide the means to create these stress and depression buffers for law students and help them to enjoy a more productive, meaningful, and satisfying law school experience.

IV. WHAT THE SCIENCE OF POSITIVE PSYCHOLOGY CAN TEACH LAW SCHOOLS

A. What Is Positive Psychology, and Why Should We Care?

Positive psychology is the study of the traits and conditions that lead to human thriving. It is often characterized as the study of happiness, but it is more accurately the study of all positive emotions and character traits, including joy, contentment, gratitude, optimism, and resilience. Positive psychologists are quick to emphasize that their research is intended to supplement and not to replace traditional psychological research; it is designed to explore areas that have been neglected by traditional psychology to portray a more accurate and in-depth picture of the range of human experience. While traditional psychology focuses on what makes people distressed and how they can get back to neutral, positive psychology focuses on how people can move above neutral.[179] It presupposes

176. *Id.* at 47-48.

177. *Id.* at 49.

178. *Id.* at 52.

179. Gable & Haidt, *supra* note 27, at 104. As two researchers described it:

> [P]ositive psychology does *not* imply that the rest of psychology is negative, although it is understandable that the name may imply that to some people. In fact, the large majority of the gross academic product of psychology is neutral, focusing on neither well-being nor distress. Positive psychology grew largely from the recognition of an

that happiness and well-being are not merely the absence of depression and anxiety, but rather are a whole host of states, traits, and emotions that combine to make life worth living.

Although the field of positive psychology draws upon research conducted by many traditional psychologists over the past half century,[180] it has been identified as a separate field of study for about ten years. It first gained widespread attention in 1998 when Martin Seligman devoted his first speech as president of the American Psychological Association to the topic and then published a special positive psychology issue of *American Psychologist* (the official journal of the American Psychological Association) in January 2000.[181] Since that time, numerous books and hundreds of articles have been published on positive psychology.[182] Positive psychology centers have been established at a number of universities,[183] and positive psychology courses are offered at both the undergraduate and graduate levels at dozens of universities in the United States and Europe.[184] The University of Pennsylvania now offers a Master of Applied Positive Psychology degree.[185] Information on positive psychology is spreading to the general public as well. There are now a number of websites devoted to positive psychology,[186] and there is even a growing interest in positive

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imbalance in clinical psychology, in which most research does indeed focus on mental illness.

Id.

180. *Id.*

181. Martin E.P. Seligman & Mihaly Csikszentmihalyi, *Positive Psychology: An Introduction*, 55 AM. PSYCHOLOGIST 5 (2000).

182. *See, e.g.*, A PSYCHOLOGY OF HUMAN STRENGTHS (Lisa G. Aspinwall & Ursula M. Staudinger eds., 2003); FLOURISHING (Corey L.M. Keyes & Jonathan Haidt eds., 2003); HANDBOOK OF METHODS IN POSITIVE PSYCHOLOGY (Anthony D. Ong & Manfred H.M. van Dulmen eds., 2007); POSITIVE PSYCHOLOGICAL ASSESSMENT: A HANDBOOK OF MODELS AND MEASURES (Shane J. Lopez & C.R. Snyder eds., 2003); POSITIVE PSYCHOLOGY IN PRACTICE (P. Alex Linley & Stephen Joseph eds., 2004); SELIGMAN, *supra* note 1; THE HANDBOOK OF POSITIVE PSYCHOLOGY (C.R. Snyder & Shane J. Lopez eds. 2002).

183. Among them are the University of Pennsylvania, the University of Michigan, the University of Illinois, and Claremont Graduate University. *See* Seligman et al., *supra* note 29, at 413.

184. *Id.* At Harvard University, for example, the Positive Psychology course taught by Tal D. Ben-Shahar is now the most widely taken undergraduate course, having displaced Introduction to Economics. *See* Carey Goldberg, *Harvard's Crowded Course to Happiness: 'Positive Psychology' Draws Students in Droves*, BOSTON GLOBE, Mar. 10, 2006, at A1, *available at* http://www.boston.com/news/local/articles/2006/03/10/harvards_crowded_course_to_happiness.

185. *See* Penn College of Liberal & Professional Studies, Master of Applied Positive Psychology, http://www.sas.upenn.edu/cgs/graduate/mapp (last visited Apr. 1, 2009). One of the coauthors of this article is a graduate of this program.

186. *See* Happier.com, http://www.reflectivehappiness.com (last visited Apr. 1, 2009); Positive Psychology News Daily, http://pos-psych.com (last visited Apr. 17, 2009); University of

psychology within the popular media.[187]

There are three essential subjects in the study of positive psychology: 1) positive individual characteristics (strengths and virtues), 2) positive subjective experience (happiness, pleasure, and meaning), and 3) positive institutions and communities.[188] First, positive psychologists have attempted to identify and substantiate the existence of certain cross-cultural character strengths that can provide a basis for human happiness and flourishing. Two of the founders of the field of positive psychology, Martin Seligman and Christopher Peterson, have published a classification of character strengths and virtues called Values in Action (VIA) that is intended to be the counterpart of the American Psychological Association's canonical Diagnostic and Statistical Manual of Mental Disorders (DSM).[189] Just as the DSM identifies the psychological disorders that afflict human beings, the VIA is designed to describe and classify the "strengths and virtues that enable human thriving."[190] Seligman and Peterson argue that psychology, already armed with a vocabulary to speak about human problems, now needs a "vocabulary for speaking about the good life and assessment strategies for investigating its components."[191] As such, the VIA identifies six virtues that extensive research shows are endorsed in nearly every world society: wisdom, courage, humanity, justice, temperance, and transcendence. Under each virtue, the VIA identifies particular strengths that met twelve separate criteria for inclusion.[192] The following table shows Peterson and

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Michigan Ross School of Business, Center for Positive Organizational Scholarship, http://www.bus.umich.edu/Positive (last visited Apr. 1, 2009); University of Pennsylvania, Authentic Happiness, http://www.authentichappiness.com (last visited Apr. 1, 2009); University of Pennsylvania, Positive Psychology Center, http://www.positivepsychology.org (last visited Apr. 1, 2009).

187. *See, e.g.*, Claudia Wallis, *The New Science of Happiness*, TIME, Jan. 17, 2005, at A2, *available at* http://www.time.com/time/magazine/article/0,9171,1015832,00.html; *see also* Time, Mind & Body Happiness, http://www.time.com/time/2005/happiness (last visited Apr. 1, 2009) (displaying additional stories from the January 17, 2005 issue of *Time* that explored the implications of positive psychology research).

188. Gabel & Haidt, *supra* note 27, at 108.

189. *See* CHRISTOPHER PETERSON & MARTIN E.P. SELIGMAN, CHARACTER STRENGTHS AND VIRTUES: A HANDBOOK AND CLASSIFICATION (2004).

190. Seligman et al., *supra* note 29, at 411.

191. CHRISTOPHER PETERSON, A PRIMER IN POSITIVE PSYCHOLOGY 137 (2006).

192. As described by Seligman, the criteria are 1) "ubiquity – is widely recognized across cultures," 2) "fulfilling – contributes to individual fulfillment, satisfaction, and happiness broadly construed," 3) "morally valued – is valued in its own right and not as a means to an end," 4) "does not diminish others – elevates others who witness it, producing admiration, not jealousy," 5) "non-felicitous opposite – has obvious antonyms that are 'negative,'" 6) "traitlike – is an individual difference with demonstrable generality and stability," 7) "measurable – has been successfully measured by researchers as an individual difference," 8) "distinctiveness – is not redundant

Seligman's classification of these six virtues and their coordinate twenty-four character strengths:

Classification of Character Strengths[193]

Wisdom and Knowledge	
Cognitive strengths that entail the acquisition and use of knowledge	
Creativity	Thinking of novel and productive ways to do things
Curiosity	Taking an interest in ongoing experience
Open-Mindedness	Thinking things through and examining them from all sides
Love of Learning	Mastering new skills, topics, and bodies of knowledge
Perspective	Being able to provide wise counsel to others
Courage	
Emotional strengths that involve the exercise of will to accomplish goals in the face of opposition, external or internal	
Authenticity	Speaking the truth and presenting oneself in a genuine way
Bravery	Not shrinking from threat, challenge, difficulty, or pain
Persistence	Finishing what one starts
Zest or Vitality	Approaching life with excitement and energy
Humanity	
Interpersonal strengths that involve "tending and befriending" others	
Kindness	Doing favors and good deeds for others
Love	Valuing close relations with others
Social Intelligence	Being aware of the motives and feelings of self and others
Justice	
Civic strengths that underlie healthy community life	
Fairness	Treating all people the same according to notions of fairness and justice
Leadership	Organizing group activities and seeing that they happen
Citizenship	Working well as member of a group or team

(conceptually or empirically) with other character strengths," 9) "paragons – is strikingly embodied in some individuals," 10) "prodigies – is precociously shown by some children or youths," 11) "selective absence – is missing altogether in some individuals," and 12) "institutions – is the deliberate targeting of societal practices and rituals to try to cultivate it." Seligman et al., *supra* note 29, at 411.

193. PETERSON & SELIGMAN, *supra* note 189, at 29-30.

Temperance	
Strengths that protect against excess	
Forgiveness	Forgiving those who have done wrong
Modesty	Letting one's accomplishments speak for themselves
Prudence	Being careful about one's choices; not saying or doing things that might later be regretted
Self-Regulation	Regulating what one feels and does
Transcendence	
Strengths that forge connections to the larger universe and provide meaning	
Appreciation of Beauty and Excellence	Noticing and appreciating beauty, excellence, and/or skilled performance in various domains of life
Gratitude	Being aware of and thankful for the good things that happen
Hope	Expecting the best and working to achieve it
Humor	Liking to laugh and tease; bringing smiles to other people
Religiousness	Having coherent beliefs about the higher purpose and meaning of life

Interestingly, these twenty-four character strengths have been endorsed by adults surveyed around the world and "defy cultural, ethnic, and religious differences."[194] Moreover, the relative distribution of strengths is similar across all fifty U.S. states and holds across gender, age, and education.[195]

Peterson and Seligman have developed an assessment tool, called the VIA Inventory of Strengths, that identifies which character strengths an individual most strongly exhibits and celebrates as his or her own. An individual's top, or "signature," strengths prove to be mostly stable over time, though they can change in response to significant life events[196] or to concerted efforts at lifestyle change.[197] While exhibiting any of the twenty-four character strengths is associated with life satisfaction, Peterson and his colleagues have found that the strengths most strongly associated with happiness are love, hope, curiosity, gratitude, and zest.[198] Other findings have been equally interesting: for instance,

194. Seligman et al., *supra* note 29, at 411.

195. The only strength whose distribution varies slightly across the United States is "religiousness, which is somewhat more evident in the South." Seligman et al., *supra* note 29, at 411.

196. Christopher Peterson & Martin E.P. Seligman, *Character Strengths Before and After September 11*, 14 PSYCHOL. SCI. 381 (2003).

197. PETERSON & SELIGMAN, *supra* note 189, at 643.

198. Nansook Park, Christopher Peterson & Martin E.P. Seligman, *Strengths of Character and Well-Being*, 23 J. SOC. & CLINICAL PSYCHOL. 603, 610 (2004); Christopher Peterson et al.,

"Students with the strengths of *perseverance*, *prudence*, and *love* earn better grades, even when ability test scores are held constant."[199] Studies at the U.S. Military Academy have shown that the strength of hope predicts who will stay in the service.[200] And the strength of zest is associated with perceiving one's life work as a calling, as opposed to simply a job.[201] The more researchers learn about which strengths correlate with which positive outcomes—for instance, success in law school—the more valuable it will be for people to learn about the VIA and reaffirm these strengths in their daily lives.

Also critical to the understanding of positive psychology is a focus on defining and measuring happiness, usually referred to as "subjective well-being."[202] Just as clinical psychologists use the Center for Epidemiological Studies Depression Scale[203] and the Beck Depression Index[204] to measure negative emotions and symptoms of depression, positive psychologists utilize measures such as the Satisfaction with Life Scale[205] and the Steen Happiness Index[206] to measure an individual's state of well-being. While differing definitions of happiness abound, it is essentially the experience of positive emotions, combined with feelings of meaning and purpose.[207] Because happiness can be an unwieldy term for empirical study, Martin Seligman and his colleagues have divided happiness into three distinct and measurable components: pleasure, engagement, and meaning.[208] Extensive research has confirmed that pursuing any

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Strengths of Character, Orientations to Happiness, and Life Satisfaction, 2 J. POSITIVE PSYCHOL. 149, 152 (2007).

199. Christopher Peterson & Nansook Park, *Character Strengths in Organizations*, 27 J. ORGANIZATIONAL BEHAV. 1149, 1151 (2006).

200. *Id.*

201. *Id.* For more on the distinction between a "calling orientation" and a "job orientation" toward work, see Amy Wrzesniewski et al., *Jobs, Careers, and Callings: People's Relations to Their Work*, 31 J. RES. PERSONALITY 21 (1997).

202. Happiness and subjective well-being are essentially the same thing, and we will continue to use the terms interchangeably here. The term "subjective well-being" is more common in scientific parlance because it emphasizes that happiness is inherently subjective; it is about how people think of their lives and what they consider to be important. ED DIENER & ROBERT BISWAS-DIENER, HAPPINESS 4 (2008).

203. *See* Lenore S. Radloff, *The CES-D Scale: A Self-Report Depression Scale for Research in the General Population*, 1 APPLIED PSYCHOL. MEASUREMENT 385 (1977).

204. *See* Beck & Burns, *supra* note 95.

205. Diener et al., *supra* note 78, at 71.

206. Seligman et al., *supra* note 29, at 414.

207. SONJA LYUBOMIRSKY, THE HOW OF HAPPINESS 32 (2007).

208. Seligman and his colleagues describe these components respectively as 1) pursuing or maximizing frequent positive feelings, 2) being engaged in the activities of life, and 3) finding meaning in life or cultivating a meaningful life. Christopher Peterson, Nansook Park & Martin E.P. Seligman, *Orientations to Happiness and Life Satisfaction: The Full Life Versus the Empty Life*, 6

of these three contributes to life satisfaction, but that the happiest people are those who experience all three together (thereby living what Peterson calls the "Full Life").[209]

In measuring the happiness of individuals, positive psychologists have made a number of interesting findings. For instance, positive emotions are not just psychological effects: they also can be significant causal factors in behavioral outcomes.[210] Psychologists Lyubomirsky, King, and Diener have discovered that happy workers are more productive than unhappy workers; they also perform better in managerial positions, produce higher sales, and receive better job evaluations and higher pay.[211] While causation goes both ways—people can be happy because they receive higher pay—longitudinal studies have found happiness to be a significant causal factor of these positive outcomes. For instance, one study measured positive emotion in 272 employees and then followed their job performance for eighteen months. Those who were happier at the beginning went on to receive better evaluations and higher pay eighteen months later, even after controlling for other factors.[212] Another study found that individuals who were happy as college freshmen went on to earn higher salaries sixteen years later, despite having no initial wealth advantage.[213] Other studies that induce happiness in the laboratory and then look at subsequent performance show that children put into a good mood choose higher goals for themselves and perform better on cognitive tasks.[214] In sum, happiness is not just a feeling that results from good events; it can also be an important part of why good events occur in the first place.

Psychologists have also discovered that, in addition to playing a causal role in behavioral outcomes, a preponderance of positive emotions can actually lead to greater physical well-being. One team of researchers exposed groups of happy,

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J. HAPPINESS STUD. 25, 25-27 (2005).

209. *Id.* at 35. In their definitions of happiness, positive psychologists often refer to the Greek term "eudaimonia," which Aristotle described as the highest good. Though directly translated as "happiness," eudaimonia can be more accurately defined as "human flourishing." It conveys not just pleasurable feelings ("hedonia") but the deeper experience of living in accordance with one's virtues. So while positive psychologists recognize that pleasure is an important part of happiness, research confirms that people who pursue meaning, or goals more eudaimonic in nature, are more satisfied with life than those who pursue only pleasure. *See* PETERSON, *supra* note 191, at 78-79.

210. *See, e.g.*, Sonja Lyubomirsky, Laura A. King & Ed Diener, *The Benefits of Frequent Positive Affect: Does Happiness Lead to Success?*, 131 PSYCHOL. BULL. 803, 846 (2005).

211. *Id.* at 822-23.

212. Barry M. Staw, Robert I. Sutton & Lisa H. Pelled, *Employee Positive Emotion and Favorable Outcomes at the Workplace*, 5 ORG. SCI. 51, 61 (1994).

213. Ed Diener et al., *Dispositional Affect and Job Outcomes*, 59 SOC. INDICATORS RES. 229 (2002).

214. *E.g.*, Harry L. Hom, Jr. & Barry Arbuckle, *Mood Induction Effects upon Goal Setting and Performance in Young Children*, 12 MOTIVATION & EMOTION 113, 119 (1988).

neutral, and unhappy people to a strain of the cold virus and then kept them isolated for a week to avoid any confounding distractions. Amazingly, the happier individuals were better able to fight off the virus. They reported fewer symptoms like sneezing and congestion, and they also had fewer objective signs of illness as measured by doctors.[215]

Researchers have made remarkable findings on the relationship between health and happiness by examining groups of people outside of the laboratory as well. One study examined autobiographical journal entries written by Catholic nuns while they were in their early twenties. The researchers found that the nuns whose autobiographies contained evidence of more positive emotions lived longer than the nuns whose autobiographies contained more negative or neutral content.[216] Indeed, 90% of the most cheerful quartile of nuns were alive at age eighty-five compared to only 34% of the least cheerful quartile.[217] Another study on the health effects of happiness followed 2282 Mexican-Americans aged sixty-five and older over the course of two years. Researchers found that those who experienced more positive emotions lived longer and suffered from less disability. "After controlling for age, income, education, weight, smoking, drinking, and disease, the researchers found that happy people were half as likely to die, and half as likely to become disabled."[218] Positive emotions do not just improve the quality of life, they can expand the length of it as well.

While the first two foundations of positive psychology—positive character traits and positive emotions—have spawned thousands of research studies over the years, the third foundation—positive institutions—has so far garnered less empirical attention. Here, even positive psychology's advocates acknowledge that the work has barely begun.[219] This third foundation is premised on the idea

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215. Sheldon Cohen et al., *Emotional Style and Susceptibility to the Common Cold*, 65 PSYCHOSOMATIC MED. 652, 655 (2003).

216. Deborah D. Danner, David A. Snowdon & Wallace V. Friesen, *Positive Emotions in Early Life and Longevity: Findings from the Nun Study*, 80 J. PERSONALITY & SOC. PSYCHOL. 804, 808-09 (2001).

217. SELIGMAN, *supra* note 1, at 4. The longitudinal nature of this study helps answer the question about causation that so often arises in correlational studies: the fact that the nuns' emotional expression at age twenty-two predicted their physical health six decades years later suggests that positive emotions are the causal factor in this relationship and makes a strong case against health as the causal factor. Indeed, after years of medical research on the physical effects of negative emotions like stress and anger, coupled with these more recent studies on positive emotions, most doctors and psychologists now accept, as the authors of the Nun Study explain, "the knowledge that there are universal, patterned emotional responses that affect physiology in ways that are potentially damaging or beneficial." Danner et al., *supra* note 216, at 804.

218. SELIGMAN, *supra* note 1, at 40. A preponderance of similar studies has led Seligman to conclude that there is now an "unambiguous picture of happiness as a prolonger of life and improver of health." *Id.*

219. Gable & Haidt, *supra* note 27, at 108.

that there are certain institutions, communities, and groups that foster human flourishing.[220] Just as emotions can be negative, neutral, or positive, so can families, churches, businesses, and national governments. What are the components of positive institutions, and what are the mechanisms behind their success? How do certain companies get the very best out of their employees, and why do some schools have happier students than others? Researchers are only beginning to answer these questions. One of the purposes of this Article is to explore further what a law school can do to become a positive institution—one that not only educates its students but also makes an active effort to preserve, if not actively improve, its students' personal well-being.

Thus far, we have discussed how positive psychology investigates and explains well-being. The next question is whether or not a person's level of well-being can be meaningfully improved and how that change can come about. Fortunately, decades of research on the inheritance of happiness have revealed a general consensus among psychologists that while 50% of our happiness is genetically predetermined and 10% is based on external circumstances, up to 40% is within our control and can be altered through intentional activities.[221] Positive psychologists encourage individuals to take advantage of this discovery by participating in exercises, or "interventions," that are designed to increase happiness and decrease depressive symptoms. Two simple, but empirically well-tested, examples will serve to illustrate.

Exercise Number 1: Using Signature Strengths in a New Way. Signature strengths are those character strengths from the VIA that are most strongly present in a particular individual. Psychologists have created a survey instrument to help individuals identify their top five strengths.[222] As tested by Seligman et

220. SELIGMAN, *supra* note 1, at xiii.

221. *See* Sonja Lyubomirsky, Kennon M. Sheldon & David Schkade, *Pursuing Happiness: The Architecture of Sustainable Change*, 9 REV. GEN. PSYCHOL. 111, 116 (2005). Evidence for an inherited happiness "set-point" can be found in Lykken and Tellgen's 1996 study on identical twins. The authors concluded that because of the strong genetic influence on happiness (their research put it at nearly 80%), "trying to be happier is as futile as trying to be taller." David Lykken & Auke Tellegen, *Happiness Is a Stochastic Phenomenon*, 7 PSYCHOL. SCI. 186, 189 (1996). however, enough opposing research emerged over subsequent years that in 2000 Lykken officially retracted that statement and allowed that individuals can in fact change their level of happiness. DAVID LYKKEN, HAPPINESS: THE NATURE AND NURTURE OF JOY AND CONTENTMENT 3 (2000). Common scientific opinion today holds that an individual's level of happiness is represented by the following equation: Happiness = genetic set-point (50%) + life circumstances (10%) + volitional activity (40%). *See, e.g.*, LYUBOMIRSKY, *supra* note 207, at 20-22; Lyubomirsky et al., *supra*, at 116.

222. *See* University of Pennsylvania Authentic Happiness, Authentic Happiness Research Projects Seeking Participants, http://www.authentichappiness.sas.upenn.edu/resources.aspx (last visited Apr. 25, 2009) (noting that the Positive Psychology Center is seeking participants for online research studies and offering the VIA Signature Strengths Questionnaire, among other assessments,

al., this exercise requires participants to take this inventory and utilize one of their top five strengths in a new and different way every day for one week.[223] In a randomized controlled study of 577 adult participants, researchers found that individuals who completed this exercise for one week were significantly happier and less depressed than those utilizing a placebo exercise. Moreover, the benefits of the intervention are enduring; they appeared at the one-month follow-up and continued for the three-month and six-month follow-ups.[224]

Exercise Number 2: Practicing Gratitude. This intervention requires that individuals write down a short list of things they are grateful for every day or every week.[225] In the first set of studies on this exercise, a group of participants wrote down five things they were grateful for once a week for ten weeks in a row. [226] At the end of the study, compared to control groups who wrote about negative or neutral topics each week, the gratitude groups were happier, more optimistic, and even reported fewer physical problems (such as headaches).[227] Further studies on individuals with chronic illnesses revealed that, on days when they wrote down what they were grateful for, they experienced increased positive emotions (including feelings of joy, excitement, and pride), they felt more connected to other people, and their quality of sleep improved.[228] In yet another study, participants who wrote down three good things each day for a week were happier and less depressed than the control group (who performed a placebo exercise) at the one-month, three-month, and six-month follow-ups. As with the signature strength exercise, participants were even more likely to remain happier the longer they continued the exercise.[229]

These examples are small but significant indications of the power of positive psychology. That such seemingly simple exercises can result in measurable and statistically significant increases in happiness and decreases in depression says much about our ability to change our own well-being through intentional activities. Interventions such as these could provide the basis for a positive psychology program for law students that could help to create a buffer against the

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for individuals who register with the website).

223. Seligman et al., *supra* note 29, at 415-16.

224. *Id.* at 418-19.

225. These items need not be profound or complicated, but they should be specific. In one of the gratitude studies that produced significant happiness benefits, typical items recorded by participants included "mom," "a healthy body," and "AOL instant messenger." LYUBOMIRSKY, *supra* note 207, at 91.

226. Robert A. Emmons & Michael E. McCullough, *Counting Blessings Versus Burdens: An Experimental Investigation of Gratitude and Subjective Well-Being in Daily Life*, 84 J. PERSONALITY & SOC. PSYCHOL. 377 (2003).

227. *Id.* (discussing the results of three randomized controlled trials).

228. ROBERT A. EMMONS, THANKS! HOW THE NEW SCIENCE OF GRATITUDE CAN MAKE YOU HAPPIER 32-33 (2007).

229. Seligman et al., *supra* note 29, at 418-19.

stress and depression associated with law school study.

B. Using Positive Psychology To Help Improve Law Student Well-Being

Although it is easy to describe the basic principles of positive psychology, it is considerably more difficult to develop a program to improve the lives of law students and help prevent stress and depression. Nevertheless, we have several suggestions to help administrators, faculty, and students begin to think about how they might utilize this powerful new research. All of these suggestions require the development of a proactive program of positive psychology interventions as part of an integrated plan to reach law students at the very beginning of their law school experience. The goal of the plan would be to develop in students habits and routines that will help them cope with any possible cause of stress and depression in law school, be it the stress of large-class Socratic teaching or the disappointment that 90% of the class will feel about not being in the top 10%. Moreover, as the research on the benefits of happiness has borne out, a positive psychology program would not simply diminish the incidence of depression in law students' lives but also help them cultivate the positive emotions and skills necessary to foster optimal performance and improve physical well-being.

1. Learned Optimism and the Emotional Paradox of Legal Education

More than three decades of scientific research have revealed that optimism is one of the most powerful predictors of both happiness and depression. While optimism is typically defined as a positive expectation about the future—a belief that good things will happen[230]—researchers in the field focus not only on the target of people's optimism ("My exam will go well next week") but also on how they believe they will reach that target ("I have faith in my ability to perform well under pressure").[231] As it turns out, people who have these beliefs

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230. Charles S. Carver & Michael F. Scheier, *Optimism*, *in* HANDBOOK OF POSITIVE PSYCHOLOGY, *supra* note 182, at 231, 231.

231. *See, e.g.*, *id.* at 232; C.R. Snyder, Kevin L. Rand & David R. Sigmon, *Hope Theory: A Member of the Psychology Family*, *in* HANDBOOK OF POSITIVE PSYCHOLOGY, *supra* note 182, at 257, 258. Psychologists often separate the concepts of optimism, optimistic explanatory style, and hope in theoretical discussions, but they are similar enough for our purposes here that we cite research from both lines of inquiry. However, it *is* important to distinguish between optimism and self-esteem. As Martin Seligman notes, "self-esteem is just a meter that reads out the state of the system. It is not an end in itself. When you are doing well in school or work, when you are doing well with the people you love, when you are doing well in play, the meter will register high. When you are doing badly, it will register low." MARTIN E.P. SELIGMAN, LEARNED OPTIMISM, at vi–vii (1998); *cf.* Roy F. Baumeister, Laura Smart & Joseph M. Boden, *Relation of Threatened Egotism to Violence and Aggression: The Dark Side of High Self-Esteem*, 103 PSYCHOL. REV. 5 (1996) (presenting a fascinating study of the literature describing genocidal killers, hit men, and gang

experience a whole host of mental, emotional, and behavioral advantages. For instance, optimists set a greater number of goals, and more difficult goals, than pessimists do, and they invest more effort in attaining these goals.[232] Optimists are also more likely to stay engaged in the face of difficulty[233] and persist when encountering obstacles.[234] In this way, optimism is often self-fulfilling. Optimists also cope better in high stress situations[235] and are able to maintain high levels of well-being during times of hardship.[236] Even physical health is affected by optimism: one study found that individuals who were optimistic after undergoing coronary bypass surgery had a higher quality of life six months later.[237] Another study found that optimistic thinking as a young adult accurately predicted good health thirty-five years later.[238]

Some of the most important optimism studies in the field of psychology have been conducted on what researchers call an individual's personal explanatory style, or "the habitual way an individual explains the causes of events."[239] Someone with an optimistic explanatory style sees negative events as local and short-lived ("It's not that bad, and it will get better"), while someone with a pessimistic explanatory style sees them as more pervasive and permanent ("It's really bad, and it's going to stay that way"). Through a series of landmark studies

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leaders and arguing that it is the unwarranted high self-esteem of such persons that causes their violence).

232. *See, e.g.*, C.R. Snyder et al., *The Will and the Ways: Development and Validation of an Individual-Differences Measure of Hope*, 60 J. PERSONALITY & SOC. PSYCHOL. 570, 577-81 (1991).

233. *See, e.g.*, Carver & Scheier, *supra* note 230, at 235; Suzanne C. Segerstrom, *Optimism, Goal Conflict, and Stressor-Related Immune Change*, 24 J. BEHAV. MED. 441, 453 (2001).

234. *See, e.g.*, SELIGMAN, *supra* note 231, at 102; Carver & Scheier, *supra* note 230, at 237.

235. *See, e.g.*, Carver & Scheier, *supra* note 230, at 235-39; Lise Solberg Nes & Suzanne C. Segerstrom, *Dispositional Optimism and Coping: A Meta-Analytic Review*, 10 PERSONALITY & SOC. PSYCHOL. REV. 235, 244-45 (2006); Michael F. Scheier, Jagdish Kumari Weintraub & Charles S. Carver, *Coping with Stress: Divergent Strategies of Optimists and Pessimists*, 51 J. PERSONALITY & SOC. PSYCHOL. 1257, 1263 (1986).

236. *See, e.g.*, Michael F. Scheier & Charles S. Carver, *On the Power of Positive Thinking: The Benefits of Being Optimistic*, 2 CURRENT DIRECTIONS PSYCHOL. SCI. 26, 27 (1993).

237. Michael F. Scheier et al., *Dispositional Optimism and Recovery from Coronary Artery Bypass Surgery: The Beneficial Effects on Physical and Psychological Well-Being*, 57 J. PERSONALITY & SOC. PSYCHOL. 1024 (1989).

238. Christopher Peterson, Martin E.P. Seligman & George Vaillant, *Pessimistic Explanatory Style Is a Risk Factor for Physical Illness: A Thirty-Five Year Longitudinal Study*, 55 J. PERSONALITY & SOC. PSYCHOL. 23 (1988).

239. Satterfield et al., *supra* note 21, at 95. As explained above, psychologists differ slightly in their conceptions of optimism, which makes optimism more of an umbrella term for these different strands of research. Explanatory style is one such strand, and for our purposes here we can use the terms optimism and optimistic explanatory style interchangeably. *See supra* note 231. For a detailed description of how these theories converge and diverge, see Carver & Scheier, *supra* note 230, at 232-33.

in the 1970s and 1980s, Martin Seligman and his fellow researchers discovered that utilizing a pessimistic explanatory style was a significant cause of depression and learned helplessness.[240] Conversely, they found that using an optimistic explanatory style is an accurate predictor of happiness, resilience, high motivation, and job success.[241] From insurance salesmen to collegiate athletes, individuals with an optimistic explanatory style perform better than their pessimistic counterparts and often exceed the expectations that their sheer abilities predict.[242] More significantly for our purposes here, researchers have found that an optimistic explanatory style also predicts academic achievement.[243] Rigorously controlled studies have shown that students who are evaluated as having an optimistic explanatory style have a higher grade point average in school, even when controlling for SAT scores and depression.[244] This holds true even at the U.S. Military Academy: Plebes who are optimistic upon entry are not only more likely to make it through the rigors of the first year, but they also perform better academically than their SATs predict; the pessimists, in contrast, perform worse than their SATs predict and are more likely to drop out.[245]

The findings on optimism are particularly impressive because they are not merely correlational; Seligman and his colleagues found that they could teach individuals to be more optimistic, and in so doing, they could actively bring about these positive outcomes.[246] In one such example, psychologists ran a twelve-week optimism training program for fifth and sixth graders. The children who were taught to adopt a more optimistic explanatory style reported fewer symptoms of depression than a control group, and remained less depressed for

240. Satterfield et al., *supra* note 21, at 95; *see also* Christopher Peterson & Martin E.P. Seligman, *Causal Explanations as a Risk Factor for Depression: Theory and Evidence*, 91 PSYCHOL. REV. 347, 369 (1984); Christopher Peterson & Lisa C. Barrett, *Explanatory Style and Academic Performance Among University Freshmen*, 53 J. PERSONALITY & SOC. PSYCHOL. 603 (1987).

241. Satterfield et al., *supra* note 21; *see also* EXPLANATORY STYLE (Gregory McClell Buchanan & Martin E.P. Seligman eds., 1995); Susan Nolen-Hoeksema, Joan Girgus & Martin E.P. Seligman, *Learned Helplessness in Children: A Longitudinal Study of Depression, Achievement, and Explanatory Style*, 51 J. PERSONALITY & SOC. PSYCHOL. 435 (1986); Peterson & Barrett, *supra* note 240, at 603; Jason M. Satterfield & Martin E.P. Seligman, *Military Aggression and Risk Predicted by Explanatory Style*, 5 PSYCHOL. SCI. 77 (1994); Scheier et al., *supra* note 237.

242. For the study on insurance agents at Met Life, see Martin E.P. Seligman & Peter Schulman, *Explanatory Style as a Predictor of Productivity and Quitting Among Life Insurance Agents*, 50 J. PERSONALITY & SOC. PSYCHOL. 832 (1986). For the study on collegiate athletes, see Martin E.P. Seligman et al., *Explanatory Style as a Mechanism of Disappointing Athletic Performance*, 1 PSYCHOL. SCI. 143 (1990).

243. Satterfield et al., *supra* note 21, at 96.

244. *Id.*; *see* SELIGMAN, *supra* note 231, at 150-54; Peterson & Barrett, *supra* note 240, at 603.

245. SELIGMAN, *supra* note 231, at 152-53.

246. *See, e.g.*, *id.* at 207-34.

two years after the program ended.[247] As Seligman explained,

> pessimism is escapable. Pessimists can in fact learn to be optimists, and not through mindless devices like whistling a happy tune or mouthing platitudes ("Every day, in every way, I'm getting better and better"), but by learning a new set of cognitive skills. Far from being the creations of boosters or of the popular media, these skills were discovered in the laboratories and clinics of leading psychologists and psychiatrists and then rigorously validated.[248]

If an optimistic explanatory style can improve both subjective well-being and academic performance, and if optimism can be learned by students, this suggests a prescription for improving both the quality of life and academic performance of law students. But there is a catch, and that is what we term the emotional paradox of law school education. In all of the studies conducted by psychologists on the impact of explanatory style on academic performance, the only academic setting in which a pessimistic explanatory style has been associated with improved academic performance is law school.

In 1997, researchers published a study of students at the University of Virginia Law School in which they attempted to correlate explanatory style with law school academic success.[249] Students were given the usual survey instrument to assess explanatory style at the start of their first semester of law school. The researchers obtained an exceptionally high response rate of 97% (n = 387).[250] Academic performance was measured by law school grade point average, class participation ratings, participation in legal assistance programs, moot court performance, and law journal membership.[251] The researchers also gathered information on the "admissions index" (comprised of the LSAT score and undergraduate GPA) assigned by the University of Virginia Law School during the admissions process, and they used this index "to partial out the effect of prior ability on law school performance."[252] The results of the study surprised the researchers: "Explanatory style scores significantly predicted GPA paradoxically showing more pessimism related to higher achievement . . . . [S]tudents scoring in the pessimistic and midrange of explanatory style significantly outperformed optimistic students."[253] Explanatory style was not predictive for other success measures including moot court performance, law review membership,

247. Jane E. Gillham & Karen J. Reivich, *Prevention of Depressive Symptoms in Schoolchildren: A Research Update*, 10 PSYCHOL. SCI. 461 (1999).

248. SELIGMAN, *supra* note 231, at 5.

249. Satterfield et al., *supra* note 21.

250. *Id.* at 96.

251. *Id.* at 97.

252. *Id.*

253. *Id.* at 98.

community involvement, and classroom participation. [254]

So, how does one explain the results of the study? The researchers suggested that a form of prudence or an analytical approach peculiar to the law might explain the apparent paradox. They hypothesized:

> Perhaps under the more rigorous demands and specific intellectual requirements of law school, diligent students who develop a sense of healthy skepticism are the highest achievers. In fact, careful attention to detail, considering all sides of an argument, seeing all potential pitfalls or catastrophes, attention to precedent rather than saltatory creativity, and thoroughness are typically seen as important traits for the successful lawyer.[255]

This conclusion may be supported by the link the researchers found between explanatory style and success on the LSAT. In their study, higher degrees of pessimism and non-optimism were strongly correlated with higher scores on the LSAT. Thus, the researchers speculated that "[p]erhaps optimism or non-pessimism is positively related to more general forms of academic achievement (e.g. SAT and UGPA) but is contraindicated for more quantitative, logical tasks (e.g. LSAT, law school)."[256]

This study poses some difficult and troubling questions for law schools. It complicates the use of positive psychology techniques for learned optimism as a solution to stress and depression in law school because it at least suggests the possibility that by teaching optimism in order to insulate against depression, we could be adversely affecting the legal analytical development of law students. Thus, it is important to examine the link between a pessimistic explanatory style and success in law school in order to determine whether a more optimistic approach could be taught without affecting the learning and development of necessary legal analytical abilities.

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254. *Id.*

255. *Id.* at 103.

256. *Id.* The researchers also looked at the other side of the equation, that pessimistic law students might be more subject to depression than would be suggested by the previous studies on explanatory style. Initially, the researchers noted that the pessimistic law students "might appear more prudent or cautious instead of helpless because other abilities or circumstances have attenuated or minimized the depressogenic effects of a pessimistic explanatory style. Perhaps talent, financial security, successful undergraduate experiences, or interpersonal skills have helped compensate for what might otherwise predispose them to depression and disempowerment." *Id.* at 103-04. The researchers did acknowledge that they could not rule out the possibility that law school pessimists were at a greater risk for depression since the study did not include any measures of depression, and they had no follow-up data. They concluded that only additional research would answer that question. *Id.* at 104. Based on the research discussed earlier in this article, it seems clear that, although we cannot directly attribute the depression to a pessimistic explanatory style, law students clearly suffer elevated levels of stress and depression.

The Virginia study's authors could be correct that there is a connection between a pessimistic explanatory style and the analytical approach that is taught and valued in law schools, but the concept of "prudence" does not precisely capture what that connection might be. Prudence is certainly a trait that is valued in the legal profession. Indeed, as one of the study's authors noted in a later article:

> Prudence enables a good lawyer to see snares and catastrophes that might conceivably occur in any given transaction. The ability to anticipate a whole range of problems that non-lawyers do not see is highly adaptive for the practicing lawyer. Indeed clients would be less effectively served if lawyers did not so behave, even though this ability to question occasionally leads to lawyers being labeled as deal breakers or obstructionists.[257]

Although this statement certainly seems correct with respect to lawyers, it does not apply to how most law students are graded in law school. For better or for worse, law students are not graded on the kinds of tasks that require lawyers to exercise the kind of prudence described by Seligman.

As the study authors recognize, law school testing focuses on the ability to analyze a complex fact situation in light of difficult legal principles, requiring students to assess a problem from all angles and see many perspectives.[258] This is different, however, from the prudence Seligman describes because it is not so much foreseeing problems that might occur in the future and planning for those problems, but rather identifying problems with legal arguments and developing a critical approach to analyzing legal issues. Law schools teach students to look for flaws in arguments, and they train them to be critical rather than accepting. This ability is a crucial skill for lawyers in practice, but, if applied to one's personal life, may have significant negative consequences. Training in critical analysis may lead students to apply the same critical approach to their own life and the problems that they encounter in personal relationships. That may lead students to overestimate the significance and permanence of the problems they encounter, which is precisely the kind of pessimistic explanatory style that leads to stress and depression.

In addition to the critical analytical style that is taught and rewarded in law school, there are other reasons why pessimistic law students may do better. The

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257. Seligman et al., *supra* note 3, at 56.

258. One truly disconcerting possibility, not mentioned by the study's authors, is that law professors may teach students to adopt a pessimistic explanatory style. If optimism can be learned, it stands to reason that pessimism can be learned as well. If we teach what we test on, and both the material that we teach and test rewards a pessimistic explanatory style, we may in effect be teaching our students to adopt a depressogenic perspective on life. If true, it is all the more reason to develop a program to help buffer students against stress and depression while they learn the legal analytical style in class.

use of the Socratic method in law schools and the goal of teaching analytical skills in class rather than simply imparting information put a unique emphasis upon extensive class preparation. In a class in which the goal is primarily to impart information, the students' level of preparation has relatively little impact on the ability of the student to learn what is necessary in class. In a Socratic classroom, however, a student who is unprepared on the day's material is unlikely to learn much from the Socratic dialogue going on in class. Pessimistic law students are likely to be more worried about being called upon in a Socratic classroom and, therefore, may tend to prepare more for class than their more optimistic compatriots. That extra preparation, and the benefit it confers in acquiring the analytical methods being taught in class, may be what gives pessimistic law students an edge on the exam.

Whatever the precise nature of the link between explanatory style and law school performance, the emotional paradox of legal education may provide an opportunity for important emotional training that will benefit law students not only while they are in law school, but in their life after law school as well. It is a truism in the legal world that lawyers have a hard time turning off their legal skills when they come home from work. Most litigators have had the experience of being told that they were "deposing" their children as they asked them about their day around the dinner table. Personal disputes and interactions do not go well when carried out with lawyerly analytical precision. Law students find out quickly that their relationships with people outside of law school suffer when they identify a tort or a breach of contract in every interaction.[259] The beginning of law school is the time to help budding lawyers sort out the difference between the skills that are useful in their legal career and the skills that will enhance their personal lives and improve their relationships.

In short, if academic success in law school does indeed require a more critical and pessimistic approach in the classroom, and if pessimism used outside the classroom is a leading cause of depression, then law students seem to be at a significant disadvantage when it comes to avoiding depression. Of course, these conclusions are based upon only one study at one law school. It is possible that additional studies may produce different results, so the subject is surely worthy of further empirical research. The Virginia study was sufficiently rigorous such that we should pay attention to its results. The findings make it clear that the use of optimism-building exercises as a means of warding off law student depression is not contra-indicated, but doubly necessary. Students need to learn how to separate the skills they use in their professional and private lives so that the pessimism necessary for academic success does not bleed into everything else.[260]

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259. *See* Iijima, *supra* note 15, at 528.

260. It is well documented that people can develop flexible optimism—the ability to be pessimistic in professional life and optimistic in private life—through training. SELIGMAN, *supra* note 1, at 181.

Optimism training would give these students a crucial set of tools to cultivate happiness outside of the classroom.

2. The Broaden-and-Build Theory of Positive Emotions

Barbara Fredrickson of the University of North Carolina has developed a theory about the impact of positive emotions that could be of significant help in designing a program to help law students resist stress and depression. Her approach, which she calls the "broaden-and-build theory," suggests that positive emotions are more than indicators that a person is flourishing; positive emotions can also create mental health and well-being.[261] Fredrickson's theory begins with the idea that positive emotions have different characteristics and functions than negative emotions. Prior to Fredrickson's work, psychologists had developed a general theory of the development of emotions that emphasized that emotions are associated with a tendency to act in a particular way.[262] Psychologists theorized that this tendency is the result of natural selection in which emotions have prompted certain actions that have a specific benefit in preserving a person's life (such as fear prompting immediate flight).[263] Fredrickson argues, however, that although this model may be appropriate for negative emotions, it does not adequately account for positive emotions.[264]

While negative emotions narrowly focus the mind and direct the body to a very specific action, positive emotions broaden a person's possibilities for thought and action.[265] For instance, Fredrickson's studies show that individuals who have been primed to feel a positive emotion (either amusement or contentment) are better able to conceive of a diverse array of immediate actions than individuals who have been primed to feel either of two negative emotions (anxiety or anger).[266] Other studies have confirmed that individuals experiencing positive emotions such as enjoyment and amusement exhibit more creativity and better cognitive organization than individuals experiencing negative emotions like sadness, anger, or anxiety.[267] For instance, four-year-old children who are

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261. Barbara L. Fredrickson, *What Good Are Positive Emotions?*, 2 REV. GEN. PSYCHOL. 300, 307 (1998).

262. *See, e.g.*, NICO H. FRIJDA, THE EMOTIONS (1986); RICHARD S. LAZARUS, EMOTION AND ADAPTATION (1991); Robert W. Levenson, *Human Emotion: A Functional View*, *in* THE NATURE OF EMOTION 123 (Paul Ekman & Richard J. Davidson eds., 1994).

263. Fredrickson, *supra* note 261, at 302.

264. *Id.* at 302-03.

265. *Id.* at 307. Fredrickson lists the ten positive emotions that are typically used in this type of research: "joy, gratitude, serenity, interest, hope, pride, amusement, inspiration, awe, and love." BARBARA L. FREDRICKSON, POSITIVITY 39 (2009).

266. Barbara L. Fredrickson & Christine Branigan, *Positive Emotions Broaden the Scope of Attention and Thought-Action Repertoires*, 19 COGNITION & EMOTION 313 (2005).

267. For a full review, see FREDRICKSON, *supra* note 265.

told to think of a happy memory are better able to complete learning tasks than children who are given neutral instructions.[268] Elementary school students who are told to think about something happy before taking a standardized math test outperform their peers.[269] And MBA students who are primed to feel positive emotions before taking part in a business negotiation secure more concessions and close the deal more successfully than their negative and neutral counterparts.[270] Because of the broadening effect of positive emotions, individuals are able to depart from habitual responses to problems and analyze complex issues to arrive at new and creative solutions.[271]

In one of the simplest, and yet most powerful, studies on this broadening effect of positive emotions, researchers divided a sample of forty-four expert doctors into three groups, all of whom were asked to make a difficult diagnosis.[272] Before performing the diagnosis task, one group was given a gift of candy (to induce positive emotion), one was given statements to read related to humanistic medicine, and one was a control group. (It should be noted that no doctor actually ate the candy, so the results can be attributed to the positive emotion caused by receiving a gift, not from raised blood sugar.) The goal of the study was not only to see how fast they performed the diagnosis, but also how flexible they were in their thinking, because diagnosis errors often result from an inflexibility called "anchoring."[273]

The results of the study were remarkable. The doctors in the positive emotion group were both more efficient with their diagnosis and showed the least "anchoring" in their thinking. Specifically, doctors in the positive emotion group gave the correct diagnosis about twice as fast and showed over 60% less anchoring (i.e., more intellectual flexibility) than the other two groups.[274] This

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268. John C. Masters, R. Christopher Barden & Martin E. Ford, *Affective States, Expressive Behavior, and Learning in Children*, 37 J. PERSONALITY & SOC. PSYCHOL. 380, 380–90 (1979).

269. Tanis Bryan & James Bryan, *Positive Mood and Math Performance*, 24 J. LEARNING DISABILITIES 490, 491-92 (1991).

270. Shirli Kopelman, Ashleigh Shelby Rosette & Leigh Thompson, *The Three Faces of Eve: Strategic Displays of Positive, Negative, and Neutral Emotions in Negotiations*, 99 ORGANIZATIONAL BEHAV. & HUM. DECISION PROCESSES 81, 88-92 (2006).

271. Fredrickson, *supra* note 261.

272. Carlos A. Estrada, Alice M. Isen & Mark J. Young, *Positive Affect Facilitates Integration of Information and Decreases Anchoring in Reasoning Among Physicians*, 72 ORGANIZATIONAL BEHAV. & HUM. DECISION PROCESSES 117 (1997).

273. *Id.* at 119. Anchoring is the tendency to latch on to the first available data and refuse to consider subsequent data that might alter the diagnosis. When a doctor remains wedded to an original theory even in the face of new information, he runs a much higher risk of misdiagnosis. *Id.*

274. *Id.* at 126-27. The positive emotion group gave the correct hypothesis 20% of the way through their transcript, as opposed to 39% for the control and 36% for the statements group. The positive emotion group received an average anchoring rating of 1.5, versus 3.9 in the control and 3.7 in the statements group. *Id.*

study is one of many to show that an influx of positive emotion (whether induced by receiving a small gift, reading positive words, or watching a humorous video) markedly improves decision-making and cognitive flexibility.[275] As the authors point out, there are some important implications: first, that "seemingly mild or small affect interventions" can induce enough positive emotion in people to create a cognitive advantage, and second, that "teaching environments that are pleasant and supportive" might lead not only to happier individuals, but also to individuals capable of greater creativity and insight.[276]

In addition to the broadening effect, positive emotions build a person's intellectual, emotional, and physical resilience. One way they do this is by correcting the damage caused by negative emotions, what Fredrickson terms "the undoing effect."[277] To test this theory, Fredrickson and her colleagues conducted an experiment in which participants were asked to prepare a difficult time-pressured speech. The participants were told that the speech might be videotaped and evaluated by their peers.[278] The subjects, when faced with this task, experienced anxiety and measurable increases in heart rate, peripheral vasoconstriction, and blood pressure. The researchers then randomly assigned the participants to view one of four different films. Two of the films were designed to provoke the positive emotions of joy and contentment, one was emotionally neutral, and the fourth was designed to induce sadness. Fredrickson's hypothesis was that the participants who viewed the films designed to induce positive emotions would experience a faster recovery from the speech-induced negative physical effects. In three separate and independent samples, the subjects who reviewed the films associated with positive emotions did in fact experience a more rapid recovery than the subjects who viewed the emotionally neutral film, and the subjects who viewed the sadness-inducing film recovered least quickly of all the participants.[279] Fredrickson concluded that although the mechanisms behind the undoing effect are still unknown, positive emotions are clearly powerful enough to mediate "undoing at the cardiovascular level."[280] In other

275. *See* Peter J.D. Carnevale & Alice M. Isen, *The Influence of Positive Affect and Visual Access on the Discovery of Integrative Solutions in Bilateral Negotiation*, 37 ORGANIZATIONAL BEHAV. & HUM. DECISION PROCESSES 1 (1986); Fredrickson & Branigan, *supra* note 266; Alice M. Isen, Kimberly A. Daubman & Gary P. Nowicki, *Positive Affect Facilitates Creative Problem Solving*, 52 J. PERSONALITY & SOC. PSYCHOL. 1122 (1987); Alice M. Isen & Barbara Means, *The Influence of Positive Affect on Decision-Making Strategy*, 2 SOC. COGNITION 18 (1983); G. Rowe, J.B. Hirsh & A.K. Anderson, *Positive Affect Increases the Breadth of Attentional Selection*, 104 PROC. NAT'L ACAD. SCI. 383 (2007).

276. Estrada et al., *supra* note 272, at 132.

277. *See* Barbara L. Fredrickson et al., *The Undoing Effect of Positive Emotions*, 24 MOTIVATION & EMOTION 237 (2000).

278. *Id.* at 243.

279. *Id.* at 245-49.

280. Barbara L. Fredrickson, *The Role of Positive Emotions in Positive Psychology*, 56 AM.

words, an influx of positive emotions not only broadens at the cognitive level but also acts to reduce stress and anxiety at the physical level.

This experiment resonates particularly powerfully in the law school context. Some law student stress and anxiety results from the prospect of having to speak and respond to questions in the large classroom context. Law students seem to experience precisely the same symptoms as the participants in Fredrickson's study from essentially the same cause (public-speaking anxiety). If positive emotions helped the subjects of Fredrickson's study to recover from the stressful event more quickly, positive emotions might accomplish a similar ameliorating effect for law students. As Fredrickson concluded, "Evidence for the undoing effect of positive emotions suggests that people might improve their psychological well-being, and perhaps also their physical health, by cultivating experiences of positive emotions at opportune moments to cope with negative emotions."[281] Positive emotions thus contribute to psychological resilience, the ability to "bounce back from stressful experiences quickly and efficiently, just as resilient metals bend but do not break."[282]

Because positive emotions are durable, they build resources that long outlast the feelings themselves; this provides continuing strength to overcome future obstacles and often creates an upward spiral of positive well-being.[283] Psychologists have long been familiar with the kind of downward spiral in which negative emotions and a pessimistic outlook can build on themselves and lead to depression.[284] Based upon the initial research on positive emotions,

> the broaden-and-build theory predicts a comparable spiral in which positive emotions and the broadened thinking they engender also influence one another reciprocally, leading to appreciable increases in emotional well-being over time. Positive emotions may trigger these upward spirals, in part by building resilience and influencing the way people cope with adversity.[285]

In fact, that is precisely what empirical research has revealed: an increase in positive emotions leads to enhanced coping skills, which in turn predicts more positive emotions.[286] In one study, Fredrickson tested individuals on their level of positive emotion and then tracked their ability to practice "broad-minded coping," that is, their ability to see multiple solutions to a problem and to step back from an obstacle and consider it objectively. Those who experienced more

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PSYCHOLOGIST 218, 222 (2001).

281. *Id.*

282. *Id.*

283. *Id.* at 223.

284. *See* Peterson & Seligman, *supra* note 240.

285. Fredrickson, *supra* note 280, at 223.

286. *Id.*

positive emotions at Time 1 were indeed better at broad-minded coping at Time 2, and as their coping skills increased, so too did their positive emotions.[287] These findings hold true not just in the laboratory but also in studies of people enduring national crises, like September 11, 2001,[288] and in studies of people who are enduring their own personal crises, such as losing a spouse.[289]

The implications of this research for law schools are striking. To put it bluntly, students who spend three years in law school focused solely on work, at the expense of time spent with friends and family, recreation, personal hobbies, and other activities that might induce positive emotion, seem to be putting their personal happiness at risk, decreasing their psychological resilience, and perhaps even limiting their cognitive ability. Whatever law schools can do to limit this occurrence would therefore be a welcome reform. A comprehensive, proactive effort to insulate law students from stress and depression should include an educational component to explain the benefits of positive emotions and a programmatic component that provides opportunities for students to discover and experience those positive emotions. This may involve advisors simply urging their students not to lose sight of the people and activities that bring them joy while in law school; it may involve offering a training on how to maintain a healthy work-life balance; or it may involve more formal law school sponsored events to directly induce positive emotion—from intramural sports and movie nights to community service days and class trips. Moving from psychological theory to its application in the law school context is obviously tricky, and the process will undoubtedly be full of false starts and experimental efforts that are less than complete successes. But two facts should motivate every law school to try: 1) the magnitude of the problem is indisputable, and 2) the only way to discover how to apply this new and potentially transformative research is to imagine ways to use it and test the options.

3. The Benefits of Strengths-Based Education

The premise behind the strengths theory of positive psychology is that people can benefit from a focus on those qualities and actions that come naturally to them, that they enjoy doing, and that they do well. In this way, a strength can be defined as a "pre-existing capacity for a particular way of behaving, thinking, or feeling that is authentic and energising to the user, and enables optimal

287. Barbara L. Fredrickson & Thomas Joiner, *Positive Emotions Trigger Upward Spirals Toward Emotional Well-Being*, 13 PSYCHOL. SCI. 172, 173-74 (2002).

288. Barbara L. Fredrickson et al., *What Good Are Positive Emotions in Crises?: A Prospective Study of Resilience and Emotions Following the Terrorist Attacks on the United States on September 11, 2001*, 84 J. PERSONALITY & SOC. PSYCHOL. 365, 365 (2003).

289. Anthony D. Ong et al., *Psychological Resilience, Positive Emotions, and Successful Adaptation to Stress in Later Life*, 91 J. PERSONALITY & SOC. PSYCHOL. 730, 730 (2006).

functioning, development, and performance."[290] In fact, people who use their strengths experience higher levels of energy,[291] goal attainment,[292] congruence,[293] and well-being.[294] Working on enhancing strengths has been associated with numerous positive outcomes in the workplace, including increased employee engagement and job success.[295] As mentioned above, research shows that at workplaces where employees believe they have the "opportunity to do what [they] do best," there is a significantly higher rate of loyalty and employee retention and also a much higher annual yield of employee productivity.[296] We also have reason to believe this relationship is causal: workplace trainings designed to help employees identify their strengths and then use them more often have proven remarkably successful at improving productivity,[297] engagement,[298] and company profit[299] and at lowering employee turnover.[300]

Identifying one's strengths and then exercising them daily has also proven to increase personal fulfillment for many people.[301] Since Peterson and Seligman made their VIA strengths assessment available online,[302] hundreds of thousands of people have received personalized feedback about their top five signature strengths.[303] As noted in Section IV.A, Peterson and Seligman's empirical research demonstrated the long-term benefits of an intervention encouraging

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290. LINLEY, *supra* note 38, at 9.

291. *Id.* at 12.

292. *Id.* at 45-47.

293. *Id.* at 154.

294. *Id.*; *see also* Reena Govindji & P. Alex Linley, *Strengths Use, Self-Concordance and Well-Being: Implications for Strengths Coaching and Coaching Psychologists*, 2 INT'L COACHING PSYCHOL. REV. 143 (2007).

295. LINLEY, *supra* note 38, at 151; Donald O. Clifton & James K. Harter, *Investing in Strengths*, *in* POSITIVE ORGANIZATIONAL SCHOLARSHIP: FOUNDATIONS OF A NEW DISCIPLINE 111, 116 (Kim S. Cameron et al. eds., 2003); Hodges & Clifton, *supra* note 39, at 262-65.

296. Harter et al., *supra* note 40, at 269, 273-74.

297. Connelly, *supra* note 41.

298. Hodges & Clifton, *supra* note 39, at 262.

299. *Id.*

300. Brad Black, *The Road to Recovery*, GALLUP MGMT. J., Dec. 15, 2001, http://gmj.gallup.com/content/772/Road-Recovery.aspx.

301. *See, e.g.*, FREDRICKSON, *supra* note 265, at 189-91; LINLEY, *supra* note 38, at 154; PETERSON, *supra* note 191, at 159; Hodges & Clifton, *supra* note 39, at 263-65; Christopher Peterson & Nansook Park, *Methodological Issues in Positive Psychology and the Assessment of Character Strengths*, *in* HANDBOOK OF METHODS IN POSITIVE PSYCHOLOGY, *supra* note 182, at 292.

302. *See* University of Pennsylvania Authentic Happiness, *supra* note 222.

303. *See* University of Pennsylvania Authentic Happiness, VIA-Inventory of Strengths, http://www.authentichappiness.sas.upenn.edu/AIESEC/content.aspx?id=821 (last visited Apr. 25, 2009).

participants to utilize their signature strengths in a new way each day.[304] Moreover, focusing on personal strengths has also proven successful in the field of education. A study at the University of California-Los Angeles showed that students who were given feedback about their strengths and taught to integrate them into their lives experienced significant increases in self-confidence, self-reflection, and direction.[305] Another study showed that strengths-based curriculum delivered over a four-year period at a Midwestern high school resulted in students with fewer absences and higher GPAs.[306] In a recent university level study, incoming freshmen were informed of their top strengths before they arrived on campus and were encouraged to reinforce these strengths throughout the year. At the end of freshman year, the students had increased levels of academic self-efficacy and life satisfaction compared to a control group.[307]

Moreover, our own research suggests that there are certain signature strengths that seem to be associated with resistance to stress and depression among law students. We discuss this aspect of our research and the additional suggestions for the use and development of signature strengths below. As we will show, there is evidence to suggest that encouraging the development of certain strengths may help law students counter the negative emotions engendered by law school.[308]

4. Applying Strengths Theory to Legal Education: An Empirical Study

We conducted an empirical study of students at The George Washington University Law School to examine the use of personal strengths as a possible component of a plan to relieve law student distress. The present study builds off the foundation of strengths-based research discussed above by further testing the theory that focusing on one's strengths in daily life is associated with greater life satisfaction. This experiment applies the theory to the law student population, in the hope that it will help explain why some students manage to maintain high levels of well-being in law school despite the heightened risk for depression. Our

304. *Id.* at 416.

305. Clifton & Harter, *supra* note 295, at 118 (citing TOM C. RATH, MEASURING THE IMPACT OF GALLUP'S STRENGTHS-BASED EDUCATION PROGRAM FOR STUDENTS (2002)).

306. Hodges & Clifton, *supra* note 39, at 260-61 (citing JAMES K. HARTER, GAGE PARK HIGH SCHOOL RESEARCH STUDY (1998)); *see also* Clifton & Harter, *supra* note 295, at 118.

307. Laurie A. Schreiner, Chair and Prof., Dep't. of Doctoral Higher Educ., Azusa Pacific Univ., Positive Psychology on Campus: The Impact of Strengths-Based Interventions, Paper Presented at the International Positive Psychology Summit, Wash., D.C., Oct. 2006 (notes on file with authors); *see also* Laurie A. Schreiner & Edward Anderson, *Strengths-Based Advising: A New Lens for Higher Education*, 25 NAT'L ACAD. ADVISING ASS'N J. 20, 20-27 (2005).

308. *See also* discussion of the "broaden-and-build theory," *supra* text accompanying notes 261-289.

hypothesis is that the students who are able to use their top strengths often in their daily lives will report higher levels of happiness and lower levels of stress and depression than those students who use their top strengths less often.

We asked professors in the first-year courses to invite their students to participate in the survey and requested the president of the Student Bar Association to send an e-mail to the student body with an invitation to take an online questionnaire. Of the approximately 1500 students enrolled at this law school, 140 students elected to participate (64 men and 76 women).[309] The majority of respondents were in their first year at law school (63%), but there were also second- (16%) and third-year (21%) students represented in the sample. Participants' ethnicity was not recorded.

The recruitment e-mail (see Appendix A) explained that the online questionnaire was part of a study on student well-being in law school. It stated that the study was unaffiliated with the law school and that participation was voluntary and anonymous. The students who agreed to participate were asked to click on a link in the e-mail that directed them to the questionnaire, which took about fifteen minutes to complete. The study was administered at the end of March, while classes were ongoing, but near the end of the law school's second semester (classes concluded in mid-April).

a. Questionnaire

The online questionnaire (see Appendix B) began with three demographic questions asking students to identify their gender, year in law school, and GPA. Among the remaining seventy-eight questions, there were four psychological measures used for this study; the first three measures assessed the well-being of the law students along three different dimensions—life satisfaction, stress, and depression—and the fourth measure assessed the different character strengths displayed by the students and how often they used them. All four measures are commonly used self-report instruments that have been tested for reliability and validity. The specific measures are as follows:

The Satisfaction With Life Scale measures overall life satisfaction by asking respondents how strongly they agree with five statements, such as "the conditions of my life are excellent." Participants then rate their responses on a seven-point scale, from "strongly disagree" to "strongly agree." The test has been used to measure life satisfaction in populations around the world and is positively associated with other measures of subjective well-being.[310]

To measure stress level, students were given the ten-item Perceived Stress

309. While for some studies a 10% response rate would be low, 140 participants comprises a relatively large study in the field of psychology and was sufficient to yield statistically significant results.

310. *See* Diener et al., *supra* note 78.

Scale (PSS-10). The PSS-10 measures the degree to which students perceive their own lives as stressful, with questions such as, "In the last month, how often have you found that you could not cope with all the things that you had to do?" Answers are rated on a five-point scale, and higher scores indicate higher levels of perceived stress.[311]

We measured depression with the Center for Epidemiological Studies Depression Scale (CES-D), which is a twenty-item scale that asks respondents to identify how often they have experienced certain depressive symptoms over the last week.[312] Scores range from zero to sixty, with higher scores indicating increased symptomology and a score of sixteen or above indicating a high risk of clinical depression.[313]

To identify the subjects' signature strengths, we used a questionnaire based upon Peterson and Seligman's *Character Strengths and Virtues: A Handbook and Classification*, in which the authors identified twenty-four strengths of character that facilitate human flourishing.[314] To identify these strengths in individuals, the authors developed a VIA Inventory of Strengths questionnaire that has been demonstrated to be valid and reliable.[315] While the full VIA Inventory of Strengths uses 240 questions to identify a person's five "signature strengths," a shorter twenty-four item VIA Brief Strengths Test has been developed for more time-pressured situations, which is what we used for this study. The test consists of twenty-four questions, each corresponding to one of the twenty-four character strengths. The questions ask participants to think of their everyday life and then say how frequently they exhibited each strength when it was possible to do so. For instance, to identify a participant's strength of gratitude, the question asks: "Think of actual situations in which someone else helped or benefited you. How frequently did you show gratitude or thankfulness?" Answers are then coded on a six-point scale, from "Never/Rarely" to "Always," with the option of choosing "Not Applicable."

Finally, to measure how often participants are able to use their strengths in

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311. *See* Sheldon Cohen, Tom Kamarck & Robin Mermelstein, *A Global Measure of Perceived Stress*, 24 J. HEALTH & SOC. BEHAV. 385 (1983); Jonathan W. Roberti, Lisa N. Harrington & Eric A. Storch, *Further Psychometric Support for the 10-Item Version of the Perceived Stress Scale*, 9 J. C. COUNSELING 135 (2006).

312. IAN MCDOWELL, MEASURING HEALTH: A GUIDE TO RATING SCALES AND QUESTIONNAIRES 350 (2006); Radloff, *supra* note 203.

313. *See* ELIZABETH A. CAPEZUTI, EUGENIA L. SIEGLER & MATHY D. MEZEY, THE ENCYCLOPEDIA OF ELDER CARE 235 (2007); LYUBOMIRSKY, *supra* note 207, at 36; MCDOWELL, *supra* note 312, at 351; Aartjan T.F. Beekman et al., *Criterion Validity of the Center for Epidemiologic Studies Depression Scale (CES-D): Results from a Community-Based Sample of Older Subjects in the Netherlands*, 27 PSYCHOL. MED. 231, 234 (1997).

314. *See* PETERSON & SELIGMAN, *supra* note 189.

315. *See* Seligman et al., *supra* note 29.

daily life, students were asked this final question: "Think about what you consider to be your top strengths. How often do you use your top strengths in your everyday life?" Answers were rated on a seven-point scale, ranging from one for "Never" to seven for "Always."

b. Results

The law students reported a mean stress score of 18.76 (n = 132; SD = 7.99) and a mean depression score of 19.65 (n = 117; SD = 11.13).[316] Sixty-two students (53%) scored above a 16 on the CES-D scale, which is the threshold for a clinically significant level of depression. On the Satisfaction with Life Scale, students reported a mean score of 21.12 (n = 140; SD = 8.01). Table 1 shows a more detailed breakdown of students' life satisfaction based on their score ranges. Forty-one percent of the law students scored in the "dissatisfied" ranges of life satisfaction. Table 2 shows the mean scores on each outcome measure, broken down by class year. Third-year students showed statistically significant decreases in stress and depression, and an increase in life satisfaction, compared to first-year students.

The study confirms the hypothesis that how often students use their top strengths in daily life is strongly associated with all three dimensions of well-being. Pearson correlational analyses show a significant positive relationship between how often students use their strengths and their satisfaction with life (R = 0.58, $p < .001$; all p values two-tailed). There is also a significant negative relationship between how often they use their strengths and their scores on the stress (R = -0.48, $p < .001$) and depression measures (R = -0.56, $p < .001$). These results indicate that students who use their strengths on a regular basis report higher satisfaction with life and lower levels of stress and depression. Grade point average was not related to any of the three measures of well-being, nor was it related to how often students use their strengths. There was no significant gender difference in any of these correlations.

Of the twenty-four character strengths tested using the VIA Brief Strengths Test, most had no significant association with the three indicators of well-being, with six exceptions. As shown in Table 3, the strength with the highest positive correlation to well-being was zest, followed by hope, love, love of learning, good judgment, and perseverance.

The final notable result of this study is the high positive correlation between stress level and depression (R = 0.81, $p < .001$), indicating that perceived stress

316. While the total number of people who took the survey was 140, some participants left certain questions blank. If a respondent didn't answer every question in a particular measure, we discounted them from that measure entirely. This is why each measure has a different number of respondents; for instance, 132 people completed all the questions for the stress measure, while only 117 people completed all the questions in the depression scale.

and depressive symptoms are closely related for the law student participants.

c. Discussion

This research confirms reports from previous studies that the law student population is in significant psychological distress. *T*-tests confirmed that the mean stress level among study participants (18.76) was significantly higher than the general population norm (13.02),[317] and that the law students' mean life satisfaction score of 21.1 was significantly lower than the 24.3 average for doctoral students ($p < .001$).[318] Most alarming, though, is that while recent studies estimate the depression rate for young adults is 11%,[319] a majority (53%) of the law student respondents in our study met the threshold for a clinically significant level of depression.[320] While previous studies have found that these high levels of distress stay constant, or even get worse, through the three years of

317. Sheldon Cohen & Gail M. Williamson, *Perceived Stress in a Probability Sample of the United States*, *in* THE SOCIAL PSYCHOLOGY OF HEALTH 31, 46 (Shirlynn Spacapan & Stuart Oskamp eds., 1988).

318. William Pavot & Ed Diener, *Review of the Satisfaction with Life Scale*, 5 PSYCHOL. ASSESSMENT 164, 166 (1993) (citing D.B. Allison, V.C. Alfonso & G.M. Dunn, *The Extended Satisfaction with Life Scale*, 5 BEHAVIOR THERAPIST 14, 15-16 (1991).

319. Daniel Eisenberg et al., *Prevalence and Correlates of Depression, Anxiety, and Suicidality Among University Students*, 77 AM. J. ORTHOPSYCHIATRY 534, 537 (2007) (finding a depression rate of 11.3% among 1662 graduate students surveyed at a large Midwestern university); *see also* T. Aalto-Setälä et al., *One-Month Prevalence of Depression and Other DSM-IV Disorders Among Young Adults*, 31 PSYCHOL. MED. 791, 795 (2001) (estimating the prevalence of depression to be approximately 11% among a sample drawn from Helsinki youth). Approximately 15% of people in the United States will become clinically depressed at some point during their lifetime. LYUBOMIRSKY, *supra* note 207, at 37 (citing Ronald C. Kessler et al., *Lifetime and 12-Month Prevalence Rates of DSM-III-R Psychiatric Disorders in the United States: Results from the National Comorbidity Survey* 51 ARCHIVES GEN. PSYCHIATRY 8 (1994)).

320. There are some important caveats to consider. First, the figure of 11% signifies the percentage of people who, based on questionnaires and face-to-face interviews, can be diagnosed with Major Depressive Disorder. Aalto-Setälä et al., *supra* note 319, at 792-93; Eisenberg et al., *supra* note 319, at 535. The CES-D, on the other hand, while a valuable tool to identify groups at a high-risk for depression, "is not intended as a clinical diagnostic tool." Radloff, *supra* note 203, at 400. In other words, scoring above a sixteen does not guarantee an individual would be diagnosed with Major Depressive Disorder were he or she to seek clinical treatment. Second, because the CES-D is a screening tool and does not involve individual interviews, it identifies a certain percentage of false positives—individuals whose depressive symptoms soon dissipate and would not meet the clinical criteria for depression. MCDOWELL, *supra* note 312, at 356. Researchers have found the CES-D false positive rate to range from 6% to 16%, depending on the study. JOHN A. RUSH, MICHAEL B. FIRST & DEBORAH BLACKER, HANDBOOK OF PSYCHIATRIC MEASURES 506, 508 (2008). Erring on the side of caution by assuming a 20% false positive rate still leaves forty-nine students, or 42% of our study participants, with clinically significant symptoms of depression.

law school,[321] our study found that third-year students fared better on all three measures of well-being. Still, they too experienced elevated levels of distress—a third of the third-year students scored above a sixteen on the CES-D, indicating symptoms of clinical depression. Taken in conjunction with similar results from previous studies on law student depression, these findings should give law schools a reason to take action on behalf of their students.

One potential aid to the reform process may be our finding that depression and stress are so highly correlated among law students. Stress is often considered an accepted and inevitable part of law school, yet law schools have tended to ignore the problems that typically result from it.[322] Our findings suggest that avoiding the consequences of stress is impossible; whether or not there is a causal link, stress and depression are inextricably connected in law school. High stress levels interfere with students' ability to process and store information[323] and can lead to disengagement from tasks,[324] increased aggression,[325] lowered performance,[326] loss of personal relationships,[327] and substance abuse problems.[328] Given the extremely elevated levels of alcohol and drug use among lawyers and its negative effect on the profession itself,[329] it seems in the best interest of law schools to contribute to the reduction of student stress. While there are some short-term salves for student stress, including relaxation techniques and physical exercise, noticeable improvements in student well-being will require larger changes.[330]

Given the large numbers of law students who suffer from depression, it is all the more remarkable that some students are able to maintain healthy levels of well-being throughout law school. With the strengths-based approach of positive psychology as our foundation, we hypothesized that the students who use their top strengths more often in daily life would be the ones to report higher levels of well-being. This was indeed the case: students who find ways to use their top strengths are less likely to suffer from depression and stress and more likely to report satisfaction with life. It should be noted that our study suggests only correlation, not causation; we do not know if a focus on personal strengths can

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321. *See, e.g.*, Benjamin et al., *supra* note 58, at 246.

322. *See* Krieger, *supra* note 73, at 115-16.

323. DANIEL GOLEMAN, SOCIAL INTELLIGENCE: THE NEW SCIENCE OF HUMAN RELATIONSHIPS 268-74 (2006); Glesner, *supra* note 15, at 637.

324. Glesner, *supra* note 15, at 636.

325. *Id.* at 638-39.

326. *Id.* at 637-38; Alfini & Van Vooren, *supra* note 33, at 65.

327. *Id.* at 65.

328. *Id.* at 63; Glesner, *supra* note 15, at 640-41.

329. Allan, *supra* note 5; Beck et al., *supra* note 4.

330. *Cf.* Alfini & Van Vooren, *supra* note 33, at 64 (arguing that relieving stress in the legal workplace will require institutional changes to work environments).

actively improve well-being in law school, or if happier law students are simply inclined to use their strengths more often. However, taken in conjunction with previous research that shows a focus on strengths improves life satisfaction and lowers depression levels in the general population,[331] we believe it is worth pursuing the theory that a strengths-based focus in law school may be able to buffer against psychological distress. Is there something specific about the law school experience that makes a focus on signature strengths particularly useful to combat the elevated risk of stress and depression? There may be.

One of the principal themes in the literature on law student distress is that students suffer from the loss of individual character. Some law students find themselves fighting a losing battle to maintain their personal code of ethics,[332] their personal relationships,[333] their creativity,[334] their ideals, and their original career aspirations.[335] In addition, the constant emphasis on linear thinking and logic can come at the expense of students' emotional selves because, as one critic notes, law school requires "a continual attempt to suppress one's emotions" and forces "the splitting and polarization of 'intellect' and 'feeling.'"[336] When this is combined with the singular focus on academic performance, "[l]aw school seems to communicate to students that it is how you do, rather than who you are, that really matters."[337] These observations are consistent with Elizabeth Mertz's study of first-year contracts classes, discussed in Part III above,[338] in which she found that the students were taught a "deceptive metapragmatic ideology" that results in "the unmooring of the self" and "a fluidity of voice and footing and position."[339]

For a law student faced with these threats to individual identity, the ability to maintain the active use of signature strengths could well serve as a powerful antidote. A student who uses his top strengths every day would feel not that law school is stripping him of who he is, but that it is bringing out the very best of what he has to offer. Perhaps not coincidentally, we found that two of the character strengths with the highest positive correlations to student well-being were hope and love. Deemed strengths of transcendence and humanity in the VIA classification,[340] hope and love are directly tied to the emotional side of life that can become endangered in law school. It would make sense, then, that the students who find ways to channel these strengths into their everyday lives would

331. Seligman et al., *supra* note 29, at 416.

332. ELIZABETH MERTZ, *supra* note 139, at 120-28.

333. Iijima, *supra* note 15, at 527-28.

334. Culp, *supra* note 15, at 67-69.

335. Sheldon & Krieger, *Understanding the Negative Effects*, *supra* note 8, at 894-95.

336. Culp, *supra* note 15, at 77-78.

337. Krieger, *supra* note 20, at 12.

338. *See supra* text accompanying notes 139-146.

339. MERTZ, *supra* note 139, at 137.

340. PETERSON & SELIGMAN, *supra* note 189.

be better prepared to combat the potentially damaging effect of law school on their emotional well-being.

The character strength our study found to be most highly correlated with law student well-being was zest, also described as vitality, or a "dynamic aspect of well-being marked by the subjective experience of energy and aliveness."[341] Zest can also be seen as a suitable foil for the potential loss of self, because student vitality is at risk in the law school classroom. Intense competition for grades can cause many students to become detached, docile, and helpless. One Harvard Law School student in writing about the experience of law school described fellow students as "demoralized, dispirited, and profoundly disengaged from the law school experience."[342] A *Harvard Law Review* editor commented on "the slow seepage of personal vibrancy which follows from single-minded devotion to legal studies."[343] If these are the battles law students are fighting, it would seem that the ability to call on the strength of zest and vitality in daily interactions would be a powerful tool in the fight. Not unrelated, studies have found that out of all twenty-four character strengths, zest is the one most strongly correlated with perceiving one's life work as a calling, instead of merely a job.[344] It certainly makes sense that the students who feel called to the field of law are the ones best able to push through the difficult circumstances and even thrive as they pursue their goal.

This analysis of law student distress and the possible buffers against it is one of many potential answers to the problem, and there are limitations to even the most concrete findings of our study. First, we examined students at only one law school, so further research is necessary to determine how generalizable these findings are. The fact that the students at the law school we studied have elevated depression and stress levels is consistent with previous findings at other law schools, but it is possible that the high levels of stress and depression were due, at least in part, to the time (late in the second semester) when the study was administered. Second, this study examined law students at only one point during their education, while it would potentially be more useful to track student well-being over the course of their three years. Third, though this study found that using strengths in daily life predicted student well-being, the mechanics of this relationship are still unknown. The answers we offer are mostly conjecture, and much more empirical research is needed on several fronts—most pressingly, on the specific causes of law student depression. Finally, our study was only correlational in nature and cannot prove a causal link between use of personal strengths and improved well-being in law school. Previous research, however,

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341. *Id.* at 273.

342. Note, *Making Docile Lawyers: An Essay on the Pacification of Law Students*, 111 HARV. L. REV. 2027, 2027 (1998).

343. With the Editors, 84 HARV. L. REV. xxi, xxi (1970).

344. Peterson & Park, *supra* note 199, at 1151.

has been able to show causation by administering strengths interventions and empirically testing participants over time. A worthy goal for further research would be to conduct such a study in the law school setting.

CONLUSION: SUGGESTIONS FOR LAW SCHOOL ACTION

We suggest that law schools take a closer look at the idea of incorporating student strengths into the law school experience. Strengths-based development has three basic stages: identification of the strength, integration of the strength into self-perception (naming it, consciously thinking about it), and capitalization on the strength through behavior.[345] It would be a small task for law schools to have their incoming students take the VIA Inventory of Strengths when they first arrive, which would at least give students knowledge of their five signature strengths and the opportunity to focus further on them should they wish. A further step for law schools would be to have advisors checking in with students to encourage (and help find ways to execute) the regular use of at least one signature strength in their class work or extracurricular activities. Such "recrafting" of daily tasks to incorporate strengths has already started to gain traction in the business world, and law schools could learn from their example.[346]

Ideally, law schools would eventually find ways to arrange their curriculum and academic advising process so that students could choose at least one elective class that plays to a signature strength. In Seligman's work on lawyer distress, he mentions the importance of letting young lawyers do work that caters more specifically to their strengths.[347] On the law school level, this recommendation has implications for career counseling in particular:

> [S]ome students have talents for litigation, for example, while others lean in the direction of less confrontational forms of practice. Some have signature strengths of valour and originality, others of social intelligence and fairness. These strengths have a real world dimension: they could be factored into the career placement function at law schools in order to provide a better fit between a first job and the talents of graduating students.[348]

This effort at the law school level might also go a long way in improving the

345. *See* Clifton & Harter, *supra* note 295, at 114; Hodges & Clifton, *supra* note 39, at 258.

346. *See, e.g.*, MARCUS BUCKINGHAM, GO PUT YOUR STRENGTHS TO WORK: 6 POWERFUL STEPS TO ACHIEVE OUTSTANDING PERFORMANCE 4 (2007); FREDRICKSON, *supra* note 265, at 206; LINLEY, *supra* note 38, at 132-37; Hodges & Clifton, *supra* note 39, at 256; Peterson & Park, *supra* note 199, at 1151; Amy Wrzesniewski, & Jane E. Dutton, *Crafting a Job: Revisioning Employees as Active Crafters of their Work*, 26 ACAD. OF MGMT. REV. 179, 180 (2001); Amy Wrzesniewski, *Finding Positive Meaning in Work*, *in* POSITIVE ORGANIZATIONAL SCHOLARSHIP: FOUNDATIONS OF A NEW DISCIPLINE 296, 303 (Kim S. Cameron, Jane E. Dutton & Robert E. Quinn eds., 2003).

347. SELIGMAN, *supra* note 1, at 181-82.

348. Seligman et al., *supra* note 3, at 65.

state of lawyer discontent that continues to devastate the profession. The solution to the problem may well be less about law firms trying to make their lawyers happier and more about ensuring that the right people are entering the right law firms to begin with or, more generally, that students are steering themselves toward the right careers.[349]

As a practical matter, how could a law school put these recommendations to work for its students? First, it may require a bit of institution building. A law school might create a Student Wellness Project as a joint venture between the law school's dean of students, the university counseling center, and the law school's career development office. A law school could then add a few days to the usual first-year orientation program. During this period these three offices could work together to administer the VIA strengths survey to every entering student and begin to counsel the new students on how to find ways to utilize their signature strengths in law school as well as in their personal lives. Later, the career development office could use the signature strengths analysis as a starting point in counseling law students about their future career options. Another strengths-related reform for law school administrators would be to design activities that are specifically aimed at increasing the zest and vitality of students. This is an area of study ripe with possibility—there are potentially numerous positive interventions that could enhance the personal strengths that risk depletion in the traditional law school environment.

Whatever the intervention, though, we believe it is less important which strengths students cultivate and more important that they maintain (or even increase) the use of their own signature strengths. If law school threaten students' sense of self, the strengths-based approach of positive psychology aims to do just the opposite. Education scholar Edward Anderson put this point as succinctly as possible: "This is the message of the strengths-based approach to student success: Do not try to be someone else. Strive to be the person you really are—fully and completely. This is your best avenue to achieving excellence."[350] While the state of law student distress is alarming, there is hope for improvement if we look at the problem through the lens of prevention. A strengths-based approach may be one way for law schools to protect the personal well-being of their students against the stress of the law school experience.

As we have discussed above, positive psychology offers many additional insights beyond the importance of building on one's signature strengths. Law schools should begin to experiment with programs that utilize all of this research to develop proactive programs to buffer students against law school stress. These

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349. *See* Nancy Levit & Douglas O. Linder, *Happy Law Students, Happy Lawyers*, 58 SYRACUSE L. REV. 351, 370-71 (2008).

350. EDWARD "CHIP" ANDERSON, WHAT IS STRENGTHS-BASED EDUCATION? 5 (2004), *available at* http://www.strengthsquest.com/Library/Documents/WhatisStrengths-Based Education.pdf.

programs can use the concepts of positive psychology to create an environment where students not only survive, but also flourish, both personally and professionally, and lay the foundation for happy and successful legal careers.

TABLE 1: SATISFACTION WITH LIFE SCALE (SWLS) SCORES

SWLS Category[351] (score range)	Percentage of students (n = 140)
Extremely Dissatisfied (5 – 9)	8.6% (n = 12)
Dissatisfied (10 – 14)	17.9% (n = 25)
Slightly Dissatisfied (15 – 19)	14.3% (n = 20)
Neutral (20)	5.0% (n = 7)
Slightly Satisfied (21 – 25)	19.3% (n = 27)
Satisfied (26 – 30)	21.4% (n = 30)
Extremely Satisfied (31 – 35)	13.6% (n = 19)

351. Pavot & Diener, *supra* note 318, at 165.

TABLE 2: MEAN WELL-BEING SCORES BY CLASS YEAR

Year in Law School	Life Satisfaction	Stress	Depression
First (n = 89)	20.37 (n = 89; SD = 7.62)	20.01 (n = 82; SD = 7.34)	21.74 (n = 74; SD = 12.31)
Second (n = 22)	21.00 (n = 22; SD = 9.35)	18.55 (n = 22; SD = 9.39)	18.63 (n = 19; SD = 15.00)
Third (n = 29)	23.52* (n = 29; SD = 7.91)	15.25** (n = 28; SD = 7.88)	14.00*** (n = 24; SD = 10.33)
Total (n = 140)	21.12 (n = 140; SD =8.01)	18.76 (n = 132; SD = 7.09)	19.65 (n = 117; SD = 11.13)

*Increase in Life Satisfaction from first-year to third-year significant at 0.05 level
**Decrease in Stress from first-year to third-year significant at 0.01 level
***Decrease in Depression from first-year to third-year significant at the 0.01 level

TABLE 3: CORRELATIONS BETWEEN CHARACTER STRENGTHS AND MEASURES OF STUDENT WELL-BEING*

Character Strengths (n = 118)	Life Satisfaction (n = 140)	Stress (n = 132)	Depression (n = 117)
Zest	.519	.453	-.505
Hope	.357	-.313	-.397
Love	.447	.263	.314
Love of Learning	.285	.373	.344
Good Judgment	.268	-.284	-.410
Perseverance	.226	-.315	-.327

*All correlations significant at the 0.01 level.

APPENDIX A. RECRUITMENT E-MAIL SCRIPT

Included in this email is a link to an online survey for a study on the well being of students in law school. The study is being conducted by Elizabeth Peterson of the University of Pennsylvania, and it has been approved by the Institutional Review Board.

The survey is unaffiliated with George Washington University and completion of the survey is voluntary. Answering the survey questions typically takes 20 minutes and is strictly anonymous. All responses are treated as confidential, and in no case will responses from individual participants be identified. Rather, all data will be pooled and published in aggregate form only.

No deception is involved in the survey, and the study involves no more than minimal risk to participants (i.e., the level of risk encountered in daily life). Participants may withdraw from taking the survey at any time during the process.

You are not likely to receive any direct benefits from taking this survey, but your cooperation may help us learn how future generations of law students can increase their levels of happiness while in law school. If you have any questions or concerns, please do not hesitate to contact Elizabeth Peterson at epeterso@sas.upenn.edu.

APPENDIX B. ONLINE QUESTIONNAIRE MEASURES

I. Preliminary Questions

What is your gender?

What year are you in law school?

What is your law school GPA?

II. Satisfaction with Life Scale

Below are five statements that you may agree or disagree with. Read each one and choose the statement that best describes how strongly you agree or disagree.

1. In most ways, my life is close to my ideal.

2. The conditions of my life are excellent.

3. I am completely satisfied with my life.

4. So far I have gotten the most important things I want in life.

5. If I could live my life over, I would change nothing.

Note. All items endorsed on the following scale:
Strongly disagree
Disagree
Slightly disagree
Neither agree nor disagree
Slightly agree
Agree
Strongly agree

III. Perceived Stress Scale

The questions in this scale ask you about your feelings and thoughts during the last month. In each case, please indicate with a check how often you felt or thought a certain way.

1. In the last month, how often have you been upset because of something that happened unexpectedly?

2. In the last month, how often have you felt that you were unable to control the important things in your life?

3. In the last month, how often have you felt nervous and "stressed"?

4. In the last month, how often have you felt confident about your ability to handle your personal problems?

5. In the last month, how often have you felt that things were going your way?

6. In the last month, how often have you found that you could not cope with all the things that you had to do?

7. In the last month, how often have you been able to control irritations in your life?

8. In the last month, how often have you felt that you were on top of things?

9. In the last month, how often have you been angered because of things that were outside of your control?

10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?

Note. All items endorsed on the following scale:
Never
Almost never
Sometimes
Fairly often
Very often

IV. Center for Epidemiologic Studies Depression Scale

Below is a list of the ways you might have felt or behaved. Please tell me how often you have felt this way during the past week.

1. I was bothered by things that usually don't bother me.

2. I did not feel like eating; my appetite was poor.

3. I felt that I could not shake off the blues even with help from my family or friends.

4. I felt I was just as good as other people.

5. I had trouble keeping my mind on what I was doing.

6. I felt depressed.

7. I felt that everything I did was an effort.

8. I felt hopeful about the future.

9. I thought my life had been a failure.

10. I felt fearful.

11. My sleep was restless.

12. I was happy.

13. I talked less than usual.

14. I felt lonely.

15. People were unfriendly.

16. I enjoyed life.

17. I had crying spells.

18. I felt sad.

19. I felt that people dislike me.

20. I could not get "going."

Note. All items endorsed on the following scale:
Rarely or none of the time (less than 1 day)
Some or little of the time (1-2 days)
Occasionally or a moderate amount of time (3-4 days)
Most or all of the time (5-7 days)

V. VIA Brief Strengths Test

Think about how you have acted in the actual situations described below during the past month (four weeks). The questions ask about behaviors that most people find desirable, but we want you to answer only in terms of what you actually did. If you did not encounter a described situation, please mark the "not applicable" option. Read each one and then click on the dropdown list next to the statement and select your response.

1. Think of actual situations in which you had the opportunity to do something that was novel or innovative. How frequently did you show CREATIVITY or INGENUITY in these situations?

2. Think of actual situations in which you had the opportunity to explore something new or to do something different. How frequently did you show CURIOSITY or INTEREST in these situations?

3. Think of actual situations in which you had a complex and important decision to make. How frequently did you show CRITICAL THINKING, OPEN MINDEDNESS, or GOOD JUDGMENT in these situations?

4. Think of actual situations in which you had the opportunity to learn more about some topic, in or out of school. How frequently did you show LOVE OF LEARNING in these situations?

5. Think of actual situations in which you had the opportunity to offer advice to another person who needed it. How frequently did you show PERSPECTIVE or WISDOM in these situations?

6. Think of actual situations in which you experienced fear or threat. How frequently did you show BRAVERY or COURAGE in these situations?

7. Think of actual situations in which you faced a difficult and time consuming task. How frequently did you show PERSEVERANCE, PERSISTENCE, DILIGENCE, or INDUSTRIOUSNESS in these situations?

8. Think of actual situations in which it was possible for you to present a false view of who you are or what had happened. How frequently did you show HONESTY or AUTHENTICITY in these situations?

9. Think of your everyday life. How frequently did you show ZEST or ENTHUSIASM when it was possible to do so?

10. Think of your everyday life. How frequently did you express your LOVE or ATTACHMENT to others (friends, family members) when it was possible to do so?

11. Think of your everyday life. How frequently did you show KINDNESS or GENEROSITY to others when it was possible to do so?

12. Think of actual situations in which the motives of other people needed to be understood and responded to. How frequently did you show SOCIAL INTELLIGENCE or SOCIAL SKILLS in these situations?

13. Think of actual situations in which you were a member of a group that needed your help and loyalty. How frequently did you show TEAMWORK in these situations?

14. Think of actual situations in which you had some power or influence over two or more other people. How frequently did you show FAIRNESS in these situations?

15. Think of actual situations in which you were a member of a group that needed direction. How frequently did you show LEADERSHIP in these situations?

16. Think of actual situations in which you had been hurt by someone else. How frequently did you show FORGIVENESS or MERCY in these situations?

17. Think of your everyday life. How frequently did you show MODESTY or HUMILITY when it was possible to do so?

18. Think of actual situations in which you were tempted to do something that you might later regret. How frequently did you show PRUDENCE, DISCRETION, or CAUTION in these situations?

19. Think of actual situations in which you experienced wishes, desires, impulses, or emotions that you wished to control. How frequently did you show SELF CONTROL or SELF REGULATION in these situations?

20. Think of your everyday life. How frequently did you show APPRECIATION OF BEAUTY AND EXCELLENCE or AWE when it was possible to do so?

21. Think of actual situations in which someone else helped or benefitted you. How frequently did you show GRATITUDE or THANKFULNESS?

22. Think of actual situations in which you experienced failure or a setback. How frequently did you show HOPE or OPTIMISM in these situations?

23. Think of your everyday life. How frequently did you show PLAYFULNESS or HUMOR when it was possible to do so?

24. Think of your everyday life. How frequently did you show RELIGIOUSNESS or SPIRITUALITY when it was possible to do so?

Note. All items endorsed on the following scale:
Not Applicable
Never/Rarely
Occasionally
Half the time
Usually
Always

VI. Using Signature Strengths in Daily Life

Think about what you consider to be your top strengths. How often do you use your top strengths in your everyday life?

Note. Question endorsed on the following scale:

Never
Rarely
Occasionally
Half the time
Usually
Almost always
Always

APPENDIX C. LAW SCHOOL WEBSITES WITH INFORMATION ON STUDENT MENTAL HEALTH PROGRAMS OR STUDENT AFFAIRS OFFICES

1. Yale Law School, Office of Student Affairs, http://www.law.yale.edu/studentlife/OfficeofStudentAffairs.asp
2. Harvard Law School, Counseling Services, http://www.law.harvard.edu/current/student-services/student-life/campus-life/counseling-services.html
3. STANFORD LAW SCH., STUDENT HANDBOOK 2008-2009 (2008), *available at* http://www.law.stanford.edu/experience/studentlife/SLS_Student_Handbook.pdf
4. NYU Law, Student Affairs, http://www.law.nyu.edu/students/studentaffairs/index.htm
5. Columbia Law School, Health and Wellness Programs, http://www.law.columbia.edu/current_student/student_service Health_and_Well
6. UNIV. OF CHICAGO, THE LAW SCH., STUDENT HANDBOOK 2008-2009 (2008), *available at* https://www.law.uchicago.edu/files/studenthandbook08-09.pdf
7. University of Pennsylvania Law School, Student Affairs, http://www.law.upenn.edu/student
8. Berkeley Law, University of California, Boalt Hall, Other Health Services, http://www.law.berkeley.edu/1681.htm
9. UNIV. OF MICH. LAW SCH., STUDENT HANDBOOK (Aug. 2006), *available at* http://www.law.umich.edu/currentstudents/studentservices handbook Document s/handbook2006.pdf;
10. Duke Law, Office of Student Affairs, http://www.law.duke.edu students osa
11. Virginia Law, Office of Student Affairs, http://www.law.virginia.edu/html/students/studentaffairs.htm
12. Northwestern Law, Student Affairs, http://www.law.northwestern.edu/studentaffairs
13. Cornell Law School, Student Life, Law School Resources, http://www.lawschool.cornell.edu/studentlife resources.cfm
14. Georgetown Law, Center for Wellness Promotion, http://www.law.georgetown.edu/wellness
15. UCLA Law, Health & Wellness Services, http://www.law.ucla.edu/home index.asp?page=1227
16. USC Law, Health & Wellness, http://law.usc.edu/students osa/health health.cfm
17. Vanderbilt University Law School, Student Resources, http://law.vanderbilt.edu/student-resources/index.aspx

18. The University of Texas at Austin School of Law, Student Services, http://www.utexas.edu/law/depts/sao/studentservices
19. Washington University Law, Student Counseling Services, http://law.wustl.edu/advising/index.asp?ID=45
20. BU School of Law, J.D. Student Central, Counseling and Support, http://www.bu.edu/law/central/jd/services/counseling.html
21. University of Minnesota Law, Counseling & Advising, http://www.law.umn.edu/current/counseling.html
22. Emory Law, The Office of Student Affairs, http://www.law.emory.edu/current-students/student-affairs-general-information.html
23. The George Washington University Law School, Health, Wellness & Support Resources, http://www.law.gwu.edu/Students/Pages/wellness.aspx
24. The University of Iowa College of Law, Health Care, http://www.law.uiowa.edu/students/studentservices-health-services.php
25. Fordham Law School, Student Affairs, http://law.fordham.edu/ihtml/sa-2home.ihtml?id=81
26. University of Illinois College of Law, Campus Services, http://www.law.illinois.edu/current-students/campus-services.asp
27. Washington and Lee University School of Law, For Current Students, http://law.wlu.edu/students
28. Boston College Law School, Counseling and Academic Support, http://www.bc.edu/schools/law/services/deanstudents/counseling.html
29. University of Notre Dame The Law School, Support and Counseling, http://law.nd.edu/student-life/student-services/support-and-counseling
30. University of Washington School of Law – Seattle, Counseling Resources, http://www.law.washington.edu/Students/StressCounseling.aspx
31. William & Mary Law School, Services for Students, http://law.wm.edu/studentlife/studentservices/index.php
32. The Ohio State University Moritz College of Law, Student Services, http://moritzlaw.osu.edu/students/services.php
33. University of Wisconsin Law School, Current Students, Student Life, http://www.law.wisc.edu/current/studentlife.html
34. George Mason University School of Law, Student Services, http://www.law.gmu.edu/students/services
35. UC Davis School of Law, On-Campus Services, Counseling Center, http://www.law.ucdavis.edu/current/on-campus-services/index.html
36. Maurer School of Law, Indiana University Bloomington, Contact Student Affairs, http://www.law.indiana.edu/students/contact.shtml

37. UNIV. OF ALABAMA SCH. OF LAW, STUDENT HANDBOOK (2008), *available at* http://www.law.ua.edu/students/handbook.pdf

38. University of California Hastings College of the Law, Counseling, http://www.uchastings.edu/health-services/counseling/index.html

39. University of Colorado at Boulder, Colorado Law, Student Life, http://www.colorado.edu/law/studentlife

40. Georgia Law, Student Handbook, Law School Student Services, http://www.law.uga.edu/facstaffstu/students/handbook/stuserv.html

41. The University of Maryland School of Law, Office of Student Affairs, http://www.law.umaryland.edu/dept/osa/index.asp

42. UNC School of Law, Student Services, http://www.law.unc.edu/pastudents/experience/studentservices/default.aspx

43. WAKE FOREST UNIV. SCH. OF LAW, STUDENT HANDBOOK 2008-2009 (2008), *available at* http://law.wfu.edu/studentlife/documents/handbook.2008.2009.pdf

44. BYU Law, Advisement, http://www.law2.byu.edu/advisement/index.php

45. The University of Arizona James E. Rogers College of Law, Counseling, http://www.law.arizona.edu/rss/counseling.cfm?page=program&link=e

46. SMU Dedman School of Law, Counseling Services, http://www.law.smu.edu/Student-Services/Counseling-Services

47. American University Washington College of Law, Confidential Counseling & Support, http://www.wcl.american.edu/studentaffairs/support.cfm

48. Tulane University Law School, Student Life, Resources for Students, http://www.law.tulane.edu/tlsstudentlife/index.aspx (follow the "Resources for Students" hyperlink on the right-hand side of the screen)

49. University of Connecticut School of Law, Guide to Student Services, http://www.law.uconn.edu/student-handbook/guide-student-services

50. University of Florida Levin College of Law, Student Affairs, http://www.law.ufl.edu/students/index.shtml

51. Arizona State University Sandra Day O'Connor College of Law, Current Students, http://www.law.asu.edu/?id=252

52. Benjamin N. Cardozo School of Law, Yeshiva University, Personal, http://www.cardozo.yu.edu/MemberContentDisplay.aspx?ccmd=ContentEdit&ucmd=UserDisplay&userid=10356&contentid=4070&folderid=322

    Benjamin N. Cardozo School of Law, Yeshiva University, FAQs, http://www.cardozo.yu.edu/MemberContentDisplay.aspx?ccmd=ContentDisplay&ucmd=UserDisplay&userid=10356&contentid=1042

53. Baylor Law School, Student Relations Committee, http://law.baylor.edu/CurrentStudents/CS_studentRelationsCommittee.html

54. Case Western Reserve University School of Law, From Our Dean of Students, http://law.case.edu/student_life/content.asp?id=111

55. Florida State University College of Law, Current Students & Student Affairs, http://www.law.fsu.edu/current_students/index.html

56. University of Tennessee – Knoxville College of Law, Student Affairs and Records, http://www.law.utk.edu/administration/records.shtml

57. University of Cincinnati College of Law, Current Students: Resources, http://www.law.uc.edu/current/#tabview=tab7

58. Pitt Law, University of Pittsburgh, Office of the Dean of Students, http://www.law.pitt.edu/students/officeofthedean

59. S.J. Quinney College of Law, The University of Utah, Barbara J. Dickey, Associate Dean for Student Affairs, http://www.law.utah.edu/profiles/default.asp?PersonID=99&name=Dickey,Barbara

60. Brooklyn Law School, Student Health, http://www.brooklaw.edu/studenthealth

61. University of Kentucky College of Law, Student Services, http://www.uky.edu/Law/current_students/student_services.html

62. University of Houston Law Center, Students, http://www.law.uh.edu/student

63. Chicago-Kent College of Law, Office of Student Services, http://www.kentlaw.edu/depts/stuservices

64. Temple University Beasley School of Law Counseling Services, http://www.law.temple.edu/servlet/RetrievePage?site=TempleLaw&page=Current_Counseling_Services

65. Villanova University School of Law, Student Affairs, http://www.law.villanova.edu/studentservices/studentaffairs

66. Loyola Law School – Los Angeles, On-Campus Psychological Counseling Office, http://intranet.lls.edu/studentaffairs/ocpco.html

67. Pepperdine University School of Law, Student Services, http://law.pepperdine.edu/academics/student_handbook/lawserv.html

68. KU School of Law, The University of Kansas, Student Services, http://www.law.ku.edu/current/services/index.shtml

69. School of Law, University of Missouri, University Resources, http://www.law.missouri.edu/students/universityresources.html

70. Loyola University Chicago School of Law, Student Resources, Student Life, http://www.luc.edu/law/current/student_life_1.html

71. Rutgers School of Law, Office of Student Affairs, http://www-camlaw.rutgers.edu/site/studentaffairs

72. Seton Hall University School of Law, The Office of the Dean of Students, http://law.shu.edu/administration/student_services

73. St. John's University School of Law, Office of Student Affairs, http://www.stjohns.edu/academics/graduate/law/current/sa.stj
74. University of Miami School of Law, Dean of Students, http://www.law.miami.edu/dos/index.php?op=1
75. University of New Mexico School of Law, Other Services, http://lawschool.unm.edu/students/support/health.php

All websites last visited Apr. 1, 2009.

Employment-Based Health Insurance and Universal Coverage: Four Things People Know that Aren't So

David A. Hyman*

It isn't what we don't know that gives us trouble,
it's what we know that ain't so.[1]

In 2001, I published an article in this journal titled "Two Cheers For Employment-Based Health Insurance."[2] That article opened with the following sentence: "Employment-based health insurance is the Rodney Dangerfield of health policy: it gets no respect from anyone."[3] The article then cataloged criticisms of employment-based coverage (EBC) from across the political spectrum, offered various reasons why EBC deserves "two cheers," and proposed tax reform, Employee Retirement Income Security Act (ERISA) reform, and greater use of purchasing pools to address shortcomings in the EBC market.[4]

EBC may not get much respect, but it does have considerable staying power. Consider four recent developments (and non-developments). First, in the 2008 Democratic presidential primaries, only Representative Dennis Kucinich proposed outright replacement of EBC with a one-payer system—and he was out of the race on January 24, 2008, after receiving no delegates in Iowa, 1.35% of the vote in New Hampshire (fifth place), and 3.65% in Michigan (third place, but second place went to "uncommitted," who got 40% of the vote).[5] Second, the

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1. BrainyQuote, Will Rogers Quotes, http://www.brainyquote.com/quotes/authors/w/will_rogers.html (last visited May 4, 2009).

2. David A. Hyman & Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 YALE J. HEALTH POL'Y L. & ETHICS 23 (2001).

3. *Id.* at 23.

4. *Id.* at 26-43. For additional background on EBC, see David Blumenthal, *Employer-Sponsored Health Insurance in the United States—Origins and Implications,* 355 NEW ENG. J. MED. 82 (2006); Alain C. Enthoven & Victor R. Fuchs, *Employment-Based Health Insurance: Past, Present, and Future*, HEALTH AFF., Nov.-Dec. 2006, at 1538.

5. CNN Election Center 2008, Results: Dennis Kucinich, http://www.cnn.com/

two leading candidates in the Democratic primary (then-Senators Barack Obama and Hillary Clinton) both proposed to build on EBC instead of proposing to replace it. Democratic primary voters are the natural constituency for a one-payer system, but their revealed preferences (or, more likely, their expectations about the electoral appeal of that approach) obviously pointed in a rather different direction. Third, although the American Recovery and Reinvestment Act of 2009 (the "stimulus bill") expands Medicaid, unemployed workers may only participate if they qualify under existing income and wealth criteria. Instead of broadening access to Medicaid, the stimulus bill subsidizes the cost of COBRA premiums for those who wish to maintain their EBC after they have been laid off. Fourth, since taking office, President Obama has stuck to the basic position he took during the Democratic primaries: if an individual is happy with his existing coverage (which for a majority of Americans is EBC), he is free to keep it.

These realities suggest that EBC has more staying power than its critics might have hoped—even if the principal explanation for that staying power is nothing more compelling than inertia, or a status-quo bias if you prefer the language of behavioral economics. To be sure, the past does not necessarily predict the future in politics, policy, or finance, and health insurance falls within all three of those categories. There are also plenty of reasons to worry about how long employers will want to remain the fiscal intermediaries for their employees to obtain health coverage. But, for the moment, EBC is here to stay—and there is (as yet) no evidence we are approaching a tipping point.

Given the likely prevalence of EBC for the foreseeable future, it is worth emphasizing four important points about EBC and universal coverage. What these points have in common is that they are myths—most people believe they are true, even though they are not.[6] The four "myths" are these:

1) Employers pay for EBC;

2) There are 45.7 million uninsured Americans;

3) Universal coverage means everyone will have access to high-quality care; and

4) Universal coverage will solve the cost problems of American health care.

ELECTION/2008/primaries/results/candidates/#1380 (last visited May 4, 2009).

6. This is not the only article that takes this approach. *See, e.g.*, Katherine Baicker & Amitabh Chandra, *Myths and Misconceptions About U.S. Health Insurance*, HEALTH AFF., Oct. 21, 2008, at W533, http://content.healthaffairs.org/cgi/content/abstract/27/6/w533 (web exclusive); Shannon Brownlee & Ezekiel Emanuel, Op-Ed., *5 Myths About Our Ailing Health Care System*, WASH. POST, Nov. 23, 2008, at B3.

Part I explains why each of these are "things people know that aren't so." Part II briefly considers whether we are likely to get to universal coverage without relying, in part, on EBC.

I. FOUR THINGS PEOPLE KNOW THAT AREN'T SO

A. Employers Pay for EBC

They don't. Although employers contribute sizeable amounts toward EBC,[7] employees actually foot the bill in the form of foregone salary and other benefits.[8] This dynamic helps explain why salaries for many workers have stagnated during the past decade: the pay increases that would otherwise have been realized as salary have been spent by employers on the rising cost of providing health insurance.[9]

Why should anyone care? The assumption that employers are paying for EBC means that employees and legislators are far less concerned about the cost of coverage and care (and the associated trade-offs) than would otherwise be the

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7. *See, e.g.*, SARA R. COLLINS, CHAPIN WHITE & JENNIFER L. KRISS, THE COMMONWEALTH FUND, WHITHER EMPLOYER-BASED HEALTH INSURANCE? THE CURRENT AND FUTURE ROLE OF U.S. COMPANIES IN THE PROVISION AND FINANCING OF HEALTH INSURANCE (2007) ("Employer contributions to health insurance coverage comprise a substantial share of the overall financing of the U.S. health system. This year, the average employer contribution for employees enrolled in single policies is $3,785; for family policies it is $8,824. These contributions account for 84% of the full premium for single policies, and 72% of the full premium for family policies. In 2005, total employer premium contributions for coverage of active employees and their dependents totaled about $420 billion, over one-fifth of total U.S. health expenditure.").

8. *See* Anna D. Sinaiko, *Employer's Response to a Pay or Play Mandate: An Analysis of California's Health Insurance Act of 2003*, HEALTH AFF., Oct. 13, 2004, http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.469/DC1 ("[E]conomic theory predicts that over the long term, employers will pass the cost of benefits to employees through lower wages . . . Previous studies report that in general, 83-100 percent of the costs of health insurance are shifted to employees through reduced wages."); *see also* Jonathan Gruber, *Health Insurance and the Labor Market*, 1 HANDBOOK OF HEALTH ECONOMICS 645–706 (A.J. Culyer & J.P. Newhouse eds., 2000); Linda J. Blumberg, *Who Pays for Employer-Sponsored Health Insurance*, HEALTH AFF., Nov.-Dec., 1999, at 58.

9. *See, e.g.*, Brownlee & Emanuel, *supra* note 6 ("Rising health-care costs are partly to blame for stagnant wages . . . In effect, about half the money you should be earning for being more productive is being sucked up by ever more expensive health-insurance premiums."); Christine Eibner & M. Susan Marquis, *Employer's Health Insurance Cost Burden, 1996-2005*, MONTHLY LAB. REV., June 2008, at 28, 28 ("Data from the Employment Cost Index show that health insurance costs relative to payroll increased 34% between 1996 and 2005 and that the increase was largest for businesses paying low wages; simultaneously, data from the Employee Benefits Survey show that benefit packages became less generous.").

case. Indeed, the assumption allows everyone to pretend that employers have an artesian well of money that they can use to take care of any and all medical bills incurred by their employees. The same assumption also makes it easier to criticize employers for "hollowing out" coverage and "shifting" the cost of coverage to employees.

The same (erroneous) assumption also helps explain part of the appeal of an employer mandate.[10] Someone who believes that employers foot the bill for EBC will understandably regard employers who do not provide health insurance as free-riders, shirking their moral and economic obligations. In reality, in a competitive labor market, employees are paid the market rate for their services, and it is completely irrelevant (apart from the tax implications) whether compensation comes in the form of a salary only, or EBC plus a lower salary.[11] Worse still, an employer mandate (as well as a pay-or-play mandate where the cost of the "pay" option is tied to the cost of coverage) effectively indexes the minimum wage to the health care inflation rate—with predictable consequences on the employment prospects for those whose marginal productivity is less than the cost of the mandated benefits.

Finally, it is possible to repackage this (factually erroneous) assumption in a way that makes employees and politicians more sympathetic to attempts by employers to control the costs of coverage—such as the claim that high health care costs hurt the global competitiveness of employers.[12] Interestingly, the Obama administration has recently embraced this claim to support its efforts to remake the health care system.[13] It would be more accurate to say that "high

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10. *See* John Oberlander, *The Politics of Paying for Health Reform: Zombies, Payroll Taxes, and The Holy Grail*, HEALTH AFF, Oct. 21, 2008, at w544, w549 http://content.healthaffairs.org/cgi/reprint/hlthaff.27.6.w544v1 (web exclusive) ("The (mis)perception that employer-sponsored insurance is paid for by employers remains a large part of employer mandate's political appeal.").

11. Of course, the existence of other benefits means that the trade-offs are more complex, since one can fund increased health coverage costs by cutting salary, cutting other benefits, or various combinations of cuts in both. Wages can also be sticky, at least in the short run. The tax implications of EBC are beyond the scope of this article. For further analysis, see Hyman & Hall, *supra* note 2, at 39.

12. Press Release, Business Roundtable, New Study Shows Health Care Costs Put U.S. Workers at Significant Disadvantage Compared with Global Competitors (Mar. 12, 2009), http://www.businessroundtable.org/sites/default/files/Health%20Value%20Comparability%20Study%20Press%20Release%20FINAL%20(2).pdf.

13. *See, e.g.*, U.S. DEP'T OF HEALTH & HUMAN SERVS., THE COSTS OF INACTION: THE URGENT NEED FOR HEALTH REFORM 2 (2009), *available at* http://www.healthreform.gov/reports/inaction/inactionreportprintmarch2009.pdf ("Health care costs add $1,525 to the price of every General Motors vehicle. The company spent $4.6 billion on health care in 2007, more than the cost of steel. As a result of these crushing health care costs, American businesses are losing their ability to compete in the global marketplace.").

wages" can hurt the global competitiveness of particular products produced in the United States—an observation that has nothing to do with whether the wages are spent on health care or widgets.[14]

B. There Are 45.7 Million Uninsured Americans in the United States

How many uninsured Americans there are depends on what you mean by "uninsured" and "American." Surveys are used to determine how many uninsured there are—but the framing of the question dramatically affects the answers one receives. Consider three different ways of asking whether someone is uninsured:

1) Were you uninsured at any point during the past year?

2) Were you uninsured for the entire past year?

3) Are you uninsured today?

Each of these questions will produce a different number of uninsured Americans—and that number can be as low as 22 million, or as high as 67 million, depending on the question and the survey population.[15] The current conventional figure of 45.7 million is derived from the Census Bureau's Current Population Survey (CPS), which uses a series of questions premised on the approach of the second question above.[16] Unfortunately, this approach

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14. To be sure, there are other reasons for skepticism about the significance of such claims. *See* James F. Blumstein, *On Prudence in Health Care Reform*, 4 CORNELL J.L. & PUB. POL'Y 422, 426 (1995) ("If a company cannot make its prices competitive, then the company has a problem. The fact that some companies have absorbed high medical care expenses in their labor negotiations is not a good reason to nationalize the system.").

15. CATHERINE HOFFMAN & JOHN HOLOHAN, KAISER COMM'N ON MEDICAID & THE UNINSURED, WHAT IS THE CURRENT POPULATION SURVEY TELLING US ABOUT THE NUMBER OF UNINSURED? 3 fig.2 (2005) (estimating the upper bound for those uninsured ever in one year at 67 million). A more recent analysis concluded that 86.7 million Americans were without insurance at some point during 2007 and 2008. FAMILIES USA, AMERICANS AT RISK: ONE IN THREE UNINSURED 2 tbl.2 (2009), *available at* http://www.familiesusa.org/assets/pdfs/americans-at-risk.pdf (showing the estimated duration of being uninsured); *see also* Thomas Miller, *What Do We Know About the Uninsured*, AMERICAN, July-Aug. 2008, http://www.american.com/archive/ 2008/july-august-magazine-contents/what-do-we-know-about-the-uninsured.

16. *See* CARMEN DENAVAS-WALT, BERNADETTE D. PROCTOR & JESSICA C. SMITH, U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2007, at 19 (2008), *available at* http://www.census.gov/prod/2008pubs/p60-235.pdf ("The Annual Social and Economic Supplement (ASEC) to the Current Population Survey (CPS) asks about health insurance coverage in the previous calendar year. The survey asks separate questions about the

predictably leads to "a likely overcount of the number of people uninsured for the full calendar year and an undercount of the number of people who had Medicaid coverage at some point in the previous calendar year."[17] There have been various attempts to quantify the degree to which the CPS overstates how many people are uninsured for the entire year, with the precise results affected by the methodology employed.[18] In the words of one set of prominent researchers in the field,

> Comparisons with other surveys show that the CPS does not provide a good measure of those who are uninsured for a full year. Rather the CPS closely approximates the estimate from other surveys of the number of uninsured at a point in time. Thus, it is including both those who are uninsured throughout the full year as well as some of those who are uninsured for shorter periods of time.[19]

It is not necessary to determine the optimal way of counting the uninsured to recognize that an obscure methodological decision has profoundly affected the perceived magnitude of the problem—and depending on the criteria and study one employs, figures ranging from 22 million to 67 million are defensible.

Second, commentators routinely assert that there are 45.7 million uninsured

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major types of health insurance, and people who answer 'no' to each of the coverage questions are then asked to verify that they were, in fact, not covered by any type of health insurance. . . People were considered 'insured' if they were covered by any type of health insurance for part or all of the previous calendar year. They were considered 'uninsured' if they were not covered by any type of health insurance at any time in that year."); HOFFMAN & HOLOHAN, *supra* note 15, at 3.

17. HOFFMAN & HOLOHAN, *supra* note 15, at 2; *see also* DENAVAS-WALT ET AL., *supra* note 16, at 19 ("Research shows health insurance coverage is underreported in the CPS ASEC for a variety of reasons . [B]ecause health insurance coverage status can change over the course of a year, answering questions about this long reference period may lead to response errors. For example, some people may report their insurance coverage status at the time of their interview rather than their coverage status during the previous calendar year. Compared with other national surveys, the CPS ASEC's estimate of the number of people without health insurance more closely approximates the number of people who were uninsured at a specific point in time during the year than the number of people uninsured for the entire year."). *But see* Jennifer Kincheloe et al., *Can We Trust Population Surveys To Count Medicaid Enrollees and the Uninsured?*, HEALTH AFF., July-Aug. 2006, at 1163, 1166 ("[P]opulation surveys using carefully crafted questions to elicit self-reported measurements of health insurance can produce reasonably accurate estimates of adult Medicaid enrollment. Although most enrollees understand that they are in Medicaid and report it, some are confused about their public coverage. Evidence suggests some under- and overreporting of Medi-Cal in CHIS, perhaps because of stigma, dual enrollment, or confusion about program name, but CHIS estimates of adult Medi-Cal enrollment match administrative counts.").

18. HOFFMAN & HOLOHAN, *supra* note 15, at 5-7.

19. *Id.* at 7.

Americans.[20] In fact, roughly 9.7 million of the 45.7 million uninsured in the CPS are non-citizens—and the rate of uninsurance is far higher among non-citizens (43.8%) than citizens (12.9%).[21] These facts will be deemed completely irrelevant by some, but they are quite significant to others—including the Clinton administration. President Clinton's Health Security Act only covered citizens and *legal* aliens.[22] The Obama administration's eight principles of health care reform do not explicitly address whether non-citizens should be covered; the plan refers at one point to "reduc[ing] the growing premiums and other costs American citizens and businesses pay for health care," and refers elsewhere to "put[ting] the United States on a clear path to cover all Americans."[23] Given the ongoing debates over immigration policy, it seems probable that many voters will be far more concerned about uninsured American citizens than uninsured non-citizens—particularly if the latter group is disproportionately composed of non-legal aliens.

Finally, it is worth noting that the 45.7 million CPS figure also includes individuals who can afford coverage and decline it, or those who qualify for a subsidized program (e.g., SCHIP or Medicaid) but are not enrolled for one reason or another.[24] To be sure, all of these individuals are still uninsured—but the list

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20. *See, e.g.*, Jennifer Pifer-Bixler, *86.7 Million Americans Uninsured over Last Two Years*, CNN.com, Mar. 4, 2009, http://www.cnn.com/2009/HEALTH/03/04 uninsured.epidemic.obama; Press Release, Commonwealth Fund, Statement from Karen Davis: New Census Data on Uninsured Americans (Aug. 26, 2008), http://www.commonwealthfund.org Content News/News-Releases/2008/Aug/Statement-from-Karen-Davis--New-Census-Data-on-Uninsured-Americans.aspx; Press Release, Consumers Union, Latest U.S. Census Estimates Show 45.7 Million Americans Are Uninsured (Aug. 26, 2008), http://www.consumersunion.org/pub/core_health_care/005988.html.

21. DENAVAS-WALT ET AL., *supra* note 16, at 22 tbl.6. The Census Bureau does not break out how many of these non-citizens are non-legal aliens. A common estimate is that there are roughly 12 million "unauthorized immigrants" in the United States. CONG. BUDGET OFFICE, THE IMPACT OF UNAUTHORIZED IMMIGRANTS ON THE BUDGETS OF STATE AND LOCAL GOVERNMENTS, at Preface (2007), *available at* http://www.cbo.gov/ftpdocs/87xx/doc8711/12-6-Immigration.pdf.

22. Health Security Act, H.R. 3600, 103rd Cong. § 1001(c) (1993) ("In this Act, the term 'eligible individual' means an individual who is residing in the United States and who is (1) a citizen or national of the United States; (2) an alien permanently residing in the United States under color of law . . ; or (3) a long-term nonimmigrant . . "). The President of the ACLU condemned this approach, arguing that the "Act's exclusion of aliens and incarcerated people is not only inequitable, but also irrational in terms of financial and public health considerations." Nadine Strossen, *National Health Care: Will Big Brother's Doctor Be Watching Us?*, 4 CORNELL J.L. & PUB. POL'Y 435, 439 (1995).

23. *Obama-Care 101, The President's 8 Principles*, POLITICO, Feb. 26, 2009, http://www.politico.com/news/stories/0209/19362.html.

24. *See, e.g.*, Joseph Antos, *Kerry, Bush and the Uninsured*, AEI HEALTH POL'Y OUTLOOK, Sept. 3, 2004, http://www.aei.org/publications/pubID.21137/pub_detail.asp.

of plausible strategies for addressing these specific populations is likely to differ from the list of plausible strategies for dealing with those who can't afford coverage and are not covered by an existing subsidy and/or program. For those who can afford coverage, reform might take the form of an individual mandate, access to a wider array of coverage options, or a change in the default (i.e., auto-enrollment in health insurance, thus forcing them to affirmatively opt out of coverage). For those who qualify for a subsidized program but are not currently enrolled, reform might take the form of greater outreach or more aggressive enrollment strategies.

The bottom line is that the uninsured are made up of several discrete sub-populations. Members of different sub-populations lack insurance for quite different reasons and live without insurance for varying periods of time. Treating the uninsured as a unitary entity may enhance the political salience of the problem, but it obscures the differences among sub-populations and the strategies that might be usefully employed to address the underlying problem.

C. Universal Coverage Means Everyone Will Have Access to High-quality Care

Health insurance is important, but having health insurance is not the same thing as having access to health care—let alone access to high-quality care. A vast body of empirical research makes both points clear and highlights the inadequacies of the care received by those who are currently insured.[25] Even well-insured people have difficulty finding a primary care physician, accessing

25. *See, e.g.*, PETER J. CUNNINGHAM & LAURIE E. FELLAND, CTR. FOR STUDYING HEALTH SYS. CHANGE, FALLING BEHIND: AMERICANS' ACCESS TO MEDICAL CARE DETERIORATES, 2003-2007, at 1 (2008) ("[I]nsured people also faced large increases in unmet need between 2003 and 2007. In fact, insured people experienced a greater percentage increase in unmet medical needs compared with uninsured people—a 62 percent increase for the insured vs. a 33 percent increase for the uninsured. As a result, ironically, the access gap between insured and uninsured people narrowed slightly Rising out-of-pocket costs in the form of higher deductibles, coinsurance and copayments likely account for much of the increased unmet need among insured people."); JOHN E. WENNBERG ET AL., DARTMOUTH ATLAS, AN AGENDA FOR CHANGE: IMPROVING QUALITY AND CURBING HEALTH CARE SPENDING: OPPORTUNITIES FOR CONGRESS AND THE OBAMA ADMINISTRATION ii (2008) ("Health care in America is not nearly as good as it should be. Quality is inconsistent and often poor, rates of error are unacceptably high, and costs are higher than anywhere else in the world."); Marshall H. Chin, *Improving Care and Outcomes of Uninsured Persons with Chronic Disease Now*, 149 ANNALS INTERNAL MED. 206, 206 (2008) ("Health care insurance reform is necessary for good care for chronic disease, but it will not be sufficient unless it is coupled with quality improvement efforts targeting the reasons that vulnerable populations with access to care often do not receive optimal care."); David A. Hyman & Charles Silver, *The Poor State of Health Care Quality in the U.S.. Is Malpractice Liability Part of the Problem or Part of the Solution?*, 95 CORNELL L. REV. 893 (2005) (reviewing evidence on the quality of care that *is* provided); Barbara Starfield & Leiyu Shu, *The Medical Home, Access to Care, and Insurance: A Review of Evidence*, 113 PEDIATRICS 1493 (2004).

the health care system during evenings and weekends, and obtaining health care when they travel.

Those more inclined to rely on anecdotal evidence should consider the case of Deamonte Driver, a twelve-year-old African American child who lived in Maryland.[26] Deamonte and his brother DaShawn were covered by Medicaid, which provides comprehensive insurance coverage, including dental care. Neither received regular dental care—and when DaShawn got a toothache, his mother had great difficulty finding a dentist willing to see him—let alone an oral surgeon able to extract several teeth that had become abscessed.[27] When Deamonte complained of a headache, his mother took him to the hospital, which gave him "medicine for a headache, sinusitis and a dental abscess."[28] It is unclear whether his mother attempted to find a dentist to treat Deamonte's dental abscess—but her experiences with DaShawn made clear the difficulties and delays she would have faced. In short order, the infection spread from the abscess to Deamonte's brain, and it resulted in two operations, six weeks of hospitalization, and, ultimately, death.

Why couldn't Deamonte and DaShawn find a dentist, even though both had insurance? Maryland's Medicaid program paid so little that only 16% of Maryland dentists were willing to accept Medicaid patients, and only 31% of the children in the Maryland Medicaid program received any dental services in 2005.[29] These problems are not unique to Maryland: in 2005, only 29.3% of children on Medicaid in the District of Columbia and 24.3% of children on Medicaid in Virginia saw a dentist.[30] These problems are also not unique to dentistry: access problems for Medicaid beneficiaries are pervasive because of

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26. Mary Otto, *For Want of a Dentist*, WASH. POST, Feb. 28, 2007, at B1; *see also The Story of Deamonte Driver and Ensuring Oral Health for Children Enrolled in Medicaid: Hearing Before the Domestic Policy Subcomm. of the H. Comm. on Oversight and Government Reform*, 110th Cong. (2007) (statement of Lorrie J. Norris, Public Justice Center), *available at* http://domesticpolicy.oversight.house.gov/documents/20070516164514.pdf [hereinafter Norris Testimony].

27. After Ms. Driver was unable to find a dentist on her own, she contacted the Public Justice Center (PJC) in Baltimore, Maryland. The PJC contacted twenty-six dentists that the Medicaid benefits administrator thought were participating in the program. None of them were willing to see a Medicaid patient. The PJC then contacted the Medicaid enrollee helpline run by the Maryland Department of Health and Mental Hygiene (DHMH). "Over the next 5 days, the DHMH case management nurse, a case manager at the Prince George's County Health Department's ombudsman unit, and an employee at United Healthcare/Americhoice worked together" to try to find a dentist for Deamonte's brother and make an appointment. Norris Testimony, *supra* note 26, at 5.

28. Otto, *supra* note 26.

29. *Id.*

30. *Id.*

low and slow payments and administrative headaches.[31] Medicare beneficiaries and those with private insurance are experiencing access problems as well, and those problems are getting worse over time.[32]

To summarize, universal coverage does not mean that everyone will receive care—let alone high-quality care. Addressing those problems will require attention to the delivery-side of the market.

D. Universal Coverage Will Solve the Cost Problems of American Health Care

It won't. But don't take it from me. Just ask President Obama:

> If we don't address cost, I don't care how heartfelt our efforts are, we will not get this done. If people think we can simply take everybody who is not insured and load them up in a system where costs are out of control, it's not going to

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31. *See, e.g.*, PETER J. CUNNINGHAM & JESSICA MAY, CTR. FOR STUDYING HEALTH SYS. CHANGE, MEDICAID PATIENTS INCREASINGLY CONCENTRATED AMONG PHYSICIANS 3 (2006), *available at* http://www.hschange.com/CONTENT/866/866.pdf ("Relatively low Medicaid payment rates and high administrative burdens are major reasons for not accepting Medicaid patients, according to physicians . . . These concerns also likely explain why physicians in smaller practices are increasingly closing their practices to new Medicaid patients."); Peter J. Cunningham & Ann S. O'Malley, *Do Reimbursement Delays Discourage Medicaid Participation by Physicians?*, HEALTH AFF., Nov. 18, 2008, at w17, http://content.healthaffairs.org/cgi content/full/28/1/w17? (web exclusive) ("Surveys show that about half of physicians accept all new Medicaid patients into their practices, compared with more than 70 percent for privately insured or Medicare patients. . . . Low Medicaid reimbursement rates relative to those of Medicare and private payers are usually considered to be the primary reason for low physician participation in Medicaid. Medicaid fee levels vary considerably across states, and research has consistently shown that Medicaid participation by physicians is higher in states with higher fees than in states with lower fees."); Kevin Sack, *In Massachusetts, Universal Coverage Strains Care*, N.Y. TIMES, Apr. 5, 2008, at A1 (quoting Dr. Katherine Atkinson, a family physician in Amherst, Massachusetts: "I calculated that every time I have a Medicaid patient, it's like handing them a $20 bill when they leave.").

32. *See* CUNNINGHAM & FELAND, *supra* note 25; Marc Siegal, *When Doctors Opt Out*, WALL ST. J. Apr. 17, 2009, at A13 ("[T]he Medicare Payment Advisory Commission reported in 2008 that 28% of Medicare beneficiaries looking for a primary care physician had trouble finding one, up from 24% the year before. The reasons are clear: A 2008 survey by the Texas Medical Association, for example, found that only 38% of primary-care doctors in Texas took new Medicare patients. The statistics are similar in New York state, where I practice medicine. More and more of my fellow doctors are turning away Medicare patients because of the diminished reimbursements and the growing delay in payments. I've had several new Medicare patients come to my office in the last few months with multiple diseases and long lists of medications simply because their longtime provider—who they liked—abruptly stopped taking Medicare. . . . The problem is even worse with Medicaid. . . . HMOs are problematic as well.").

happen. We will run out of money.[33]

Whether universal coverage will make it easier to solve the cost problems of American health care is, of course, a different question—but the early returns from Massachusetts are not particularly encouraging.[34] Several commentators have asserted that the Massachusetts approach (do universal coverage first, and then do cost control) will make it easier to implement cost control,[35] but there is

33. CNN.com, Transcripts, http://transcripts.cnn.com/TRANSCRIPTS/0903/05/sitroom.01.html (transcript of The Situation Room, aired on Mar. 5, 2009).

34. *See, e.g.*, DIANE ARCHER, INST. FOR AM.'S FUTURE, MASSACHUSETTS HEALTH REFORM: NEAR UNIVERSAL COVERAGE, BUT NO COST CONTROLS OR GUARANTEE OF QUALITY, AFFORDABLE HEALTH CARE FOR ALL (2009), *available at* http://ourfuture.org/healthcare/massachusetts ("While reform has been very effective at increasing accessibility of insurance . . the Massachusetts model is unsustainable, with skyrocketing costs and no systems in place to drive value."); David A. Hyman, *The Massachusetts Health Plan: The Good, the Bad, and the Ugly*, 55 U. KAN. L. REV. 1103, 1115 (2007) ("Finally, the regulations that were adopted do nothing about the cost of health care in Massachusetts—and in the long run, that problem will swamp any reform proposal, including the Massachusetts health plan."); Kevin Sack, *With Health Care for Nearly All, Massachusetts Now Faces Costs*, N.Y. TIMES, Mar. 15, 2009, at A1 ("Those who led the 2006 [Massachusetts reform] effort said it would not have been feasible to enact universal coverage if the legislation had required heavy cost controls. The very stakeholders who were coaxed into the tent—doctors, hospitals, insurers and consumer groups—would probably have been driven into opposition by efforts to reduce their revenues and constrain their medical practices, they said. Now those stakeholders and the state government have a huge investment to protect.").

35. *See, e.g.*, Jonathan Gruber, The Treatment, *Response: In Massachusetts, We Got Reform Right*, NEW REPUBLIC, Mar. 22, 2009, http://blogs.tnr.com/tnr/blogs/the_treatment/archive/2009/03/22/response-in-massachusetts-we-got-reform-right.aspx ("[T]he Massachusetts law explicitly did not take on the fundamental determinants of medical cost growth—and this is, in my mind, the genius of the approach. For decades, efforts to move towards universal coverage have always floundered on the shoals of cost control [T]he choice between coverage first or coverage as part of a comprehensive cost control package is a false one. Coverage first is the natural stepping stone to a comprehensive cost control. By bringing everyone into the tent of insurance coverage, and getting all the interest groups behind a common goal, a move to universal coverage could be viewed in retrospect as the key step towards the cost control this country so desperately needs."); *see also* Michael Vitez, *Mass. Health Care Has Lessons*, PHIL. INQUIRER, Mar. 31, 2009, at A1 ("'We did it right in Massachusetts. That's the most important lesson,' said Stuart Altman, a health-policy expert at Brandeis University. 'The first part was cover everyone, make it work . . Trying to control costs brings every constituent group out against you.'"); Jonathan Cohn, The Treatment, *Massachusetts Miracle—or Catastrophe?*, NEW REPUBLIC, Mar. 17, 2009, http://blogs.tnr.com/tnr/blogs/the_treatment/archive/2009/03/17/massachusetts-miracle-or-disaster.aspx ("Note, by the way, that the state is now moving forward on cost control. A new commission is investigating ways of moving the state away from straight fee-for-service and towards payment systems that reward high quality and efficiency . . [M]any officials and experts in Massachusetts have argued that it is the clear progress on coverage that makes this new discussion possible.").

no evidence to support that assertion, beyond generalized expressions of optimism, and the hope that forthcoming recommendations from yet another blue-ribbon commission will be game-changing.[36] Even those who believe that this approach is sound recognize that cost-containment is likely to be an extremely tough sell in Massachusetts.[37]

Putting the dynamic in poker terms, Massachusetts has gone "all in" on coverage—based on the hope that providers will fold on cost-containment. If they don't, President Johnson anticipated the likely impact on the Massachusetts state budget and the health care system:

> Well, I remember one time they were giving a test to a fellow who was going to be a switchman on the railroad, giving him an intelligence test, and they said, "What would you do if a train was coming east going sixty miles per hour, and you looked over your shoulder and another one was coming from the west going sixty miles an hour?". . . And the fellow said, "I'd go get my brother." And they said, "Why would you get your brother?" And he said, "Because he hasn't ever seen a train wreck."[38]

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36. *See, e.g.*, Sack, *supra* note 34 ("Both Gov. Deval Patrick and a high-level state commission have set out to revamp the way public and private insurers reimburse physicians and hospitals. They want a new payment method that rewards prevention and the effective control of chronic disease, instead of the current system, which pays according to the quantity of care provided. By late spring, the commission is expected to recommend such a system to the legislature."); Gruber, *supra* note 35 ("[D]oing coverage first is the single most important thing we can do to get to cost control . . . We have one of the strongest and most effective advocacy groups for health care for the poor in the country . . . After playing such an important role in passing our law, this group suddenly realized that their hard won gains may be lost if we didn't eventually figure out a way to control health care costs. The result was an intense and broad-reaching campaign that resulted in the most significant cost-control legislation we have seen in Massachusetts in at least fifteen years. This includes the appointment of a commission . This legislation, and commission, would simply not have happened without our reform law motivating concerted action to preserve the gains we have made for the uninsured. Whether this commission can make headway in a state so dominated by the health care sector is uncertain, but at least more progress is being made than had been made in recent years.").

To be clear, I certainly agree that we should change the ways in which we compensate health care providers. *See, e.g.*, David A. Hyman & Charles Silver, *You Get What You Pay for: Result-Based Compensation for Health Care*, 58 WASH. & LEE L. REV. 1427 (2001).

37. *See, e.g.*, Sack, *supra* note 34 ("[T]he task of cost-cutting remains difficult in a state with a long tradition of heavy spending on health care. Massachusetts has more doctors per capita than any state, Boston is home to some of the country's most expensive academic medical centers, and a new state law requires comprehensive benefits like prescription drug and mental health coverage . 'Just as this may have been the easiest place to do coverage, it may be the most difficult place to do cost control,' said Jonathan Gruber, a health economist at the Massachusetts Institute of Technology.").

38. David Blumenthal & James Morone, *The Lessons of Success—Revisiting the Medicare*

Finally, it is interesting to speculate how our nation's budgetary policies, procurement and programmatic decisions, and tax burdens might differ from the status quo if legislators and the executive branch routinely followed a similar "dessert first, spinach later, we hope" approach.

II. UNIVERSAL COVERAGE AND EBC

It is clear that EBC won't deliver universal coverage. In 2007, EBC covered about 177.4 million people, or roughly 60% of the population.[39] The percentage of the population that is covered by EBC depends on the interaction of a host of factors, including the cost of coverage, the size and sophistication of the employer, the market sector in which the employer competes, whether the employer is unionized, and the availability of publicly-financed coverage. The terms on which EBC is offered (including whether it is offered at all), and whether there is uptake, are also contingent on larger macroeconomic trends and a host of decisions and trade-offs made by individual employers and employees. Because EBC is "employment based coverage," job loss and loss of insurance generally go together.[40] To be sure, newly unemployed workers have the right to purchase COBRA coverage from their former employers—but many are unable to afford the substantial associated premiums once they are unemployed—and it remains to be seen whether the subsidy for such premiums in the stimulus bill will close the gap. More generally, Medicare, Medicaid, and SCHIP were enacted because EBC proved incapable of ensuring universal coverage.[41] Yet, it

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Story, 359 NEW ENG. J. MED. 2384, 2385 (2008) (quoting President Johnson).

39. DENAVAS-WALT ET AL., *supra* note 16, at 61 tbl.C-1.

40. *See* Robert Pear, *When A Job Disappears, So Does the Health Care*, N.Y. TIMES, Dec. 6, 2008, at A30. The standard estimate is that every 1% increase in the unemployment rate results in an additional 1 million uninsured individuals. *See* KAISER COMM'N ON MEDICAID AND THE UNINSURED, RISING UNEMPLOYMENT, MEDICAID AND THE UNINSURED, A MULTI-YEAR SNAPSHOT OF STATE FINANCING EFFECTS (2009) ("Assuming that states maintain eligibility levels for public programs, every one percentage point increase in unemployment is likely to result in one million more Medicaid and SCHIP enrollees and 1.1 million more uninsured.).

In an interview on PBS, Uwe Reinhardt, in typically understated fashion, suggested that "the devil systematically built our health insurance system [with] the feature that when you're down on your luck, you're unemployed, you lose your insurance [O]nly the devil could ever have invented such a system. Humans of goodwill would never do this." PBS.org, Healthcare Crisis: Uwe E. Reinhardt, Ph.D., http://www.pbs.org/healthcarecrisis/Exprts_intrvw/u_reinhardt.htm (last visited May 4, 2009). As I have noted elsewhere, Reinhardt does not consider the possibility that the Devil has a diversified portfolio. *See generally* DAVID A. HYMAN, MEDICARE MEETS MEPHISTOPHELES xviii (2006).

41. Of course, this is a separate question than the degree of crowd-out caused by these programs. *See generally* David M. Cutler & Jonathan Gruber, *Does Public Insurance Crowd Out Private Insurance?*, 111 Q.J. ECON. 391 (1996); Jonathan Gruber & Kosali Simon, Crowd-Out Ten Years Later: *Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?*,

does not follow that the United States can get to universal coverage without EBC, for two distinct reasons: budgetary reality and the logic of collective action.

Budgetary reality creates a substantial incentive for policymakers to build on existing institutional arrangements, rather than start over from scratch. The budgetary issue is simple: strategies to replace EBC outright will require the government to impose substantial additional taxes. Enthusiastic supporters of universal coverage will view those taxes as a reasonable exchange for the resulting health insurance security—but that opinion is far from universal.[42] Public support for health reform predictably drops dramatically once a price-tag is attached—and the larger the price-tag, the larger the drop.

Stated differently, taxes matter. The basic design of President Clinton's Health Security Act (specifically, the reliance on regional alliances to collect premiums and arrange for coverage) was driven by the Administration's need to keep the Congressional Budget Office (CBO) from scoring the premiums as taxes.[43] When the CBO scored those payments as taxes, the Act was effectively dead.[44] During the campaign before the 2008 election, one of President Obama's

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(Nat'l Bureau of Econ. Research Working Paper No. 12858, 2007), *available at* http://www.nber.org/papers/w12858.

42. *See* Oberlander, *supra* note 10, at w547 ("When middle-class, insured Americans think about health reform, what they have in mind is not a proposal to make their health insurance benefits subject to taxation.").

43. *See* William M. Sage, *Legislating Delivery System Reform: A 30,000 Feet View of the 800 Pound Gorilla*, HEALTH AFF., Nov.-Dec. 2007, at 1553, 1554 ("Two principal elements of that plan (nominally private 'health alliances' and global limits on premiums) existed mainly to persuade the Congressional Budget Office to confer a favorable 'score.'").

44. *See* Ezra Klein, *The Number Cruncher in Chief*, AM. PROSPECT, Jan. 14. 2009, http://www.prospect.org/cs/articles?article=numbercruncherinchief ("How much a bill costs is central to whether it gets enacted. And not just how much it costs but *how much the CBO says it costs*. The Number. The CBO's most famous—or infamous—intervention in a legislative battle was its estimate of the 1994 Clinton health-care proposal. 'The major issue,' recalls Robert Reischauer, then director of the CBO, 'was not how much it cost but whether the premiums that you were charged as an individual were governmental in nature and would thus be in the budget.' Reischauer and the CBO decided they were. The premiums paid by every American would be included in the Number. This meant the Number was *huge* – vastly larger than the price tag previously affixed to the proposal by the Clinton administration. Hearing the news, one senior administration official moaned to the Washington Post, 'The Republicans will jump all over this and say we're increasing the budget by 25 percent and putting through the biggest tax increase in history.' The New York Times editorialized that 'the opponents of President Clinton's health care bill think they have struck political gold in an analysis of the bill just released by the Congressional Budget Office.' They were right. Donna Shalala, Clinton's secretary of health and human services, called the ruling 'devastating.' That was the Number, and it helped kill the bill.").

The significance of the CBO decision is also shown by the pressure CBO came under from President Clinton's supporters to treat the alliances as private entities. *See* HAYNES JOHNSON & DAVID S. BRODER, THE SYSTEM 283-284 (1996) ("The politics became intense, personal, and

most popular ads emphasized that he would follow a different course: "On health care reform -- two extremes. On one end, government-run health care, higher taxes. On the other, insurance companies without rules, denying coverage. Barack Obama says both extremes are wrong."[45]

The practical politics of the situation are related to the budgetary realities, but they also reflect the underlying collective action problem. Machiavelli nicely summarized the challenge awaiting potential reformers:

> And it should be realised that taking the initiative in introducing a new form of government is very difficult and dangerous, and unlikely to succeed. The reason is that all those who profit from the old order will be opposed to the innovator, whereas all those who might benefit from the new order are, at best tepid supporters of him. This lukewarmness arises partly from fear of their side, partly from the skeptical temper of men, who do not really believe in new things unless they have been seen to work well.[46]

As I noted in the pages of this journal eight years ago, "in health care, there are . . too few people who are fundamentally dissatisfied with the coverage they now have, for comprehensive reform to be politically viable."[47] Although dissatisfaction with the American health care system is certainly widespread, it has not yet reached the critical mass necessary to eliminate EBC.[48]

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abusive. . As time for his final report neared, Reischauer was subjected to the most intense and unpleasant pressure of his life . . . . 'I received numerous phone calls,' Reischauer said some weeks later, 'from people of great fame and with common household names telling me what they thought the right answer to this question was and questioning why I would have the audacity to decide otherwise.' Some who called accused him of trying to destroy a President. Others angrily warned him that if health reform died because of an unfavorable CBO verdict, children would suffer, and some would die. That's going to be on your conscience, he was told.")

Senator Kennedy was particularly abusive. *See id.* at 284-285 ("For nearly half an hour, Kennedy assailed Reischauer, bellowing his outrage: Reischauer was going to bring down the Clinton administration. Here was a President with a once-in-a-lifetime opportunity to do something as historic as health reform, and you, a minor staff official, are taking it upon yourself to thwart the will of the American people. The American people elected President Clinton because they wanted to have national health insurance, and now when the President is delivering on that promise, you block him. You aren't elected. Who are you to say the President didn't fulfill his promise? Who are you to say this isn't private insurance? Who are you to say whether this is on budget or off budget?")

45. BarackObama.com, BarackTV, Ads, http://origin.barackobama.com/tv/advertisements (use scrollbar on the right to select "Two Extremes" ad).

46. NICCOLO MACHIAVELLI, THE PRINCE 20-21 (Quentin Skinner & Russell Prince eds., Cambridge Univ. Press 1988) (1513).

47. *See* Hyman & Hall, *supra* note 2, at 39.

48. *See* Robert J. Blendon et al., *Voters and Health Reform in the 2008 Presidential Election*, 359 NEW ENG. J. MED. 2050, 2051 (2008) ("The majority of respondents rate the state of the U.S.

Again, don't take my word for it; if the issue had reached a tipping point, the administration's reform proposal would not have as its starting point "if you like your current health insurance, nothing changes."[49] Of course, "nothing changes" only if EBC remains available on terms that employers and employees find acceptable and affordable, and the proposed "public plan" option does not exploit its monopsony power—and none of those things are guaranteed.[50] Indeed, proponents will candidly admit that the whole point of the public plan is to exploit the government's monopsony purchasing power, in order to encourage employers and employees to abandon private insurance entirely.[51]

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health care system at the time of the election as 'fair' or 'poor,' and although most respondents do not see the health system as being in a crisis situation today, they do see it as facing major problems.")

49. White House, The Agenda—Health Care, http://www.whitehouse.gov/agenda/health_care (last visited Apr. 6, 2009).

50. *See, e.g.*, Richard A. Epstein, *The Taxation of Employee Health Care Benefits*, FORBES, Mar. 17, 2009, http://www.forbes.com/2009/03/16/taxation-employee-benefits-opinions-columnists-healthcare.html ("Earmarking these new dollars for helping the uninsured will salvage the centerpiece of the Obama health care policy, which builds existing employer health care plans as a key driver for broader health care coverage. What he fails to see is that present employer health care coverage is not immutable [H]igh marginal tax rates will surely overshoot the mark by putting an enormous crimp in job creation and retention. The present health care system could easily unravel as unemployment rises, and employer health plans fall by the wayside. Total nationalization is the likely long-run outcome."); Laura Meckler, *Health Care Battle Set To Focus on Public Plan*, WALL ST. J., Mar. 24, 2009, at A4 ("Opponents say a public plan would be an unfair competitor because it could become big enough to drive down reimbursements to doctors and hospitals, much like Medicare does, putting more cost pressure on the private sector. Consumers would then flock to the public plan because its premiums would be cheaper, opponents fear, and ultimately no viable private plans would remain."); Karen Tumulty, *Max Baucus and the "Public Plan,"* Swampland, Mar. 26, 2009, http://swampland.blogs.time.com/2009/03/26/max-baucus-and-the-public-plan ("The insurance companies hate this idea, saying it . . . would be unfair for them to be forced to compete with the government. Many health care experts, however, argue that this provision is crucial, as a means of holding down health care costs. (The idea being that the government would use its muscle--much as it does in the Medicare and Veterans Administration programs--to negotiate lower reimbursement rates.) Conservatives oppose it as well, because they see it as a first step toward a Canadian-style single-payer system.").

51. *See, e.g.*, Ezra Klein, *A Public Insurance Option Primer*, AM. PROSPECT, Mar. 26, 2009, http://www.prospect.org/csnc/blogs/ezraklein_archive?month=03&year=2009&base_name=a_public_insurance_option_prim ("A public insurance plan able to use Medicare's bargaining power to secure deep discounts for its customers and ensure the maximum possible network would be cheaper and more efficient than private insurers. Over time, this increased efficiency would make the plan more attractive because it could offer more coverage for less money. As consumers recognized this fact, they would increasingly migrate towards the plan, and the public insurer would become, if not a de facto single payer system, something close to it. The public insurer, in this scenario, is a game changer. But it's a game-changer because it's a form of single payer using a

In combination, these factors lead to the basic dynamic outlined above: EBC won't get you to universal coverage, but it is hard to see how you get to universal coverage without EBC, given the status quo. Finally, insured Americans are more likely to support a health reform proposal when it does not (at least initially) disrupt their existing coverage arrangements.

CONCLUSION

EBC is not perfect—but perfection is not the appropriate standard for judging real world policies and institutions. To believe otherwise is to indulge in the nirvana fallacy.[52] A better approach is to recognize that "bad is often best, because it is better than the existing alternatives."[53] When assessing the merits of the EBC-based status quo and of any given reform, it is critical to understand the advantages and disadvantages of both.[54]

Critics of EBC routinely treat the existence of the uninsured as a moral trump card, justifying condemnation of employers and the imposition of an employer mandate. Such arguments are fundamentally mistaken. As I have noted previously,

> Employers provide coverage (or fail to do so) out of self-interest, and employees accept or decline coverage after making a similar assessment. Employers operate in a competitive labor market—and they are no more morally blameworthy for failing to offer insurance to their employees than they are blameworthy for not paying their minimum wage employees more than

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mild version of monopsony buying power."); Timothy Noah, *Lemon Capitalism: What a Level Playing Field for Health Insurance Really Means*, SLATE, Mar. 27, 2009, http://www.slate.com/id/2214801; *see also* Meckler, *supra* note 50; Tumulty, *supra* note 50.

52. *See* RICHARD EPSTEIN, SIMPLE RULES FOR A COMPLEX WORLD 32 (1995) ("First-best solutions are rarely if ever, possible; thus the beginning of wisdom is to seek rules that minimize the level of imperfections, not to pretend that these do not exist. No contract, no association is ever bullet proof: no matter what rights, duties, institutions, and remedies are chosen, in some circumstances they will be found wanting. Bad outcomes are therefore consistent with good institutions and we cannot discredit these institutions with carefully selected illustrations of their failures. Counterexamples may be brought to bear against any set of human institutions. The social question, however, is concerned with the *extent* of the fall from grace. The fact of the fall should be taken as a necessary truth, not a shocking revelation. Perfection is obtainable in the world of mathematics, not in the world of human institutions."); Harold Demsetz, *Information and Efficiency: Another Viewpoint*, 12 J.L. & ECON. 1, 1 (1969) ("The view that now pervades much public policy economics implicitly presents the relevant choice as between an ideal norm and an existing 'imperfect' institutional arrangement. This *nirvana* approach differs considerably from a *comparative institution* approach in which the relevant choice is between alternative real institutional arrangements.").

53. *See* NEIL KOMESAR, IMPERFECT ALTERNATIVES 204 (1997).

54. *See* Hyman & Hall, *supra* note 2, at 26-38 (cataloging the costs and benefits of EBC).

> minimum wage. Similarly, employees who decline to accept coverage either assess their risks differently, or simply have a better use for their money than buying coverage. There is no compelling theoretical or practical reason to treat all of these decisions, which occur in the shadow of a competitive labor market, as a failure of employers or of the employment-based coverage market.
>
> The availability of employment-based pooling mechanisms may (or may not) offer the best opportunity to address various social problems, but this possibility should not be viewed as creating a moral obligation on the part of employers to meet the social needs that our society has proven unwilling to address, despite repeated opportunities to do so.[55]

To be sure, defaults do matter—and a well-structured "nudge" has the potential to get some of those who are currently uninsured into the system—particularly if the price they are charged reflects the value of the coverage they receive, and not a covert attempt to cross-subsidize those with a different risk/cost profile.[56] Regardless, universal coverage will cost real money, and "[a]ll of the major financing options have serious political liabilities; they risk arousing either public opposition and anti-tax sentiment or stakeholder opposition, or both."[57]

To summarize: talk is cheap; health care is expensive. The underlying problems in the coverage market are attributable to both market failure and government failure—and even if we get to universal coverage, equally (if not more) daunting challenges await us on the delivery-side of the market.

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55. *Id.*, at 41-42; *see also* David A. Hyman, *Health Insurance: Market Failure or Government Failure*, 14 CONN. INS. L.J. 307 (2008).

56. *See, e.g.*, RICHARD THALER & CASS SUNSTEIN, NUDGE: IMPROVING DECISIONS ABOUT HEALTH, WEALTH, AND HAPPINESS (2008).

57. Oberlander, *supra* note 10.

Working Sick: Lessons of Chronic Illness for Health Care Reform

Elizabeth Pendo*

INTRODUCTION

Although chronic illness is generally associated with the elderly or disabled, chronic conditions are widespread among working-age adults and pose significant challenges for employer-based health care plans.[1] Indeed, a recent study found that the number of working-age adults with a major chronic condition has grown by 25% over the past ten years, to a total of nearly 58 million in 2006.[2] Chronic illness imposes significant costs on workers, employers, and the overall economy. This population accounts for three-quarters of all health care expenditures in the United States,[3] and a Milken Institute study recently estimated that lost workdays and lower productivity as a result of the seven most common chronic diseases results in an annual loss of over $1 trillion dollars.[4]

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1. Chronic illness is generally defined as a condition, impairment or disease that lasts three or more months and creates ongoing health consequences, the need for ongoing medical care, or both. *See, e.g.*, Catherine Hoffman, Dorothy Rice & Hai-Yen Sung, *Persons with Chronic Conditions: Their Prevalence and Costs*, 276 JAMA 1473 (1996) (citing the National Medical Expenditures Survey definition of chronic condition, which includes a disease, symptoms, or impairment lasting years, not months or days); Kathryn Anne Paez, Lan Zhao & Wenke Hwang, *Rising Out-of-Pocket Spending for Chronic Conditions: A Ten-Year Trend*, HEALTH AFF., Jan.-Feb. 2009, at 16 (defining chronic conditions as those that "had lasted or [were] expected to last twelve or more months and result in functional limitation and/or the need for ongoing medical care"). Of course, many of the considerations discussed in this Article also apply to workers with a chronically ill family member.

2. Catherine Hoffman & Karyn Schwartz, *Eroding Access Among Nonelderly U.S. Adults with Chronic Conditions: Ten Years of Change*, HEALTH AFF., July 22, 2008, at w342, http://content.healthaffairs.org/cgi/content/abstract/27/5/w340 (web exclusive).

3. Hoffman et al., *supra* note 1, at 1477 fig.1.

4. Press Release, Milken Inst., Annual Economic Impact of Chronic Disease on U.S. Economy Is $1 Trillion (Oct. 2, 2007), http://www.milkeninstitute.org/newsroom/

I am focusing on this significant and growing population as a challenge for employers and as a critical test case for current health care reform proposals. Many of the cost-control methods used by employer-based plans simply shift rather than lower health care costs. This disproportionately burdens people with chronic illnesses and creates long-term social and economic costs. The experiences and challenges of workers with chronic illness provide an opportunity to examine the larger framework of health care reform, not just the employer's role in isolation, and they make clear that chronic illness is an issue that must be addressed by employers and policymakers.

I. CHRONIC ILLNESS IN THE WORKPLACE

Scholars have paid surprisingly little attention to chronic illness in the workplace.[5] One of the first studies to assess the prevalence of chronic illness, published in the *Journal of the American Medical Association* (*JAMA*) in 1996, found that that over 45% of non-institutionalized Americans, or 90 million people, were living with one or more chronic condition.[6] The study also found that the health care costs for this population were disproportionately high, accounting for three-quarters of U.S. health care expenditures.[7]

Two studies that focused on the working-age population found that chronic illnesses affected more than a third of working-age Americans in 1999.[8] A more recent and comprehensive study, published in 2008, found that more than 40% of the population lives with one or more chronic conditions; 60% of them, about 65 million people, are working-age adults.[9] The majority of people defined by this study to have chronic illnesses were not "disabled." Only 2% reported having problems with activities of daily living, although many did report some work limitations.[10] Significantly, this study also found that the number of working-age

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newsroom.taf?cat=press&function=detail&level1=new&ID=129 (citing ROSS DEVOL & ARMEN BEDROUSSIAN, AN UNHEALTHY AMERICA, THE ECONOMIC BURDEN OF CHRONIC DISEASE (2007)).

5. *See* Hoffman et al., *supra* note 1, at 1474 (noting that the prevalence and costs of chronic conditions as a whole have rarely been estimated.).

6. *Id.* at 1475-76.

7. *Id.* at 1476.

8. "Working-age" generally means between eighteen to sixty-four years of age. MARIE C. REED & HA T. TU, TRIPLE JEOPARDY: LOW INCOME, CHRONICALLY ILL AND UNINSURED IN AMERICA 1 (Ctr. for Studying Health Syst. Change, Issue Brief, Feb. 2002).

9. Hoffman & Schwartz, *supra* note 2, at w340; *see also* Paez et al., *supra* note 1, at 17 (reporting that 43.8% of civilian, non-institutionalized Americans had one or more chronic conditions).

10. This was also noted in the 1996 study. Hoffman et al., *supra* note 1. Several definitions of disability could be relevant. The Social Security Administration defines "disability" as the "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be

adults with a major chronic condition has grown 25% over ten years, and the percentage has increased from 28% in 1997 to 31% by 2006.[11]

Scholars offer several reasons for the increased prevalence of chronic illness, including the aging population.[12] Factors that relate to the increased prevalence of chronic illness among the working-age population include rising rates of risk factors such as obesity and advances in medical treatment that have converted once-fatal conditions to manageable chronic conditions.[13]

The majority of this significant and growing population of 65 million is able to work, suggesting that millions of people may be working with chronic illness, and participating in employer-based health care plans. Indeed, the studies referenced above[14] found that people with chronic conditions were more likely to be insured than people without chronic conditions, and 71% of working-age adults with chronic conditions were covered by private insurance, including employer-based plans.[15]

Although employer-based coverage has its critics,[16] the experiences of the

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expected to last for a continuous period of not less than twelve months' employment." 42 U.S.C. § 416(i)(1)(A) (2000). An employer's long-term disability plan typically defines "disability" as an inability to perform the material duties of your own occupation or as the inability to perform any occupation for which you are is suited by education, training, or experience. *See* Elizabeth Pendo, *Disability, Doctors and Dollars: Distinguishing the Three Faces of Reasonable Accommodation*, 35 U.C. DAVIS L. REV. 1175 (2002) (discussing these definitions and collecting cases). Finally, the Americans with Disabilities Act defines "disability" to mean, with respect to any individual: 1) a physical or mental impairment that substantially limits one or more major life activities; 2) a record of such impairment; or 3) being regarded as having such an impairment regardless of whether the individual actually has the impairment. 42 U.S.C.A. § 12102(1) (2000).

11. Hoffman & Schwartz, supra note 2, at w342.

12. *See, e.g.*, Thomas Bodenheimer et al., *Confronting the Growing Burden of Chronic Disease: Can the U.S. Health Care Workforce Do the Job?*, HEALTH AFF., Jan.-Feb. 2009, at 64, 65 (describing America's aging population and the rise in obesity among this group); Edward H. Wagner et al., *Improving Chronic Illness Care: Translating Evidence into Action*, HEALTH AFF., Nov.-Dec. 2001, at 64 (discussing rapid aging of the population and increased longevity of people with chronic conditions).

13. *See, e.g.*, Aviva Must et al., *The Disease Burden Associated with Overweight and Obesity*, 282 JAMA 1523 (1999) (noting the association of obesity with heart disease, diabetes, stroke, arthritis, and some forms of cancer); Kenneth R. Thorpe, *Differences in Disease Prevalence as a Source of the U.S.-European Health Care Spending Gap*, HEALTH AFF., Oct. 2, 2007, at w678, w684 (web exclusive) ("A voluminous literature exists highlighting the association between obesity, smoking, and several chronic conditions.").

14. *See* REED & TU, *supra* note 8.

15. *Id.* at 1.

16. *See, e.g.*, David A. Hyman & Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 YALE J. HEALTH POL'Y L. & ETHICS 23 (2001) (discussing the costs and benefits of the employer-based system).

chronically ill who are both working and insured highlight the advantages of employer-based coverage—at least relative to other currently-available options—since workers with chronic illness enjoy some federally-mandated protections. For example, employer-based plans can not deny or discriminate on the basis of health history, nor can they exclude pre-existing conditions from coverage.[17] For the same reasons, workers with chronic illness may also suffer the disadvantages of employer-based coverage, including labor market distortions such as job lock.[18]

It is well established that chronic illness accounts for a disproportionate share of health care costs. As stated above, the 1996 *JAMA* article contains the oft-quoted finding that health care costs for the chronically ill account for three-quarters of U.S. health care expenditures, and other studies have made similar findings.[19] In fact, one later study found that the treatment of one or more of just five chronic conditions accounted for $62.3 billion in health care costs in 1996—almost half of the total U.S. health care spending for that year.[20]

II. THE MEANING OF "CONTROLLING COSTS"

Despite the erosion of employer-based coverage, it is still true that most Americans get their health insurance through employment.[21] Although no one can predict with certainty, it appears that employer-based coverage is here to stay, at least for a while. The leading Democratic proposals for health care reform, discussed below in Part IV, include efforts to maintain or strengthen the employer-based system and envision that people who have coverage through their employer or otherwise would be permitted to keep that coverage.[22] The

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17. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, 110 Stat. 1936 (1996), prohibits insurers from excluding or medically underwriting individuals in group health plans, but offers no such protection for individuals seeking individual policies. *See* 42 U.S.C. § 201 *et seq.* (2000).

18. Kevin T. Stroupe, Eleanor D. Kinney & Thomas J.J. Kniesner, *Chronic Illness and Health Insurance-Related Job Lock*, 20 J. POL'Y ANALYSIS & MGMT. 525 (2001) (finding that job lock is substantial among workers with a chronic illness).

19. *See, e.g.*, ROBERT L. MOLLICA & JENNIFER GILLISPE, NAT'L ACAD. FOR STATE HEALTH POLICY, CARE COORDINATION FOR PEOPLE WITH CHRONIC CONDITIONS 3 (2003) (noting that care for people with chronic illness consumes 78% of all health care spending); Centers for Disease Control and Prevention, Chronic Disease Overview, http://www.cdc.gov/NCCdphp/overview.htm.

20. Benjamin G. Druss et al., *Comparing the National Economic Burden of Five Chronic Conditions*, HEALTH AFF., Nov.-Dec. 2001, at 233.

21. THE HENRY J. KAISER FAMILY FOUND., EMPLOYER HEALTH BENEFITS 2008 ANNUAL SURVEY 46 (2008) (finding that 60% of workers and 158 million people are covered by employer-based plans).

22. *See* SEN. MAX BAUCUS, CALL TO ACTION: HEALTH REFORM 2009 (2008), *available at* http://finance.senate.gov/healthreform2009/finalwhitepaper.pdf [hereinafter CALL TO ACTION]

continuing role of employers as sponsors of health insurance plans for millions of chronically ill employees and their families places them in a key position to influence developments in health care policy.

Clearly, a major challenge facing employers is the increasing cost of providing health insurance benefits. A recent survey found that 54.2% of employers identified controlling costs as their highest health care priority, and they do recognize workers with chronic illness as a significant cost factor. In a recent survey, over 56% of responding employers identified chronic health conditions as a top source of health care costs, topped only by the aging population at 58%.[23] Employers turned to managed care to control costs in the 1990s, but they retreated in the face of a backlash against its most restrictive practices. More recently, employers have turned toward consumer-driven health plans.[24] Nonetheless, costs continue to rise beyond the means of many employers.

Of course, "controlling costs" has more than one meaning. Often, it means limiting the share of the cost borne by employers by pushing a greater share of the costs to employees. This can mean requiring them to pay a higher percentage of the premium or imposing cost-sharing measures such as higher deductibles, co-insurance, and co-payments.

Increased cost-sharing is bad for the chronically ill because they require a higher level of health care services.[25] For this reason, even when they are insured, people with chronic conditions spend more out-of-pocket than do people without chronic conditions.[26] One study found that having one chronic condition

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(published by Max Baucus in his capacity of Chairman of the Senate Finance Committee); Obama-Biden, Barack Obama and Joe Biden's Plan To Lower Health Care Costs and Ensure Affordable, Accessible Health Coverage for All, http://www.barackobama.com/pdf/issues/HealthCareFullPlan.pdf (last visited May 2, 2009) [hereinafter Obama Plan]. Compare these with Senator Ron Wyden's Healthy Americans Act, which would dismantle the employer-based system in favor of an individual mandate satisfied through the purchase of coverage (termed "Healthy Americans Private Insurance") from private insurers in a state or regional insurance exchanges. Healthy Americans Act, S. 391, 111th Cong. (2009).

23. *Most Employers Favor Health System Reform that Keeps Job-Based System, Survey Shows*, BNA DAILY HEALTH CARE REPORT (Bureau of Nat'l Affairs), Nov. 17, 2008 (on file with author).

24. *See* Elizabeth Pendo, *Images of Health Insurance in Popular Film: The Dissolving Critique*, 37 J. HEALTH L. 267 (2004).

25. *See* John V. Jacobi, *Consumer-Directed Health Care and the Chronically Ill*, 38 U. MICH. J.L. REFORM 531 (2005); Deborah Stone, *Protect the Sick: Health Insurance Reform in One Easy Lesson*, 36 J.L. MED. & ETHICS 652, 655 (2008).

26. Wenke Hwang et al., *Out-of-Pocket Medical Spending for Care of Chronic Conditions*, HEALTH AFF., Nov.-Dec. 2001, at 267, 275; Paez et al., *supra* note 1.

increases it by more than 70%, and having two conditions increases it by 300%.[27] There is also evidence that the out-of-pocket spending of the chronically ill is increasing over time: by nearly 40% in less then ten years according to one estimate.[28] If it is true that chronic illnesses are increasingly treated with prescription drugs and in outpatient settings, cost-sharing will be even more detrimental to the chronically ill.[29]

At some point, cost becomes prohibitive for everybody; insured people with chronic conditions report going without needed medical care due to cost.[30] Indeed, "[t]he evidence is overwhelming that cost-sharing reduces the use of medically effective care."[31] Increased cost-sharing disproportionately impacts people with chronic illness, causing long-term health consequences and potentially increased health care costs.[32] Deborah Stone neatly illustrates this point with reference to prescription drugs:

> Cost-sharing for prescription drugs lowers adherence to drug regimens. It leads people to refill prescriptions sporadically only when they can afford the co-payment, and sometimes to discontinue drugs altogether. For patients with some serious chronic illnesses such as congestive heart failure, diabetes, and schizophrenia, higher cost-sharing for prescription drugs is associated with greater use of medical services.[33]

Pushing additional costs onto the chronically ill might help employers control costs in the short term but it may also increase costs in the long term and it hinders efforts to spread risk and subsidize losses across the insured population.

This point is not lost on employers, who are concerned that employees who forgo needed medical care "could end up costing . . . more later in both additional health care expenditures and increased absenteeism should a serious health threat go untreated or a chronic condition get worse."[34] Employers also bear costs

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27. Hoffman & Schwartz, *supra* note 2, at w346.

28. Paez et al., *supra* note 1, at 22 (noting that "[p]eople using health services spent an average of $741 in 2005 for health care services," a 39.4% increase from 1996 when adjusted for inflation).

29. Sandra L. Decker et al., *Use of Medical Care for Chronic Conditions*, HEALTH AFF. Jan.-Feb. 2009, at 26 (reporting that delivery of care for chronic conditions is shifting from inpatient to ambulatory setting); Paez et al., *supra* note 1, at 20 (summarizing research on increased use of medications).

30. Hoffman and Schwartz, *supra* note 2, at w345.

31. Stone, *supra* note 25, at 655.

32. *See* Paez et al., *supra* note 1.

33. Stone, *supra* note 25, at 656; *see also* SARA R. COLLINS ET AL., THE COMMONWEALTH FUND, GAPS IN HEALTH INSURANCE: AN ALL-AMERICAN PROBLEM 9 (2006) (reporting that 59% of uninsured adults with a chronic condition such as diabetes and asthma did not fill a prescription or skipped medications due to cost).

34. Joanne Wojcik, *Skimping on Health Care Feared in Tough Times*, BUS. INS., Nov. 3, 2008, http://www.businessinsurance.com/cgi-bin/article.pl?article_id=26367.

relating to chronic illness in terms of productivity; although estimates of these costs vary tremendously—from $75 billion to $1 trillion annually—everybody recognizes that they are enormous.[35]

If "controlling costs" can refer to an employer's strategy to shift a greater share of the costs to employees, it can also refer to an employer's efforts to lower the overall cost of health care, not just its own share. Via their funding of health-promotion and wellness programs, some employers are emphasizing long-term cost-effectiveness rather than just short-term costs-savings.[36] However, it is not yet clear whether these programs achieve long-term cost-effectiveness. In addition, as Wendy Mariner has written, wellness programs may effectively raise premiums for people with risk factors such as obesity, smoking, or diabetes by giving "discounts" to people without these risk factors.[37] To the extent that these programs increase the cost of health care for people with high health care needs, they raise some of the same concerns as increased cost-sharing in terms of detrimentally affecting the chronically ill.[38]

III. LESSONS FOR EMPLOYERS AND REFORMERS

The rising incidence and prevalence of chronic illness in the workplace leaves employers in a difficult position: although they need to control escalating costs, they recognize the problems designing and implementing cost-saving measures. Thus, the experiences and challenges of chronic illness in the workplace provide an opportunity to examine the larger puzzle of national health care reform. Indeed, the economic and social burdens created by chronic illness reveal the need to look for systemic solutions rather than isolated fixes.

A proposal that addresses the employment-based system in isolation, for example, fails to address the fact that employer-sponsored coverage is eroding

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35. *Opportunities Lost and Costs to Society: The Social and Economic Burden of Disease, Injuries, and Disability: Hearing Before the Subcomm. on the Dep'ts of Labor, Health and Human Servs., Educ., & Related Agencies of the H. Comm. on Appropriations*, 110th Cong. 2 (2008) (statement of Kenneth E. Thorpe) [hereinafter Thorpe Statement]; PAUL FRONSTIN & RAY WERNTZ, THE "BUSINESS CASE" FOR INVESTING IN EMPLOYEE HEALTH: A REVIEW OF THE LITERATURE AND EMPLOYER SELF-ASSESSMENTS (Employee Benefit Research Inst., Issue Brief No. 267, 2004), *available at* http://www.ebri.org/pdf/briefspdf/0304ib.pdf; MEENA SESHAMANI, CTR. FOR AM. PROGRESS, OPPORTUNITY COSTS AND OPPORTUNITIES LOST: BUSINESSES SPEAK OUT ABOUT THE U.S. HEALTH CARE SYSTEM (2007).

36. *See* Ron Z. Goetzel, *Do Prevention or Treatment Services Save Money? The Wrong Debate*, HEALTH AFF., Jan.-Feb. 2009, at 37 (discussing studies of employer health promotion programs).

37. Wendy K. Mariner, *Social Solidarity and Personal Responsibility in Health Reform*, 14 CONN. INS. L.J. 190 (2008).

38. *See* Stone, *supra* note 25.

and becoming increasingly unstable for many workers. As unemployment figures climb, millions of workers face losing their coverage along with their jobs. There are, of course, some legal protections against such double jeopardy. In some cases, recently unemployed workers can continue group coverage under the Consolidated Omnibus Reconciliation Act of 1985 (COBRA), and then secure an offer of individual coverage under the Health Insurance Portability and Accessibility Act (HIPAA).[39] But COBRA is expensive: a recent study found that although most unemployed workers are eligible, fewer than one in ten extends coverage under this option.[40] In recognition of this, the recent stimulus bill included premium subsidies and extended COBRA coverage periods for some of the recently unemployed.[41]

There have also been some reports of "health discrimination," a practice by which employers find reasons to fire or avoid hiring employees with expensive or chronic illnesses.[42] Although the extent of this practice is unclear, its illegality is not. The Employee Retirement Income Security Act (ERISA) prohibits an employer from terminating an employee for the purpose of interfering with the worker's protected rights to benefits such as participation in health insurance plans.[43] There are also some important but limited protections for sick or disabled workers under the Americans with Disabilities Act and the Family and Medical Leave Act.[44]

Notwithstanding these protections, workers are right to be concerned about

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39. Under COBRA, recently unemployed workers may be eligible to extend their health insurance coverage for eighteen months at the group rate, and this coverage cannot be denied on the basis of health history. 29 U.S.C. § 1162(4) (2000). However, cost is often prohibitive, as the worker would be responsible for the entire premium plus administrative costs. *Id.* § 1162(3). Once the COBRA extension period is exhausted, HIPAA provides for conversion of group coverage into a renewable individual policy without exclusion for pre-existing conditions. *Id.* § 300gg-42. However, cost could be prohibitive under this option, as well, as HIPAA does not limit the premium that the offering insurer may charge. 42 U.S.C. § 300gg-41(f)(1) (2000).

40. MICHELLE M. DOTY ET AL., MAINTAINING HEALTH INSURANCE DURING A RECESSION: LIKELY COBRA ELIGIBILITY 1 (Commonwealth Fund, Issue Brief Pub. 1225, 2009), *available at* http://www.commonwealthfund.org/usr_doc/Doty_maintainighltinsrecessionCOBRA_1225_ib.pdf.

41. *See* American Recovery and Reinvestment Act of 2009 Pub. L. No. 111-5, § 1899f (2009).

42. *See, e.g.*, Steven Greenhouse & Michael Barbaro, *Wal-Mart Memo Suggests Ways To Cut Employee Benefits Costs*, N.Y. TIMES, Oct. 26, 2005, at C1 (reporting one particularly offensive recommendation in an internal Wal-Mart memo: to require physical activity as part of all jobs in order to discourage unhealthy applicants); Robyn Shelton, *Sick and Fired: Fighting Breast Cancer, She Lost Her Job and Her Insurance at a Critical Time*, ORLANDO SENTINEL, July 19, 2008, at A1.

43. *See* 29 U.S.C. § 1140 (2000). This does not, however, prevent an employer from amending the plan to change benefits generally. *See* McGann v. H & H Music Co., 946 F.2d 401 (5th Cir. 1991).

44. *See* 42 U.S.C. § 12101 *et seq.* (2000); 29 U.S.C. 2601 *et seq.*

maintaining their coverage after losing their job: individual insurance policies are difficult to find and harder to afford. Without access to group coverage or a public program, workers with chronic illness are unlikely to get individual coverage at any price. Absent state law to the contrary, health insurers in the individual market are not required to offer or provide coverage.[45] In an unregulated market, insurers can exclude or impose waiting periods for coverage of pre-existing conditions, including chronic illnesses.[46] The Kaiser Family Foundation studied the efforts that seven hypothetically ill individuals would have to make to find health insurance. The applicants—of varying age, gender, and life circumstances and with seven different pre-existing conditions (hay fever, a surgically repaired knee, asthma and recurrent ear infections, breast cancer, depression, high blood pressure, and HIV-positive status)—were rejected 37% of the time.[47] Only 10% of the offers that were made were at the standard rate and most of them contained benefit restrictions, surcharges, or both.[48] In the unregulated individual market, people with chronic illness are offered coverage at prohibitively high rates or denied coverage all together.[49] A more recent study by the Commonwealth Fund reported that one in five applicants for an individual policy were declined, charged higher rates due to a pre-existing condition, or offered a policy with significant exclusions.[50]

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45. Under HIPAA individuals leaving group coverage and for small employer-based groups of two to fifty employees have the right to buy an individual policy, but federal law does not ensure access for those previously uninsured or covered by a different individual policy. 42 U.S.C. § 300gg-42 (2000). As of 2008, only fifteen states had enacted laws creating a right to purchase insurance in the individual market. *See* StateHealthFacts.org, Individual Market Guaranteed Issue – Kaiser State Health Facts, http://www.statehealthfacts.org/comparetable.jsp?cat=7&ind=353 (last visited May 4, 4009); *see also* CLAUDIA H. WILLIAMS & BETH C. FUCHS, ROBERT WOOD JOHNSON FOUND., EXPANDING THE INDIVIDUAL HEALTH INSURANCE MARKET: LESSONS FROM THE STATE REFORMS OF THE 1990S, at 7 fig.6 (2004), *available at* http://www.rwjf.org/files/research/no4synthesisreport.pdf. As of 2000, twelve states had enacted guaranteed issue laws. *Id.*

46. *Id.* at 10. As of 2000, thirty-one states had enacted laws limiting exclusions for pre-existing conditions. *Id.* at 7 fig.6.

47. KAREN POLLITZ, RICHARD SORIAN & KATHY THOMAS, HENRY J. KAISER FAMILY FOUND., HOW ACCESSIBLE IS INDIVIDUAL HEALTH INSURANCE FOR CONSUMERS IN LESS-THAN-PERFECT HEALTH? ii (2001), *available at* http://www.kff.org/insurance/upload/How-Accessible-is-Individual-Health-Insurance-for-Consumer-in-Less-Than-Perfect-Health-Report.pdf.

48. *Id.* The average annual premium offered was $3,996, a significant increase from the standard average annual rate of $2,988. *Id.* at iii.

49. *See* ALLIANCE FOR HEALTH REFORM, HEALTH CARE COVERAGE IN AMERICA: UNDERSTANDING THE ISSUES AND PROPOSED SOLUTIONS 10 (2006), *available at* http://www.allhealth.org/Publications/Uninsured/Health_Care_Coverage_in_America_2008_82.pdf.

50. SARA R. COLLINS ET AL., THE COMMONWEALTH FUND, SQUEEZED: WHY RISING EXPOSURE TO HEALTH CARE COSTS THREATENS THE HEALTH AND FINANCIAL WELL-BEING OF AMERICAN

Without access to group coverage or a public program, most people with chronic illness would find themselves without insurance.[51] And that means that their health would deteriorate further; it is well documented that people without insurance receive less care, receive delayed care, and suffer worse outcomes than people with insurance.[52] Similar or worse disparities seem to exist for the uninsured with chronic illness.[53] For example, recent studies have reported that people with chronic illness and without insurance were twice as likely as those with insurance to delay or forgo needed care, including basic preventative care,[54] and were four to six times more likely to experience access problems.[55] In addition to the detrimental health consequences, lack of insurance can bring financial ruin, and medical debt has a devastating effect on many families.[56] So it is no surprise that people are working sick, scared, or both in order to retain much needed health insurance, and that stories of workers facing such choices have begun to appear in the news.[57]

FAMILIES i (2006).

51. According to a study published in 2008, 13% of working-age adults with chronic conditions were uninsured in 2006. Hoffman & Schwartz, *supra* note 2, at w342; *see also* COLLINS ET AL., *supra* note 50, at 19 tbl.1 (finding that 22% of full-time workers and 34% of part-time workers who were in fair or poor health, with any chronic condition or with a disability were uninsured for all or part of 2005); REED & TU, *supra* note 8, at 1 (finding that 12% of working-age adults with chronic conditions were uninsured in 1999).

52. *See, e.g.* INST. OF MED., CARE WITHOUT COVERAGE: TOO LITTLE, TOO LATE (2002); AM. COLL. OF PHYSICIANS & AM. SOC'Y OF INTERNAL MED., NO HEALTH INSURANCE? IT'S ENOUGH TO MAKE YOU SICK (2003) (summarizing research over a ten-year period).

53. *See* REED & TU, *supra* note 8, at 3.

54. *See, e.g.*, Hoffman & Schwartz, *supra* note 2, at w345; *see also* Jack Hadley, *Insurance Coverage, Medical Care Use and Short-Term Health Changes Following an Unintentional Injury or the Onset of a Chronic Condition*, 297 JAMA 1073, 1074 (2007) ("Among individuals who experienced a health shock caused by an unintentional injury or a new chronic condition, uninsured individuals reported receiving less medical case and poorer short-term changes in health than those with insurance."); Andrew P. Wilper et al., *A National Study of Chronic Disease Prevalence and Access to Care in Uninsured U.S. Adults*, 149 ANNALS INTERNAL MED. 170, 170 (2008) (reporting that people with chronic illness and without insurance were much less likely to have a usual source of care or to have seen a doctor in the past year, and much more likely to use the emergency room than the insured chronically ill).

55. *See* Wilper et al., *supra* note 54, at 174.

56. *See, e.g.*, David U. Himmelstein et al., *Illness and Injury as Contributors to Bankruptcy*, HEALTH AFF., Feb. 2, 2005, at w5-63, http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w5.63v1 (web exclusive); Robert W. Seifert & Mark Rukavina, *Bankruptcy Is the Tip of a Medical-Debt Iceberg*, HEALTH AFF., Feb. 28, 2006, at w89, http://content.healthaffairs.org/cgi/content/full/25/2/w89 (web exclusive).

57. *See* Lisa Belkin, *Ill and at Work: Sick and Vulnerable, Workers Fear for Health and Their Jobs*, N.Y. TIMES, Dec. 17, 2005, at A1; Tom Murphy, *Few Options Remain When Job Insurance Disappears*, ABCNEWS, Nov. 3, 2008, *available at* http://abcnews.go.com/print?id=6169291;

Consideration of the chronically ill also reminds us to look at the costs of chronic illness borne by public programs such as Medicare and Medicaid. Although in 2002 the majority of working-age people with chronic illness were covered by private insurance such as employer-based plans, 14% were covered by Medicare, Medicaid, or both.[58] By some reports, ninety-six cents of every Medicare dollar and eighty-three cents of every Medicaid dollar are used to treat chronic diseases.[59] There is also evidence that the employer-based system interacts with public programs, as some employers push the cost of providing coverage to their workers onto public programs,[60] and public programs create additional costs for private plans.[61]

IV. CHRONIC ILLNESS AND PROPOSALS FOR COMPREHENSIVE REFORM

Health care reform is at the top of the national agenda. It played a prominent role in the 2008 presidential election, and several members of Congress introduced bills during the 110th session aimed at health care reform.[62] The burdens of chronic illness on workers, employers, and others reveal deep fault lines in our current system and the need to look for comprehensive solutions rather than isolated fixes. How might the lessons presented by the growing ranks of workers with chronic illness be applied to these health care reform efforts?

One influential proposal is the policy paper issued by Senate Finance Committee Chairman Max Baucus, in November 2008, outlining a plan to

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Robert Pear, *When a Job Disappears, So Does the Health Care*, N.Y. TIMES, Dec. 7, 2008, at A30; Shelton, *supra* note 42; Eve Tahmicioglu, *Working Through a Chronic Illness: More Employees Learn To Cope with Debilitating Diseases*, MSNBC.com, Nov. 19, 2007, http://www.msnbc.msn.com/d/21837760; Wojcik, *supra* note 34.

58. REED & TU, *supra* note 8, at 1.

59. Thorpe Statement, *supra* note 35, at 1.

60. *See, e.g.*, Retail Indus. Leaders Ass'n v. Fielder, 475 F.3d 180, 183-84 (4th Cir. 2007) (noting testimony in legislative record regarding participation of children of Wal-Mart employees in the Medicaid and SCHIP programs in several states); Reed Abelson, *States Are Battling Against Wal-Mart Over Health Care*, N.Y. TIMES, Nov. 1, 2004, at A1; Ralph Thomas, *Over 3,100 Wal-Mart Workers Got State Health Aid*, SEATTLE TIMES, Jan. 24, 2006, at A1.

61. According to a recent study by Milliman, Inc., commercial payers subsidize Medicare and Medicaid by $88.8 billion annually by paying relatively higher rates. WILL FOX & JOHN PICKERING, MILLIMAN, INC., HOSPITAL AND PHYSICIAN COST SHIFT: PAYMENT LEVEL COMPARISON OF MEDICARE, MEDICAID, AND COMMERCIAL PAYERS 4 chart 4 (2008) (estimating that employers pay an additional $1115 and participants pay an additional $397 in premiums).

62. For a review of these Bills, see SARA R. COLLINS, JENNIFER L. NICHOLSON & SHEILA D. RUSTGI, THE COMMONWEALTH FUND, AN ANALYSIS OF LEADING CONGRESSIONAL HEALTH CARE BILLS, 2007-2008: PART I, INSURANCE COVERAGE (2009).

address health care coverage, quality, and cost.[63] His proposal is intended to summarize points of consensus—at least among Democrats—and to create a place from which discussions about health care reform can start. The plan has three prongs: increasing access to affordable coverage for all Americans, improving the delivery system to increase value, and reforming health care financing to eliminate waste and promote efficiency. Not surprisingly, the Baucus Plan emphasizes shared responsibility, and employers are central players in his vision:

> Employers, individuals, and government all have a role to play—and a contribution to make—to the system. Employers should contribute toward health insurance choices and financing. Individuals have the responsibility to get coverage, to take better care of their own health, and to play a larger role in health care treatment decisions. Providers should improve their performance to ensure consistent, high-quality health care. Society, through state and Federal governments, should help those who lack the means to buy insurance on their own and ensure that the insurance market is fair and transparent.[64]

The Baucus Plan shares key similarities with the plan outlined by President Obama during his campaign[65] and also with the proposal put forth by the Commonwealth Fund in May 2008, referred to as the "Building Blocks" framework,[66] in that all propose comprehensive reform, including expansion of coverage through a mix of public and private group insurance options offered through a national exchange.[67] Significantly, all three proposals build on the employer-based system.[68] As stated by Senator Baucus,

> We must ensure the continued viability of the employer-based system—the principal source of health coverage for most Americans—to allow workers to keep the insurance that they currently have and value. Eliminating employer-based coverage, as some have proposed, would upend health care for more than half of the American people—159 million in all. This plan envisions a role for employers to contribute to employees' access to health care.[69]

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63. CALL TO ACTION, *supra* note 22.

64. *Id.* at 9.

65. *See* Obama Plan, *supra* note 22.

66. *See* Cathy Schoen, Karen Davis & Sara R. Collins, *Building Blocks for Reform: Achieving Universal Coverage with Private and Public Group Health Insurance*, HEALTH AFF., May-June 2008, at 646.

67. The plans by Baucus and Obama both use the term "National Health Insurance Exchange" while the Building Blocks framework uses the term "Connector." *See, e.g.*, Call to Action, *supra* note 22, at iv ("Health Insurance Exchange"); Obama Plan, *supra* note 22, at 3 ("National Health Insurance Exchange"); Schoen et al., *supra* note 66, at 1 ("a national insurance connector").

68. *See, e.g.*, CALL TO ACTION, *supra* note 22, at 13.

69. *Id.*

The Baucus Plan envisions that the majority of employers would continue to provide health insurance benefits and that people who have coverage through their employer or otherwise could keep that coverage. This is good news for the significant number of workers with chronic illness who have employer-based coverage.[70] Maintaining the employer-based system—at least in the absence of an acceptable alternative—is also in alignment with public opinion, as between 63% and 81% of respondents in one survey thought a move away from employer-based insurance and into the individual market would make things worse for them.[71] Building upon the existing system preserves the advantages of employer-based health care, including increased risk pooling, lower premiums and administrative costs, greater expertise and negotiating power, ERISA and HIPAA protections discussed above, and ease of payment through payroll deduction.[72] The Baucus Plan also contains an employer mandate, commonly referred to as a "pay or play" provision: except for small businesses, employers who do not provide health insurance benefits would be required to contribute to a fund that would help cover those who remain uninsured.[73]

Of course, as discussed above, a proposal that addresses the employment-based system in isolation fails to address the fact that employer-sponsored coverage is increasingly unstable for many workers and that without access to group coverage or a public program, many people, including people with chronic illness, are unlikely to secure individual coverage at any price. Under the Baucus Plan, people without access to employment-based coverage, including employees of small businesses that are unable to offer coverage, could obtain coverage through the Health Insurance Exchange (the Exchange), a nationwide insurance pool. The Exchange would include a structured selection of private insurance plans as well as a public plan option.[74] Once the Exchange was able to provide adequate and affordable coverage options for all, an individual mandate would be

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70. *See supra* note 8 and accompanying text and text accompanying 14 and 15.

71. *See* Drew Altman, Kaiser Family Found., Moving Away from Employer Based Coverage: Don't Forget Public Opinion (June 26, 2008), http://www.kff.org/pullingittogether/062608_altman.cfm.

72. *See* CALL TO ACTION, *supra* note 22, at 16; *see also* Schoen et al., *supra* note 66, at 647 (acknowledging advantages of employer-based coverage, including risk-pooling, but also noting that employer-based health insurance undermines the continuity of coverage).

73. The Baucus Plan and the Obama Plan suggest that the contribution be based on a percentage of payroll earnings taking into account the size and annual revenues of each firm. CALL TO ACTION, *supra* note 22, at 16-17; Obama Plan, *supra* note 22, at 5-6. The Building Blocks proposal suggests a payroll tax of 7% of earnings, up to $1.25 per hour. Schoen et al., *supra* note 66, at 649.

74. The public plan option, similar to Medicare, would be subject to the same requirements in terms of rating practices and benefits packages.

instituted, possibly enforced through the tax system.[75]

At present, in an unregulated individual market, people with chronic illness are offered coverage at prohibitively high rates, or denied coverage altogether. Under the Baucus Plan, insurers participating in the Exchange would have to meet certain federal standards with respect to rating practices established by a new Independent Health Coverage Council.[76] These standards are designed to provide individuals with protections often lacking in the individual market and to ensure broad risk-pooling within groups. Several of these relate directly to the experience of the chronically ill: for example, insurers participating in the Exchange could not exclude or consider pre-existing conditions. Insurers also would be required to meet certain standards with respect to coverage, as established by the Council. Differences in price would be based on differences in benefits, rather than the actual or perceived health status of anticipated enrollees, and insurers would be required to offer the coverage at the same price inside and outside the Exchange.

The Independent Health Coverage Council would also implement strategies to minimize adverse selection by individuals with high health care costs as well as "cherry picking" of individuals with low health care costs within the Exchange,[77] such as requiring employers to enroll all employees for coverage through the Exchange, not just those with the highest health care costs.[78] Similarly, the Building Blocks proposal suggests community or modified community rating and a guaranteed issue requirement in order for an Exchange to operate in a given state.[79] In addition, the Obama Plan includes a proposal to reimburse employer-based health insurance plans for a portion of any catastrophic expenditures, as long as such reimbursement is used to reduce employee premiums, a feature which could benefit employers of chronically ill workers.[80]

Affordability is a key issue, as people with chronic illness use more

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75. President Obama's plan currently includes a mandate only for children. *See* Obama Plan, *supra* note 22, at 5.

76. Under the Baucus Plan, insurers participating in the Exchange also would be subject to state consumer protection laws, such as requirements regarding "grievance procedures, external review, oversight of agent practices and training, market conduct." CALL TO ACTION, *supra* note 22, at 18.

77. Adverse selection is a process by which people who have higher health care costs seek health insurance at a disproportionate rate to people who have (or think they have) relatively lower health care costs. *See* Peter Siegelman, *Adverse Selection in Insurance Markets: An Exaggerated Threat*, 113 YALE L.J. 1223 (2004). "Cherry picking" refers to the practice of offering coverage only to people who have or are perceived to have lower health care costs.

78. CALL TO ACTION, *supra* note 22, at 17.

79. Schoen et al., *supra* note 66, at 650.

80. Obama Plan, *supra* note 22, at 2, 5.

necessary health care services and bear more out-of-pocket costs even when insured. "Affordability" would be defined by the Independent Health Coverage Council, and refundable tax credits would be available to individuals and families with incomes at or below four times the federal poverty level—which would mean at or below $88,200 for a family of four[81]—for the purchase of coverage through the Exchange. Small businesses would be offered a structured tax credit for the purchase of employee coverage through the Exchange. The Council would also be empowered to protect enrollees against high health care expenses, including out-of-pocket costs.[82]

The tax-treatment of employer-based benefits also impacts affordability. Currently, employees are not taxed on the value of the job-based health insurance benefits.[83] Some, including Senator Baucus, have suggested capping the income tax exclusion for workers or eliminating the exclusion entirely in favor of a tax credit or tax deduction for coverage from any source.[84] Capping the exclusion could create new inequities for people with chronic illness, as well as others whose benefits exceed the cap for reasons other than comprehensiveness of their coverage.[85] Attempts to offer and select coverage with a value under the cap might also result in a further decline in the offer, selection, and use of comprehensive coverage, which could be detrimental to those with high health care costs.[86] As one author has noted, "it could be challenging to determine alternative tax benefits to replace the exclusion without adversely affecting

81. *See* Dep't of Health & Human Servs., Office of the Sec'y, Annual Update of the HHS Poverty Guidelines, 74 Fed. Reg. 4199, 4200 tbl.1 (Jan. 23, 2009) (listing the poverty level for a family of four in the contiguous U.S. states and Washington, D.C. as $22,050).

82. *See* CALL TO ACTION, *supra* note 22, at 19.

83. The employer's contribution is excluded from an employee's income for tax purposes, and the employee's contribution can be excluded as well if made through a cafeteria benefit plan under Section 125 of the Internal Revenue Code. 26 U.S.C. § 106(a) (2000). For an overview of this issue, see BOB LYKE, CONG. RESEARCH SERV., THE TAX EXCLUSION FOR EMPLOYER-PROVIDED HEALTH INSURANCE: POLICY ISSUES REGARDING THE REPEAL DEBATE 1 (2008), *available at* http://www.allhealth.org/BriefingMaterials/RL34767-1359.pdf.

84. *See* PAUL FRONSTIN, CAPPING THE TAX EXCLUSION FOR EMPLOYMENT-BASED HEALTH COVERAGE: IMPLICATIONS FOR EMPLOYERS AND WORKERS (Employee Benefit Research Inst., Issue Brief No. 325, 2009). The Healthy Americans Act proposes eliminating the income tax exclusion for employer health benefits in favor of a standard tax decision (in the Senate version) or a tax credit (in the House version). *See* Healthy Americans Act, S. 391, 111th Cong. (2009); Healthy Americans Act, H.R.1321, 111th Cong. (2009).

85. *See* FRONSTIN, *supra* note 84 (noting that the value of health coverage might be above the tax cap due to variation of cost by employer size, employee health status, average age, and geographic region).

86. *Id.*

people with high costs."[87]

Consideration of the chronically ill also reminds us to look at the costs borne by public programs such as Medicare and Medicaid, and the Baucus Plan includes suggestions to strengthen public programs. For example, under the Baucus Plan and the Building Blocks framework, people aged fifty-five to sixty-four would be permitted to buy into Medicare until their coverage needs could be met through the Exchange, and the two-year waiting period for people with disabilities would also be phased out. Medicaid would be expanded to cover everyone living below the federal poverty level, and SCHIP would cover all children at or below 250% of poverty.

Apart from issues of financing and insurance, there is also a focus on improving the health care delivery system, including the prevention and treatment of chronic disease.[88] This is proposed as part of an overall effort to improve care and lower costs: "National spending on health care can be lowered, and quality improved, by realigning the health care system toward prevention and primary care, rewarding providers that deliver quality, evidence-based care, and investing in critical research and health information technology that can lead to higher-value health care."[89] Under the Baucus Plan, the Independent Health Coverage Council would set standards for chronic care management and quality reporting, and insurers in the Exchange would collect and report on the performance of providers in their networks in order to allow comparison by consumers, the Council, and other regulatory entities. The Obama Plan provides that it will improve coordination and care for people with chronic conditions through disease management, team care, and medical home models.[90] There is also a focus on preventative services, which would be covered by all options available through the Exchange. Medicare, Medicaid and SCHIP recipients would be eligible for these services at little or no out-of-pocket cost, as would people without insurance until they are able to secure coverage through the Exchange. While there is debate as to whether such measures would achieve cost-savings,[91] there is evidence that they could improve care and outcomes for

87. *See* LYKE, *supra* note 83, at 12.

88. The Obama Plan, like the Building Blocks Plan, also emphasizes prevention and chronic disease management. *See* Obama Plan, *supra* note 22.

89. *See* CALL TO ACTION, *supra* note 22, at 65-66. The Baucus Plan also looks to lower costs and curb excess spending by: reducing health care fraud, waste and abuse; increasing transparency regarding costs of care, quality of care, and relationships between providers and drug and device manufacturers; reform of medical malpractice laws; eliminating overpayments of private insurance plans in Medicare; reorientation of long term care, including home and community based care; and fair distribution of tax incentives to provide care.

90. *See* Obama Plan, *supra* note 22, at 2-3.

91. *See, e.g.*, Goetzel, *supra* note 36 just short-term costs-savings.; Louise B. Russell, *Preventing Chronic Disease: An Important Investment, But Don't Count on Cost Savings*, HEALTH

people with chronic illness.[92]

CONCLUSION

Health care reform is critical. Heath care spending accounts for nearly one-sixth of the national economy,[93] and the Congressional Budget Office recently projected that without changes that number will rise to nearly one-fifth, or almost $4.3 trillion a year, by 2017.[94] Peter Orzag, now director of the Office of Management and Budget, argued in 2008 that rising health care costs represent the "single most important fact influencing the Federal government's long-term fiscal balance."[95]

As the nation struggles with rising health care costs, the rising incidence and prevalence of working-age people with chronic illness is cause for concern, in part because we know too little about it.[96] In order to design an adequate response to the problem of chronic illness, we need to know who is bearing what cost. The cost does not fall on the sick alone—it is borne by families, employers, landlords, lenders, creditors, and our entire society. It is not an individual problem, and it seems we are paying for it anyway, often inefficiently and with poor results.

Chronically ill workers also illustrate some basic truths about the employer-based system, and remind us of some key points to consider for reform. Employer-based coverage is still an important source of coverage, and will remain so unless and until we have a suitable alternative. Damaging this system without a suitable alternative would disrupt coverage for the majority of the insured, including as many as 65 million people with chronic illness. At the same time, looking only at employer-based plans—simply one part of a complex, haphazard and inadequate series of coverage arrangements—prevents us from moving forward with informed discussions about more equitable ways to improve cost, access and quality of health care for every one, including people with chronic illness.

AFF., Jan.-Feb. 2009, at 42.

92. *See* Katie Coleman et al., *Evidence on the Chronic Care Model in the New Millennium*, HEALTH AFF., Jan.-Feb. 2009, at 75.

93. Kaiser Family Found., Trends in Health Care Costs and Spending (2007).

94. Sean Keehan et al., *Health Spending Projections Through 2017: The Baby-Boom Generation Is Coming to Medicare*, HEALTH AFF., Feb. 26, 2008, at w145, http://content.healthaffairs.org/cgi/content/abstract/hlthaff.27.2.w145v1 (web exclusive).

95. CALL TO ACTION, *supra* note 22, at 1 (citing PETER R. ORSZAG, CONG. BUDGET OFFICE, GROWTH IN HEALTH CARE COSTS (2008)).

96. Hoffman et al., *supra* note 1, at 1474 ("Despite concerns about the costs of managing chronic conditions, there are few sources of data that allow us to weigh the overall economic and social impact of chronic conditions.").

The experiences and challenges of chronic illness in the workplace provide an opportunity to examine the larger framework of health care reform, not just the employer's role in isolation. There is a national interest, one that employers share, in striking a better balance between caring for the chronically ill and controlling costs. Although many important elements are yet to be defined, comprehensive reform efforts such as that proposed by Senator Max Baucus attempt to strike that balance and to learn from the lessons of chronic illness in the workplace and the health care system.

BOOK REVIEW

Prenatal Screening Policy in International Perspective: Lessons from Israel, Cyprus, Taiwan, China, and Singapore

Dov Fox*

Heredity and Hope: The Case for Genetic Screening. By Ruth Schwartz Cowan. Cambridge, MA: Harvard University Press, 2008. Pp. 304.

The word "eugenics" derives from the Greek words *eu* (ευ) [beautiful] and *gen* (γευ) [relating to birth], or *eugenes*, which means "good in stock."[1] In *Heredity and Hope*, historian Ruth Schwartz Cowan defends modern genetic testing—the new genetics, by distinguishing it from twentieth century eugenics—the old genetics. While we rightfully recoil from the old genetics, with its coercive methods and hateful motives, Cowan maintains that we should embrace the new genetics to enhance reproductive choice and promote the well-being of our offspring. In this Review I argue that the analogy between the old and new genetics can be less readily cast aside than Cowan appreciates.

In Part I, I discuss Cowan's historical arguments and theoretical commitments. In Part II, I argue that Cowan overlooks a crucial moral similarity between the old genetics and new genetics: namely, whatever the differences between the means by which each is carried out, both are biological approaches to solve what are in large part social ills. Part III concludes with two ways in which the new genetics, no less than the old, might undermine social equality for people with disabilities. First, the new genetics threatens to express demeaning judgments about the lives of persons with disabilities. Second, a tendency to treat disabilities as predominantly genetic problems worthy of reproductive prevention could weaken our collective willingness to welcome into the world those whose abilities fail to meet the demands of modern society.

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1. RUTH SCHWARTZ COWAN, HEREDITY AND HOPE: THE CASE FOR GENETIC SCREENING 14 (2008) (citing FRANCIS GALTON, INQUIRIES INTO HUMAN FACULTY AND ITS DEVELOPMENT (1883)).

I. THE HISTORY AND ETHICS OF GENETIC TESTING

In *Heredity and Hope* Ruth Schwartz Cowan brings a "historian's tools"[2] to bear on the question of whether and under what conditions individuals and communities ought to encourage parental screening or offspring testing for genetic diseases and disabilities. Prompted in part by her own experiences of pregnancy, Cowan seeks to better understand the science and sociology of modern prenatal screening and provides fresh answers to some of the most vexing questions posed by our emerging powers of reproductive biotechnology: What does it mean to be a good parent? And how can we use genetic knowledge and scientific advances to improve society and lead worthy lives?[3] Cowan explains that simple carrier screening combined with pre-conception genetic counseling can be used to assess the risks of passing on a particular condition.[4] More sophisticated methods of prenatal diagnosis range from the non-invasive but less predictive—such as ultrasound imaging, performed between weeks sixteen and twenty of a normal pregnancy—to the more invasive and highly predictive—such as amniocentesis, performed at fifteen to sixteen weeks of gestation.[5]

Controversy marks each of these approaches, even carrier screening, which does not involve the destruction of prenatal life. Consider screening for untreatable and late-onset disorders, such as Duchenne's Muscular Dystrophy or Huntington's chorea.[6] Or consider susceptibility testing to reveal the statistical probability of a child developing, at some point over the course of his or her life, certain debilitating conditions, such as heart disease or mental illness.[7] For genetic diseases that do not manifest themselves until later in life, for those for which there is no available treatment, and for those for which testing offers no better than imprecise odds of acquisition, the desirability of genetic screening is less obvious.

Early in the first chapter of *Heredity and Hope*, Cowan uncovers the religiously inspired drive toward eugenics in Catholic countries such as France, Brazil, Argentina, and Mexico.[8] But eugenics gained popularity in the early-twentieth century not only across the globe but also across the political spectrum.[9] Cowan tells a fascinating story of eugenics in the former Soviet

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2. COWAN, *supra* note 1, at 9.

3. *See id.* at 1-2.

4. *See id.* at 10.

5. *See id.* at 74-77, 99, 107.

6. *See* Michael Parker & Anneke Lucassen, *Concern for Families and Individuals in Clinical Genetics*, 29 J. MED. ETHICS 70, 71-72 (2003).

7. *See id.* at 73.

8. *See* COWAN, *supra* note 1, at 22-25.

9. *See id.* at 27-28.

Union, where "left-wing biologists found themselves trying to convince communist officials of the social value of eugenics . . . ."[10] Cowan illustrates the early origins of Nazi eugenics, which lay harrowingly close to home in the United States and Great Britain.[11]

From the turn of the century until World War II, the United States embarked on an ambitious program to produce a more genetically fit population.[12] America's embrace of eugenics owed to the widespread perception that reproductive mechanisms promised more effective chances of social reform than compensatory, educational, or other institutional measures. Because "[a]cquired characters are not inherited," *The Nation* magazine wrote in 1910, "the improved environment of one generation does not either raise or lower the inherent qualities of the next."[13] That same year, New York biologist Charles Davenport established the Eugenics Records Office to keep genetic records of people in American hospitals, insane asylums, almshouses, and prisons.[14] In 1913, United States President Theodore Roosevelt wrote in a letter to Davenport,

> Some day, we will realize that the prime duty, the inescapable duty, of the good citizen of the right type is to leave his or her blood behind him in the world; and that we have no business to permit the perpetuation of the citizens of the wrong type.[15]

Twenty-nine states would eventually pass legislation requiring sterilization of populations thought to have undesirable genetic qualities.[16] In 1927, the Supreme Court upheld the constitutionality of forced sterilization laws in *Buck v. Bell*.[17] A

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10. *Id.* at 25.

11. *See id.* at 28-31.

12. For an in-depth review of primary sources detailing the history of the eugenics movement in the United States, see EDWIN BLACK, WAR AGAINST THE WEAK: EUGENICS AND AMERICA'S CAMPAIGN TO CREATE A MASTER RACE (2003); and DANIEL KEVLES, IN THE NAME OF EUGENICS (1985). Michael Sandel expertly condenses this history in his recent book, *The Case Against Perfection*, which is echoed by some of the facts presented here. MICHAEL SANDEL, THE CASE AGAINST PERFECTION (2007).

13. Editorial, *Eugenics and Social Reform*, NATION, Aug. 27, 1910, at 2C.

14. *See* STEPHEN TROMBLEY, THE RIGHT TO REPRODUCE: A HISTORY OF COERCIVE STERILIZATION 54-54 (1988).

15. BLACK, *supra* note 12, at 99 (quoting Letter from Theodore Roosevelt to Charles B. Davenport, Dir. of Biological Lab., Carnegie Dept. of Genetics and Eugenics Record Office (Jan. 3, 1913)). This passage has also been included in SANDEL, *supra* note 12, at 64-65.

16. BLACK, *supra* note 12, at 122; SANDEL, *supra* note 12, at 65-66.

17. 274 U.S. 200 (1927). Justice Oliver Wendell Holmes wrote for an eight justice majority: "It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind." *Id.* at 207.

1929 report on the results of sterilizations undertaken in California[18] was widely cited by the Third Reich and informed the design of Germany's eugenic sterilization law.[19] And in 1935, the *Los Angeles Times* published an enthusiastic report of Nazi eugenics: "Here, perhaps, is an aspect of the new Germany that America, with the rest of the world, can little afford to criticize."[20]

After providing an authoritative history of medical genetics in Chapter Two, Cowan allays our misgivings about the new genetics in Chapters Three through Six, where she traces the history of carrier, prenatal, and infant screening programs for four hereditary diseases for which prenatal predictions are reliable and early detection is routine. These are Tay-Sachs disease and phenylketonuria (PKU), which are caused by enzyme deficiencies, and sickle-cell anemia and β-Thalassemia, which result from defects in the production of β-hemoglobin. In a series of richly textured narratives, Cowan recounts the fascinating tales of the scientists, clinicians, and counselors who developed gene mutation carrier screening programs for PKU, Tay Sachs, and β-Thalassemia to help people with high-risk genes bear healthy children.

By contrast to these success stories, her account of sickle cell screening for African-Americans in Chapter Five is disturbing. Cowan deftly describes a mismanaged program of defective screening and ineffective counseling that bears the mark of racial indifference or worse. While the sickle cell screening program falls squarely within Cowan's understanding of the new genetics, the failure of this program does not temper Cowan's endorsement of modern genetic testing—"without guilt, without ambivalence, and without apology"[21]—as scientifically and morally distinguishable from that which was objectionable about the old genetics.

Cowan defends the new genetics by dislodging contemporary reproductive practices from their pejorative connection to Nazi eugenics.[22] Cowan condemns coercive and discriminatory practices like sex segregation, anti-miscegenation laws, anti-immigration policies, forced sterilization, and genocide, which were built upon a flawed "genetics of probability and statistics in large populations."[23] The old genetics adopted a collectivist approach to human betterment, in which the desirability of the targeted traits corresponded to some *Wunschbild*, or "ideal

18. E.S. GOSNEY & PAUL POPENOE, STERILIZATION FOR HUMAN BETTERMENT: A SUMMARY OF RESULTS OF 6,000 OPERATIONS IN CALIFORNIA, 1909-1929 (1929).

19. PHILIP REILLY, THE SURGICAL SOLUTION: A HISTORY OF INVOLUNTARY STERILIZATION IN THE UNITED STATES 106 (1991).

20. K. Burchardi, *Why Hitler Says: "Sterilize the Unfit!,"* L.A. TIMES, Aug. 11, 1935, at F9; *see* SANDEL, *supra* note 12, at 67.

21. COWAN, *supra* note 1, at 227.

22. *See id.* at 40, 113-14.

23. *Id.* at 234.

type," for the model human form as determined by national character.[24] Collectivist thinking about eugenics was exemplified in a 1914 report to the American Breeders Association[25] delivered by then-director of Eugenics Records Office Harry Laughlin, to whom Cowan attributes the strategy for the 1924 immigration quotas.[26] Laughlin argued: "Society must look upon germ-plasm as belonging to society and not solely to the individual who carries it."[27] However objectionable we find the collectivist coercion of the old genetics, Cowan warns us not to commit the "genealogical fallacy" of holding the new genetics responsible for the sins of the old.[28]

In Chapters Five and Six, Cowan attempts to expose as "historically fallacious" the popular argument that the old and new genetics are morally equivalent.[29] Cowan argues that, whereas the goal of the old genetics was to prevent carriers of genetic mutations from reproducing, the new genetics seeks to enhance procreative freedom and offspring well-being. Cowan endorses a program of genetic screening that involves neither threat nor force, and instead privileges clinical biology, parental choice, and prevention of disease. Cowan follows legal scholars such as John Robertson in endorsing parents' procreative freedom to use genetic testing and prenatal interventions "to control the use of one's reproductive capacity."[30] Decisions about whether and what type of children to have considerably influence a parent's sense of identity, and these choices also give rise to a host of ensuing benefits and burdens. Even if prospective parents feel pressure to exercise their procreative freedom in ways that conform to reproductive norms, "eugenics is about state control of reproduction," Cowan emphasizes, "not about internalized standards of normality."[31] Procreative freedom is also connected to offspring welfare. "Parents tend to pay closer attention to the well-being of their offspring," philosopher Nicholas Agar explains, "than does the state pursuing some broad program of human stock improvement."[32]

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24. *See id.* at 28-37, 235-36; *cf.* DESMOND KING, IN THE NAME OF LIBERALISM: ILLIBERAL SOCIAL POLICY IN THE USA AND BRITAIN 52 (1999).

25. JONATHAN PETER SPIRO, DEFENDING THE MASTER RACE: CONSERVATION, EUGENICS, AND THE LEGACY OF MADISON GRANT 236 (2008).

26. *See* COWAN, *supra* note 1, at 21.

27. SPIRO, *supra* note 25, at 236 (quoting Harry H. Laughlin).

28. *See* COWAN, *supra* note 1, at 67.

29. COWAN, *supra* note 1, at 234.

30. JOHN A. ROBERTSON, CHILDREN OF CHOICE: FREEDOM AND THE NEW REPRODUCTIVE TECHNOLOGIES 16 (1994).

31. Ruth Schwartz Cowan, *Moving up the Slippery Slope: Mandated Genetic Screening on Cyprus*, 151C AM. J. MED. GENETICS 95, 95 n.1 (2009).

32. Nicholas Agar, *Liberal Eugenics*, 12 PUB. AFF. Q. 137, 142 (1998).

II. AN ANALOGY BETWEEN NEW AND OLD

The moral distinction Cowan tries to draw between the old genetics and the new genetics is important but incomplete. Cowan recognizes that the old genetics was not always carried out through coercion by the state. Some practices belonging to the old genetics she recounts in the United States were both voluntary and private. In the early decades of the twentieth century, "Better Baby"[33] and "Fitter Families"[34] contests awarded trophies at state fairs across the country for families with the finest genetic histories. Cowan notes that many universities and even high schools offered courses instructing students how to make wise reproductive decisions.[35] And she makes clear that supporters of Margaret Sanger's birth control clinic sought to discourage childrearing among those deemed unfit.[36] What Cowan fails to appreciate is the important normative connection between these examples of what she labels the "old genetics" and varied incarnations of the "new genetics" operating around the world today, especially in southeast Asia.

Just as the old genetics was not always coercive or state-sponsored, the new genetics is not always free of state sponsorship or coercion. Cowan acknowledges this fact but nonetheless fails to incorporate its significance into her analysis. In parts of Asia, the Middle East, and the Mediterranean, laws aimed at the propagation of healthy people are enforced to this day.[37] In Israel, a 1986 ordinance provides federal funding for voluntary genetic testing of all citizens to determine carrier status of Tay-Sachs disease among Jews of Eastern European descent.[38] In Cyprus, the 1972 Thalassemia Program makes screening of all high school students compulsory for the hereditary blood disease β-Thalassemia; the state then pays for voluntary prenatal screening of and abortion

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33. *See* ANNETTE K. VANCE DOREY, BETTER BABY CONTESTS: THE SCIENTIFIC QUEST FOR PERFECT CHILDHOOD HEALTH IN THE EARLY TWENTIETH CENTURY (1999).

34. *See* Steven Selden, *Transforming Better Babies into Fitter Families: Archival Resources and the History of the American Eugenics Movement, 1908–1930*, 149 PROC. AM. PHIL. SOC'Y 199, 210-11 (2005) (citing KAN. BUREAU OF CHILD RESEARCH, FITTER FAMILIES FOR FUTURE FIRESIDES: A REPORT OF THE EUGENICS DEPARTMENT OF THE KANSAS FREE FAIR, 1920-1924 (1924)); *see also* KEVLES, *supra* note 12, at 61-62 (detailing the history of the Fitter Families competitions, which began in Topeka in 1920); SANDEL, *supra* note 12, at 65 (noting that families underwent medical, psychological, and intelligence testing to determine winners).

35. *See* COWAN, *supra* note 1, at 20; *see also* SANDEL, *supra* note 12, at 65.

36. *See* COWAN, *supra* note 1, at 172.

37. *See id.*, at chs. 4, 5.

38. *See* Etty Broide et al., *Screening for Carriers of Tay-Sachs Disease in the Ultra-Orthodox Ashkenazi Jewish Community in Israel*, 47 AM. J. MED. GENETICS 213, 215 (1993); *see also* COWAN, *supra* note 1, at 133-39 (describing the history of Tay-Sachs screening in the United States).

services for all affected persons.[39] In Taiwan, the Genetic Health Law has mandated prenatal screening since 1985; physicians must recommend sterilization if it is "considered necessary" to address an incurable "genetic, infectious, or psychiatric disease," and they must also advise abortion when it is "considered necessary" for an "abnormal fetus."[40] And in China, the 1994 Law on Maternal and Infant Health Care stipulates as a condition of marriage that couples must undergo genetic screening. If either partner is diagnosed with certain genetic diseases, the couple is not permitted to marry without undergoing sterilization or long-term contraceptive measures.[41]

If genetic screening for disease and disability seems disquieting only insofar as it deprives parents of free choice, consider Singapore's voluntary program of new genetics. Michael Sandel provides a vivid account of the Prime Minister's Policy Statement of 1983, which encouraged childbearing among the well-educated classes by providing for state-subsidized "love boat" cruises for unmarried individuals with university degrees, incentives for childbearing among college-educated women, "courtship classes" in universities, and an official dating service.[42] Singapore's eugenics program also discouraged reproduction by members of society perceived as possessing undesirable hereditary traits. Sandel notes that "low-income women who lacked a high school degree were offered $4,000 as a down payment on a low-cost apartment—provided they were willing to be sterilized."[43]

Singapore's sterilization payments and love boat cruises were state-sponsored and "collectivist" in character, Sandel observes, but they were not coercive, at least not in the conventional sense of forcing people, under threat of punishment, to breed or be made sterile.[44] If the Singapore case gives reason for unease, this suggests that doing away with bad science, racist intentions, and

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39. *See* COWAN, *supra* note 1, at 208-12; Panayiotis Ioannou, *Thalassemia Prevention in Cyprus. Past, Present and Future*, *in* THE ETHICS OF GENETIC SCREENING 55, 62-63 (Ruth Chadwick et al., eds., 1999).

40. Bureau of Health Promotion, Dep't of Health, ROC (Taiwan), Genetic Health Law (effective Jan. 1, 1985), *available at* http://www.bhp.doh.gov.tw/bhpnet/portal/LawShow.aspx?No=200712250017; *see also* ROC, Public Health: Health Promotion Programs—Maternal and Child Health Care (2002), http://www.gio.gov.tw/taiwan-website/5-gp/yearbook/2002/chpt15-3.htm.

41. Muying Baojian Fa [Law on Maternal and Infant Health] (promulgated by Standing Comm. Nat'l People's Cong., Oct. 27, 1994, effective June 1, 1995), 1994 FA GUI HUI BIAN 158, *translation available at* http://www.npc.gov.cn/englishnpc/Law/2007-12/12/content_1383796.htm; *see also* James M. Reichman, Mayer Brezis & Avraham Steinberg, *China's Eugenics Law on Maternal and Infant Health Care*, 125 ANNALS INTERNAL MED. 425, 426 (1996).

42. SANDEL, *supra* note 12, at 69.

43. *Id.* (citations omitted).

44. *Id.* at 70.

coercive practices might not make a sociotechnical system of genetic control as admirable or innocuous as Cowan would have us believe.

The core of Cowan's argument is that the new genetics is "anti-eugenic" and "pro-natalist."[45] Modern genetic screening facilitates reproduction among those with recessive gene mutations, she claims, by enabling individuals to find partners without such recessive mutations and by "allow[ing] people who are genetically 'at-risk' to have as many children as they want."[46] This argument works well for Cowan's four case studies of Tay-Sachs, PKU, β-Thalassemia, and sickle-cell anemia. But it does not apply to prenatal screening for Down syndrome, which among all genetic anomalies, is the condition for which fetuses are tested and aborted at the highest rate.[47] Cowan notes that the conception of children with Down syndrome cannot be prevented through carrier screening since the condition can, to date, be detected only through prenatal diagnosis and reliably prevented before birth only through abortion.[48] But she fails to acknowledge the accompanying fact that for Down syndrome, the new genetics cannot be pro-natalist in the way that screening programs for Tay-Sachs and PKU have been. Cowan's claim that "[t]he technologies of genetic screening reduce, rather than increase, the likelihood of selective abortion"[49] is simply wrong when applied to testing for Down syndrome.

III. A CHALLENGE TO THE NEW GENETICS

There are two additional reasons to worry about the new genetics. Both flow from the fact that the new genetics shares with the old genetics the goal of applying scientific knowledge of hereditary processes to the practice of human reproduction for the purpose of creating people of a particular type, even if only to avoid bringing into the world children with certain disabilities. The first reason is that the new genetics threatens "expressive" harm toward those whose genetic traits are targeted for elimination through reproductive measures.[50] On this account, parental screening, genetic testing, and selective abortion on the basis of disability can express harmful and demeaning judgments about the lives of

45. COWAN, *supra* note 1, at 95 ("The first provider of prenatal diagnosis was a physician who wanted to help the carrier of a genetic disease *have* a baby; the first patient was a woman who, absent the test, would have probably terminated her pregnancy.").

46. *Id.* at 116.

47. *See* Caroline Mansfield, Suellen Hopfer & Theresa M. Marteau, *Termination Rates After Prenatal Diagnosis of Down Syndrome, Spinal Bifida, Anencephaly, and Turner and Klinefelter Syndromes: A Systematic Literature Review*, 19 PRENATAL DIAGNOSIS 808, 810 (1999) (reporting U.K. abortion rates of 92% following a prenatal diagnosis of Down syndrome).

48. *See* COWAN, *supra* note 1, at 84-87, 104-05.

49. *Id.* at 240.

50. *See* Jaime King, *Predicting Probability: Regulating the Future of Preimplantation Screening*, 8 YALE J. HEALTH POL'Y L. & ETHICS 285, 317 (2008).

people with disabilities.[51] Some disability activists argue that selecting against disability sends a message that people with disabilities "are 'too flawed' in [their] very DNA to exist,"[52] and thus are "viewed as unfit to be alive, as second-class humans, at best, or as unnecessary persons who would not have been born if only someone had gotten to them in time."[53]

Is there good reason to think that preventing the birth of people with disabilities sends a disparaging message to people living with disabilities, who can observe their diminishing numbers?[54] Critics of this claim argue that choosing to prevent the birth of certain types of offspring does not express negative attitudes about the moral worth of people with those traits. The message that genetic screening sends, Cowan argues, turns exclusively on the reasons for which it is sought. Prospective parents who choose to terminate a pregnancy on the basis of fetal disability need not believe that people with disabilities are defective or inferior.[55] Indeed, most probably believe simply that a child with a disability is less likely to enjoy the full range of activities and opportunities available to children without disabilities.[56] Parents who wish to avoid giving birth to a child with a disability likely feel this way not because they negatively value people with disabilities, but instead because they positively value the autonomy that disabilities circumscribe.[57]

This reply misfires. While the idea that noble intentions determine the meaning of prenatal screening might be appealing, the social meanings of prenatal screening are a function of context, not intent.[58] Prenatal testing takes

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51. *See* Erik Parens & Adrienne Asch, *The Disability Rights Critique of Prenatal Genetic Testing: Reflections and Recommendations*, *in* PRENATAL TESTING AND DISABILITY RIGHTS 3, 13 (Erik Parens & Adrienne Asch eds., 2000).

52. Marsha Saxton, *Disability Rights and Selective Abortion*, *in* ABORTION WARS: A HALF CENTURY OF STRUGGLE, 1950-2000, at 374, 391 (Rickie Solinger ed., 1998).

53. ROBERT H. BLANK, REGULATING REPRODUCTION 91 (1990).

54. *See generally* Rayna Rapp, *Moral Pioneers: Women, Men and Fetuses on a Frontier of Reproductive Technology*, *in* EMBRYOS, ETHICS, AND WOMEN'S RIGHTS: EXPLORING THE NEW REPRODUCTIVE TECHNOLOGIES 101 (Elaine Hoffman Baruch, Amadeo F. D'Adamo Jr., & Joni Seager eds., 1988).

55. *See* Allen Buchanan, *Choosing Who Will Be Disabled: Genetic Intervention and the Morality of Inclusion*, 13 SOC. PHIL. & POL. 18, 31 (1996) (suggesting that women who choose to abort on the basis of disability might "simply wish to be spared avoidable and serious strains on one's marriage or on one's family").

56. *See* Robert L. Shinn, *Foetal Diagnosis and Selective Abortion: An Ethical Exploration*, *in* GENETICS AND THE QUALITY OF LIFE 74, 78-79 (Charles Birch & Paul Abrecht eds., 1975).

57. *See* ALLEN BUCHANAN ET AL., FROM CHANCE TO CHOICE: GENETICS AND JUSTICE 283-84 (2000).

58. *See* Rayna Rapp, *Refusing Prenatal Diagnosis: The Meanings of Bioscience in a Multicultural World*, 23 SCI. TECH. & HUM. VALUES 45, 45 (1998) (analyzing the social impact and

place against a cultural background in which people with disabilities have been "subjected to a history of purposeful unequal treatment, and relegated to a position of political powerlessness in our society."[59] Although the Supreme Court has declined to treat disability as a suspect class under the Equal Protection Clause,[60] the Court has recognized that people with disabilities in America have been systematically "shunted aside, hidden, and ignored."[61] The meaning of a practice that seeks to prevent the existence of people with disabilities should be considered against this history of disability-based discrimination, segregation, forced institutionalization, infanticide, and compulsory sterilization.[62] Disability-selective abortion may be chosen for benign reasons, but when that decision is understood in light of a community's shared meanings, it may nevertheless transmit a message that people with disabilities are "less worthy of toleration or respect than of aversion and surgical repair."[63] Even if prospective parents do not intend to express hurtful ideas, it may be reasonable to expect people with disabilities to receive these messages and be pained by them.

A second reason to worry about genetic testing is that disability-selective abortion might encourage an unwillingness to accommodate, care for, or find ways to improve the lives of those whose abilities fail to meet the demands of modern society.[64] Consider that when the earliest prenatal diagnostic techniques

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contextually-bound cultural meanings "of prenatal diagnosis, a cluster of technologies used for assessing the chromosomal and genetic normalcy of fetuses in utero . all backed up by abortion technology, for those who receive bad news about the health of their fetuses and choose to end specific pregnancies").

59. Americans with Disabilities Act of 1990, Pub. L. No. 101-336, § 2, 104 Stat. 327, 329 (1990) (codified as amended at 42 U.S.C. § 12101(a)(7) (2000) (deleted by amendment in 2008)).

60. City of Cleburne v. Cleburne Living Ctr., Inc., 473 U.S. 432 (1985) (denying constitutional status as a quasi-suspect or suspect class to the disabled, but applying rational basis review to strike down a municipal zoning ordinance under which the city refused to grant a permit to build a group home for the mentally retarded); *see also* Michael Ashley Stein, *Same Struggle, Different Difference: ADA Accommodations as Antidiscrimination*, 153 U. PA. L. REV. 579, 612-15 (2004). Stein notes that "[c]anonical scholarship distinguishes the treatment of people with disabilities from that of other protected groups because it conceives of and discusses disability as a biologically compelled reality, rather than as a contingent social construct." *Id.* at 612.

61. Alexander v. Choate, 469 U.S. 287, 296 (1985).

62. *See* JOSEPH P. SHAPIRO, NO PITY: PEOPLE WITH DISABILITIES FORGING A NEW CIVIL RIGHTS MOVEMENT 12-40 (1993).

63. *See* Dov Fox, *Safety, Efficacy, and Authenticity: The Gap Between Ethics and Law in FDA Decisionmaking*, 2005 MICH. ST. L. REV. 1135, 1149 (making a similar argument with regard to the larger social consequences of cosmetic operations used to alter non-Anglo-Saxon-identified racial and ethnic features).

64. *See* Wendy F. Hensel, *The Disabling Impact of Wrongful Birth and Wrongful Life Actions*, 40 HARV. C.R.-C.L. L. REV. 141, 180 ("[S]ociety's compassion towards the mother of a child with disabilities will diminish if she 'easily' could have prevented the hardships resulting from her

were introduced in the 1970s, abortion was thought to be a temporary approach that would soon be replaced by therapeutic measures for fetal disease.[65] However, there are few treatments for genetic disabilities today, and the search for such therapies has slowed considerably.[66] If reproductive fixes replace therapeutic approaches to genetic conditions, the new genetics could enervate our collective will to confront the challenge of disabilities.[67]

A straightforward objection to this argument is that that society can seek to prevent disabilities before birth and, at the same time, provide for the needs of those born with disabilities.[68] I do not disagree that *ex ante* and *ex post* approaches can be coherently pursued in tandem, at least as a matter of moral logic. However, these approaches are seriously at odds as a matter of moral psychology. The "why not both?" objection neglects the influence of prevailing norms on social attitudes and the way that changes in social practice can bring about changes in the ways we understand ourselves and the ways we choose to solve the challenges we face.[69] Selective abortion reinforces the view that

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child's condition.").

65. *See* Theodore Friedmann, *Opinion: The Human Genome Project—Some Implications of Extensive "Reverse Genetic" Medicine*, 46 AM. J. HUM. GENETICS 407, 412 (1990); Abby Lippman, *The Genetic Construction of Prenatal Testing: Choice, Consent, or Conformity for Women?*, *in* WOMEN AND PRENATAL TESTING: FACING THE CHALLENGES OF GENETIC TECHNOLOGY 9, 26 (Karen H. Rothenberg & Elizabeth J. Thomson eds., 1994).

66. *See* Patricia E. Bauer, *If the Test Says Down Syndrome*, WASH. POST, Nov. 16, 2007, at A33 ("The diagnostics carry the unspoken message that people with Down syndrome are 'bad outcomes,' people whose lives are not worth living. Yet there hasn't been a comprehensive effort to collect data on the outcomes of adults with the condition, nor have there been well-funded efforts to develop treatments for them.").

67. *See* LORI B. ANDREWS, FUTURE PERFECT: CONFRONTING DECISIONS ABOUT GENETICS 101 (2001) ("Once prenatal diagnosis and testing are made available for a particular disorder, there may be a tendency to discontinue funding for research to help combat the medical problems for existing people with that disorder and to discontinue social services for such individuals."); BARBARA KATZ ROTHMAN, TENTATIVE PREGNANCY: PRENATAL DIAGNOSIS AND THE FUTURE OF MOTHERHOOD 9 (1986) (arguing that the rise of prenatal genetic testing transforms disability from a social problem into an individual problem).

68. *See* Bonnie Steinbock, *Preimplantation Genetic Diagnosis and Embryo Selection*, *in* A COMPANION TO GENETHICS 175, 182 (Justine Burley & John Harris eds., 2002) (arguing that the rise of prenatal screening has "coincided with more progressive attitudes toward the inclusion of people with disabilities, as evidenced in the United States by the passage of the Americans with Disabilities Act").

69. *See* Dov Fox, *Silver Spoons and Golden Genes: Genetic Engineering and the Egalitarian Ethos*, 33 AM. J.L. & MED. 568, 611 (2007) ("Even with disability rights legislation on the books, if poverty or poor school performance become genetic problems to be cured by technology, rather than social problems worthy of political remedy, then conditions that were once addressed through education or economic intervention will be managed instead by producing people who better fit the

individual impairment alone explains why disability disadvantages.[70] Only in unaccommodating infrastructures does an impairment of normal psychological or physiological functioning burden the capacity to achieve a basic activity such as moving about freely. The biological view of disability overlooks and inadequately addresses the important social component of what makes impairments disabling.[71]

CONCLUSION

While Cowan's unqualified celebration of the new genetics will not convince its critics, *Heredity and Hope* offers a provocative reply to those disability advocates, reproductive feminists, and antiabortionists who would compare modern, prenatal genetic screening to Nazi eugenics. This perspective comes at a critical moment. Cowan's historical analysis of Tay-Sachs, PKU, and β-Thalassemia provides the strongest case yet for the December 2007 recommendation by the American College of Obstetricians and Gynecologists that hospitals and physicians should be required to expand their offer of prenatal testing for a range of conditions to pregnant women of all ages.[72] Cowan is right that the founders of medical genetics "viewed their basic project as the relief of human suffering, not improvement of the race."[73] But this argument about intentions misses the point. If we come to believe that the fitting way to deal with disabilities is to keep the people who would have them from ever coming into existence, there is a serious risk we will lose our commitment to reform society in ways that meaningfully include people with disabilities.

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social roles we choose to reward.").

70. *See* Martha Saxton, *Prenatal Screening and Discriminatory Attitudes About Disability*, *in* EMBRYOS, ETHICS, AND WOMEN'S RIGHTS: EXPLORING THE NEW REPRODUCTIVE TECHNOLOGIES, *supra* note 54, at 217, 221-22 ("[T]he disability can produce considerable inconvenience . But it is the discriminatory attitudes and thoughtless behavior that make life difficult.").

71. *See* Christoper Newell, *The Social Nature of Disability, Disease and Genetics: A Response to Gillam, Persson, Holtug, Draper and Chadwick*, 25 J. MED. ETHICS 172, 173 (1999) ("I suggest a social constructivist account, but this does not deny a physiological component Genetic conditions occur in a social context, and their meaning and impact are inherently social.").

72. *ACOG Practice Bulletin No. 88: Invasive Prenatal Testing for Aneuploidy*, 110 OBSTETRICS & GYNECOLOGY 1459 (2007); *see also* Press Release, Am. Coll. of Obstetricians & Gynecologists, New Recommendations for Down Syndrome: Screening Should Be Offered to All Pregnant Women (Jan. 2, 2007), http://www.acog.org/from_home/publications/press_releases/nr01-02-07-1.cfm.

73. COWAN, *supra* note 1, at 236.