

**DISCRIMINATION OUT OF DISMISSIVENESS:
THE EXAMPLE OF INFERTILITY**

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In recent years, anti-discrimination theory and doctrine have rested heavily on the “anti-caste” principle first enunciated in Strauder v. West Virginia. According to this principle, equal protection law and anti-discrimination statutes should eradicate public—and private—policies that subject some persons to ongoing stigma and subordination and therefore to second-class status in society.

This article argues that while a focus on stigma and subordination is important, it misses a key source of discrimination—the discrimination that arises from dismissiveness. Anti-discrimination law has recognized the need to overcome the discrimination that results from invidious bias, unfair stereotyping, irrational fear, accumulated myths, or simple neglect. All of these forms of discrimination reflect situations in which society disfavors people because of traits or conditions that are unpopular. Yet it is important to recognize as well that discrimination can—and does—occur when majorities dismiss the impact that a person’s differences can have and disfavor people because of traits or conditions that are not unpopular. Indeed, the trait or condition may even be viewed as desirable by others, even though it is viewed as undesirable by many of those who have the trait or condition.

This article illustrates discrimination from dismissiveness with the example of infertility. Infertile men and women suffer from one or another physical abnormality of their reproductive capacity, and they experience high levels of psychological distress. By standard measures, infertility is a disability.

Yet despite the level of suffering and the presence of a real bodily dysfunction, many policymakers and scholars do not treat infertility as a disability. Although infertile persons may be deprived of the opportunity to procreate, such a deprivation, it is argued, is the loss of a lifestyle option. Infertile persons still can carry on their lives at work or at play at normal levels, with no reduction in functioning.

This article traces the evolution in views about fertility and reproduction in Western society and demonstrates how changes in perspective about the value of reproduction can turn infertility from an obvious disability into a condition that may be viewed by many as non-disabling. To protect the interests of persons with infertility and anyone else who might be subject to discrimination on the basis of dismissiveness, it is critical to ensure that public policy recognizes the possibility of discrimination from dismissiveness as it shapes anti-discrimination theory and doctrine.

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INTRODUCTION

In recent years, anti-discrimination theory and doctrine have rested heavily on the “anti-caste” principle that the Supreme Court first enunciated in *Strauder v. West Virginia*.¹ According to this principle, equal protection law and anti-discrimination statutes should eradicate public—and private—policies that subject some persons to ongoing stigma and subordination and therefore to second-class status in the courts, the political system, schools, the workplace, and other public settings. Thus, for example, in explaining why discrimination on the basis of sex is constitutionally suspect, the Supreme Court pointed to the long and pervasive history of second-class status for women in society.² Many legal scholars have argued that the anti-caste principle provides the best understanding of the equal protection clause’s meaning.³

This article argues that while a focus on stigma and subordination is important, it misses a key source of discrimination—the discrimination that arises from dismissiveness. Anti-discrimination law has recognized the need to overcome the discrimination that results from invidious bias,⁴ unfair stereotyping,⁵ irrational fear, accumulated myths,⁶ or simple neglect.⁷ Advocates for disfavored groups also have called for greater protection from discrimination that arises from the attitude that some individuals (e.g., the obese) have earned their disadvantaged status.⁸ All of these forms of discrimination reflect situations in which society disfavors people because of traits or conditions that are unpopular. Yet it is important to recognize as well that discrimination can—and does—occur when majorities dismiss the impact that a person’s differences can have and disfavor people because of traits or conditions that are not unpopular. Indeed, the trait or condition may even be viewed as desirable by others, even though it is viewed as undesirable by many of those who have the trait or condition.

¹ 100 U.S. 303 (1880).

² *Frontiero v. Richardson*, 411 U.S. 677 (1973). The Court also cited the immutable nature of a person’s sex and the irrelevance of a person’s sex to one’s qualifications.

³ LAURENCE H. TRIBE, *AMERICAN CONSTITUTIONAL LAW* 1515-1521 (2d ed. 1988) (“A more promising theme in equal protection doctrine may well be an antistatist principle”); Owen Fiss, *Groups and the Equal Protection Clause*, 5 *PHIL. & PUBLIC AFFAIRS* 107, 108 (1976); Cass Sunstein, *The Anti-Caste Principle*, 92 *MICH. L. REV.* 2410 (1994).

⁴ *Strauder*, 100 U.S. at 307-308; *Brown v. Board of Education*, 347 U.S. 483 (1954); *Hunter v. Underwood*, 471 U.S. 222, 229-230 (1985) (striking down an Alabama law that limited voting rights of persons convicted of certain felonies on grounds that the law was motivated by racial animus); *Georgia v. McCollum*, 502 U.S. 42, 58-59 (1992) (finding unconstitutional a criminal defendant’s use of peremptory challenges to potential jurors on the basis of race).

⁵ *United States v. Virginia*, 518 U.S. 515, 549-551 (1996) (rejecting arguments based on stereotypes about the suitability of military training for women).

⁶ *School Board of Nassau County v. Arline*, 480 U.S. 273, 284 (1987) (discussing Congress’ concern with discrimination against the disabled because of accumulated myths and irrational fear).

⁷ *Alexander v. Choate*, 469 U.S. 287, 295 (1985) (observing that discrimination against the disabled often results from benign neglect).

⁸ Cary LaCheen, *Achy Breaky Pelvis, Lumber Lung and Juggler’s Despair: The Portrayal of the Americans with Disabilities Act on Television and Radio*, 21 *BERKELEY J. EMP. & LAB. L.* 223, 227-230 (2000).

To illustrate the problem of discrimination from dismissiveness, I use the example of infertility and protection from discrimination on the basis of disability. I argue that to be complete, anti-discrimination theory must take account of the fact that people with certain disabilities may experience real and serious suffering, yet others may view their condition as non-disabling and therefore deny the individuals the medical care or other services that they need. Infertility is an important case in point. Infertility plagues millions of couples in the United States, causing high levels of psychological distress, and driving many men and woman to spend thousands of dollars trying to conceive or adopt a child, either at home or abroad.⁹ Infertile men and women suffer from one or another physical abnormality of their reproductive capacity. By many measures, infertility is a disability. And so the U.S. Supreme Court seemed to hold in *Bragdon v. Abbott*, a case in which the Court held that an HIV-infected woman was protected from discrimination by the Americans with Disabilities Act because her HIV-infection compromised her ability to reproduce.¹⁰

Yet despite the level of suffering and the presence of a real bodily dysfunction, many policymakers and scholars do not treat infertility as a disability. In their view, disability involves a diminution in regular, day-to-day functioning, and by that standard, infertile persons are whole. Although infertile persons may be deprived of the opportunity to procreate, such a deprivation, it is argued, is the loss of a lifestyle option.¹¹ Infertile persons still can carry on their lives at work or at play at normal levels, with no reduction in functioning.

The two very different views on infertility as disability are well captured in the majority and dissenting opinions in *Bragdon*. According to the five-justice majority, an impairment in the ability to procreate rises to the level of disability because “[r]eproduction and the sexual dynamics surrounding it are central to the life process itself.”¹² The four dissenters saw it differently. In their view, infertility is not a disability because it does not amount to an activity, like walking, seeing, breathing or learning, that is “essential in the day-to-day existence of a normally functioning individual.”¹³

Why such a difference in opinion between the majority and the other justices? This article argues that the willingness of the *Bragdon* dissenters to dismiss the idea that infertility constitutes a disability reflects both a broad social sentiment that infertility is not disabling and a less prevalent, but still common view that infertility may in fact protect individuals from becoming disabled. Under some important accounts, *parenting* is disabling in its effects on a person’s place in society. As Germaine Greer has written, “modern society is unique in that it is profoundly hostile to children Mothers who are deeply involved in exploring and developing infant intelligence and personality . . .

⁹ ELIZABETH BARTHOLET, FAMILY BONDS: ADOPTION AND THE POLITICS OF PARENTING 1-23 (1993) (describing her experiences with adoption in Peru); Guido Pennings, *Reproductive Tourism as Moral Pluralism in Motion*, 28 J. MED. ETHICS 337, 338 (2002) (observing that individuals or couples may travel abroad for fertility treatments because of the high costs in their home countries).

¹⁰ 524 U.S. 624 (1998) (Rehnquist, C.J., with Scalia, J., Thomas, J. and O’Connor, J., dissenting in part).

¹¹ Elizabeth A. Pendo, *The Politics of Infertility: Recognizing Coverage Exclusions as Discrimination*, 11 CONN. INS. L.J. 293, 338-340 (2004/2005) (discussing and criticizing the argument that reproduction is a lifestyle option).

¹² *Bragdon*, 524 U.S. at 638.

¹³ *Bragdon*, 524 U.S. at 660.

share the infant's ostracized status."¹⁴ The possibility that infertility may protect from disability is reflected in the fact that many people choose to become infertile,¹⁵ whether temporarily with birth control pills or other means of contraception, or permanently with a tubal ligation or vasectomy.¹⁶

This article traces the evolution in views about fertility and reproduction in Western society and demonstrates how changes in perspective about the value of reproduction can turn infertility from an obvious disability into a condition that may be viewed by many as non-disabling. To protect the interests of persons with infertility and anyone else who might be subject to discrimination on the basis of dismissiveness, it is critical to ensure that public policy recognizes the possibility of discrimination from dismissiveness as it shapes anti-discrimination theory and doctrine.

Part I of this article discusses the anti-caste principle's prominence in equality theory; Part II considers the failure of the anti-caste principle to reach discrimination on the basis of infertility; and Part III demonstrates the weak protection that anti-discrimination law provides to persons suffering from infertility. This article concludes with a recognition of the need for anti-discrimination theory and doctrine to take account of discrimination on the basis of dismissiveness.¹⁷

I. THE ANTI-CASTE PRINCIPLE'S PROMINENCE IN EQUALITY THEORY

As legal scholars have analyzed Supreme Court doctrine, constitutional history, and moral theory, they have come to emphasize the "anti-caste" role of the equal protection clause and anti-discrimination statutes. In this view, a key justification for the Fourteenth Amendment's guarantee of equal protection under the law lies in the desire to maintain a truly egalitarian society, one that is free of classes of persons who are relegated by government to pervasive social disadvantage and a second-class level of citizenship.¹⁸ Similarly, antidiscrimination statutes like the Civil Rights Act of 1964 or

¹⁴ GERMAINE GREER, *SEX AND DESTINY: THE POLITICS OF HUMAN FERTILITY* 2-3 (1984).

¹⁵ Cf., DONALD EVANS, *VALUES IN MEDICINE: WHAT ARE WE REALLY DOING TO PATIENTS* 89 (observing that for some people, infertility is a blessing).

¹⁶ In a tubal ligation, both of a woman's fallopian tubes are blocked, preventing eggs from reaching the uterus from the ovaries. Herbert B. Peterson, *Sterilization*, 111 *OBSTETRICS & GYNECOLOGY* 203 (2008). In a vasectomy, a man's vas deferens on each side are blocked, preventing sperm from reaching the urethra from the testes. Lisa Memmel & Melissa Gilliam, *Contraception*, in *DANFORTH'S OBSTETRICS AND GYNECOLOGY* 567, 582 (Ronald S. Gibbs, et al. eds. 10th ed. 2008).

¹⁷ Discrimination from dismissiveness has some similarities to, but is different than, what I would characterize as discrimination out of denial. As an example of the latter, consider claims that affirmative action is no longer needed because racial discrimination no longer exists. Individuals taking that position would not be dismissing the seriousness of racial discrimination. Rather, they would be denying the *existence* of racial discrimination.

¹⁸ While the anti-caste principle is very important, it does not exhaust the meaning of equal protection. Sunstein, *Anti-Caste Principle*, *supra* note 3, at 2412. Consider, in this regard, *Village of Willowbrook v. Olech*, 528 U.S. 562 (2000). In that case, the Supreme Court found a violation of equal protection when a zoning board treated a homeowner less favorably than it treated other homeowners with respect to her request to be connected to the municipal water supply. There was no suggestion that the woman had suffered discrimination on other occasions or that she was part of a class of persons that suffered persistent discrimination. Rather, the Court applied the equal protection clause in the setting of a single act of discrimination against a single person.

the Americans with Disabilities Act of 1990 are designed to prevent private parties from imposing second-class citizenship on different minorities.

A. The anti-caste principle in legal scholarship

The anti-caste principle is widely emphasized in legal scholarship. Drawing on fundamental tenets of our Constitution, the legislative history of the Fourteenth Amendment, and essential moral precepts, legal scholars have found the anti-caste principle to provide an important way to understand the Constitution's requirement of equal protection.

Some scholars have derived the anti-caste principle by focusing on what it means to require equality among citizens. Charles Black observed, for example, that although the full meaning of the equal protection clause is not obvious, it is quite clear that equality does not exist when "a whole race of people finds itself confined within a system which is set up and continued for the very purpose of keeping it in an inferior station."¹⁹ Similarly, Kenneth Karst found the anti-caste principle to be implicit in the concept of equality. As he wrote, "[t]he essence of equal citizenship is the dignity of full membership in the society."²⁰ To ensure full membership, the principle of equality must "presumptively forbid[] . . . society to treat an individual either as a member of an inferior or dependent caste or as a nonparticipant. Accordingly, the principle guards against degradation or the imposition of stigma."²¹

Other scholars have looked to the history of the Fourteenth Amendment. Owen Fiss identified an anti-caste principle in the equal protection clause by starting with the important reality that while the Fourteenth Amendment recognizes rights for all persons, the primary intent of the Amendment was to safeguard the rights of blacks.²² And indeed, courts have provided blacks with the highest degree of protection under the equal protection clause.²³ In further understanding the meaning of the equal protection clause, argued Fiss, it is essential to recognize that what is distinctive about blacks as a class is their history of severe subjugation and political powerlessness and the long-standing duration of that subjugation.²⁴ In other words, the equal protection clause is quintessentially directed at protecting the interests of groups that are specially disadvantaged in society and preventing the implementation of laws or practices that

¹⁹ Charles L. Black, Jr., *The Lawfulness of the Segregation Decisions*, 69 YALE L.J. 421, 424 (1960). See also Paul Brest, *The Supreme Court, 1975 Term -- Foreword: In Defense of the Antidiscrimination Principle*, 90 HARV. L. REV. 1, 8-12 (1976) (discussing the role of the antidiscrimination principle in protecting against stigmatic harm).

²⁰ Kenneth L. Karst, *The Supreme Court, 1976 Term -- Foreword: Equal Citizenship Under the Fourteenth Amendment*, 91 HARV. L. REV. 1, 5 (1977).

²¹ Karst, *Foreword: Equal Citizenship*, *supra* note 20, at 6. See also Kenneth L. Karst, *Why Equality Matters*, 17 GA. L. REV. 245, 248 (1983) (making the same points).

Some scholars distinguish between the imposition of stigma and the creation of a caste-like system. See, e.g., ANDREW KOPPELMAN, *ANTIDISCRIMINATION LAW AND SOCIAL EQUALITY* 57-61, 83-84 (1996). As the Karst excerpt, indicates, however, the two concerns are closely intertwined, and any differences are not material for purposes of this article. See also Sunstein, *Anticaste Principle*, *supra* note 3, at 2430-2431 (discussing the linkage between a caste-like system and stigma).

²² Fiss, *Groups*, *supra* note 3, at 147.

²³ Fiss, *Groups*, *supra* note 3, at 147.

²⁴ Fiss, *Groups*, *supra* note 3, at 150.

aggravate or perpetuate a specially disadvantaged group's subordinate position in society.²⁵

In his constitutional law treatise, Laurence Tribe also emphasizes the history of the Fourteenth Amendment in favoring an anti-caste principle as an explanatory theme for the equal protection clause. Or as he characterizes the principle, the equal protection clause represents “an antisubjugation principle, which aims to break down legally created or legally reinforced systems of subordination that treat some people as second-class citizens.” Equal protection does not permit society to treat some of its members as “outsiders or as though they were worth less than others.”²⁶ Tribe points out that the Thirteenth, Fourteenth and Fifteenth Amendments were drafted specifically with the goal of overturning the holding from *Dred Scott* that blacks were not citizens but constituted an inferior class subject to subjugation.²⁷ In the words of the *Dred Scott* Court,

We think they are not, and that they are not included, and were not intended to be included, under the word “citizens” in the Constitution, and can therefore claim none of the rights and privileges which that instrument provides for and secures to citizens of the United States. On the contrary, they were at that time considered as a subordinate and inferior class of beings, who had been subjugated by the dominant race, and, whether emancipated or not, yet remained subject to their authority, and had no rights or privileges but such as those who held the power and the Government might choose to grant them.²⁸

Cass Sunstein traces the anti-caste principle not only to the history of the Fourteenth Amendment but also to the original framing of the Constitution. He sees the principle as “captur[ing] an understanding that has strong roots in American legal traditions . . . and fits well with the best understandings of liberty.”²⁹ As Sunstein points out, the anti-caste principle grows out of the Constitution's original rejection of the legacy of monarchy,³⁰ made explicit in the Constitution's ban on titles of nobility,³¹ in favor of a government that is constituted from the people and elected by the people.

The legislative debate over the Fourteenth Amendment also reflects the importance of the anti-caste principle. Sunstein recounts the testimony of Senator Jacob Howard of Michigan, who brought the proposal for the Fourteenth Amendment to the Senate floor from committee.³² According to Howard, the Fourteenth Amendment “abolishes all class legislation in the States and does away with the injustice of subjecting one caste of persons to a code not applicable to another.”³³ In his mention of “class legislation” and “code not applicable to another,” everyone understood that Senator Howard was referring to concerns with the “Black Codes” that southern states had

²⁵ Fiss, *Groups*, *supra* note 3, at 155-157.

²⁶ TRIBE, *AMERICAN CONSTITUTIONAL LAW*, *supra* note 3, at 1515.

²⁷ TRIBE, *AMERICAN CONSTITUTIONAL LAW*, *supra* note 3, at 1516.

²⁸ *Dred Scott v. Sandford*, 60 U.S. 393, 404-405 (1856).

²⁹ Sunstein, *Anticaste Principle*, *supra* note 3, at 2412.

³⁰ Sunstein, *Anticaste Principle*, *supra* note 3, at 2428-2429.

³¹ U.S. CONST. art. I, § 9, cl. 8; U.S. CONST. art. I, § 10, cl. 1.

³² David P. Currie, *The Reconstruction Congress*, 75 U. CHI. L. REV. 383, 404 (2008).

³³ Cong. Globe, 39th Cong., 1st Sess. 2766 (1866) (cited by Sunstein, *Anticaste Principle*, *supra* note 3, at 2435).

quickly enacted following the adoption of the Thirteenth Amendment's ban on slavery. These Codes denied basic civil rights to the newly freed slaves and maintained their legal and social subjugation.³⁴

B. The anti-caste principle in case law

The anti-caste principle has ample support from legal scholars not only because it fits closely with the principle of equality and the motivations behind the adoption of the equal protection clause. The principle also finds strong support from language in leading Supreme Court decisions, dating as far back as the Court's first case interpreting the Fourteenth Amendment's application to claims of discrimination on the basis of race. *Strauder v. West Virginia* involved a challenge to a state law disqualifying blacks from eligibility to serve on juries. A unanimous Court struck down the disqualification, writing that the Fourteenth Amendment provides protection to blacks "from legal discriminations, implying inferiority in civil society . . . and [those] discriminations which are steps towards reducing [blacks] to the condition of a subject race."³⁵ Less than two decades later, Justice John Harlan sounded a similar theme when he delivered his classic understanding of the equal protection clause in objecting to a Louisiana law that required railroad companies to maintain segregated passenger cars for their customers. "There is no caste here," wrote Harlan.³⁶

More recent examples from Supreme Court doctrine reinforce the anti-caste principle of equal protection jurisprudence. In *Brown v. Board of Education*, the Court found "separate but equal" public school education unconstitutional because it "generates a feeling of inferiority as to [children's] status in the community that may affect their hearts and minds in a way unlikely ever to be undone."³⁷

The Court's opinion in *Plyler v. Doe* is similarly illustrative. In that case, the Court considered whether Texas could deny a free education in the public schools to children whose families were lawful citizens of other countries and did not have legal status in the United States. In concluding that the equal protection clause required Texas to give the children access to its schools, the Court wrote that "[l]egislation imposing special disabilities upon groups disfavored by virtue of circumstances beyond their control suggests the kind of 'class or caste' treatment that the Fourteenth Amendment was designed to abolish."³⁸

The anti-caste principle also played a key role in shaping the Court's recognition that discrimination on the basis of sex generally cannot survive constitutional scrutiny. In the important case of *Frontiero v. Richardson*,³⁹ the Court highlighted the anti-caste principle in striking down the military's differential treatment of male and female soldiers when it came to housing and medical benefits for spouses. According to the Court, discriminations on the basis of sex deserve heightened scrutiny because of this country's "long and unfortunate history" of discrimination that "in practical effect, put women, not

³⁴ GEOFFREY R. STONE, ET AL., CONSTITUTIONAL LAW 458-459 (5th ed. 2005)

³⁵ *Strauder*, 100 U.S. at 108.

³⁶ *Plessy v. Ferguson*, 163 U.S. 537, 559 (1896) (Harlan, J., dissenting).

³⁷ 347 U.S. 483, 492 (1954).

³⁸ 457 U.S. 202, 217 n.14 (1982)

³⁹ 411 U.S. 677 (1973).

on a pedestal, but in a cage.”⁴⁰ The court also expressed its concern with “statutory distinctions . . . [that] often have the effect of invidiously relegating the entire class of females to inferior legal status.”⁴¹

Romer v. Evans provides another important illustration of the critical role that the anti-caste principle plays in equal protection case law. In *Romer*, the Court struck down an amendment to the Colorado constitution that would have denied individuals protection from discrimination on the basis of their sexual orientation. The Court was especially troubled by the fact that the amendment called for a “sweeping and comprehensive” diminution in the legal status of homosexuals⁴²

In short, the Supreme Court has consistently placed great weight on the anti-caste principle as it has shaped its equal protection jurisprudence in key cases, whether involving discrimination against blacks, women, homosexuals or undocumented alien children.

C. The anti-caste principle and disability law

Just as the anti-caste principle runs through theory and doctrine that address discrimination on the basis of race or sex, so does it drive theory and doctrine with respect to discrimination on the basis of disability. Indeed, the legislative history of the Americans with Disabilities Act of 1990 emphasizes the need to overcome the second-class status that persons with disabilities endure. According to the congressional findings, for example, “studies have documented that people with disabilities, as a group, occupy an inferior status in our society,”⁴³ Congress also found that “individuals with disabilities are a discrete and insular minority who have been faced with restrictions and limitations, subjected to a history of purposeful unequal treatment, and relegated to a position of political powerlessness in our society.”⁴⁴ The unequal treatment of the disabled reflects a number of sources, including invidious bias,⁴⁵ inaccurate stereotypes,⁴⁶ irrational fears,⁴⁷ aesthetic and existential anxiety,⁴⁸ and simple neglect.⁴⁹

⁴⁰ *Frontiero*, 411 U.S. at 684.

⁴¹ *Frontiero*, 411 U.S. at 686-687.

⁴² 517 U.S. 620, 627, 632 (1996).

⁴³ 42 U.S.C. § 12101(a)(6). Compared to other persons, individuals with disabilities have lower levels of education, employment and family income and higher rates of incarceration. Samuel R. Bagenstos, *Subordination, Stigma, and ‘Disability,’* 86 VA. L. REV. 397, 420-422 (2000). Surprisingly, the Americans with Disabilities Act has not increased the likelihood that persons with disabilities will be employed. Samuel R. Bagenstos, *The Future of Disability Law*, 114 YALE L.J. 1, 19-23 (2004).

⁴⁴ 42 U.S.C. § 12101(a)(7).

⁴⁵ *School Board of Nassau County v. Arline*, 480 U.S. 273, 279 (1987).

⁴⁶ Bagenstos, *Subordination*, *supra* note 43, at 423-424. Sometimes, persons with disabilities suffer unequal treatment out of misplaced concern that certain activities would be harmful to them. Michael A. Rebell, *Structural Discrimination and the Rights of the Disabled*, 74 GEO. L.J. 1435, 1437 (1986).

⁴⁷ *Arline*, 480 U.S. at 284-285 (referring to discriminatory treatment of persons with noninfectious diseases like epilepsy or cancer “based on the irrational fear that they might be contagious”).

⁴⁸ Harlan Hahn, *Antidiscrimination Laws and Social Research on Disability: The Minority Group Perspective*, 14 BEHAV. SCI. & L. 41, 54 (1996) (describing aesthetic anxiety as a “deep sense of discomfort” from persons with physically unappealing characteristics and existential anxiety as reflecting “unconscious fears about the prospect of becoming disabled”).

⁴⁹ *Alexander v. Choate*, 469 U.S. 287, 295-296 (1985).

A number of scholars have developed a minority group model of disability to illuminate the nature of disability and the discriminatory treatment that persons with disabilities face.⁵⁰ According to the minority group model, individuals with disabilities have been relegated to second-class status because of exclusionary social practices and structures that are shaped by public policy and that turn various physical features into disabling conditions.

In other words, there are two important components to the minority group model: Disabilities are not inherent in the person's physical condition, but are socially constructed,⁵¹ and the social construction of disability can be traced to public policies that anti-discrimination law should address.⁵²

The importance of the anti-caste principle in the development of disability discrimination law has led one prominent scholar to argue that the Americans with Disabilities Act should provide protection when—and only when—individuals with a disability form a subordinated class of persons. According to Samuel Bagenstos, the Act's definition of disability should encompass individuals only when they are stigmatized and “constitute an identifiable group of people who face systematic disadvantage in society” because of the public's prejudice, stereotyping or neglect.⁵³

In sum, the anti-caste principle has played a dominant role in theory, case law and legislative history for the equal protection clause and anti-discrimination statutes like the Americans with Disabilities Act. As such, it has provided a strong basis for striking down policies that impose second-class status on different minorities.⁵⁴ However, as discussed in the next two sections, the anti-caste principle does not account for groups, like the infertile, that experience discrimination out of dismissiveness.

II. THE ANTI-CASTE PRINCIPLE'S FAILURE TO PROTECT INFERTILE PERSONS

As an historical matter in the United States, infertility often—but not always—has constituted a disability that conferred disfavored status in society. In recent years, however, with the evolution of socioeconomic conditions that have made procreation less

⁵⁰ Michelle Fine & Adrienne Asch, *Disability Beyond Stigma: Social Interaction, Discrimination, and Activism*, 44 J. SOC. ISSUES 3 (1988); Mary Crossley, *The Disability Kaleidoscope*, 74 NOTRE DAME L. REV. 621, 659-665 (1999) (both describing the development of the minority group model).

⁵¹ In a society that relied on spiral ramps rather than angular steps to connect different floors of buildings, Anita Silvers writes, moving around in a wheelchair would be much less challenging. Similarly, more reliance on recordings and less on printed text to convey information would make blindness much less handicapping. Anita Silvers, *Formal Justice*, in ANITA SILVERS, DAVID WASSERMAN, & MARY MAHOWALD, *DISABILITY, DIFFERENCE, DISCRIMINATION: PERSPECTIVES ON JUSTICE IN BIOETHICS AND PUBLIC POLICY* 13, 74 (1998).

⁵² Crossley, *Disability Kaleidoscope*, *supra* note 50, at 659; Hahn, *Antidiscrimination Laws*, *supra* note 48, at 53. See also MICHAEL OLIVER, *UNDERSTANDING DISABILITY: FROM THEORY TO PRACTICE* 32-33 (1996); David Orentlicher, *Deconstructing Disability: Rationing of Health Care and Unfair Discrimination Against the Sick*, 31 HARV. C.R.-C.L. L. REV. 49, 66-71 (1996); Richard K. Scotch, *Models of Disability and the Americans with Disabilities Act*, 21 BERKELEY J. EMP. & LAB. L. 213, 214-217 (2000); Silvers, *Formal Justice*, *supra* note 51, at 39-76.

⁵³ Bagenstos, *Subordination*, *supra* note 43, at 418-445.

⁵⁴ Although powerful, the anti-caste principle has not always been followed in this country. *Plessy*, 163 U.S. at 551-552 (upholding “separate but equal” facilities for blacks and whites); *Bowers v. Hardwick*, 478 U.S. 186 (1986) (upholding conviction of two adult males who engaged in consensual sex).

desired, infertility has become less stigmatized, and even seen by some as conferring protection from the disabling consequences of parenthood.⁵⁵ Accordingly, the anti-caste principle has become less effective in protecting the interests of infertile persons.

A. Infertility

Infertility is defined as occurring when a couple engages in unprotected intercourse for one year without being able to conceive a child, and it is estimated to affect 10 to 15 percent of couples in the United States.⁵⁶ Although it is commonly thought that environmental factors or high-risk behaviors have increased the likelihood of infertility, that is not the case. Rather, there is greater awareness of the condition and therefore a greater likelihood that couples will seek treatment for their inability to reproduce and be diagnosed as infertile.⁵⁷ In addition, a person's chances of creating a pregnancy decline after age 25. Men and women at age 25 have twice the likelihood of conceiving a child in a particular month as men and women at age 35.⁵⁸ Thus, as many couples have postponed efforts to have children until their 30's or 40's, their likelihood of becoming pregnant has become less than if they tried to have children in their 20's.⁵⁹

Infertility can result from a number of different abnormalities in the male or female reproductive system. For example, because of sexually transmitted diseases, chemotherapy, mumps during adolescence, testicular injury or other causes, a man may produce low levels of sperm or the sperm may be dysfunctional. Women may have trouble ovulating, or their fallopian tubes may be scarred from infection and not allow passage of eggs from the ovaries to the uterus. Women who have had a ruptured appendix or abdominal or pelvic surgery also may end up infertile. Endometriosis (uterine cells growing outside the uterus) can interfere with the function of ovaries or fallopian tubes, and in many cases, the cause of infertility is unknown.⁶⁰

A number of treatments are available for infertility. For women whose fertility is blocked by fallopian tube dysfunction, for example, in vitro fertilization (IVF) often is successful. With IVF, doctors retrieve eggs from a woman's ovary after hormonal stimulation of the ovaries, fertilize the eggs with sperm in a petri dish, and transfer some of the embryos to the woman's uterus. The remaining embryos are frozen for future use.⁶¹ Male infertility can be overcome much more easily today than in past decades. In

⁵⁵ In other countries, infertility still results in a disfavored status. Tara Cousineau & Alice D. Domar, *Psychological Impact of Infertility*, 21 CLINICAL OBSTETRICS & GYNAECOLOGY 293, 296 (2007); S.J. Dyer, N. Abrahams, M. Hoffman & Z.M. van der Spuy, 'Men Leave Me as I Cannot Have Children': Women's Experiences with Involuntary Childlessness, 17 HUMAN REPRODUCTION 1663 (2002) (documenting serious effect of infertility on social status of women in South Africa); Karen Springen, *Infertility: What It Means to Be a Woman*, NEWSWEEK, Sept. 15, 2008, at www.newsweek.com/id/158625/page/1 (describing ostracism of infertile women in developing countries).

⁵⁶ Kristin P. Wright & Julia V. Johnson, *Infertility*, in DANFORTH'S OBSTETRICS AND GYNECOLOGY 705, 705 (Ronald S. Gibbs, et al. eds. 10th ed. 2008).

⁵⁷ Wright & Johnson, *Infertility*, *supra* note 56, at 705. For example, data do not support the claim that environmental or other factors have caused a decline in sperm counts worldwide. Harry Fisch, *Declining Worldwide Sperm Counts: Disproving a Myth*, 35 UROLOGIC CLINICS N. AM. 137 (2008).

⁵⁸ Adam H. Balen & Anthony J. Rutherford, *Management of Infertility*, 335 BMJ 608, 608 (2007).

⁵⁹ Wright & Johnson, *Infertility*, *supra* note 56, at 705.

⁶⁰ Wright & Johnson, *Infertility*, *supra* note 56, at 706.

⁶¹ Bradley J. Van Voorhis, *In Vitro Fertilization*, 356 NEW ENG. J. MED. 379, 380 (2007).

particular, with the development of intracytoplasmic sperm injection (ICSI), in which a doctor injects a single sperm into each of the women's eggs that have been retrieved as part of IVF, men who produce even very low levels of functioning sperm can procreate with their partners.⁶² Overall, treatment allows 85 percent of infertile couples to have a child.⁶³

The emotional impact of infertility can be severe, particularly for women. As the Supreme Court has recognized, procreation constitutes a fundamental interest.⁶⁴ Indeed, for many people, having and raising children is the most important endeavor of their lives. For people who want to reproduce, but cannot, the loss can be devastating.⁶⁵ In one study, half of the women in an infertility treatment program reported that their infertility was the most upsetting experience of their lives.⁶⁶ In another study, participants were asked to rate their most stressful experiences, and infertility rated as high as the death of a spouse or child.⁶⁷ In a third study, researchers found that the likelihood of depression doubled for women with infertility.⁶⁸ According to a fourth study, infertile women suffer levels of depression comparable to those of women with cancer, HIV-infection or who were undergoing rehabilitation after a heart attack.⁶⁹ And when infertility is a consequence of cancer or its treatment, some cancer survivors describe the loss of fertility as causing as much emotional pain as the cancer itself.⁷⁰ As

⁶² Gianpiero Palermo, et al., *Pregnancies After Intracytoplasmic Injection of Single Spermatozoon into an Oocyte*, 340 LANCET 17 (1992). There are some concerns, however, that ICSI may raise the risks of abnormalities in the child. Sacha Lewis & Hillary Klonoff-Cohen, *What Factors Affect Intracytoplasmic Sperm Injection Outcomes*, 60 OBSTETRICAL AND GYNECOLOGICAL SURVEY 111, 111 (2005). Other methods of assisted reproduction present important risks to the couple or the children that result. Michelle Goodwin, *Prosecuting the Womb*, 76 GEO. WASH. L. REV. 1657, 1723-1736 (2008).

⁶³ CHARLES R. B. BECKMANN, ET AL., OBSTETRICS AND GYNECOLOGY 385 (5th ed. 2005).

⁶⁴ *Skinner v. Oklahoma*, 316 U.S. 535 (1942).

⁶⁵ Lori B. Andrews & Lisa Douglass, *Alternative Reproduction*, 65 S. CAL. L. REV. 623, 629-630 (1991); Judith F. Daar, *Accessing Reproductive Technologies: Invisible Barriers, Indelible Harms*, 23 BERKELEY J. GENDER L. & JUST. 18, 30 (2008); Katherine T. Pratt, *Inconceivable? Deducting the Costs of Fertility Treatment*, 89 CORNELL L. REV. 1121, 1126-1130 (2004).

⁶⁶ Ellen W. Freeman, et al., *Psychological Evaluation and Support in a Program of In Vitro Fertilization and Embryo Transfer*, 43 FERTILITY AND STERILITY 48, 50 (1985). Fewer men described their infertility as the most upsetting experience of their lives—15 percent overall. *Id.* While the studies find high levels of distress among women regardless of the cause of the infertility, men appear to experience comparable levels of distress only when their infertility is the cause of the couple's infertility. Robert D. Nachtigall, et al., *Stigma, Disclosure, and Family Functioning Among Parents of Children Conceived Through Donor Insemination*, 68 FERTILITY & STERILITY 83, 87-88 (1997).

Because studies of the psychological impact of infertility typically involve couples who seek treatment, they may find higher levels of distress than they would in a random sample of infertile couples. Linda Hammer Burns & Sharon N. Covington, *Psychology of Infertility*, in INFERTILITY COUNSELING: A COMPREHENSIVE HANDBOOK FOR CLINICIANS 3, 7 (Linda Hammer Burns & Sharon N. Covington eds. 1999).

⁶⁷ Mimi Meyers, et al., *An Infertility Primer for Family Therapists: I. Medical, Social, and Psychological Dimensions*, 34 FAMILY PROCESS 219, 223 (1995).

⁶⁸ Alice D. Domar, et al., *The Prevalence and Predictability of Depression in Infertile Women*, 58 FERTILITY & STERILITY 1158, 1160-1161 (1992).

⁶⁹ Alice D. Domar, Patricia C. Zuttermeister & Richard Friedman, *The Psychological Impact of Infertility: A Comparison with Patients with Other Medical Conditions*, 14 (SUPPL.) J. PSYCHOSOMATIC OBSTETRICS & GYNECOLOGY 45, 47 (1993).

⁷⁰ Carrie L. Nieman, et al., *Fertility Preservation and Adolescent Cancer Patients: Lessons from Adult Survivors of Childhood Cancer and Their Parents*, 138 CANCER RESEARCH 201, 201 (2007).

one woman who had been diagnosed with Hodgkin's lymphoma said, "When I was first diagnosed with cancer, my friends couldn't believe how well I took the news. But the one fear that continued to haunt me was the thought that I might become infertile."⁷¹ Reported symptoms of infertility include feelings of grief, sadness and despair, a sense of panic, helplessness and isolation, and loss of control.⁷²

B. Infertility is a disability

Does infertility constitute a disability? Given the nature and impact of infertility, it readily satisfies the definition of a disability.

First, consider the definition of a disability. "Disability" refers to the existence of substantial limitations on a person's "major life activities."⁷³ Major life activities include functions like "walking, seeing, hearing, speaking, breathing, learning, and working."⁷⁴ Commonly, disability is caused by an impairment, which is defined as a "physical or mental anomaly." If a person has the impairment of paralyzed legs, then the person is disabled with respect to the major life activity of walking. A person with the impairment of advanced emphysema may be disabled with respect to the major life activities of walking, breathing or working. One also can be disabled without being impaired. If someone has a history of a serious illness that has been fully treated, other people might regard the person as being impaired and therefore limit the person's opportunities at work or in other settings.⁷⁵ This example of a disability without impairment illustrates the social contribution to disability, a contribution that exists as well with respect to disabilities caused by impairment. If one is confined to a wheelchair, one is much less disabled in an environment that has ramps and elevators than in one that has just steps to connect different heights.

Just as a person can be disabled without being impaired, one can be impaired without being disabled. A kidney donor has the impairment of having one instead of two kidneys, but there are no functional limitations as a result of the impairment.⁷⁶ Note too that while illness and impairment overlap, they are not the same. One can be ill with cancer and be disabled as a result. One also can have an impairment (and be disabled)

⁷¹ *Personal Accounts of Cancer and Infertility*, 138 *CANCER RESEARCH* 243, 243 (2007).

⁷² Cousineau & Domar, *Psychological Impact*, *supra* note 55, at 295-296; Sara L. Berga, Barbara L. Parry & Jill M. Cyranowski, *Psychiatry and Reproductive Medicine*, in KAPLAN & SADOCK'S COMPREHENSIVE TEXTBOOK OF PSYCHIATRY 2293, 2300 (Benjamin J. Sadock & Virginia A. Sadock eds. 8th ed. 2005); Linda D. Applegarth, *The Psychological Aspects of Infertility*, in INFERTILITY: EVALUATION AND TREATMENT 25, 27 (William R. Keye, Jr., et al., eds. 1995); ALINE P. ZOLDBROD, MEN, WOMEN, AND INFERTILITY 3 (1993). See also Lynn White & Julia McQuillan, *No Longer Intending: The Relationship Between Relinquished Fertility Intentions and Distress*, 68 *J. MARRIAGE & FAMILY* 468 (2006) (finding that "individuals who relinquish their intentions to have (more) children report more increases in depressive symptoms than those who continue to feel confident about their childbearing intentions").

⁷³ ANITA SILVERS, DAVID WASSERMAN, & MARY MAHOWALD, DISABILITY, DIFFERENCE, DISCRIMINATION: PERSPECTIVES ON JUSTICE IN BIOETHICS AND PUBLIC POLICY 8-9 (1998).

⁷⁴ 45 C.F.R. § 84.3(j)(2)(ii).

⁷⁵ SILVERS, ET AL., *supra* note 73.

⁷⁶ Hassan N. Ibrahim, et al., *Long-Term Consequences of Kidney Donation*, 360 *NEW ENG. J. MED.* 459 (2009).

without being ill.⁷⁷ Someone who loses an arm or a leg in an accident is impaired but not ill.

Infertile persons generally meet the definition of a disability because they have an impairment of their reproductive tracts (e.g., scarred fallopian tubes) that substantially limits the major life activity of procreation. Having children is an interest of fundamental importance to many people; for many people, it is the most important endeavor they undertake in their lives. Thus, as mentioned, the Supreme Court has recognized it as a fundamental right.⁷⁸ Indeed, it would be odd to identify working at a job as a major life activity but not similarly recognize bearing and raising children as a major life activity. Because of the central role that reproduction plays in the lives of so many individuals, the Supreme Court has held that reproduction is a major life activity.⁷⁹

To be sure, some would argue that infertility is an inevitable result of aging and therefore represents a natural state, not a disabling condition. This argument ignores the fact that many infertile persons are of normal childbearing age, but have lost their reproductive capacity through illness or injury.⁸⁰ Moreover, many well-recognized disabilities are a common result of aging, including hearing loss and osteoporosis.⁸¹ If we are willing to provide hearing aids for the hearing-impaired and hip replacements for seniors with reduced bone density to overcome their disabilities, we also should be willing to provide treatments for infertility to overcome that disability.

C. Evolution of social views on infertility

In colonial America, infertility was a serious burden for the affected woman, and it could subject her to suspicion in her community. Indeed, in New England, among women accused of being witches, there was a disproportionate representation of women with no or few children.⁸²

But the social structure of the family offered opportunities for the infertile to overcome their neighbors' suspicions. Households were not based solely on the nuclear family; rather, it was common for couples to take in related children who had lost one or both parents⁸³ or unrelated children as apprentices to learn a trade and help out with the demands of rural life. Children, especially those with single mothers, might be indentured for long periods to employers or "rented out" in exchange for wages. Parents with many children—more than they wanted or could afford—might send them to live

⁷⁷ OLIVER, UNDERSTANDING DISABILITY, *supra* note 52, at 33-37.

⁷⁸ See, *supra*, TAN note 64.

⁷⁹ *Bragdon*, 524 U.S. at 638.

⁸⁰ See, *supra*, TAN 60.

⁸¹ BONE HEALTH AND OSTEOPOROSIS: A REPORT OF THE SURGEON GENERAL 69 (2004), at www.surgeongeneral.gov/library/bonehealth/docs/full_report.pdf.

⁸² ELAINE TYLER MAY, *BARREN IN THE PROMISED LAND: CHILDLESS AMERICANS AND THE PURSUIT OF HAPPINESS* 26-29 (1995).

⁸³ Children commonly lost one or both of their parents before the age of adulthood. In one county, twenty percent of children by the age of thirteen had lost both parents. If a mother died, leaving young children, and the father did not remarry quickly, he often would send the children to live with relatives. Widows too might send children to live with relatives. John Hancock of Declaration of Independence fame was brought up from the age of eight by an aunt and uncle after his father died. MARGARET MARSH & WANDA RONNER, *EMPTY CRADLE: INFERTILITY IN AMERICA FROM COLONIAL TIMES TO THE PRESENT* 17-18 (1996).

with childless couples.⁸⁴ In addition, childraising was more of a communal responsibility, with adults participating in the rearing and disciplining of children living in other homes. Even though infertile couples could not have their own children, they did take in unrelated apprentices and children from related families, and they also participated in the rearing and disciplining of all children.⁸⁵ In short, the public and communal nature of childrearing meant that infertile couples were able to experience much of the social role of parents.⁸⁶

The status of infertile couples began to change toward the end of the eighteenth century as families took on more of a private, nuclear nature. At this time, the center of economic activity moved from the household, with men working outside the home in the commercial centers and women working in the homes.⁸⁷ As the economic role of the household decreased, the home became more of a place for marital fulfillment and cultivation of the next generation of citizens. Children needed more attention both because of their future roles in society and because of their place in the family's circle of love and intimacy.⁸⁸ And as immigration and urbanization resulted in more diverse populations, reformers discouraged the earlier practices by which children flowed easily from one household to another.⁸⁹ By the middle of the nineteenth century, households had lost most of their public function, with the ideal family constituting a married couple and their offspring,⁹⁰ and a glorification of motherhood suggested that having children was the sole reason for a woman's existence. In this view, the home was portrayed as the central institution of American life, and the mother became the linchpin of social unity.⁹¹

⁸⁴ MARSH & RONNER, *EMPTY CRADLE*, *supra* note 83, at 18-19; BARBARA BENNETT WOODHOUSE, *HIDDEN IN PLAIN SIGHT* 63-65 (2008). The latter part of the nineteenth century through the early years of the twentieth century saw a somewhat similar practice of "placing out" of children from poor families. More than 200,000 children were moved from their urban homes to rural homes where childless couples wanted a family, homemakers wanted help around the house, or farmers and merchants wanted workers. MARILYN IRVIN HOLT, *THE ORPHAN TRAINS: PLACING OUT IN AMERICA* 1-7, 119 (1992). The children might come from asylums for orphans or indigent children, prisons, the streets, or parents who hoped for a better life for their children. *Id.* at 24, 47-48.

⁸⁵ ELIZABETH C. BRITT, *CONCEIVING NORMALCY: RHETORIC, LAW, AND THE DOUBLE BINDS OF INFERTILITY* 20 (2001).

⁸⁶ See generally MILTON C. REGAN, JR., *FAMILY LAW AND THE PURSUIT OF INTIMACY* 17-19 (1993) (describing the overlap of family and community in colonial America).

⁸⁷ BRITT, *CONCEIVING NORMALCY*, *supra* note 85, at 20-21; REGAN, *FAMILY LAW*, *supra* note 86, at 19; SUSAN HOUSEHOLDER VAN HORN, *WOMEN, WORK, AND FERTILITY, 1900-1986*, at 4 (1988).

⁸⁸ MAY, *BARREN*, *supra* note 82, at 36-40; STEVEN MINTZ, *HUCK'S RAFT: A HISTORY OF AMERICAN CHILDHOOD* 78 (2004).

⁸⁹ MAY, *BARREN*, *supra* note 82, at 40. See also WOODHOUSE, *HIDDEN*, *supra* note 84, at 241-243 (describing the chasm between middle-class Americans and the children of poor immigrants).

⁹⁰ MARSH & RONNER, *EMPTY CRADLE*, *supra* note 83, at 10-11; GORDON S. WOOD, *THE RADICALISM OF THE AMERICAN REVOLUTION* 148 (1992); JAMIL ZAINALDIN, *LAW IN ANTEBELLUM SOCIETY* 70 (1983). Historians cite a number of reasons for the shift from the communal to the private household. In addition to economic changes, scholars point to the diminished sense of obligation to authority of Revolutionary democracy and the individualism of evangelistic religion. MARSH & RONNER, *EMPTY CRADLE*, *supra* note 83, at 19; WOOD, *RADICALISM*, at 145-148. The informal practices of children flowing from one household to another were replaced with formal laws of adoption. MAY, *BARREN*, *supra* note 82, at 40.

⁹¹ MARSH & RONNER, *EMPTY CRADLE*, *supra* note 83, at 31-32. Interestingly, single women could find a respected social role "by providing maternal functions in the civic arena." MAY, *BARREN*, *supra* note 82, at 49; Martha Minow, "Forming Underneath Everything that Grows:" *Toward a History of Family Law*, 1985 *WIS. L. REV.* 819, 877-882 (1985).

This did not mean that fertility rates were high. Indeed, they declined throughout the nineteenth century as economic changes made children's labor less necessary for the family's economic security and also demanded more investment in children to prepare them for the new workforce with its more complex trades and professions. This shift was reinforced by the child's new place in the family.⁹² Altogether, it made sense to have fewer children and spend more per child on education and other activities.⁹³ Also, women developed interests in activities beyond their domestic responsibilities including working for pay in the marketplace.⁹⁴

Still, even though a suffrage movement was active and social roles were being rethought, a "culture of matrimony" had developed by the early part of the twentieth century, with a norm for women of marriage and childbearing.⁹⁵ Women who did not meet this norm were considered abnormal, and a man who was childless faced suspicions that he had infected his wife with a sexually transmitted disease.⁹⁶

With the economic turmoil of the Great Depression, voluntary childlessness among married couples peaked in the United States,⁹⁷ and fertility rates dropped to their lowest levels. With World War II and the revival of the American economy, the baby boom ensued, and fertility rates in the mid-1950's rose again to levels last seen in 1898.⁹⁸ Much of the increase in birth rates reflected pent-up demand from the Depression⁹⁹ and World War II¹⁰⁰ and so turned out to be a temporary interruption of a long-term decline in fertility rates. Also contributing to the increase in fertility rates was a period of unusual economic prosperity for families. Because of the low birth rates of the Depression, fewer young adults (mostly men) were entering the labor market, driving up

⁹² MARSH & RONNER, *EMPTY CRADLE*, *supra* note 83, at 98; MINTZ, *HUCK'S RAFT*, *supra* note 88, at 77-78; WOODHOUSE, *HIDDEN*, *supra* note 84, at 243. Fertility rates declined more rapidly in cities, while remaining higher in rural areas where land was cheaper and children had greater economic value. VAN HORN, *WOMEN*, *supra* note 87, at 15-17. With fertility rates beginning their decline by the beginning of the nineteenth century and declining more rapidly in the nineteenth century than in the twentieth century, *id.* at 2, the availability of birth control pills and the recognition of a constitutional right to contraception turn out to be minor factors in the story.

⁹³ Naomi Cahn and June Carbone, *Red Families V. Blue Families*, at 9, 11 (2007), at <http://ssrn.com/abstract=1025898>. Parents were devoting more attention and resources to their children also because attitudes toward children were becoming more enlightened. HOLT, *ORPHAN TRAINS*, *supra* note 84, at 11-13; MINTZ, *HUCK'S RAFT*, *supra* note 88, at 77-78

⁹⁴ MARSH & RONNER, *EMPTY CRADLE*, *supra* note 83, at 75, 97-98; VAN HORN, *WOMEN*, *supra* note 87, at 2, 10-14.

⁹⁵ VAN HORN, *WOMEN*, *supra* note 87, at 19-20. See also MAY, *BARREN*, *supra* note 82, at 69 (observing that a woman's "most exalted role in life was motherhood"). There were ethnic and racial elements to the concerns about infertility. Birth rates may have been declining for white families, but birth rates remained high in minority and immigrant families. Fears about "race suicide" were common. MARSH & RONNER, *EMPTY CRADLE*, *supra* note 83, at 113; MAY, *BARREN*, *supra* note 82, at 61-63. At this time, the eugenics movement became very influential. Lori B. Andrews, *Past as Prologue: Sobering Thoughts on Genetic Enthusiasm*, 27 *SETON HALL L. REV.* 893, 893-897 (1997); MAY, *BARREN*, *supra* note 82, at 63-64.

⁹⁶ BRITT, *CONCEIVING NORMALCY*, *supra* note 85, at 24-25; MARSH & RONNER, *EMPTY CRADLE*, *supra* note 83, at 123; MAY, *BARREN*, *supra* note 82, at 63.

⁹⁷ MARSH & RONNER, *EMPTY CRADLE*, *supra* note 83, at 154.

⁹⁸ Herbert S. Klein, *The U.S. Baby Bust in Historical Perspective*, in *THE BABY BUST: WHO WILL DO THE WORK? WHO WILL PAY THE TAXES?* 113, 129 (Fred R. Harris ed. 2006).

⁹⁹ Economic constraints discouraged procreation at this time. Klein, *Baby Bust*, *supra* note 98, at 122.

¹⁰⁰ The mobilization of the military diverted large numbers of young males from marriage and procreation. Klein, *Baby Bust*, *supra* note 98, at 122.

wages. And because of the GI Bill's unprecedented funding of higher education, these young adults came into the labor market able to take on better-paying jobs.¹⁰¹ During this period, parenthood was celebrated, and childless couples were marginalized and stigmatized.¹⁰²

During the 1960's and 1970's, childbearing became less valued by society. While it is difficult to be confident about the exact causes of the decline in valuation, the decline appears to represent more of a resumption of long-term trends than short-term phenomena. Experts cite a number of social changes that came together:

The women's movement pushed for greater equality between the sexes and a reconsideration of traditional gender roles. As women experienced greater opportunities in the workplace, many found their professional work more rewarding than rearing children. Many women delayed marriage and procreation, and when they did have children, they spaced them farther apart. Many women also shortened the duration of their years of procreation. This has resulted in fewer children per woman and fewer women having children.¹⁰³

In addition, the entry of women into the workplace built upon the long-term changes that had altered the economics of procreation, with the cost-benefit ratio of children continuing to become less favorable.¹⁰⁴ First, as women could earn more outside the home, the opportunity cost of raising children rose substantially. Costs increased further as children needed to remain in the home longer for a suitable education and the development of skills necessary to compete in the increasingly complex marketplace.¹⁰⁵ Costs also rose as the pursuit of higher education became more common. At the same time that costs were increasing, the economic benefits of children continued to decrease. In our agrarian past, children played an important role as farm workers.

¹⁰¹ Klein, *Baby Bust*, *supra* note 98, at 126-127. VAN HORN, WOMEN, *supra* note 87, at 112-113. The federal government's subsidization of home mortgage credit also made housing cheaper, lowering the costs of parenting. Klein, *Baby Bust*, *supra* note 98, at 127.

¹⁰² MAY, BARREN, *supra* note 82, at 139. Voluntary childlessness was especially stigmatized. *Id.* Male infertility was also singled out for disfavor, as social myths connected fertility with virility. *Id.* at 159-166.

¹⁰³ Van Voorhis, *In Vitro Fertilization*, *supra* note 61, at 379; Klein, *Baby Bust*, *supra* note 98, at 143. Among US women age 40-44 in 2006, 20 percent had no children. That number is double the percentage of childless women age 40-44 in 1976. U.S. CENSUS BUREAU, CURRENT POPULATION SURVEY: FERTILITY OF AMERICAN WOMEN (June 2006), at www.census.gov/population/socdemo/fertility/cps2006/SupFertTab2.xls.

Female participation in the workplace is an important, but not complete answer to declining fertility rates. Fertility rates in Italy are among the lowest in Europe even though the employment rate for women is relatively low. Fiona McAllister and Lynda Clarke, *Voluntary Childlessness: Trends and Implications*, in *INFERTILITY IN THE MODERN WORLD: PRESENT AND FUTURE PROSPECTS* 189, 217 (Gillian R. Bentley & C. G. Nicholas Mascie-Taylor eds. 2000). Apparently, because gender roles are much more traditional in Italy than other parts of Europe, and women bear a much larger share of household responsibilities, Italian women are less inclined to have additional children than their counterparts in European countries where men assume a larger share of household responsibilities. Melinda Mills, et al., *Gender Equity and Fertility Intentions in Italy and the Netherlands*, 18 *DEMOGRAPHIC RESEARCH* 1 (2008), at www.demographic-research.org/volumes/vol18/1/18-1.pdf. The availability of childcare and the flexibility of workplace hours also can influence the willingness of working women to procreate. Ronald R. Rindfuss, Karen Benjamin Guzzo & S. Philip Morgan, *The Changing Institutional Context of Low Fertility*, 22 *POPULATION RESEARCH & POLICY REV.* 411, 416-417 (2003).

¹⁰⁴ GARY BECKER, *A TREATISE ON THE FAMILY* 96-112 (1981)

¹⁰⁵ WOODHOUSE, *HIDDEN*, *supra* note 84, at 243.

With fewer and fewer families living on farms and farms becoming heavily mechanized, rural children had less to offer in terms of family finances. Urban children also had little to offer economically; their earning potential was limited by child labor laws.¹⁰⁶

The economics of procreation changed in other important ways. As infant and child mortality rates declined and life expectancy increased,¹⁰⁷ parents recognized that they needed to have fewer children to ensure that one or two would live long enough to provide financial support when the parents no longer could support themselves.¹⁰⁸ Accordingly, as had already started to happen in the nineteenth century, the economics of childrearing favored fewer children. They also favored higher per child investments, which would increase the likelihood that children would enjoy increased prosperity and be able to support their parents.¹⁰⁹ The development of private pension funds and the implementation of Social Security further diminished the need to rely on reproduction for security in older age. Declining mortality rates led to reductions in fertility also as increases in the population put pressure on land and other resources.¹¹⁰

Other social changes have played a role in the declining fertility rate. During the 1960's and 70's, the youth of the time challenged traditional social institutions including the family.¹¹¹ Sociologists have described a process of “reflexive modernization:” As individuals have realized greater freedom to construct their own identities rather than have their identities shaped by social norms, they have changed the nature of family roles.¹¹² Many couples voluntarily choose to be childless, believing that the ideal intimate relationship involved another adult, unencumbered by children.¹¹³ Also, reflexive modernization brought with it risk aversion—if people can construct their own identities, they bear more responsibility for outcomes. Hence, couples are more likely to be cautious about making major commitments. This had led to an increase in cohabitation before marriage and a rise in the average age at marriage, so individuals can be surer that they have chosen the right spouse, as well as delays in procreation.¹¹⁴ As divorce has become more acceptable and more common, becoming a parent is also a riskier endeavor,¹¹⁵ and people find that there are diminished benefits from investing time and energy in raising a family rather than cultivating a professional career.¹¹⁶

The risk aversion of reflexive modernization has been increased by the “new capitalism.” As free-market ideology spread in the 1980's and 1990's, labor markets

¹⁰⁶ HERBERT JACOB, *SILENT REVOLUTION: THE TRANSFORMATION OF DIVORCE LAW IN THE UNITED STATES* 20 (1988).

¹⁰⁷ Between 1900 and 1960, life expectancy in the US increased from a little over 47 years to nearly 70 years. <http://www.cdc.gov/nchs/data/hus/07.pdf#027>. See also MAY, BARREN, *supra* note 82, at 25 (discussing the connection between high infant mortality rates and high fertility rates in colonial America).

¹⁰⁸ In the late 18th Century, a couple might have twelve children, with only three reaching adulthood. MARSH & RONNER, *EMPTY CRADLE*, *supra* note 83, at 11 (describing the Holyoke family's experience in Massachusetts).

¹⁰⁹ BECKER, *TREATISE*, *supra* note 104, at 100-101, 111.

¹¹⁰ Klein, *Baby Bust*, *supra* note 98, at 116.

¹¹¹ BRITT, *CONCEIVING NORMALCY*, *supra* note 85, at 27.

¹¹² Peter McDonald, *Low Fertility and the State: The Efficacy of Policy*, 32 *POPULATION & DEVELOPMENT REV.* 485, 488 (2006).

¹¹³ BRITT, *CONCEIVING NORMALCY*, *supra* note 85, at 27.

¹¹⁴ McDonald, *Low Fertility*, *supra* note 112, at 489.

¹¹⁵ Rindfuss, et al., *Changing Institutional Context*, *supra* note 103, at 414.

¹¹⁶ ALLEN M. PARKMAN, *NO-FAULT DIVORCE: WHAT WENT WRONG?* 27-38 (1992).

became more fluid—the days of life-long employment and company-provided pension plans have been replaced by job mobility and self-directed retirement accounts. The new capitalism has meant greater potential for gain but also greater potential for failure. An important way to hedge against the risks of the new capitalism is to invest more in education and work experience and less in family formation and expansion.¹¹⁷

Concern about global overpopulation also may have contributed to the declining desire for procreation. In 1968, Paul Ehrlich published *The Population Bomb*, a best seller that sounded the alarm about overpopulation,¹¹⁸ and in 1972, the Club of Rome issued *The Limits to Growth*, a best-selling prediction about the collapse of the world's social and economic systems from unsustainable growth in the population.¹¹⁹ A number of advocates mounted aggressive environmental arguments against procreation, arguing that the survival of the planet Earth required dramatic reductions in population growth.¹²⁰ Current concerns about global warming could reinforce environmental arguments against procreation. Higher density housing uses less energy, but higher density housing is less conducive to raising a family.

With all of these changes in social attitude, more and more couples have chosen to forego procreation. In England and Wales, for example, women born in 1972 are expected to end their reproductive years with a childless rate twice that of women born in 1942.¹²¹ Similarly, a 40-44 year old woman in the United States was twice as likely to be childless in 2006 than was a 40-44 year old woman in 1976.¹²²

Declining fertility rates in the United States and other western countries also are striking indicators of changing views on reproduction. In the United States, the total fertility rate hovers around the replacement rate of 2.1,¹²³ while in other western

¹¹⁷ McDonald, *Low Fertility*, *supra* note 112, at 490-494. The new capitalism also can promote procreation. If greater job mobility makes it easier to leave and re-enter the workforce, then women may be more willing to interrupt their careers to have children. Hans-Peter Kohler, Francesco C. Billari & José A. Ortega, *Low Fertility in Europe: Causes, Implications and Policy Options*, in *THE BABY BUST: WHO WILL DO THE WORK? WHO WILL PAY THE TAXES?* 48, 92-93 (Fred R. Harris ed. 2006). Also, for those for whom the new capitalism results in greater family wealth, they are in a better position to afford more children. BEN J. WATTENBERG, *FEWER: HOW THE NEW DEMOGRAPHY OF DEPOPULATION WILL SHAPE OUR FUTURE* 64-65 (2004).

¹¹⁸ PAUL R. EHRLICH, *THE POPULATION BOMB* (1968).

¹¹⁹ DONELLA H. MEADOWS, ET AL., *THE LIMITS TO GROWTH* (1972) (describing the work of the Club of Rome).

¹²⁰ JAMES REED, *FROM PRIVATE VICE TO PUBLIC VIRTUE* 373 (1978). Interestingly, data suggest that people felt more strongly that population growth was a serious problem than took the view that married couples had a responsibility to limit their procreation because of overpopulation. Larry D. Barnett, *U.S. Population Growth as an Abstractly-Perceived Problem*, 7 *DEMOGRAPHY* 53 (1970).

Views may be changing about world population. As fertility rates have declined, a number of experts have warned about the threat from underpopulation. WATTENBERG, *FEWER*, *supra* note 117, at 115-149; Russell Shorto, *No Babies?*, *N.Y. TIMES SUNDAY MAGAZINE*, June 29, 2008 (discussing very low fertility rates in Europe).

¹²¹ McAllister & Clarke, *Voluntary Childlessness*, *supra* note 103, at 192.

¹²² U.S. CENSUS BUREAU, *CURRENT POPULATION*, *supra* note 103, at www.census.gov/population/socdemo/fertility/cps2006/SupFertTab2.xls.

¹²³ The total fertility rate refers to the number of children per woman throughout her life, and the replacement rate refers to the number of children required per woman to maintain a country's population at a steady level. Fertility rates are also measured in terms of children per 1,000 women in a specific year. For example, the baby boom fertility rate peaked in 1957 at 122.9 births per 1,000 women. VAN HORN, *WOMEN*, *supra* note 87, at 85.

countries, women do not have enough children to maintain their nation's population levels. In Italy, for example, the fertility rate is 1.3 and in the Netherland, Sweden and the UK, it is close to 1.7.¹²⁴ Within countries, fertility rates vary among women of different race, educational attainment and state of residence. Women who did not graduate high school, for example, have a fertility rate 50 percent higher than women with a graduate degree.¹²⁵

As fertility rates have dropped, voluntary sterilization rates have risen. In the United States, voluntary sterilization was rarely employed before the 1960's.¹²⁶ Indeed, states commonly prohibited sterilization for contraceptive purposes.¹²⁷ Since then, sterilization has become the most common form of birth control used by couples, with 36 percent of couples relying on that method. Three-fourths of the couples choose tubal ligation for the woman, and 9 percent choose vasectomy for the man. (Almost 31 percent of couples rely on the woman taking oral contraceptive pills for their birth control.)¹²⁸

As fertility rates dropped, perceptions about infertility changed. By the 1970's, attitudes about infertility were shifting. Instead of eliciting a sympathetic response to their plight, a childless couple might be told that pregnancy was unattractive, that the world was already overpopulated, or that their friends wished they had infertility problems.¹²⁹ The infertile also would face similar sentiments in the media. In 1970, the widely-read weekly magazine, *Look*, published an article, "Motherhood—Who Needs It," in which Betty Rollin suggested that children made marriages worse, that women should place greater emphasis on seeking happiness from the development of their own selves and that God today would say, "Be fruitful. Don't multiply."¹³⁰ Anti-child sentiments of the time led Michael Novak to write, "Choosing to have a family used to be uninteresting. It is, today, an act of intelligence and courage."¹³¹

While parenthood became more valued in the 1980's,¹³² it is no longer the case that the role of women revolves around a strict norm of parenting, nor is it the case that women suffer from stigma by virtue of their childlessness. To be sure, couples commonly value parenting, and it is a high priority for them. Nevertheless, social attitudes about infertility have changed to the point that rather than being viewed as a seriously abnormal condition, a condition that elicits disfavor and second-class status,

¹²⁴ Daphna Birenbaum-Carmeli & Martha Dirnfeld, *In Vitro Fertilisation Policy in Israel and Women's Perspectives: The More the Better?*, 16 REPRODUCTIVE HEALTH MATTERS 182, 183 (2008); CIA, THE 2008 WORLD FACTBOOK (2008). Israel's total fertility rate is slightly higher than India or Egypt at 2.77. *Id.*

¹²⁵ U.S. CENSUS BUREAU, CURRENT POPULATION, *supra* note 103, at www.census.gov/population/socdemo/fertility/cps2006/table7-4044.xls. Women in politically more conservative states have higher fertility rates than women in more liberal states. Cahn & Carbone, *supra* note 93, at 26.

¹²⁶ ROBERT BLANK AND JANNA C. MERRICK, HUMAN REPRODUCTION, EMERGING TECHNOLOGIES, AND CONFLICTING RIGHTS 50 (1995).

¹²⁷ BLANK AND MERRICK, HUMAN REPRODUCTION, *supra* note 126, at 66-67.

¹²⁸ Deborah Bartz & James A. Greenberg, *Sterilization in the United States*, 1 REV. OBSTETRICS GYNECOLOGY 23, 24 (2008).

¹²⁹ MARSH & RONNER, EMPTY CRADLE, *supra* note 83, at 211-216.

¹³⁰ Betty Rollin, *Motherhood—Who Needs It?*, LOOK, Sept. 22, 1970:17

¹³¹ Michael Novak, *The Family Out of Favor*, HARPERS, April 1976:37.

¹³² BRITT, CONCEIVING NORMALCY, *supra* note 85, at 27. Babies became stars in popular movies like *Three Men and a Baby* and *Look Who's Talking*. MAY, BARREN, *supra* note 82, at 214.

infertility often now is seen as a non-disabling condition, and people therefore dismiss the idea that infertility entails a disability.¹³³ The next section elaborates on this point.

D. Contemporary public views on infertility

There is much evidence for the view that people generally do not see infertility as really disabling in the way emphysema, rheumatoid arthritis, paraplegia or blindness is seen as disabling, that fertile persons frequently dismiss the idea that infertility is a significant problem.

1. Infertility is not seen as disabling

Perhaps the most important evidence comes from leading studies of infertile couples by university-based researchers. In her study of infertility, for example, Elizabeth Britt found that “the infertile often feel as if the seriousness of their condition is trivialized.” Disclosure of their infertility might elicit “jokes about the couple not knowing how to have sex or about the fun the couple must be having trying to conceive a child.” Other people “might suggest that infertility is a blessing in disguise” or that it’s not as bad as other medical conditions since reproduction “supposedly is so optional.” Or they might say something like, “Oh well, so what so you don’t have to have a baby, so what, just adopt.”¹³⁴

Similarly, Arthur Greil found from his interviews with infertile couples that they criticized fertile people for “treating the plight of the infertile as if trivial and inconsequential.”¹³⁵ The infertile also were troubled that fertile individuals “acted as if . . . infertility were a small and relatively easy problem to solve.”¹³⁶ As one woman reported, her friends might say, “‘Why don’t you go on a cruise?’ Or ‘Why don’t you just relax? And then you’ll get pregnant.’”¹³⁷ According to Greil, infertile couples do not feel like they are viewed as inferior because of their infertility. Rather, the discrimination they feel arises out of a “failure of others to acknowledge the seriousness

¹³³ Cf. KAREY HARWOOD, *THE INFERTILITY TREADMILL* 102-103 (2007) (discussing changing social views about the importance of parenting). See also Tanya Koropecj-Cox, Victor Romano & Amanda Moras, *Through the Lenses of Gender, Race, and Class: Students’ Perceptions of Childless/Childfree Individuals and Couples*, 56 *SEX ROLES* 415 (2007) (documenting increasingly favorable views of the infertile among college students).

¹³⁴ BRITT, *CONCEIVING NORMALCY*, *supra* note 85, at 41.

¹³⁵ ARTHUR L. GREIL, *NOT YET PREGNANT: INFERTILE COUPLES IN CONTEMPORARY AMERICA* 128 (1991).

¹³⁶ GREIL, *NOT YET PREGNANT*, *supra* note 135, at 129.

¹³⁷ GREIL, *NOT YET PREGNANT*, *supra* note 135, at 130. See also HARWOOD, *INFERTILITY TREADMILL* *supra* note 133, at 54 (finding that infertile persons often are told to “Just relax, you’ll get pregnant”). The “just relax” advice is consistent not only with a dismissive view of infertility but also a stigmatizing view of infertility. Charlene E. Miall, *Community Constructs of Involuntary Childlessness*, 31 *CANADIAN REV. SOCIOLOGY & ANTHROPOLOGY* 392, 405-407 (1994) (studying infertility in Canada). Undoubtedly, perceptions of the infertile encompass a range of views, including both dismissiveness and stigma. Nevertheless, the weight of evidence indicates that dismissiveness plays a very important role in the response of others to infertility, particularly when compared to earlier periods in history.

of infertility.”¹³⁸ In one typical remark, an infertile person observed, “I think [fertile people] discriminate by making light of the problem.”¹³⁹

Discussion of relevant constitutional and tax law principles by legal scholars also indicates that infertility is not seen as a real disability. In the constitutional context, Carl Coleman and Radhika Rao have considered whether a ban on access to IVF or other infertility treatments would violate an infertile couple’s constitutional right to procreate. Both of them quickly dismiss the interests of infertile couples in constitutional protection and conclude that restrictions on access to infertility treatments would be constitutionally valid.¹⁴⁰ It is difficult to imagine that they would conclude so readily that restrictions on access to wheelchairs or hearing aids would survive a constitutional challenge.¹⁴¹

In the tax context, scholars have debated the question whether expenses for IVF and other fertility treatments are deductible as medical expenses. In her analysis of the issue, Katherine Pratt describes an exchange among tax specialists on a law professors’ listserv. One leading expert argued against the deductibility of fertility treatment costs on the ground that reproductive dysfunction does “not involve the sort of catastrophic losses that justify a medical expense deduction.”¹⁴² Of course, this argument ignored the fact that the costs of prescription drugs for diabetes and high blood pressure are deductible even though there is no catastrophic loss involved. Another leading expert also rejected the deductibility of fertility treatment costs on the ground that the treatments do not constitute health care. Rather, in his view, reproduction is an optional activity, a lifestyle choice.¹⁴³

This is an unusual way to speak about the exercise of a fundamental right. One ordinarily would not describe voting as a lifestyle choice. But it is a classic way for people to dismiss the claims for recognition of others, as when some characterize homosexuality as a “lifestyle choice.”¹⁴⁴

A third important source of evidence for the view that infertility is not seen as a disability comes from the policies of health care insurers. As a general and long-standing practice, health care plans do not cover the costs of IVF and similar procedures to help

¹³⁸ GREIL, NOT YET PREGNANT, *supra* note 135, at 132. See also Constance N. Scharf & Margot Weinschel, *Infertility and Late-Life Pregnancies*, in COUPLES ON THE FAULT LINE: NEW DIRECTIONS FOR THERAPISTS 104, 108 (Peggy Papp ed. 2000) (observing that the infertile “couple’s experience is usually little understood and not valued by their family and friends”). To be sure, some infertile individuals face negative sentiments from others.

¹³⁹ GREIL, NOT YET PREGNANT, *supra* note 135, at 128.

¹⁴⁰ Carl H. Coleman, *Assisted Reproductive Technologies and the Constitution*, 30 FORDHAM URB. L.J. 57, 68-70 (2002); Radhika Rao, *Assisted Reproductive Technology and Reproductive Equality*, 76 GEO. WASH. L. REV. 1457, 1478 (2008). Although Coleman and Rao give very short shrift to the interests of the infertile, their arguments have some merit and are worth considering in more depth. For that discussion, see Part III.C.

¹⁴¹ I am grateful to Alicia Ouellette for this point.

¹⁴² Pratt, *Inconceivable?*, *supra* note 65, at 1125.

¹⁴³ Pratt, *Inconceivable?*, *supra* note 65, at 1124. Ironically, the same expert argued that expenses for treatment of sexual dysfunction (e.g., costs of Viagra) might qualify for a tax deduction. *Id.* at 1124-1125.

¹⁴⁴ See, e.g., Mable Jackson, *Homosexuality Is a Lifestyle Choice*, CENTRAL MICHIGAN LIFE, November 7, 2005, at media.www.cm-life.com/media/storage/paper906/news/2005/11/07/Voices/Homosexuality.Is.A.Lifestyle.Choice-2499936.shtml

infertile couples have children.¹⁴⁵ According to a recent estimate, fewer than 20 percent of large employers (those with 500 or more employees) provide coverage for IVF.¹⁴⁶ Among employers with fewer than 500 employees, only 25 percent offer any infertility services, and they typically exclude coverage for IVF or other assisted reproductive technologies.¹⁴⁷ The plan of this article's author through Indiana University is typical. It's an Anthem preferred provider plan,¹⁴⁸ and while its coverage is generally quite good (no deductible, the same coverage for mental health problems and substance abuse as for heart disease, cancer or other illnesses, and a \$2,000 cap on annual out-of-pocket expenses), it does not cover artificial insemination, in vitro fertilization (IVF), infertility drugs or any procedures or testing related to fertilization.¹⁴⁹ Another Indiana University preferred provider plan with a \$900 deductible and a \$2,400 annual cap on out-of-pocket expenses has the same coverage exclusions for infertility treatment.¹⁵⁰

Surprisingly, coverage for abortion is much more common than coverage for infertility treatments. In a survey of private health insurance plans in Washington State, researchers found that only 2 percent of enrollees were covered for infertility services while 47 percent of female enrollees were covered for elective abortion.¹⁵¹ Moreover, none of the plans that covered infertility services included coverage of IVF or other assisted reproductive technologies. The percentage of plans offering abortion coverage was even higher—67 percent or more, depending on the type of plan (e.g., HMO, PPO, etc.).¹⁵² Coverage for reversible contraception exceeds coverage for abortion. A national study found that 89 percent of plans provide coverage.¹⁵³

It also is useful to compare coverage of infertility treatments with coverage for medical equipment like wheelchairs and medical devices like prosthetic limbs. Some scholars question whether it makes sense to view IVF and other methods of assisted reproduction as medical treatments since they bypass rather than correct the causes of infertility.¹⁵⁴ IVF may help an infertile couple have a child, but it does not address the reasons for the infertility. Similarly, a wheelchair bypasses the reasons for a person's inability to walk. According to this argument, insurance coverage should be available for treatments like antibiotics that eliminate the underlying problem but not for treatments that leave the underlying cause alone. While there are a number of problems with this

¹⁴⁵ Peter J. Neumann, *Should Health Insurance Cover IVF? Issues and Options*, 22 J. HEALTH POL. POL'Y & L. 1215, 1215-1218 (1997).

¹⁴⁶ Joseph C. Isaacs, *Infertility Coverage Is Good Business*, 89 FERTILITY & STERILITY 1049, 1049 (2008).

¹⁴⁷ Isaacs, *Infertility Coverage*, *supra* note 146, at 1049.

¹⁴⁸ Under a preferred provider plan, the insurer identifies physicians, hospitals and other health care providers as "preferred" and requires a higher co-payment when their customers seek care from a non-preferred provider.

¹⁴⁹ INDIANA UNIVERSITY BLUE PREFERRED PRIMARY POS—BENEFIT SUMMARY, at www.indiana.edu/~uhhs/pubs/books/POS-Summary09.pdf.

¹⁵⁰ INDIANA UNIVERSITY PPO \$900 DEDUCTIBLE HEALTHCARE PLAN—BENEFIT SUMMARY, at www.indiana.edu/~uhhs/pubs/books/PPO900-Summary09.pdf.

¹⁵¹ Ann Kurth, et al., *Reproductive and Sexual Health Benefits in Private Health Insurance Plans in Washington State*, 33 FAMILY PLANNING PERSPECTIVES 153, 157 (2001).

¹⁵² Kurth, et al., *Reproductive*, *supra* note 151, at 156.

¹⁵³ Adam Sonfield, et al., *U.S. Insurance Coverage of Contraceptives and the Impact of Contraceptive Coverage Mandates, 2002*, 36 PERSPECTIVES ON SEXUAL AND REPRODUCTIVE HEALTH 72 (2004).

¹⁵⁴ THE NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, *ASSISTED REPRODUCTIVE TECHNOLOGIES: ANALYSIS AND RECOMMENDATIONS FOR PUBLIC POLICY* 96 (1998).

argument,¹⁵⁵ it turns out that coverage for infertility pales even when compared with coverage for medical equipment or devices that compensate for a disability like paraplegia or amputation without correcting the underlying cause of the disability. In one study, for example, less than 7 percent of children who were privately insured lacked access to mobility aids or devices or to hearing aids or hearing care.¹⁵⁶ The author's own insurance plan is typical. Although it provides no coverage for IVF or other infertility treatments, it covers 80% of the costs of medical equipment and devices. Once a person's out-of-pocket spending for all medical treatment reaches \$2,000 for the year, the plan picks up 100% of the costs of medical equipment and devices.¹⁵⁷

Advocates for infertility treatment coverage have had some success in getting legislation passed to support their cause.¹⁵⁸ Eleven states mandate insurance coverage for infertility treatments,¹⁵⁹ and three states require that coverage be offered.¹⁶⁰ However, even when legislation exists, it may be limited. California and New York expressly exclude IVF from the mandate to cover or offer coverage,¹⁶¹ and Arkansas allows insurers to cap lifetime benefits for IVF at \$15,000.¹⁶² Moreover, the Employee Retirement Income Security Act of 1974 (ERISA) preempts state insurance mandates like those for infertility coverage when an employer self-insures for employee health care insurance.¹⁶³

¹⁵⁵ As other scholars have responded, many medical treatments restore lost function without correcting the underlying problem, as when insulin is prescribed for diabetes. *Id.*

¹⁵⁶ Stacey C. Dusing, Asheley Cockrell Skinner & Michelle L. Mayer, *Unmet Need for Therapy Services, Assistive Devices, and Related Services: Data From the National Survey of Children With Special Health Care Needs*, 4 *AMBULATORY PEDIATRICS* 448, 451 (2004). Even for children on Medicaid, the unmet needs were low. Somewhat more than 12 percent of Medicaid recipients lacked access to mobility aids or devices, and less than 9 percent lacked access to hearing aids or hearing care. *Id.*

¹⁵⁷ There also is a precertification requirement for medical equipment and devices. INDIANA UNIVERSITY BLUE PREFERRED, *supra* note 149.

This is not to say that coverage for medical equipment and devices is optimal. Private health plans may limit the kinds of medical equipment that are covered. And most disabled persons who rely on medical equipment are not employed so lack access to private health insurance. On the other hand, when private health insurance is not available, government programs may pick up the slack. Overall, disabled persons or their families pay 40 percent of the costs of assistive technologies, which include medical equipment and devices, as well as architectural modifications in the home. Dawn Carlson and Nat Ehrlich, *Sources of Payment for Assistive Technology: Findings from a National Survey of Persons with Disabilities*, 18 *ASSISTIVE TECHNOLOGY* 77 (2006) (noting that the federal government spent \$845 million on powered wheelchairs in 2002).

¹⁵⁸ BRITT, *CONCEIVING NORMALCY*, *supra* note 85, at 1-2 (observing that state laws were proposed and lobbied for by RESOLVE a support and advocacy group for infertility treatments). RESOLVE's website is at www.resolve.org. For a recent discussion of state mandates, see Jessica L. Hawkins, Note, *Separating Fact from Fiction, Mandated Coverage of Infertility Treatments*, 23 *WASH. U. J. L. & POL'Y* 203, 204 (2007)

¹⁵⁹ NCSL, *STATE LAWS RELATED TO INSURANCE COVERAGE FOR INFERTILITY TREATMENT* (October 2008), at www.ncsl.org/programs/health/50infert.htm.

¹⁶⁰ Cal. Health & Safety Code § 1374.55; Cal. Insurance Code § 10119.6 (1989); Ohio Rev. Code § 1751.01(A)(1); Tex. Insurance Code Ann. § 1366.001 et seq.

¹⁶¹ Cal. Health & Safety Code § 1374.55; Cal. Insurance Code § 10119.6 (1989); N.Y. Insurance Law § 3216 (13), 3221 (6) and 4303

¹⁶² 054 Ark. Code R. § 001 (2008).

¹⁶³ Timothy S. Jost & Mark A. Hall, *The Role of State Regulation in Consumer-Driven Health Care*, 31 *AM. J. L. AND MED.* 395, 398 (2005).

The limited success with efforts to pass legislative mandates for infertility coverage stands in contrast to other efforts to pass insurance coverage mandates. It is common to find state law requirements for private insurers to provide coverage when people want to evade parenting (i.e., contraceptive legislation). And Congress has twice passed legislation to require coverage for mental health treatment that is comparable to coverage for treatment of physical illnesses like cancer or heart disease.¹⁶⁴

Public health plans are no different. Consider, for example, the Oregon Health Plan. The Oregon Health Plan represented Oregon's major effort to provide health care to all of its residents. Under the Plan, the state's Medicaid program would eliminate coverage for care when the marginal benefits of the care could not justify its costs and use the savings to ensure that all persons had insurance. In other words, instead of providing Cadillac care to some indigent people, Oregon hoped to provide Chevrolet care to all of its poor.¹⁶⁵ To implement its Plan, Oregon ranked medical treatments in terms of their benefits and costs and drew a line between covered treatments and uncovered treatments based on the amount of funding available. For example, the May 2002 ranking included 736 different treatments, and the cut-off for coverage fell such that all treatments ranked 566 or higher were covered.¹⁶⁶ Notably, Oregon chose not to cover treatment for infertility even while it covered treatments to block procreation. In the May 2002 ranking, for example, the Plan covered contraception to prevent pregnancy temporarily, sterilization to prevent it permanently or abortion to terminate a pregnancy. For infertile Oregonians who wanted to have children, however, the Plan did not cover treatments to help them reproduce. Among the uncovered treatments were surgery on a woman's fallopian tubes to restore fertility, artificial insemination, IVF and gamete intrafallopian transfer (GIFT).¹⁶⁷ Medicaid programs in other states typically exclude coverage for IVF and other infertility treatments as well.¹⁶⁸

In short, from a number of perspectives—public attitudes toward infertile couples, views of constitutional and tax law experts, and policies of health care insurance plans—infertility is no longer seen as a disabling condition in the United States.

¹⁶⁴ See, *infra*, Part III.D.

¹⁶⁵ The Plan never realized its goal. At its height, the Plan reduced the number of uninsured by one-third. However, within a decade of its implementation, Oregon had the same percentage of uninsured residents that it had before the Plan was adopted. Jonathan Oberlander, *Health Reform Interrupted: The Unraveling of the Oregon Health Plan*, 26 HEALTH AFFAIRS w96, w99 (2007).

¹⁶⁶ Oregon Health Plan, Prioritized List of Health Services (May 1, 2002), at <http://www.oregon.gov/OHPPR/HSC/docs/PList5-02.pdf>.

¹⁶⁷ Oregon Health Plan, Prioritized List of Health Services (May 1, 2002), at <http://www.oregon.gov/OHPPR/HSC/docs/PList5-02.pdf>.

With IVF, a fertility specialist combines a woman's egg and a man's sperm in the laboratory to create an embryo. After a couple of days, the embryo is inserted into the woman's uterus. GIFT is much like IVF except the fertility specialist places the embryo into the woman's fallopian tube.

¹⁶⁸ Elena N. Cohen, *Assisted Reproductive Technologies (ART)*, 5-22 TREATISE ON HEALTH CARE LAW § 22.04 (Matthew Bender 2008); National Health Law Program and National Association of Community Health Centers, "Chart 2: State Law on Family Planning Benefits," in *Role of State Law in Limiting Medicaid Changes*, at <http://www.healthlaw.org/library/item.100796>

2. Infertility may even be seen as enabling

Moreover, in the view of many people, the infertile person is better off than the fertile person. Having children, it is said, places one at a disadvantage when it comes to opportunities for a fulfilling life, in the professional world or particularly with one's partner. In Elaine Tyler May's study of childless persons in the United States, she recounts a number of representative comments. According to one voluntarily childless woman, she and her husband chose not to have children because "we like the freedom." And she prefers to call herself "childfree" rather than "childless" because childfree suggests the absence of something undesirable.¹⁶⁹ Another woman said that she and her husband did not care to have children interfere in their relationship. A man reported that he "simply did not want the troubles and commitment associated with raising children."¹⁷⁰ While some voluntarily childless couples explain their decision in terms of a desire to devote more time to careers or civic endeavors, it is far more common for the voluntarily childless to talk about their preference for a private life without children over a private life with children. A private life without children allows them more time with their partner for love, intimacy, and enjoyable pursuits.¹⁷¹

In a British study, common reasons given by persons who were certain that they did not want children include the increased and permanent responsibility that parenthood entails, the sacrifice of spontaneity and freedom that goes along with the increased responsibility, and the greater opportunities for self-fulfillment without children.¹⁷² Representative comments from that study include a man citing the advantages of a freer schedule and the time that he could spend enjoying his wife's company. A woman spoke of the independence she enjoyed and the freedom from the constraints of parenthood.¹⁷³

There are many social practices that reflect a less than enthusiastic view of children in society. Consider this excerpt from *Sex and Destiny*:

At the heart of our insistence upon the child's parasitic role in the family lurks the conviction that children must be banished from adult society. . . . The heinousness of taking an infant or a toddler to an adult social gathering is practically unimaginable. . . . Restaurants, cinemas, offices, supermarkets, even Harrods auction rooms, are all no places for children. In England, restaurants

¹⁶⁹ MAY, BARREN, *supra* note 82, at 181-182.

¹⁷⁰ MAY, BARREN, *supra* note 82, at 196.

¹⁷¹ MAY, BARREN, *supra* note 82, at 185, 208. Some studies have found that marital happiness is greater both before the arrival of the first child and after the last child leaves for college. Peggy L. Dalgas-Pelish, *The Impact of the First Child on Marital Happiness*, 18 J. ADVANCED NURSING 437 (1993) (finding greater marital happiness in childless couples than in couples with a first pregnancy or first child); Sara M. Gorchoff, Oliver P. John & Ravenna Helson, *Contextualizing Change in Marital Satisfaction During Middle Age: An 18-Year Longitudinal Study*, 19 PSYCHOLOGICAL SCIENCE 1194 (2008) (finding increased marital satisfaction for married women when they became "empty nesters"). See also S. Mark Pancer, et al., *Thinking Ahead: Complexity of Expectations and the Transition to Parenthood*, 68 J. PERSONALITY 253, 257 (2000) (discussing studies that find a decline in marital satisfaction with reproduction, but not for all couples).

¹⁷² McAllister & Clarke, *Voluntary Childlessness*, *supra* note 103, at 209, 223-224. See also J. E. VEEVERS CHILDLESS BY CHOICE 73-74 (1980) (reporting the importance of spontaneity for couples who choose not to have children).

¹⁷³ McAllister & Clarke, *Voluntary Childlessness*, *supra* note 103, at 222-223.

mentioned in *The Good Food Guide* boldly advise parents to “leave under-fourteens and dogs at home. . . .”

. . . .

There is so little interpenetration between the worlds of the child and the adult that we can easily call to mind whole districts of our inner cities where no child is ever seen.¹⁷⁴

The contrast with child-friendly cultures is striking. While children often are not welcome to attend weddings in the United States—the adults-only wedding is a common event—children are front and center at weddings in Orthodox Jewish communities and typically included in invitation lists throughout Israel.¹⁷⁵

Scholars who write on reproductive issues reflect the increasingly prevalent sense that a life without children may be preferable to a life with children. Consider, for example, Yale Law Professor Jed Rubenfeld’s vision of parenting in his discussion of why the right to privacy should invalidate laws that prohibit abortion:

To be sure, motherhood is no unitary phenomenon that is experienced alike by all women. Nonetheless, it is difficult to imagine a state-enforced rule whose ramifications within the actual, everyday life of the actor are more far-reaching [than a ban on abortion]. For a period of months and quite possibly years, forced motherhood shapes women's occupations and preoccupations in the minutest detail; it creates a perceived identity for women and confines them to it; and it gathers up a multiplicity of approaches to the problem of being a woman and reduces them all to the single norm of motherhood.¹⁷⁶

. . . .

Thus it is difficult to imagine a single proscription with a greater capacity to shape lives into singular, normalized, functional molds than the prohibition of abortions.¹⁷⁷

. . . .

¹⁷⁴ GREER, *SEX AND DESTINY*, *supra* note 14, at 3. See also MAY, BARREN, *supra* note 82, at 16 (referring to society’s collective hostility toward children); David Orentlicher, *Spanking and Other Corporal Punishment of Children by Parents: Overvaluing Pain, Undervaluing Children*, 35 HOUS. L. REV. 147, 173-177 (1998) (discussing the many ways in which the law withholds fundamental rights from children).

¹⁷⁵ It may be the case that the high costs of weddings cause the wedding hosts to exclude children from their invitation lists, reasoning that it is better to invite the adults of two families rather than the adults and children of one family. But if costs were the issue, then the hosts could simply provide a less expensive meal and include children. In Israel, it is common to have a more formal meal for the inner circle of guests and a more modest buffet for a larger circle of guests.

¹⁷⁶ Jed Rubenfeld, *The Right of Privacy*, 102 HARV. L. REV. 737, 788 (1989). Rubenfeld seems to conflate a ban on abortion with a different kind of forced motherhood, one in which the state were to commandeer women to become pregnant and bear children.

¹⁷⁷ *Id.* at 791.

Compelled child-bearing occupies a woman's life in the largest and subtlest respects, puts her body to use in the most extreme and intrusive ways, and forces upon her a well-defined . . . role or identity.¹⁷⁸

. . . .

The danger, then, is a particular kind of creeping totalitarianism, an unarmed *occupation* of individuals' lives. That is the danger of which . . . the right to privacy is warning us: a society standardized and normalized, in which lives are too substantially or too rigidly directed. That is the threat posed by state power in our century.¹⁷⁹

Rubinfeld's view of parenting—"singular and normalized," a life "rigidly directed"—is striking. Many people believe their lives have been greatly enriched by their children and that parenting expands their options in life. As one friend and single mother said to me, "my child gives me a purpose in life, something that is lacking in the lives of my single friends who don't have children." Oddly, Rubinfeld considers it a greater constitutional concern if the state were to ban abortion than if the state were to prohibit parents from having more than two children.¹⁸⁰

Rebecca Kukla, a professor of philosophy and obstetrics and gynecology who specializes in bioethics, has argued against the use of experimental procedures to preserve ovarian tissue from children before they undergo cancer treatment that might render them infertile. In Kukla's view, ovarian tissue preservation is problematic because such medical interventions may result in the girls being seen primarily in terms of their reproductive capacity and "start [them] on the path to biological motherhood."¹⁸¹

Janice Raymond warns of the dangers of technological advances like in vitro fertilization (IVF) that allow infertile women to have children. Raymond writes, "[n]ew reproductive arrangements are presented as a woman's private choice. But they are publicly sanctioned violence against women."¹⁸² Raymond also says this about IVF:

¹⁷⁸ *Id.* at 796.

¹⁷⁹ *Id.* at 784

¹⁸⁰ *Id.* at 796-797.

¹⁸¹ Rebecca Kukla, *The Oncofertility Project: Ethics at the Intersection of Reproductive Medicine and Pediatric Care*, Presentation at the Annual Meeting of the American Society of Bioethics and Humanities (October 2008).

¹⁸² JANICE G. RAYMOND, *WOMEN AS WOMBS: REPRODUCTIVE TECHNOLOGIES AND THE BATTLE OVER WOMEN'S FREEDOM* ix (1993). See also Robyn Rowland, *Of Women Born, But for How Long? The Relationship of Women to the New Reproductive Technologies and the Issue of Choice*, in *MADE TO ORDER: THE MYTH OF REPRODUCTIVE AND GENETIC PROGRESS* 67, 77-80 (Patricia Spallone & Deborah Lynn Steinberg ed. 1987) (expressing concern over the loss of choice for women from IVF).

To be sure, Raymond raises some valid concerns about IVF and the extent to which it has involved experimentation on women. Still, one could raise similar concerns about surgical procedures to treat heart disease without referring to them as violence against men—who are the predominant users of the technologies. In 2005, nearly 69 percent of coronary artery bypass surgery patients were men, and slightly more than 69 percent of patients who received coronary artery stents were men. AMERICAN HEART ASSOCIATION & AMERICAN STROKE ASSOCIATION, *HEART DISEASE AND STROKE STATISTICS: 2008 UPDATE AT-A-GLANCE* 36 (2008), at www.americanheart.org/downloadable/heart/1200082005246HS_Stats%202008.final.pdf.

Raymond is not the only person to worry about the violence of IVF. In its first "Instruction" on new reproductive technologies, the Catholic Church characterized IVF as a "dynamic of violence and

“Represented as expanding women’s choices, IVF technology, for example, actually narrows the life choices of women who consume the technology.”¹⁸³

The point is not that Rubenfeld, Kukla and Raymond raise insignificant issues. Rather, the concern is that they worry more about the consequences of encouraging parenting than the consequences of discouraging parenting. For Rubenfeld, it is worse to deny the option of abortion than to deny the option of procreation. For Kukla, it is more problematic to preserve a girl’s future reproductive capacity than to let her become infertile. Raymond sees more danger to women in giving them the opportunity to procreate when infertile than in withholding new reproductive options.

And their views are influential. As prominent scholars, they play an important role as opinion leaders in shaping public policy. Indeed, Rubenfeld’s article is cited as providing a leading argument for the right to privacy in major constitutional law casebooks,¹⁸⁴ and it is one of the most frequently referenced among law review articles, with more than 430 citations since it was published as the lead article in a 1989 issue of the *Harvard Law Review*.¹⁸⁵ Clearly, the article and its reasoning are resonating widely. (By way of comparison, Harvard Law Professor (and now Obama Administration regulatory czar) Cass Sunstein’s important article, “The Anticaste Principle,” in the *Michigan Law Review* has been cited 160 times.¹⁸⁶)

All of this is not to suggest that infertility is never felt or perceived as disabling. Indeed, studies have found that infertile persons often experience a sense of stigma from their infertility.¹⁸⁷ This is particularly the case for persons from cultural backgrounds that highly value procreation.¹⁸⁸ And there have been articles and books in both popular

domination,” albeit one against the embryos rather than the woman. CONGREGATION FOR THE DOCTRINE OF THE FAITH, INSTRUCTION ON RESPECT FOR HUMAN LIFE IN ITS ORIGIN AND ON THE DIGNITY OF PROCREATION: REPLIES TO CERTAIN QUESTIONS OF THE DAY 21 (February 22, 1987). In a 2008 revised Instruction, the Vatican continued to condemn IVF but did not repeat the dynamic of violence and domination language. CONGREGATION FOR THE DOCTRINE OF THE FAITH, INSTRUCTION *DIGNITAS PERSONAE* ON CERTAIN BIOETHICAL QUESTIONS (September 8, 2008).

¹⁸³ RAYMOND, *WOMEN AS WOMBS*, *supra* note 182, at 86.

¹⁸⁴ PAUL BREST, ET AL., *PROCESSES OF CONSTITUTIONAL DECISIONMAKING: CASES AND MATERIALS* 1480 (5th ed. 2006); KATHLEEN M. SULLIVAN & GERALD GUNTHER, *CONSTITUTIONAL LAW* 422 (16th ed. 2007); STONE, ET AL., *CONSTITUTIONAL LAW*, *supra* note 34, at 854.

¹⁸⁵ Article shepherded on Lexis for citations on ---, 2009.

¹⁸⁶ The article is cited in Part I.A. of this article. U.S. Court of Appeals for the 7th Circuit Judge Frank Easterbrook’s important Harvard Law Review Foreword on the role of economic analysis in judicial decisionmaking, Frank H. Easterbrook, *The Supreme Court, 1983 Term -- Foreword: The Court and the Economic System*, 98 HARV. L. REV. 4 (1984), has been cited only four more times than Rubenfeld’s even though it was published 4.5 years earlier, and Harvard Law Professor Frederick Schauer’s, *Easy Cases*, 58 S. CAL. L. REV. 399 (1985), has been cited about 250 times. Some classic articles, like Robert Cover’s *Nomos and Narrative*, 97 HARV. L. REV. 4 (1983), have been cited more than 1,000 times. See Fred R. Shapiro, *The Most-Cited Law Review Articles Revisited*, 71 CHI.-KENT L. REV. 751 (1996) for a list of frequently cited articles.

¹⁸⁷ See, e.g., Charlene E. Miall, *The Stigma of Involuntary Childlessness*, 33 SOC. PROBS. 268, 271-272 (1986) (finding that infertile women regarded their condition as a “discreditable attribute”); Charlene E. Miall, *Perceptions of Informal Sanctioning and the Stigma of Involuntary Childlessness*, 6 DEVIANT BEHAVIOR 383 (1985); Diana C. Parry, *Work, Leisure, and Support Groups: An Examination of the Ways Women with Infertility Respond to Pronatalist Ideology*, 53 SEX ROLES 337 (2005) (reporting on infertile women who felt that they were “considered lacking, incomplete, or inadequate”).

¹⁸⁸ See, *supra*, note 55.

and academic publications that praise assisted reproduction for infertile persons.¹⁸⁹ Nevertheless, public attitudes have changed considerably in recent years to the point that childlessness does not provoke the levels of social disadvantage that it once did or that other disabilities currently do.

And the public attitudes have changed most for people of higher education and greater wealth,¹⁹⁰ arguably people with more influence in shaping public policy. Indeed, past changes in attitude about family and procreation have been driven by a small part of the population. In the nineteenth century, the newly developing urban middle class led the way in the decline of fertility rates.¹⁹¹

In sum, as infertility has evolved from a condition widely viewed as disabling to one that is viewed by many as not disabling, and even enabling, the anti-caste principle may no longer provide protection for infertile persons from discrimination. As the next section indicates, legal doctrine confirms this concern. Although some law does recognize the disabling nature of infertility, infertile persons generally do not enjoy much protection under the law. For the most part, public policy does not reflect the view that infertility is a meaningful disability.

III. THE WEAK PROTECTION FOR INFERTILE PERSONS FROM DISCRIMINATION IN CASE LAW

A. The law's recognition of infertility as a disability

The most important recognition of infertility as disability came in surprising form from the U.S. Supreme Court in *Bragdon v. Abbott*, the Court's first decision interpreting the Americans with Disabilities Act of 1990 (ADA).¹⁹² While the case was not an obvious vehicle for deciding whether infertility meets the ADA's definition of disability, the Court's decision turned on its holding that infertility is a disability, at least in the context of that case.

Bragdon v. Abbott—Infertility is a disability

Bragdon involved a claim of discrimination by Sidney Abbott, a woman with an asymptomatic HIV infection, who received dental care from Randon Bragdon in 1994. During his examination, Dr. Bragdon discovered a dental cavity. Because of Ms. Abbott's HIV infection, which she had disclosed on her patient registration form, Dr. Bragdon informed her that he would not fill the cavity in his office but only in a hospital setting, in accordance with his infection-control policy. Under the policy, Ms. Abbott

¹⁸⁹ Chloé Diepenbrock, *God Willed It! Gynecology at the Checkout Stand: Reproductive Technology in the Women's Service Magazine, 1977-1996*, in *BODY TALK: RHETORIC, TECHNOLOGY, REPRODUCTION* 98 (Mary M. Lay et al., eds. 2000); JOHN A. ROBERTSON, *CHILDREN OF CHOICE: FREEDOM AND THE NEW REPRODUCTIVE TECHNOLOGIES* 29-42 (1994).

¹⁹⁰ Cahn & Carbone, *Red Families*, *supra* note 93, at 2.

¹⁹¹ Cahn & Carbone, *Red Families*, *supra* note 93, at 10.

¹⁹² The Americans with Disabilities Act is codified at 42 U.S.C. §§ 12101, et seq. The Court had previously decided cases involving discrimination on the basis of disability under the Rehabilitation Act of 1973.

would have been responsible for the costs of using the hospital's facilities.¹⁹³ Ms. Abbott thereupon sued Dr. Bragdon under the ADA.

The case presented two key issues for the Supreme Court—Did Ms. Abbott's HIV infection meet the ADA's definition of disability even though she was not experiencing any of the symptoms of an HIV infection? If Ms. Abbott was disabled for purposes of the ADA, was Dr. Bragdon justified in implementing his special infection-control policy to protect himself from becoming infected with HIV?¹⁹⁴

For purposes of this article, the important part of the opinion came in the Court's answer to the question whether asymptomatic HIV infection constitutes a disability under the ADA.¹⁹⁵ Under the ADA, a disability is "a physical or mental impairment that substantially limits one or more . . . major life activities."¹⁹⁶ The Court first concluded that an HIV infection is a physical impairment; it then decided that an HIV infection substantially limits the major life activity of reproduction.

As to whether HIV infection is a physical impairment, the Court observed that HIV infection is a physical impairment from the moment of infection because the virus immediately invades different cells in the body, causing damage in particular to the white blood cells and resulting over time in serious symptoms, including pneumonias, malignancies and eventually death.¹⁹⁷ In short, wrote the Court, "HIV infection must be regarded as a physiological disorder with a constant and detrimental effect on the infected person[] HIV infection satisfies the statutory and regulatory definition of a physical impairment during every stage of the disease."¹⁹⁸

The question whether Ms. Abbott's HIV infection substantially limited a major life activity was a little trickier for the Court. Ms. Abbott's HIV infection had not progressed to AIDS. In fact, it had not resulted in any of the symptoms that characterize HIV disease, whether fever, nausea, diarrhea, pneumonia, Kaposi's sarcoma, lymphoma, etc. In the absence of any physical symptoms from her infection, how could it be said that the infection was substantially limiting a major life activity, like speaking, learning, walking or working?

Ms. Abbott avoided this difficulty by claiming that her infection limited the major life activity of reproduction. And the Court agreed. The Court noted that major life activities are those that are of significant importance to the individual and that "[r]eproduction falls well within the phrase 'major life activity.' Reproduction and the sexual dynamics surrounding it are central to the life process itself."¹⁹⁹

¹⁹³ *Bragdon*, 524 U.S. at 628-9.

¹⁹⁴ *Bragdon*, 524 U.S. at 628.

¹⁹⁵ On the second question regarding Dr. Bragdon's justification for his infection-control policy, the Court remanded the case for further proceedings. *Bragdon*, 524 U.S. at 655. On remand, the court of appeals concluded that Dr. Bragdon was not justified in requiring Ms. Abbott to come to the hospital to have her cavity filled. Rather, the universal precautions recommended by the U.S. Centers for Disease Control to prevent transmission of HIV from patient to dentist (or other health care provider) were sufficient to protect Dr. Bragdon from risk to his own health. *Abbott v. Bragdon*, 163 F.3d 87 (1st Cir. 1998), *cert. denied*, 526 U.S. 1131 (1999).

¹⁹⁶ 42 U.S.C. § 12102(2)(A).

¹⁹⁷ *Bragdon*, 524 U.S. at 636-637.

¹⁹⁸ *Bragdon*, 524 U.S. at 637.

¹⁹⁹ *Bragdon*, 524 U.S. at 638.

Moreover, said the Court, HIV infection substantially limits a person's ability to reproduce. If a woman infected with HIV engaged in sexual intercourse with a male partner in order to procreate, he would face a significant risk of infection—20 percent according to data cited by the Court. Their child would also be at risk of infection—25 percent of babies born to an HIV-infected mother became HIV-infected if the mother went without treatment. Even with treatment to prevent HIV-transmission, a child faced at an 8 percent risk of infection.²⁰⁰ While these risks don't make reproduction impossible, wrote the Court, they do make it "dangerous to the public health," and that is sufficient to satisfy the demands of the substantial limitation requirement.²⁰¹

Under *Bragdon*, then, infertile persons would appear to enjoy protection from denials of health care under the ADA. And to an important extent, that is the case. If a doctor refused to dialyze or operate on a patient because of the patient's infertility, the patient could seek redress under the ADA, just as Sidney Abbott did when her dentist refused to fill her cavity in his dental office.

But the main discrimination that infertile persons face in the health care system does not involve denials of treatment for kidney disease, heart disease or cancer. Rather, as discussed above, the infertile generally cannot obtain coverage for the costs of medical treatments that allow them to overcome their infertility and reproduce—unlike persons with other disabling conditions like heart disease, arthritis, emphysema or paraplegia who enjoy recourse to health care insurance when they need medical services. Most health care plans will not reimburse patients or physicians for the costs of in vitro fertilization or other technologies to assist reproduction, and even when insurance provides coverage, it typically is inadequate.²⁰² For the most part, infertile persons are uninsured for the costs of having children. And, as the next section indicates, the ADA offers no help in remedying this differential treatment by health care insurers.²⁰³

B. The failure to recognize infertility as a disability under the law

Although *Bragdon* holds that infertility is a disability under the ADA, courts have held that insurers do not violate the ADA when they fail to cover the costs of in vitro fertilization (IVF) or other treatments for infertility. According to the courts, there is no discrimination on the basis of disability since coverage is denied for all persons, not just for persons who are disabled.²⁰⁴

²⁰⁰ *Bragdon*, 524 U.S. at 639-640.

²⁰¹ *Bragdon*, 524 U.S. at 641. Since the Court's decision, the risk of transmission from mother to child has dropped to less than one percent. American Academy of Pediatrics, *HIV Testing and Prophylaxis to Prevent Mother-to-Child Transmission in the United States*, 122 PEDIATRICS 1127, 1129 (2008).

²⁰² Daar, *Accessing Reproductive Technologies*, *supra* note 65, at 36. See also, *supra*, Part II.D.1.

²⁰³ An infertile person might be protected from discrimination by an employer who fires the person for missing time from work while seeking medical treatment for the infertility. See *Hall v. Nalco Co.*, 534 F.3d 644 (7th Cir. 2008); *LaPorta v. Wal-Mart Stores, Inc.*, 163 F.Supp.2d 758 (W.D. Mich. 2001).

²⁰⁴ There have been cases in which an infertile person successfully challenged a denial of coverage for treatment, but those cases involve claims that the insurer has in fact promised to provide coverage. See, e.g., *Egert v. Connecticut General Life Ins. Co.*, 900 F.2d 1032 (7th Cir. 1990) (finding that insurer viewed infertility as an illness, that it had committed to covering necessary treatment for illness and that IVF was a necessary treatment for the plaintiff's infertility under the terms of the insurance contract).

Saks v. Franklin Covey—Health insurers need not cover in vitro fertilization

*Saks v. Franklin Covey*²⁰⁵ illustrates this point well. In that case, Rochelle Saks received health insurance benefits through her employer, the Franklin Covey Co. Because of infertility, Ms. Saks underwent numerous tests, and tried various drugs and procedures to become pregnant, including intrauterine insemination (IUI) and IVF. When Franklin Covey refused to cover the costs of her infertility care, Ms. Saks sued under the ADA to recover those costs,²⁰⁶ and the district court found no ADA violation. The court observed that

Franklin Covey's plan offers the same insurance coverage to all its employees. It does not offer infertile people less pregnancy and fertility-related coverage than it offers to fertile people. Therefore, as a matter of law, the Plan does not violate the ADA. In *EEOC v. Staten Island Savings Bank*, 207 F.3d 144 (2d Cir. 2000), the Court of Appeals, joining the Third, Seventh and Eighth Circuits, held that insurance distinctions that apply equally to all insured employees do not discriminate on the basis of disability.²⁰⁷

Although the *Saks* court gives the impression that its hands were tied and that it could not find discrimination under the ADA, the law was uncertain enough that the court could have found discrimination on the basis of disability. The case law cited by the court involved cases in which insurance plans provided higher coverage for some disabilities than for other disabilities. In the *Staten Island* case that the court mentions,

²⁰⁵ 117 F.Supp.2d 318 (S.D. N.Y. 2000).

²⁰⁶ She also brought claims under Title VII of the Civil Rights Act and under the Pregnancy Discrimination Act but was unsuccessful with those claims as well. Those claims failed, said the Second Circuit, because an insurer's denial of coverage for IVF and other infertility treatments disadvantage both the female and male members of the couple. *Saks v. Franklin Covey Co.*, 316 F.3d 337, 345-349 (2nd Cir. 2003). For a discussion of the current failure of these anti-discrimination statutes to protect infertile persons and observations for how anti-discrimination claims might succeed in the future, see Pendo, *Politics of Infertility*, *supra* note 11, at 317-325; Brietta R. Clark, *Erickson v. Bartell Drug Co.: A Roadmap for Gender Equality in Reproductive Health Care or An Empty Promise?*, 23 LAW & INEQ. J. 299 (2005); Katherine E. Abel, Note: *The Pregnancy Discrimination Act and Insurance Coverage for Infertility Treatment: An Inconceivable Union*, 37 CONN. L. REV. 819 (2005).

²⁰⁷ *Saks*, 117 F.Supp.2d at 326-327. Courts have issued similar rulings when plaintiffs have challenged limits on treatment that disfavor persons with a particular kind of disability. As long as the coverage limitation applies to all members of the health insurance plan, courts do not find a violation of the ADA. See, e.g., *Lenox v. Healthwise of Kentucky*, 149 F.3d 453 (6th Cir. 1998) (rejecting challenge to health insurance plan that did not cover heart transplants); *Chaudhry v. Neighborhood Health Partnership, Inc.*, 176 Fed. App'x 900, 903 (11th Cir. 2006).

However, if insurers cover a type of treatment for some patients who need it but not for others who need the same treatment, they may be in violation of the ADA. See *Henderson v. Bodine Aluminum, Inc.*, 70 F.3d 958, 960 (8th Cir. 1995) (requiring insurer that provided bone marrow transplants to some cancer patients also to provide the transplants to patients with comparable cancers when evidence indicates that the transplants provide a significant improvement in outcome over alternative treatments). Under this reasoning, if Franklin Covey covered IVF for women who had a fallopian tube blockage but not for women who were infertile for other reasons, it might be in violation of the ADA. Franklin Covey escaped the *Henderson* principle because it denied coverage for IVF to everyone.

the insurers provided more generous long-term disability insurance coverage for physical disabilities like cancer or heart disease than for mental disabilities like depression or schizophrenia. For all disabilities, benefits were available for persons who became disabled before the age of 60, and benefits would cease when the person reached age 65.²⁰⁸ While persons with physical disabilities faced no other limits on the duration of their benefits, persons with mental disabilities could receive benefits for no more than 18 or 24 months.²⁰⁹ But the Supreme Court had earlier drawn a distinction under disability law between providing no coverage and a meaningful level of coverage. In *Alexander v. Choate*, the Court upheld Tennessee's cap on hospital coverage of 14 days per year, even though it disfavored persons with disabilities, on the ground that the disabled still had meaningful access to hospital coverage.²¹⁰ The *Saks* court could have distinguished the differential treatment of fertile and infertile persons in its case from the differential treatment of mental and physical disabilities in *Staten Island* on the ground that persons with mental disabilities still had meaningful access to long-term disability coverage in *Staten Island* while infertile persons employed at Franklin Covey had no access to treatment for their infertility.²¹¹

The *Saks* court also cited the insurance provisions of the ADA to reject Ms. Saks' disabilities discrimination claim. According to those provisions, the ADA does not limit the ability of an employer to establish and administer its own health care plan that is exempt from state regulation under the Employee Retirement Income Security Act of 1974 (ERISA).²¹² Since Franklin Covey ran a self-insured health care plan, it was exempt from state regulation under ERISA and therefore also not subject to the dictates of the ADA.²¹³

Even if Franklin Covey had not self-insured its employees, its health insurance plan would have enjoyed an exemption from the ADA under the insurance provisions. Those provisions allow health insurers to employ their usual practices of classifying risks, as long as the practices are actuarially sound.²¹⁴ The ADA withdraws the protection of the insurance provisions when they are used as a subterfuge to escape the requirements of the Act, but Franklin Covey's exclusion of coverage for IUI and IVF preceded the enactment of the ADA.²¹⁵

²⁰⁸ EEOC v. Staten Island Savings Bank, 207 F.3d 144, 146-147 (2d Cir. 2000).

²⁰⁹ *Staten Island*, 207 F.3d at 146-147 (describing two plans, one with an 18-month limit, and the other with a 24-month limit).

²¹⁰ 469 U.S. 287, 301 (1985). The 14-day cap disfavored persons with disabilities since they were more likely to require more than 14 days of hospital care in a given year. *Id.* at 289-290.

²¹¹ *Saks*, 117 F. Supp. 2d at 320.

²¹² 42 U.S.C. 12201(c)(3). Under ERISA, private employee benefit plans must satisfy minimum federal standards. The Act also preempts many state benefit plan regulations, including regulation of health care plans. The application of ERISA to health care plans is complicated and beyond the scope of this article. Suffice it to say that it has proved controversial—a statute designed to protect the interests of employees has often served to compromise their interests with respect to health care coverage. Linda P. McKenzie, *Eligibility, Treatment, or Something In-Between? Plaintiffs Get Creative to Get Past ERISA Preemption*, 23 J. CONTEMP. HEALTH L. & POL'Y 272, 275-276 (2007).

²¹³ *Saks*, 117 F. Supp. 2d at 327-328.

²¹⁴ 42 U.S.C. 12201(c)(1).

²¹⁵ *Saks*, 117 F. Supp. 2d at 328.

In sum, although infertile persons experience widespread discrimination when it comes to access to medical care for their infertility, they cannot turn to anti-discrimination law for protection.

C. Infertile persons are wrongly deprived of the protection of the Americans with Disabilities Act

Some scholars have suggested that it may be appropriate for courts to deny claims of discrimination by infertile persons, that the infertile should not have recourse to the courts to protect themselves from discrimination in access to medical care for their infertility. In this view, it is not a problem that the anti-caste principle fails to reach the infertile. Rather, principles of judicial review explain why anti-discrimination law should be reserved for persons who belong to a stigmatized class.

To be sure, the judicial review argument is a constitutional argument, and need not carry over to the setting of statutory protections against discrimination. Indeed, statutory protections like the Americans with Disabilities Act are designed to fill in the gaps of constitutional protections. Still, one might invoke the judicial review argument in the setting of statutory protections against discrimination. Recall the earlier discussion in Part I about the role of the anti-caste principle in understanding both the equal protection clause and the Americans with Disabilities Act.

The judicial review argument draws on the work of John Hart Ely and his important procedural theory of judicial authority.²¹⁶ In this view, our constitutional structure relies primarily on the political process to resolve disputes and allocate benefits and burdens, with majority preferences being decisive. If courts were to intervene, judges would be substituting their own preferences for those of the majority, and that normally would entail an improper exercise of judicial power. But sometimes, the political process operates in an unfair manner. In particular, when the interests of a stigmatized minority are at stake, the majority is likely to disfavor the minority out of prejudice or other illegitimate motives and fail to give due recognition to the minority's interests. In such circumstances, courts should intervene. Judges ought to thwart the majority on behalf of a minority when the political process does not treat the minority fairly. On the other hand, when the political process gives a particular group a fair chance to advocate for its interests, then the group is not entitled to a judicial rescue simply because it lost in the political process. Under this view of the role of courts, write Carl Coleman and Radhika Rao, the infertile do not qualify for judicial protection. The infertile enjoy sufficient influence in the political process. People using IVF and other treatments are disproportionately white and wealthy, and they are able to mobilize the support of other influential interest groups, like the medical community and the pharmaceutical industry to avoid unfair treatment by legislatures.²¹⁷

²¹⁶ JOHN HART ELY, *DEMOCRACY AND DISTRUST: A THEORY OF JUDICIAL REVIEW* (1980).

²¹⁷ Coleman, *Assisted Reproductive Technologies*, *supra* note 140, at 68-69; Rao, *Assisted Reproductive Technology*, *supra* note 131, at 1478. Interestingly, while Samuel Bagenstos argues in favor of limiting the ADA's protection to stigmatized groups, he does think that chronically infertile persons would qualify for protection from discrimination under the ADA. Bagenstos, *Subordination*, *supra* note 43, at 490-491.

While initially appealing, the judicial review argument ultimately fails. As Rao recognizes, infertility crosses racial and economic lines.²¹⁸ In fact, blacks and other minorities are more likely than whites, and the poor are more likely than the wealthy, to be infertile.²¹⁹ Moreover, while Coleman and Rao observe that the users of infertility treatments are overwhelmingly white and wealthy, that simply reflects the fact that discrimination against the infertile has its biggest impact on minority and poor persons. As a number of scholars have argued, this disparate impact may be intentional—the denial of insurance coverage for infertility treatments may reflect a social sentiment against reproduction by blacks, the poor and other disfavored minorities. In other words, eugenic motivations likely play an important role in shaping public policy on treatment for infertility, as they have historically.²²⁰ Reproductive policies in the United States have long favored procreation by whites and wealthier persons and disfavored procreation by minorities and poor individuals.²²¹ When health care insurance does not cover infertility treatments and couples (or individuals) must pay out-of-pocket for the treatments, then the significant costs of those treatments mean that the treatments tend to be reserved for wealthier, white couples who can fund their treatments out of personal resources.

Costs are not the only factor in explaining higher use of infertility treatments by whites. Minorities often feel more stigmatized by their infertility and may be less willing to identify themselves as infertile and seek treatment for it; minorities are more likely to distrust the health care system because of past racist experiences; and white physicians may be less likely to recommend assisted reproductive technologies for infertile black patients.²²² Nevertheless, the financial barriers are important and a useful strategy for limiting access to care.

Most fundamentally, the judicial review argument is not persuasive because it does not account for discrimination on the basis of dismissiveness. When there is dismissiveness-based discrimination, one would expect a failure of the political process. Just as stigmatized individuals do not receive fair consideration of their needs in the political process, so are dismissed individuals denied fair consideration of their needs.

D. Costs of infertility treatment do not explain the poor insurance coverage

Can one defend the absence of coverage for IVF or other treatments by pointing to costs and benefits? Some critics have cited high costs and poor results of IVF. While

²¹⁸ Rao, *Assisted Reproductive Technology*, *supra* note 140, at 1478.

²¹⁹ Marcia C. Inhorn & Michael Hassan Fakh, *Arab Americans, African Americans, and Infertility: Barriers to Reproduction and Medical Care*, 85 FERTILITY & STERILITY 844, 845 (2006).

²²⁰ Daar, *Accessing Reproductive Technologies*, *supra* note 65, at 40, 80-81; Inhorn & Fakh, *Arab Americans*, *supra* note 219, at 845; Deborah L. Steinberg, *A Most Selective Practice: The Eugenic Logics of IVF*, 20 WOMEN'S STUD. INT'L F. 33 (1997).

²²¹ See, e.g., Dorothy E. Roberts, *Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy*, 104 HARV. L. REV. 1419, 1436-1450 (1991) (discussing the history of public policies in the United States that devalued black motherhood).

²²² Daar, *Accessing Reproductive Technologies*, *supra* note 65, at 38-43; Inhorn & Fakh, *Arab Americans*, *supra* note 219, at 845-847; Dorothy E. Roberts, *Race and the New Reproduction*, 47 HASTINGS L.J. 935, 937-942 (1996).

it is true that (1) an average IVF cycle costs between \$10,000 and 15,000,²²³ (2) many couples will need multiple cycles of IVF before they give birth to a child, and (3) many other couples will never reproduce with IVF, the costs and benefits actually seem quite reasonable. Although success rates have not been high in the past,²²⁴ they have improved considerably. According to the most recent national report, using 2006 data, a live birth resulted from 28.6 percent of IVF cycles using fresh embryos.²²⁵ If each cycle costs \$10-15,000, and 28.6 percent of cycles are successful, then it costs between \$35,000 and \$52,500 for each live birth from IVF.²²⁶

To put that figure in perspective, consider the use of QALY's to measure the cost-effectiveness of health care. QALY (pronounced like "kwallee") is an acronym that stands for quality-adjusted life year, and it takes into account improvements in both length of life and quality of life. Thus, for example, one QALY equals an additional year of life at 100 percent quality (1 x 1.00). One QALY also results from an increase in the quality of life from 80 percent to 90 percent that lasts for 10 years ((0.90-0.80) x 10).²²⁷ Researchers generally agree that health care is cost-effective when it can provide just one QALY for less than \$50,000, and many experts deem medical care cost-effective up to \$100,000 for an extra year of life.²²⁸ Thus, if a live birth from IVF were to produce at least one QALY, it would be deemed cost effective according to current standards.

²²³ David S. Guzik, *Should Insurance Coverage for in Vitro Fertilization Be Mandated?*, 347 NEW ENG. J. MED. 686, 687 (2002). See also <http://www.advancedfertility.com/ivfprice.htm>; <http://yourtotalhealth.ivillage.com/duration-cost-ivf-treatment.html>

²²⁴ RAYMOND, WOMEN AS WOMBS, *supra* note 182, at 9-11 (reporting live birth rates below ten percent from IVF).

²²⁵ "Fresh" embryos are distinguished from cycles in which the embryos have been frozen and thawed before transfer to the woman's uterus. Frozen embryos transferred to the woman's uterus result in a live birth about 28 percent of the time, while fresh embryos result in a live birth about 34 percent of the time following transfer to the woman's uterus. Note that the success rate from fresh embryo transfer is higher than the success rate from IVF cycles because not all cycles result in an embryo that can be transferred to the woman's uterus. U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION, 2005 ASSISTED REPRODUCTIVE TECHNOLOGY SUCCESS RATES NATIONAL SUMMARY AND FERTILITY CLINIC REPORTS (2007), at <http://cdc.gov/art/ART2005/index.htm> [hereinafter, CDC, 2005 ART REPORT].

The likelihood of success is much higher for a woman age 30-35 than a woman who is 40 or older. A 30 year old woman has a 38 percent chance of a live birth, a 35 year old woman has a 32 percent chance of a live birth, but a 40 year old woman has only a 16 percent chance of a live birth. CDC, 2005 ART REPORT, at cdc.gov/ART/ART2005/sect2_fig5-15.htm#15.

²²⁶ If each cycle costs \$10-15,000, then 100 cycles will cost \$1-1.5 million. 28.6 of those cycles will result in a live birth. Thus, the cost of a successful cycle is \$1-1.5 million/28.6, or \$35-52,500.

²²⁷ David C. Hadorn, *The Oregon Priority-Setting Exercise: Quality of Life and Public Policy*, 21(3) HASTINGS CENTER REP. 11, 13 (1991); QALY's are a widely used measure in health care. The United Kingdom, for example, uses QALY's as its measure of cost-effectiveness in deciding whether to provide coverage for a new treatment as part of its national health care plan. Michael D. Rawlins & Anthony J. Culyer, *National Institute for Clinical Excellence and Its Value Judgments*, 329 BMJ 224, 224 (2004). That said, their use provokes some controversy. In particular, it is difficult to assign numerical measures to a person's quality of life. Hadorn, *Oregon Priority-Setting*, at 13-16. Also, QALY's can disfavor persons with disabilities. Philip G. Peters, Jr., *Health Care Rationing and Disability Rights*, 70 IND. L.J. 491, 500-505 (1995).

²²⁸ Richard A. Hirth, et al., *Willingness to Pay for a Quality-adjusted Life Year: In Search of a Standard*, 20 MED. DECISION MAKING 332, 333 (2000) (citing common thresholds of \$50,000 and \$100,000 but finding that the public may support even higher costs per QALY).

There are two ways in which reproduction produces additional years of high quality life. For the parents, there will be an increase in their quality of life. Recall the high levels of depression in infertile women discussed above.²²⁹ If reproduction restores an infertile woman's mental health, then for many years of life thereafter, her quality of life will be higher. Reproduction produces additional QALY's through the lives of the children it creates.²³⁰

Data from Massachusetts also indicate that IVF coverage is an affordable component of health care insurance policies. In 1987, Massachusetts enacted its mandate for coverage of infertility services, including IVF, and researchers examined the impact on insurance premiums through 1993 from the mandate. The researchers found that premiums increased by about four-tenths of a percent for the coverage of infertility services.²³¹

Experience in other countries illustrates the affordability of coverage for IVF. France provides full coverage for IVF,²³² and Israel also has shown that IVF can be covered with a much smaller budget for health care. In Israel, the national health service covers IVF (and other assisted reproductive services) for all women up to age 45 until a woman has had two children with her current partner. Moreover, the two children limit is not strictly applied in practice, and women can still receive substantial funding for treatment to have more than two children.²³³ Israeli women also enjoy generous child support payments and maternity leave benefits.²³⁴

Coverage for mental health needs also illustrates the weakness of the cost argument. In response to insurers' limiting coverage for mental health care and courts upholding the limits, Congress enacted legislation in 1996 and again in 2008 to achieve coverage for mental illness equal to coverage for physical illness.²³⁵ As indicated above, legislative efforts have been much less successful at ensuring coverage for infertility. Fewer than a third of states have enacted some legislation for infertility coverage, and Congress has not enacted any legislation requiring such coverage. Moreover, the coverage for mental illness is more generous than coverage for infertility even though

²²⁹ See, *supra*, Part II.A.

²³⁰ To be sure, this claim is more controversial since the new child's life does not exist when the costs of IVF are incurred.

²³¹ Martha Griffin & William F. Panak, *The Economic Cost of Infertility-Related Services: An Examination of the Massachusetts Infertility Insurance Mandate*, 70 FERTILITY & STERILITY 22, 27 (1998).

²³² Lisa Garceau, et al., *Economic Implications of Assisted Reproductive Technologies*, 17 HUMAN REPRODUCTION 3090, 3090 (2002).

²³³ Birenbaum-Carmeli & Dirnfeld, *In Vitro Fertilisation Policy*, *supra* note 124, at 184.

²³⁴ Birenbaum-Carmeli & Dirnfeld, *In Vitro Fertilisation Policy*, *supra* note 124, at 183. While Israel provides ample financial assistance to women who want children, the national health service does less to help women who don't want children. For contraceptive services or abortion, only partial health coverage is available; abortion also requires a committee's approval. *Id.* at 183. For more information about the abortion committee process, see Delila Amir & Orly Biniamin, *Abortion Approval as a Ritual of Symbolic Control*, 3(1) WOMEN & CRIMINAL JUSTICE 5 (1992).

²³⁵ Robert Pear, *Bailout Provides More Mental Health Coverage*, N.Y. TIMES, Oct. 5, 2008.

<http://www.nytimes.com/2008/10/06/washington/06mental.html>. Earlier parity legislation, the Mental Health Parity Act of 1996, included loopholes that prevented full parity. While the 1996 Act required equal annual and lifetime caps on coverage for mental and physical illness, it did not prevent insurers from imposing other disparities in coverage, like higher co-payments for mental health services or caps on the number of visits to a physician during a particular month or year. John V. Jacobi, *Parity and Difference: The Value of Parity Legislation for the Seriously Mentally Ill*, 29 AM. J. L. & MED. 185, 192-193 (2003).

mental health care costs much more than treatment for infertility. Care for mental health needs consumes about four percent of the private health care insurance premium,²³⁶ or 10 times the cost of infertility coverage in Massachusetts after private insurers were required to cover infertility treatment.²³⁷ Note too that while mental health coverage has been inadequate, there at least has been partial coverage. For infertility treatment, there typically is no coverage.

Upon close examination, then, the claims that infertility treatments cost too much money are not persuasive. However, the existence of such claims is consistent with a theory of dismissiveness. If society does not believe that childlessness is a significant disability, then it will not support even modest expenditures to foster procreation among the infertile. Indeed, this is the whole point of a cost argument. The cost argument essentially boils down to the sentiment that helping people have children is not valued. As a result, infertile persons suffer discrimination when it comes to having their health care needs met. Or to put it another way, the cost argument reflects the devaluation of parenting. As discussed above, economic and other considerations have led people to view childlessness as much more desirable than it was viewed in previous generations.²³⁸ That being the case, it is not surprising that society would deem coverage for infertility treatments undesirable.

E. Does discrimination against the infertile reflect forms of invidious bias?

Although discrimination on the basis of dismissiveness appears to be the major basis for discrimination against the infertile, it probably is not the exclusive basis. There may be an element of bias against infertile couples on the ground that they could have had children when they were younger and that therefore they are responsible for their predicament.²³⁹ This would be analogous to the stigma that lung cancer patients face from others who blame the patients for having brought on their disease by smoking cigarettes.²⁴⁰

Still while blaming the infertile may be an element of the discrimination against them, it likely is a smaller part than the discrimination from dismissiveness. Many infertile persons cannot conceive because of problems unrelated to their age. As discussed above, for example, many women are infertile because of scarring from a ruptured appendix, a pelvic infection or endometriosis.²⁴¹ In addition, most users of IVF are 35 years or younger, and more than 80 percent are 40 years of age or younger.²⁴² If couples are being blamed for their infertility, one would expect such blame to be reserved for couples over age 40. Also, studies of infertile persons do not find that expressions of blame from others are prominent. Finally, if denial of coverage were driven primarily by

²³⁶ Tami L. Mark, et al., *Mental Health Treatment Expenditure Trends, 1986-2003*, 58 PSYCHIATRIC SERVICES 1041, 1043 (2007).

²³⁷ See, *supra*, TAN 231.

²³⁸ See Part II.C.

²³⁹ GREIL, NOT YET PREGNANT, *supra* note 135, at 127.

²⁴⁰ Alison Chapple, Sue Ziebland & Ann McPherson, *Stigma, Shame, and Blame Experienced by Patients with Lung Cancer: Qualitative Study*, 318 BMJ 1470 (2004).

²⁴¹ See Part II.A.

²⁴² CDC, 2005 ART REPORT, *supra* note 225, at www.cdc.gov/ART/ART2005/sect2_fig5-15.htm#13

bias against couples that have delayed childbearing, then we would expect to see IVF covered until a specific age cut-off (whether 35, 40 or another age), just as Israel covers infertility treatments only until a woman reaches age 45.

CONCLUSION

The anti-caste principle generally serves as a powerful explanatory tool in understanding discrimination, and at one time, it did so for discrimination on the basis of infertility. However, as infertility is seen less as a disabling condition, and more as a condition that can protect against disability, the anti-caste principle falls short as an anti-discrimination theory. As the example of infertility illustrates, discrimination can result when people dismiss the idea that a condition is disabling, and public policy therefore fails to provide adequate services to overcome the disability.

Infertility is not the only disabling condition that elicits attitudes of dismissiveness. Individuals disabled by chronic fatigue syndrome often have found that doctors and lay persons are dismissive of their complaints,²⁴³ and individuals whose functioning is hampered by depression may be told to stop whining and pull themselves together.²⁴⁴

Currently, anti-discrimination law does not provide adequate protection against discrimination on the basis of dismissiveness. The failure of anti-discrimination theory to give adequate recognition to the possibility of such discrimination is an important part of the problem. While doctrine does not always track theory, it is difficult to expect doctrine to reject practices that are not viewed as problematic from a perspective of underlying theory.

It is therefore important that anti-discrimination theory be developed in a way that reaches all important forms of discrimination. Recognizing the discrimination that comes out of dismissiveness can ensure that the legal system has more comprehensive anti-discrimination theory and doctrine, both under the equal protection clause and statutes like the Americans with Disabilities Act.

²⁴³ Thomas H. Maugh, II, *Chronic Fatigue Is in the Genes, Study Finds*, L.A. TIMES, April 21, 2006, at A1.

²⁴⁴ These examples of dismissiveness are somewhat different from the example of infertility. With infertility, the impact of the condition on the infertile person is recognized by others but not viewed as truly disabling. With chronic fatigue syndrome and depression, others do not acknowledge the impact of the condition on the person suffering from it.