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David Orentlicher
Indiana University School of Law - Indianapolis

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DAVID ORENTLICHER*

In recent years, antidiscrimination theory and doctrine have rested heavily on the "anticaste" principle first invoked in Strauder v. West Virginia. *According to this principle, equal protection law and antidiscrimination 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. Antidiscrimination 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*

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* Samuel R. Rosen Professor of Law, Indiana University School of Law – Indianapolis. M.D., Harvard University; J.D., Harvard University. I am grateful for the comments of Jennifer Bard, Judith Daar, Jennifer Drobac, Judith Lynn Failer, Alicia Ouellette, Peter Schwartz, and participants at the Health Care System and Disability session at the 2009 Annual Meeting of the Association of American Law Schools. I also am grateful for the research assistance of Jennifer Lemmon and Ryan Schwier.

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 it 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 antidiscrimination theory and doctrine.

INTRODUCTION

In recent years, antidiscrimination theory and doctrine have rested heavily on the "anticaste" principle that the Supreme Court first invoked in *Strauder v. West Virginia*.[1] According to this principle, equal protection law and antidiscrimination statutes should eradicate public and private policies that subject some persons to ongoing stigma and subordination, which then relegates them to second-class status in the courts, political system, schools, workplace, and other public settings. 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 experienced by women in society.[2] Many legal scholars have argued that the anticaste 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. Antidiscrimination law has recognized the need to overcome the discrimination that results from invidious bias,[4] unfair stereotyping,[5] irrational fear,[6]

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1. 100 U.S. 303 (1880).

2. Frontiero v. Richardson, 411 U.S. 677, 684–88 (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. *Id.* at 686.

3. *E.g.*, LAURENCE H. TRIBE, AMERICAN CONSTITUTIONAL LAW § 16–21, at 1514–15 (2d ed. 1988) ("A more promising theme in equal protection doctrine may well be an antisubjugation principle, which aims to break down legally created or legally reenforced [sic] systems of subordination that treat some people as second-class citizens."); Owen M. Fiss, *Groups and the Equal Protection Clause*, 5 PHIL. & PUB. AFF. 107, 108 (1976); Cass R. Sunstein, *The Anticaste Principle*, 92 MICH. L. REV. 2410 (1994).

4. *E.g.*, Georgia v. McCollum, 505 U.S. 42, 58–59 (1992) (finding unconstitutional a

accumulated myths,[7] or simple neglect.[8] Advocates for disfavored groups have also called for greater protection from discrimination that arises from the attitude that some individuals (e.g., the obese) have earned their disadvantaged status.[9] 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.

To illustrate the problem of discrimination from dismissiveness, I use the examples of infertility and protection from discrimination on the basis of disability. I argue that to be complete, antidiscrimination 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 nondisabling 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 women to spend thousands of dollars trying to conceive or adopt a child, either at home or abroad.[10] Infertile men and women suffer from one or another physical abnormality of their reproductive capacity. By many measures, infertility is a disability, as the U.S. Supreme Court seemed to hold in *Bragdon v. Abbott*.[11] In *Bragdon*, the Court held that an HIV-infected woman was protected from discrimination by the Americans with Disabilities Act of 1990 (ADA) because her HIV infection compromised her ability to reproduce.[12]

Yet despite the level of suffering and the presence of a real bodily dysfunction, many policy makers 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

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criminal defendant's use of peremptory challenges to strike potential jurors on the basis of race); Hunter v. Underwood, 471 U.S. 222, 229–30 (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); Brown v. Bd. of Educ., 347 U.S. 483 (1954); *Strauder*, 100 U.S. at 307–08.

5. *E.g.*, United States v. Virginia, 518 U.S. 515, 549–51 (1996) (rejecting arguments based on stereotypes about the suitability of military training for women).

6. Sch. Bd. v. Arline, 480 U.S. 273, 284 (1987) (discussing Congress's concern with discrimination against the disabled because of accumulated myths and irrational fear).

7. *Id.*

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

9. *E.g.*, 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, 227–30 (2000).

10. 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).

11. 524 U.S. 624 (1998).

12. *Id.* at 637–39.

standard, infertile persons are whole.[13] Although infertile persons may be deprived of the opportunity to procreate, such a deprivation, it is argued, is the loss of a lifestyle option.[14] Infertile persons still can carry on their lives at work or at play at normal levels, with no reduction in functioning.[15]

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."[16] In the dissenters' 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."[17]

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 . . . share the infant's ostracized status."[18] The possibility that infertility may protect from disability is reflected in the fact that many people choose to become infertile,[19] whether temporarily with birth control pills or other means of contraception, or permanently with a tubal ligation or vasectomy.[20]

This Article traces the evolution in views about fertility and reproduction in Western society, and it demonstrates how changes in perspective about the value of

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13. *See, e.g.*, Shorge Sato, Note, *A Little Bit Disabled: Infertility and the Americans with Disabilities Act*, 5 N.Y.U. J. LEGIS. & PUB. POL'Y 189, 200 (2001) (observing that "infertility is not a disability in the same sense as the loss of a limb or a degenerative disease. . . . [and] poses no threat to the patient's physical health").

14. Krauel v. Iowa Methodist Med. Ctr., 915 F. Supp. 102, 106 (S.D. Iowa 1995); Elizabeth A. Pendo, *The Politics of Infertility: Recognizing Coverage Exclusions as Discrimination*, 11 CONN. INS. L.J. 293, 338–40 (2005) (discussing and criticizing the argument that reproduction is a lifestyle option).

15. Wendy Kaminer, *Reproductive Entitlement*, AM. PROSPECT, Mar. 27, 2000, at 14, 14 (quoting infertile woman who noted that she could "do mostly everything--run, jump, skip"); Sato, *supra* note 13, at 200 (pointing out that infertility "does not directly affect the participation of men or women in the economy or in public life").

16. *Bragdon*, 524 U.S. at 638.

17. *Id.* at 660.

18. GERMAINE GREER, SEX AND DESTINY: THE POLITICS OF HUMAN FERTILITY 2–3 (1984).

19. *See* DONALD EVANS, VALUES IN MEDICINE: WHAT ARE WE REALLY DOING TO PATIENTS? 89 (2008) (observing that for some people, infertility is a blessing).

20. 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 189, 190–98 (2008). In a vasectomy, both of a man's vas deferens 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).

reproduction can turn infertility from an obvious disability into a condition that may be viewed by many as nondisabling. 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 antidiscrimination theory and doctrine are shaped.

Part I of this Article discusses the anticaste principle's prominence in equality theory; Part II considers the failure of the anticaste principle to reach discrimination on the basis of infertility; and Part III demonstrates the weak protection that antidiscrimination law provides to persons suffering from infertility. This Article concludes with a recognition of the need for antidiscrimination theory and doctrine to take account of discrimination on the basis of dismissiveness.[21]

I. THE ANTICASTE 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 "anticaste" role of the Equal Protection Clause and antidiscrimination 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 both pervasive social disadvantage and a second-class level of citizenship.[22] Similarly, antidiscrimination statutes like the Civil Rights Act of 1964 or the ADA are designed to prevent private parties from imposing second-class citizenship on different minorities.

A. The Anticaste Principle in Legal Scholarship

The anticaste 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 anticaste principle to provide an important way to understand the Constitution's requirement of equal protection.

Some scholars have derived the anticaste principle by focusing on what it means to require equality among citizens. Charles Black observed, for example, that although

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21. 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.

22. While the anticaste principle is very important, it does not exhaust the meaning of equal protection. *See* Sunstein, *supra* note 3, at 2412. Consider, in this regard, *Village of Willowbrook v. Olech*, 528 U.S. 562 (2000) (per curiam). 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. *Id.* at 564–65. 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. *Id.* Rather, the Court applied the Equal Protection Clause in the setting of a single act of discrimination against a single person. *Id.*

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."[23] Similarly, Kenneth Karst found the anticaste principle to be implicit in the concept of equality.[24] As he wrote, "[t]he essence of equal citizenship is the dignity of full membership in the society."[25] 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."[26]

Other scholars have looked to the history of the Fourteenth Amendment. Owen Fiss identified an anticaste 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.[27] And indeed, courts have provided blacks with the highest degree of protection under the Equal Protection Clause.[28] Fiss argued that in further understanding the meaning of the Equal Protection Clause, 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.[29] In other words, the Equal Protection Clause is quintessentially directed at both protecting the interests of groups that are specially disadvantaged in society and preventing the implementation of laws or practices that aggravate or perpetuate a specially disadvantaged group's subordinate position in society.[30]

In his constitutional law treatise, Laurence Tribe also emphasizes the history of the Fourteenth Amendment in favoring an anticaste principle as an explanatory theme for the Equal Protection Clause.[31] That is, 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."[32] Equal protection does not permit society to treat some of its members as "outsiders or

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23. 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).

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

25. *Id.*

26. *Id.* at 6; *see also* Kenneth L. Karst, *Why Equality Matters*, 17 GA. L. REV. 245, 248 (1983). 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 Sunstein excerpt indicates, however, the two concerns are closely intertwined, and any differences are not material for purposes of this Article. Sunstein, *supra* note 3, at 2430–31 (discussing the linkage between a caste-like system and stigma).

27. Fiss, *supra* note 3, at 147.

28. *Id.*

29. *Id.* at 150.

30. *Id.* at 155–57.

31. TRIBE, *supra* note 3, § 16–21, at 1516.

32. *Id.* § 16–21, at 1515.

as though they were worth less than others."[33] 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 rather constituted an inferior class subject to subjugation.[34] In the words of the *Dred Scott* Court,

> We think [blacks] 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.[35]

Cass Sunstein traces the anticaste principle not only to the history of the Fourteenth Amendment but also to the original framing of the Constitution.[36] 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."[37] As Sunstein points out, the anticaste principle grows out of the Constitution's original rejection of the legacy of monarchy,[38] made explicit in the Constitution's ban on titles of nobility,[39] in favor of a government that is constituted from the people and elected by the people.[40]

The legislative debate over the Fourteenth Amendment also reflects the importance of the anticaste 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.[41] 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."[42] In his mention of "class legislation" and a "code not applicable to another," everyone understood that Senator Howard was referring to concerns with the "Black Codes" that Southern States had quickly enacted following the adoption of the Thirteenth Amendment's ban on slavery.[43] These Codes denied basic civil rights to the newly freed slaves and maintained their legal and social subjugation.[44]

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33. *Id.*
34. *Id.* § 16–21, at 1516.
35. Dred Scott v. Sandford, 60 U.S. 393, 404–05 (1857).
36. Sunstein, *supra* note 3, at 2412.
37. *Id.*
38. *Id.* at 2428–29.
39. U.S. CONST. art. I, § 9, cl. 8; *see also id.* § 10, cl. 1.
40. Sunstein, *supra* note 3, at 2428–29.
41. *Id.* at 2435; *see also* David P. Currie, *The Reconstruction Congress*, 75 U. CHI. L. REV. 383, 404 (2008).
42. Sunstein, *supra* note 3, at 2435 (quoting CONG. GLOBE, 39th Cong., 1st Sess. 2766 (1866)).
43. *Id.*
44. GEOFFREY R. STONE, LOUIS M. SEIDMAN, CASS R. SUNSTEIN, MARK V. TUSHNET & PAMELA S. KARLAN, CONSTITUTIONAL LAW 458–59 (5th ed. 2005).

B. The Anticaste Principle in Case Law

The anticaste 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; it 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*[45] involved a challenge to a state law disqualifying blacks from eligibility to serve on juries.[46] 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."[47] 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:

> [T]here is in this country no superior, dominant, ruling class of citizens. There is no caste here. Our Constitution is color-blind, and neither knows nor tolerates classes among citizens. In respect of civil rights, all citizens are equal before the law. The humblest is the peer of the most powerful.[48]

More recent examples from Supreme Court doctrine reinforce the anticaste principle of equal protection jurisprudence. In *Brown v. Board of Education*,[49] 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."[50]

The Court's opinion in *Plyler v. Doe*[51] is similarly illustrative. In *Plyler*, 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.[52] 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."[53]

The anticaste 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

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45. 100 U.S. 303 (1880).
46. *Id.* at 304.
47. *Id.* at 308.
48. Plessy v. Ferguson, 163 U.S. 537, 559 (1896) (Harlan, J., dissenting), *overruled by* Brown v. Bd. of Educ., 347 U.S. 483 (1954).
49. 347 U.S. 483 (1954).
50. *Id.* at 494.
51. 457 U.S. 202 (1982).
52. *Id.* at 205.
53. *Id.* at 217 n.14.

the important case of *Frontiero v. Richardson*,[54] the Court highlighted the anticaste principle in striking down the military's differential treatment of male and female soldiers when it came to housing and medical benefits for spouses.[55] 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 on a pedestal, but in a cage."[56] 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."[57]

Romer v. Evans[58] provides another important illustration of the critical role that the anticaste 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.[59] The Court was especially troubled by the fact that the amendment called for a "sweeping and comprehensive" diminution in the legal status of homosexuals.[60]

In short, the Supreme Court has consistently placed great weight on the anticaste 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 Anticaste Principle and Disability Law

Just as the anticaste principle runs through theories and doctrine that address discrimination on the basis of race or sex, so does it drive theories and doctrine with respect to discrimination on the basis of disability. Indeed, the legislative history of the ADA 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."[61] 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."[62] The unequal treatment of the disabled reflects a

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54. 411 U.S. 677 (1973).
55. *Id.* at 688–91.
56. *Id.* at 684.
57. *Id.* at 686–87.
58. 517 U.S. 620 (1996).
59. *Id.* at 626–36.
60. *Id.* at 627, 632.
61. 42 U.S.C. § 12101(a)(6) (2006). 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, 420–22 (2000) [hereinafter Bagenstos, *Subordination, Stigma, and Disability*]. Surprisingly, the ADA has not increased the likelihood that persons with disabilities will be employed. *See* Samuel R. Bagenstos, *The Future of Disability Law*, 114 YALE L.J. 1, 19–23 (2004).
62. § 12101(a)(7).

number of sources, including invidious bias,[63] inaccurate stereotypes,[64] irrational fears,[65] aesthetic and existential anxiety,[66] and simple neglect.[67]

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.[68] 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.[69] 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,[70] and the social construction of disability can be traced to public policies that antidiscrimination law should address.[71]

The importance of the anticaste principle in the development of disability discrimination law has led one prominent scholar to argue that the ADA 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.[72]

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63. *See* Sch. Bd. v. Arline, 480 U.S. 273, 279 (1987).

64. *See* Bagenstos, *Subordination, Stigma, and Disability*, *supra* note 61, at 423–24. 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).

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

66. 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").

67. Alexander v. Choate, 469 U.S. 287, 295–96 (1985).

68. Mary Crossley, *The Disability Kaleidoscope*, 74 NOTRE DAME L. REV. 621, 659–65 (1999) (describing the development of the minority-group model); Michelle Fine & Adrienne Asch, *Disability Beyond Stigma: Social Interaction, Discrimination, and Activism*, 44 J. SOC. ISSUES 3 (1988) (same).

69. Crossley, *supra* note 68, at 659.

70. *Id.* 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 B. MAHOWALD, DISABILITY, DIFFERENCE, DISCRIMINATION: PERSPECTIVES ON JUSTICE IN BIOETHICS AND PUBLIC POLICY 13, 74 (1998).

71. Crossley, *supra* note 68, at 659; Hahn, *supra* note 66, at 53; *see also* MICHAEL OLIVER, UNDERSTANDING DISABILITY: FROM THEORY TO PRACTICE 32–33 (1996); Silvers, *supra* note 70, at 39–76; 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, 214–17 (2000).

72. Bagenstos, *Subordination, Stigma, and Disability*, *supra* note 61, at 418–45.

In sum, the anticaste principle has played a dominant role in theory, case law, and legislative history for the Equal Protection Clause and antidiscrimination statutes like the ADA. As such, it has provided a strong basis for striking down policies that impose second-class status on different minorities.[73] However, as discussed in the next two Parts, the anticaste principle does not account for groups, like the infertile, that experience discrimination out of dismissiveness.

II. THE ANTICASTE PRINCIPLE'S FAILURE TO PROTECT INFERTILE PERSONS

As a historical matter, in the United States infertility has often—but not always—constituted a disability that conferred disfavored status in society. In recent years, however, with the evolution of socioeconomic conditions that have made procreation less desired, infertility has become less stigmatized, and even seen by some as conferring protection from the disabling consequences of parenthood.[74] Accordingly, the anticaste 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 ten to fifteen percent of couples in the United States.[75] Although it is commonly thought that environmental factors or high-risk behaviors increase the likelihood of infertility, this is not the case.[76] Rather, there is greater awareness of the condition and therefore a greater likelihood that couples will seek treatment for their inability to reproduce and will therefore be diagnosed as infertile.[77] In addition, a person's chances of becoming a parent decline after age twenty-five. Men and women at age twenty-five have twice the likelihood of conceiving a child in a particular month as do men and women at age

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73. Although powerful, the anticaste principle has not always been followed in this country. *E.g.*, Bowers v. Hardwick, 478 U.S. 186 (1986) (upholding the conviction of two adult males who engaged in consensual sex), *overruled by* Lawrence v. Texas, 539 U.S. 558 (2003); Plessy v. Ferguson, 163 U.S. 537, 551–52 (1896) (upholding "separate but equal" facilities for blacks and whites) *overruled by* Brown v. Bd. of Educ., 347 U.S. 483 (1954).

74. In other countries, infertility still results in a disfavored status. *See* Tara M. Cousineau & Alice D. Domar, *Psychological Impact of Infertility*, 21 BEST PRAC. & RES. CLINICAL OBSTETRICS & GYNECOLOGY 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 the effect serious of infertility on social status of women in South Africa); Karen Springen, *Infertility: What It Means to Be a Woman*, NEWSWEEK, Sept. 15, 2008, www.newsweek.com /id/158625/page/1 (describing ostracism of infertile women in developing countries).

75. Kristin P. Wright & Julia V. Johnson, *Infertility*, *in* DANFORTH'S OBSTETRICS AND GYNECOLOGY, *supra* note 20, at 705, 705.

76. *Id.* For example, data does 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).

77. Wright & Johnson, *supra* note 75, at 705.

thirty-five.[78] Thus, as many couples have postponed efforts to have children until their thirties or forties, their likelihood of becoming pregnant has become less than if they tried to have children in their twenties.[79]

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.[80] Women may have trouble ovulating, or their fallopian tubes may be scarred from infection, preventing the passage of eggs from the ovaries to the uterus.[81] Women who have had a ruptured appendix, abdominal surgery, or pelvic surgery also may become infertile.[82] Moreover, 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.[83]

A number of treatments are available for infertility. For women whose fertility is blocked by fallopian tube dysfunction, for example, in vitro fertilization (IVF) is often 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.[84] The remaining embryos are frozen for future use.[85] Male infertility can be overcome much more easily today than in past decades. In particular, with the development of intracytoplasmic sperm injection (ICSI), in which a doctor injects a single sperm into each of the woman'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.[86] Overall, treatment allows eighty-five percent of infertile couples to have a child.[87]

The emotional impact of infertility can be severe, particularly for women. Reported symptoms of infertility include feelings of grief, sadness, and despair; a sense of panic, helplessness, and isolation; and a loss of control.[88] As the Supreme Court has

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78. Adam H. Balen & Anthony J. Rutherford, *Management of Infertility*, 335 BRIT. MED. J. 608, 608 (2007).

79. Wright & Johnson, *supra* note 75, at 705.

80. *Id.* at 706.

81. *Id.*

82. *Id.*

83. *Id.*

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

85. *Id.*

86. Hubert Joris & Gianpiero Palermo, *Pregnancy 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. *See generally* Michelle Goodwin, *Prosecuting the Womb*, 76 GEO. WASH. L. REV. 1657, 1723–36 (2008).

87. OBSTETRICS AND GYNECOLOGY 385 (Charles R.B. Beckmann et al. eds., 5th ed. 2006).

88. Linda D. Applegarth, *The Psychological Aspects of Infertility*, *in* INFERTILITY: EVALUATION AND TREATMENT 25, 27 (William R. Keye, Jr. et al. eds., 1995); Sara L. Berga, Barbara L. Parry & Jill M. Cyranowski, *Psychiatry and Reproductive Medicine*, *in* 2 KAPLAN & SADOCK'S COMPREHENSIVE TEXTBOOK OF PSYCHIATRY 2293, 2300 (Benjamin J. Sadock &

recognized, procreation constitutes a fundamental interest.[89] 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.[90] In one study, nearly half of the women in an infertility treatment program reported that their infertility was the most upsetting experience of their lives.[91] 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.[92] In a third study, researchers found that the likelihood of depression doubled for women with infertility.[93] According to a fourth study, infertile women suffer levels of depression comparable to those of women with cancer, HIV, or those who were undergoing rehabilitation after a heart attack.[94] 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.[95] As one woman who

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Virginia A. Sadock eds., 8th ed. 2005); ALINE P. ZOLDBROD, MEN, WOMEN, AND INFERTILITY 3 (1993); Cousineau & Domar, *supra* note 74, at 295–96; *see also* Lynn White & Julia McQuillan, *No Longer Intending: The Relationship Between Relinquished Fertility Intentions and Distress*, 68 J. MARRIAGE & FAM. 478, 487 (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").

89. Skinner v. Oklahoma, 316 U.S. 535, 541 (1942).

90. Lori B. Andrews & Lisa Douglass, *Alternative Reproduction*, 65 S. CAL. L. REV. 623, 629–30 (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, 1126–30 (2004).

91. Ellen W. Freeman, Andrea S. Boxer, Karl Rickels, Richard Tureck & Luigi Mastroianni, Jr., *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—fifteen 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, Jeanne M. Tschann, Seline Szkupinski Quiroga, Linda Pitcher & Gay Beckeret, *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 H. Burns & Sharon N. Covington, *Psychology of Infertility*, *in* INFERTILITY COUNSELING: A COMPREHENSIVE HANDBOOK FOR CLINICIANS 3, 7 (Linda H. Burns et al. eds., 1999).

92. Mimi Meyers, Ronny Diamond, David Kezur, Constance Scharf, Margot Weinshel & Douglas S. Rait, *An Infertility Primer for Family Therapists: Medical, Social, and Psychological Dimensions*, 34 FAM. PROCESS 219, 223 (1995).

93. Alice D. Domar, Alexis Broome, Patricia C. Zuttermeister, Machelle Seibel & Richard Friedman, *The Prevalence and Predictability of Depression in Infertile Women*, 58 FERTILITY & STERILITY 1158, 1160–61 (1992).

94. Alice D. Domar, Patricia C. Zuttermeister & Richard Friedman, *The Psychological Impact of Infertility: A Comparison with Patients with Other Medical Conditions*, J. PSYCHOSOMATIC OBSTETRICS & GYNECOLOGY, Special Issue 1993, at 45, 47–49.

95. Carrie L. Nieman, Karen E. Kinahan, Susan E. Yount, Sarah K. Rosenbloom, Kathleen J. Yost, Elizabeth A. Hahn, Timothy Volpe, Kimberly J. Dilley, Laurie Zoloth & Teresa K. Woodruff, *Fertility Preservation and Adolescent Cancer Patients: Lessons from Adult Survivors*

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."[96]

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.

"Disability" refers to the existence of substantial limitations on a person's "major life activities."[97] Major life activities include "walking, seeing, hearing, speaking, breathing, learning, and working."[98] Commonly, disability is caused by an impairment, which is defined as a "physical or mental anomaly."[99] A person with the impairment of paralyzed legs 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.[100] 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 a world that only has 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 kidney instead of two, but there are no functional limitations as a result of the impairment.[101] 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 be disabled from an impairment without being ill.[102] For instance, 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

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of Childhood Cancer and Their Parents, *in* CANCER TREATMENT & RESEARCH: ONCOFERTILITY: FERTILITY PRESERVATION FOR CANCER SURVIVORS 201, 201 (Steven T. Rosen et al. eds., 2007).

96. Fertile Hope, *Personal Accounts of Cancer and Infertility*, *in* CANCER TREATMENT & RESEARCH, *supra* note 95, at 243.

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

98. 45 C.F.R. § 84.3(j)(2)(ii) (2009).

99. SILVERS ET AL., *supra* note 97, at 9.

100. *Id.*

101. *See* Hassan N. Ibrahim, Robert Foley, LiPing Tan, Tyson Rogers, Robert F. Bailey, Hongfei Guo, Cynthia R. Gross & Arthur J. Matas, *Long-Term Consequences of Kidney Donation*, 360 NEW ENG. J. MED. 459, 459 (2009).

102. OLIVER, *supra* note 71, at 33–37.

recognized it as a fundamental right.[103] 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.[104]

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.[105] Moreover, many well-recognized disabilities are a common result of aging,[106] including hearing loss[107] and osteoporosis.[108] 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 an affected woman, and it could subject her to suspicion in her community.[109] Indeed, in New England, among women accused of being witches, there was a disproportionate representation of women with no or few children.[110]

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 parents[111] or unrelated children as apprentices to learn a trade and help out with

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103. Skinner v. Oklahoma, 316 U.S. 535, 541 (1942) ("We are dealing here with legislation which involves one of the basic civil rights of man. Marriage and procreation are fundamental to the very existence and survival of the race.").

104. Bragdon v. Abbott, 524 U.S. 624, 638 (1998) ("Reproduction falls well within the phrase 'major life activity.' Reproduction and the sexual dynamics surrounding it are central to the life process itself.").

105. *See generally* Wright & Johnson, *supra* note 75, at 705–06 (discussing the main causes of infertility and their approximate frequencies in both male and females).

106. Jack M. Guralnik, Linda P. Fried & Marcel E. Salive, *Disability as a Public Health Outcome in the Aging Population*, 17 ANN. REV. PUB. HEALTH 25, 32 (1996).

107. Lisa Fook & Rosemary Morgan, *Hearing Impairment in Older People: A Review*, 76 POSTGRADUATE MED. J. 537, 537 (2000).

108. *See generally* U.S. PUB. HEALTH SERV., U.S. DEP'T HEALTH AND HUMAN SERVS., BONE HEALTH AND OSTEOPOROSIS: A REPORT OF THE SURGEON GENERAL 69 (2004), *available at* http://www.surgeongeneral.gov/library/bonehealth/docs/full_report.pdf (discussing the frequency of bone disease, which is highly prevalent in the elderly, and its role as a common cause of debilitating fractures in the elderly).

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

110. *Id.* at 28.

111. *See* MARGARET MARSH & WANDA RONNER, THE EMPTY CRADLE: INFERTILITY IN AMERICA FROM COLONIAL TIMES TO THE PRESENT 17–18 (1996). Children commonly lost one or both of their parents before the age of adulthood during colonial times. *Id.* at 18. In one county,

the demands of rural life.[112] Children might be indentured for long periods to employers or "rented out" in exchange for wages.[113] Parents with many children—more than they wanted or could afford—might send them to live with childless couples.[114] In addition, child raising was a communal responsibility, with adults participating in the rearing and disciplining of children living in other homes.[115] Thus, even though infertile couples could not have their own children, they did take in unrelated apprentices and children from related families, as well as participate in the rearing and disciplining of all children.[116] In short, the public and communal nature of child rearing meant that infertile couples were able to experience much of the social role of parents.[117]

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.[118] At this time, the center of economic activity moved away from the household, with men working outside the home in the commercial centers and women working in the homes.[119] As the economic role of the household decreased, the home became a place for marital fulfillment and for cultivation of the next generation of citizens.[120] A belief developed that 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.[121] And as immigration and urbanization created a more diverse population, reformers discouraged the earlier practices by which children flowed easily from one household to another.[122] By the

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twenty percent of children by the age of thirteen had lost both parents. *Id.* If a mother died, leaving young children, and the father did not remarry quickly, he often would send the children to live with relatives. *Id.* Widows too might send children to live with relatives. *See id.* In fact, John Hancock, who signed the Declaration of Independence, was brought up from the age of eight by an aunt and uncle after his father died. *Id.*

112. *See id.* at 19.

113. BARBARA BENNETT WOODHOUSE, HIDDEN IN PLAIN SIGHT: THE TRAGEDY OF CHILDREN'S RIGHTS FROM BEN FRANKLIN TO LIONEL TATE 63–65 (2008).

114. MARSH & RONNER, *supra* note 111, at 18–19. The latter part of the nineteenth century through the early years of the twentieth century saw a somewhat similar practice of "placing out" children from poor families. MARILYN IRVIN HOLT, THE ORPHAN TRAINS: PLACING OUT IN AMERICA 1, 4 (1992). Thousands of 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. *Id.* at 2–3, 119. 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.

115. *See* MARSH & RONNER, *supra* note 111, at 18–19.

116. *Id.*; *see also* ELIZABETH C. BRITT, CONCEIVING NORMALCY: RHETORIC, LAW, AND THE DOUBLE BINDS OF INFERTILITY 20 (2001); MAY, *supra* note 109, at 30–31.

117. BRITT, *supra* note 116, at 20; MARSH & RONNER, *supra* note 111, at 18–19; MAY, *supra* note 109, at 30–31. *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).

118. *E.g.*, MARSH & RONNER, *supra* note 111, at 19.

119. BRITT, *supra* note 116, at 20–21; SUSAN HOUSEHOLDER VAN HORN, WOMEN, WORK, AND FERTILITY, 1900–1986, at 4 (1988); *see also* REGAN, *supra* note 117, at 19.

120. *See* BRITT, *supra* note 116, at 21.

121. MAY, *supra* note 109, at 36–40; STEVEN MINTZ, HUCK'S RAFT: A HISTORY OF AMERICAN CHILDHOOD 78 (2004).

122. MAY, *supra* note 109, at 40; *see also* WOODHOUSE, *supra* note 113, at 241–43 (describing the chasm between middle-class Americans and the children of poor immigrants).

middle of the nineteenth century, households had lost most of their public function, with the ideal family constituting a married couple and their offspring,[123] and a glorification of motherhood suggested that having children was the sole reason for a woman's existence.[124] In this view, the home was portrayed as the central institution of American life, and the mother became the linchpin of social unity.[125]

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.[126] This shift was reinforced by the child's new place in the family.[127] Altogether, it made sense to have fewer children and spend more per child on education and other activities.[128] Also, women developed interests in activities beyond their domestic responsibilities, including working for pay in the marketplace.[129]

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.[130] Women who did not

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123. MARSH & RONNER, *supra* note 111, 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, *supra* note 111, at 19; WOOD, *supra* at 145–48. The informal practices of children flowing from one household to another were replaced with formal laws of adoption. MAY, *supra* note 109, at 40.

124. MARSH & RONNER, *supra* note 111, at 31.

125. *Id.* at 32. Interestingly, single women could find a respected social role "by providing maternal functions in the civic arena." MAY, *supra* note 109, at 49. *See generally* Martha Minow, *"Forming Underneath Everything That Grows": Toward a History of Family Law*, 1985 WIS. L. REV. 819, 877–82 (1985) (providing an overview of women's involvement in these civic roles).

126. MINTZ, *supra* note 121, at 77–78; WOODHOUSE, *supra* note 113, at 243.

127. MARSH & RONNER, *supra* note 111, at 98. 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, *supra* note 119, 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.

128. Naomi Cahn & June Carbone, *Red Families v. Blue Families* 9–11 (George Washington Univ. Sch. of Law, Pub. Law & Legal Theory Working Paper Group, Paper No. 343, 2007), *available at* http://ssrn.com/abstract=102589. Parents were devoting more attention and resources to their children also because attitudes toward children were becoming more enlightened. HOLT, *supra* note 114, at 11–13; MINTZ, *supra* note 121, at 77–78.

129. MARSH & RONNER, *supra* note 111, at 75; VAN HORN, *supra* note 119, at 2.

130. VAN HORN, *supra* note 119, at 19–20; *see also* MAY, *supra* note 109, 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, MARSH & RONNER, *supra* note 111, at 113, but the overall birth rates remained higher among black women and immigrants, MAY, *supra* note 109, at 75. Fears about "race suicide" were common. MARSH & RONNER, *supra* note 111, at 113. At this time, the eugenics movement

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.[131]

With the economic turmoil of the Great Depression, voluntary childlessness peaked in the United States, and fertility rates dropped to their lowest levels.[132] With World War II and the revival of the American economy, the "Baby Boom" ensued, and fertility rates in the mid-1950s rose again to levels last seen in 1898.[133] Much of the increase in birth rates reflected pent-up demand from the Depression[134] and World War II,[135] 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 low birth rates during the Depression, fewer young adults were entering the labor market, driving up wages.[136] And because of the GI Bill's funding of higher education, these young adults came into the labor market able to take on better-paying jobs.[137] During this period, parenthood was celebrated, and childless couples were marginalized and stigmatized.[138]

During the 1960s and 1970s, childbearing became less valued by society.[139] 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.[140] Experts cite a number of social changes that came together.

For example, the women's movement pushed for greater equality between the sexes and a reconsideration of traditional gender roles.[141] As women experienced greater opportunities in the workplace, many found their professional work more rewarding than rearing children. Many women delayed marriage and procreation,[142] and when they did have children, they spaced them farther apart.[143] Many women also shortened the duration of their years of procreation.[144] This has resulted in fewer children per woman and fewer women having children.[145]

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became influential. MAY, *supra* note 109, at 63–64 (describing the efforts of some eugenicists). *See generally* Lori B. Andrews, *Past as Prologue: Sobering Thoughts on Genetic Enthusiasm*, 27 SETON HALL L. REV. 893, 893–97 (1997) (discussing the development and rise in popularity of eugenics in America).

131. BRITT, *supra* note 116, at 24–25; MARSH & RONNER, *supra* note 111, at 123; MAY, *supra* note 109, at 63.

132. MARSH & RONNER, *supra* note 111, at 154.

133. 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).

134. Economic constraints discouraged procreation at this time. *Id.* at 122.

135. The mobilization of the military diverted large numbers of young males away from marriage and procreation. *Id.*

136. VAN HORN, *supra* note 119, at 112–13.

137. Klein, *supra* note 133, at 126–27. The federal government's subsidization of home mortgage credit also made housing cheaper, lowering the costs of parenting. *Id.* at 127.

138. MAY, *supra* note 109, at 139. Voluntary childlessness was especially stigmatized. *See id.* Male infertility was also singled out for disfavor, as social myths connected fertility with virility. *Id.* at 159.

139. *See* Klein, *supra* note 133, at 129, 132.

140. *Id.* at 129–45.

141. *Id.* at 134.

142. *See* Van Voorhis, *supra* note 84, at 379.

143. Klein, *supra* note 133, at 143.

144. *Id.* (observing that women not only delayed the beginning of their childbearing years

In addition, the entry of women into the workplace continued to build upon long-term changes that had altered the economics of procreation, with the cost-benefit ratio of children continuing to become less favorable.[146] As women could earn more outside the home, the opportunity costs of raising children rose substantially. Costs increased further as children needed to remain in the home longer for a suitable education and for the development of skills necessary to compete in the increasingly complex marketplace,[147] 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. 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.[148]

The economics of procreation changed in other important ways. As infant and child mortality rates declined and life expectancy increased,[149] 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.[150]

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but also ended their childbearing at younger ages).

145. *Id.*; Van Voorhis, *supra* note 84, at 379. Among U.S. women age forty to forty-four in 2006, twenty percent had no children. That number is double the percentage of childless women age forty to forty-four in 1976. U.S. CENSUS BUREAU, ECON. & STATISTICS ADMIN., U.S. DEP'T OF COMMERCE, FERTILITY OF AMERICAN WOMEN: 2006, at 4 (2008), *available at* http://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 & Lynda Clarke, *Voluntary Childlessness: Trends and Implications*, *in* INFERTILITY IN THE MODERN WORLD 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, Letizia Mencarini, Maria Leitizia Tanturri & Katia Begall, *Gender Equity and Fertility Intentions in Italy and the Netherlands*, 18 DEMOGRAPHIC RESEARCH 1 (2008), *available at* http://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 RES. & POL'Y REV. 411, 416–17 (2003).

146. GARY S. BECKER, A TREATISE ON THE FAMILY 93–112 (1981).

147. WOODHOUSE, *supra* note 113, at 243.

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

149. Between 1900 and 1960, life expectancy in the United States increased from a little over forty-seven years to nearly seventy years. NAT'L CTR. FOR HEALTH STATISTICS, U.S. DEP'T OF HEALTH & HUMAN SERVS., HEALTH, UNITED STATES, 2007, at 175 tbl.27 (2007), *available at* http://www.cdc.gov/nchs/data/hus/hus07.pdf; *see also* MAY, *supra* note 109, at 25 (discussing the connection between high infant mortality rates and high fertility rates in colonial America).

150. In the late eighteenth century, a couple might have twelve children, with only three reaching adulthood. *See* MARSH & RONNER, *supra* note 111, at 11 (describing the Holyoke family's experience in Massachusetts).

Accordingly, as had already started to happen in the nineteenth century, the economics of childrearing favored fewer children. The economics of childrearing also favored higher per-child investments, which would increase the likelihood that children would enjoy increased prosperity and be able to support their parents.[151] The implementation of Social Security further diminished the need to rely on reproduction for security in older age.[152] Also, declining mortality rates led to reductions in fertility as increases in the population put pressure on land and other resources.[153]

Other social changes have played a role in the declining fertility rate. During the 1960s and 1970s, the youth of the time challenged traditional social institutions including the family.[154] 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,[155] they have changed the nature of family roles. Many couples voluntarily choose to be childless, believing that the ideal intimate relationship involves another adult, unencumbered by children.[156] Also, reflexive modernization brings with it risk aversion—if people can construct their own identities, they bear more responsibility for outcomes.[157] Hence, couples are more likely to be cautious about making major commitments. This has led to an increase in cohabitation before marriage and a rise in the average age at marriage (so that individuals can be surer that they have chosen the right spouse); it also has led to delays in procreation.[158] As divorce has become more acceptable and more common, becoming a parent has also become a riskier endeavor,[159] and people may find that there are diminished benefits from investing time and energy in raising a family rather than cultivating a professional career.[160]

The risk aversion of reflexive modernization has been increased by the "new capitalism." As free-market ideology spread in the 1980s and 1990s, labor markets 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.[161] 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.[162]

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151. BECKER, *supra* note 146, at 111.

152. Population Reference Bureau, *Social Security Systems Around the World*, TODAY'S RESEARCH ON AGING, Jan. 2009, at 1, 3, *available at* http://www.prb.org/pdf09/TodaysResearchAging15.pdf. The development of private pension plans has probably contributed as well to the decline in fertility rates.

153. Klein, *supra* note 133, at 116.

154. BRITT, *supra* note 116, at 27.

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

156. BRITT, *supra* note 116, at 27.

157. McDonald, *supra* note 155, at 489.

158. *Id.*

159. Rindfuss et al., *supra* note 145, at 414.

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

161. *See* McDonald, *supra* note 155, at 491.

162. *Id.* at 490–94. The new capitalism can also promote procreation. If greater job mobility makes it easier to leave and reenter the workforce, then women may be more willing to interrupt their careers to have children. *See* Hans-Peter Kohler, Francesco C. Billari & José A. Ortega,

Concern about global overpopulation also may have contributed to the declining desire for procreation. In 1968, Paul Ehrlich published *The Population Bomb*,[163] a best seller that sounded the alarm about overpopulation, and in 1972, the Club of Rome issued *The Limits to Growth*,[164] a best-selling book that predicts the collapse of the world's social and economic systems because of unsustainable growth in the population. A number of advocates mounted aggressive environmental arguments against procreation, asserting that the survival of the planet Earth required dramatic reductions in population growth.[165] Current concerns about global warming could reinforce environmental arguments against procreation.[166] Higher-density housing uses less energy, but higher-density housing is less conducive to raising a family.[167]

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.[168] Similarly, a forty- to forty-four-year-old woman in the United States was twice as likely to be childless in 2006 than was a forty- to forty-four-year-old woman in 1976.[169]

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,[170] while in other Western 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 Netherlands, Sweden,

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Low Fertility in Europe: Causes, Implications and Policy Options, *in* THE BABY BUST, *supra* note 133, at 48, 92–93. Also, those for whom the new capitalism results in greater family wealth 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).

163. PAUL R. EHRLICH, THE POPULATION BOMB (1968).

164. DONELLA H. MEADOWS, DENNIS L. MEADOWS, JØRGEN RANDERS & WILLIAM W. BEHRENS III, THE LIMITS TO GROWTH (1972) (describing the work of the Club of Rome).

165. *See* JAMES REED, FROM PRIVATE VICE TO PUBLIC VIRTUE 373 (1978). Interestingly, one study of limited-income women suggests 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, 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. *See, e.g.*, WATTENBERG, *supra* note 162, at 23–27 ("Today . . . every modern nation . . . is below the 2.1 replacement level."); Russell Shorto, *No Babies?*, N.Y. TIMES, June 29, 2008, (Magazine) at 36 (discussing very low fertility rates in Europe).

166. *See, e.g.*, Paul A. Murtaugh & Michael C. Schlax, *Reproduction and the Carbon Legacies of Individuals*, 19 GLOBAL ENVTL. CHANGE 14, 18 (2009) (calling for a consideration of a person's reproductive choices in calculating that person's impact on the global environment).

167. David Owen, *Green Manhattan*, NEW YORKER, Oct. 18, 2004, at 111.

168. *See* McAllister & Clarke, *supra* note 145, at 192 tbl.6.1.

169. U.S. CENSUS BUREAU, *supra* note 145.

170. 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, *supra* note 119, at 85.

and the United Kingdom, it is close to 1.7.[171] Within countries, fertility rates vary among women of different race, educational attainment, and state of residence. For example, in the United States, women who did not graduate high school have a fertility rate fifty percent higher than women with a graduate degree.[172]

As fertility rates have dropped, voluntary sterilization rates have risen. In the United States, voluntary surgical sterilization was rarely employed before the 1960s.[173] Indeed, states commonly restricted sterilization for contraceptive purposes.[174] Since then, sterilization has become the most common form of birth control, with thirty-six percent of couples relying on that method.[175] Three-fourths of these couples choose tubal ligation for the woman, and one-fourth of these couples choose vasectomy for the man.[176]

As fertility rates dropped, perceptions about infertility changed. By the 1970s, attitudes about infertility were shifting.[177] 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.[178] 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."[179] Antichild 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."[180]

While parenthood became more valued in the 1980s,[181] 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 still commonly value parenting, and it is a high priority for them. Nevertheless, social

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171. CENT. INTELLIGENCE AGENCY, THE CIA WORLD FACTBOOK 2008, at 414, 556, 608 (2007). Israel's total fertility rate is slightly higher than India or Egypt at 2.77. *Id.* at 179, 270, 290; Daphna Birenbaum-Carmeli & Martha Dirnfeld, *In Vitro Fertilisation Policy in Israel and Women's Perspectives: The More the Better?*, 16 REPROD. HEALTH MATTERS 182, 183 (2008).

172. U.S. CENSUS BUREAU, *supra* note 145. Also, the fertility rates in more politically conservative states tend to be higher than fertility rates in more liberal states. Cahn & Carbone, *supra* note 128, at 26.

173. ROBERT BLANK & JANNA C. MERRICK, HUMAN REPRODUCTION, EMERGING TECHNOLOGIES, AND CONFLICTING RIGHTS 59 (1995).

174. *Id.* at 66–67.

175. Deborah Bartz & James A. Greenberg, *Sterilization in the United States*, 1 REV. OBSTETRICS & GYNECOLOGY 23, 24 (2008). Almost thirty-one percent of couples rely on the woman taking oral contraceptive pills for their birth control. *Id.*

176. *Id.*

177. MARSH & RONNER, *supra* note 111, at 211.

178. *Id.* at 211–16.

179. Betty Rollin, *Motherhood: Who Needs It?*, LOOK, Sept. 22, 1970, at 15, 17.

180. Michael Novak, *The Family Out of Favor: The Courage to Marry and Raise Children Presupposes a Willingness (Presently Unfashionable) to Grow Up*, HARPER'S MAG., Apr. 1976, at 37, 37.

181. BRITT, *supra* note 116, at 27. In fact, babies became stars in popular movies like *Three Men and a Baby* and *Look Who's Talking*. MAY, *supra* note 109, at 214.

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, infertility is now often seen as a nondisabling condition, and people therefore dismiss the idea that infertility entails a disability.[182] 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; rather 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."[183] 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."[184] Other people "might suggest that infertility is a blessing in disguise" or that it is not as bad as other medical conditions because reproduction "supposedly is so optional."[185] Or they might say something like, "Oh well, so what, so you don't have to have a baby, so what, just adopt."[186]

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."[187] The infertile also were troubled that fertile individuals "acted as if . . . infertility were a small and relatively easy problem to solve."[188] 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.'"[189] According to Greil, infertile couples do

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182. *See* Tanya Koropeckyj-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); *cf.* KAREY HARWOOD, THE INFERTILITY TREADMILL 102–03 (2007) (discussing changes in social views that reduced the importance of parenting in living a full life).

183. BRITT, *supra* note 116, at 41.

184. *Id.*

185. *Id.*

186. *Id.*

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

188. *Id.* at 129.

189. *Id.* at 130; *see also* HARWOOD, *supra* note 182, at 54 (noting that many infertile persons are told to "[j]ust 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. SOC. & ANTHROPOLOGY 392, 405–07 (1994) (studying infertility in Canada). Undoubtedly, perceptions of the infertile encompass a range of views, including both dismissiveness and stigma.

not feel like they are viewed as inferior because of their infertility.[190] Rather, the discrimination they feel arises out of a "failure of others to acknowledge the seriousness of infertility."[191] In one typical remark, an infertile person observed, "I think [fertile people] discriminate by making light of the problem."[192]

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.[193] 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.[194] 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.[195]

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.[196] 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."[197] Of course, this argument ignored the fact that the costs of prescription drugs for diabetes and high blood pressure are deductible[198] 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.[199]

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 other fundamental rights, as when some characterize homosexuality as a "lifestyle choice."[200]

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.

190. GREIL, *supra* note 187, at 132.

191. *Id.*; *see also* Constance N. Scharf & Margot Weinshel, *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" (citation omitted)).

192. GREIL, *supra* note 187, at 128.

193. Carl H. Coleman, *Assisted Reproductive Technologies and the Constitution*, 30 FORDHAM URB. L.J. 57 (2002); Radhika Rao, *Equal Liberty: Assisted Reproductive Technology and Reproductive Equality*, 76 GEO. WASH. L. REV. 1457 (2008).

194. Coleman, *supra* note 193, at 68–70; Rao, *supra* note 193, at 1478–80. 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.

195. I am grateful to Alicia Ouellette for this point.

196. Pratt, *supra* note 90, at 1124–25.

197. *Id.* at 1125 (citation omitted).

198. *Id.* at 1140–41.

199. *Id.* at 1124. Ironically, the same expert argued that expenses for treatment of sexual dysfunction (e.g., the costs of Viagra) might qualify for a tax deduction. *Id.* at 1125.

200. *See, e.g.*, Mable Jackson, *Homosexuality Is a Lifestyle Choice*, CENT. MICH. LIFE, Nov.

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 infertile couples have children.[201] According to a recent estimate, fewer than twenty percent of large U.S. employers (those with 500 or more employees) provide coverage for IVF.[202] Among employers with fewer than 500 employees, only twenty-five percent offer any infertility services, and they typically exclude coverage for IVF or other assisted reproductive technologies.[203] The health insurance plan of this Article's author through Indiana University is typical. It is an Anthem preferred-provider plan,[204] and while its coverage is generally quite good (no in-network 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 in-network expenses), it does not cover artificial insemination, IVF, infertility drugs, or any procedures or testing related to fertilization.[205] Another Indiana University preferred-provider plan (with a $900 in-network deductible and a $2,400 annual cap on out-of-pocket, in-network expenses) has the same coverage exclusions for infertility treatment.[206]

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 two percent of enrollees were covered for infertility services while forty-seven percent of female enrollees were covered for elective abortion.[207] Moreover, none of the plans that covered infertility services included coverage for IVF or other assisted reproductive technologies. The percentage of plans offering abortion coverage was even higher—sixty-seven percent or more, depending on the type of plan (e.g., HMO, PPO, etc.).[208] And coverage for reversible contraception exceeds coverage for abortion.[209]

7, 2005, at 7A, *available at* media.www.cm-life.com/media/storage/paper906/news/2005/11/07/Voices/Homosexuality.Is.A.Lifestyle.Choice-2499936.shtml.

201. *See* Peter J. Neumann, *Should Health Insurance Cover IVF? Issues and Options*, 22 J. HEALTH POL. POL'Y & L. 1215, 1215–18 (1997).

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

203. *Id.* Other assisted reproductive technologies include artificial insemination, ICSI, and gamete intra-fallopian transfer (GIFT). *See supra* note 226; *infra* note 86.

204. Under a preferred-provider plan, the insurer identifies physicians, hospitals and other health-care providers as "preferred" and requires higher payments when their customers seek care from a nonpreferred provider. MARK A. HALL, MARY ANNE BOBINSKI & DAVID ORENTLICHER, HEALTH CARE LAW AND ETHICS 1335 (7th ed. 2007).

205. INDIANA UNIVERSITY, BLUE PREFERRED PRIMARY POS—BENEFIT SUMMARY (2009), *available at* http://www.indiana.edu/~uhrs/pubs/books/POS-Summary09.pdf.

206. INDIANA UNIVERSITY, PPO $900 DEDUCTIBLE HEALTH CARE PLAN—BENEFIT SUMMARY, (2009), *available at* http://www.indiana.edu/~uhrs/pubs/books/PPO900-Summary09.pdf.

207. Ann Kurth, Kris Graap, John Conniff & Frederick A. Connell, *Reproductive and Sexual Health Benefits in Private Health Insurance Plans in Washington State*, 33 FAM. PLAN. PERSP. 153, 157 tbl.3 (2001).

208. *Id.* at 156 tbl.2.

209. A national study found that eighty-nine percent of plans provide coverage. Adam Sonfield, Rachel Benson Gold, Jennifer J. Frost & Jacqueline E. Darroch, *U.S. Insurance Coverage of Contraceptives and the Impact of Contraceptive Coverage Mandates, 2002*, 36

It also is useful to compare coverage of infertility treatments with coverage for medical equipment, like wheelchairs, and medical devices, like prosthetic limbs. Some commentators 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.[210] 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 argument,[211] 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 seven percent of children who were privately insured lacked access to mobility aids or devices or to hearing aids or hearing care.[212] The author's own insurance plan is typical. Although it provides no coverage for IVF or other infertility treatments, it covers eighty percent of the costs of medical equipment and devices.[213] 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.[214]

Advocates for infertility treatment coverage have had some success in getting legislation passed to support their cause.[215] Twelve states mandate insurance coverage for infertility treatments,[216] and two states require that coverage be offered.[217] However, even when legislation exists, it may be limited. California and New York expressly exclude IVF from the mandate to cover or offer coverage,[218] and Arkansas allows

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PERSP. ON SEXUAL AND REPROD. HEALTH 72, 72 (2004).

210. THE N.Y. STATE TASK FORCE ON LIFE AND THE LAW, ASSISTED REPRODUCTIVE TECHNOLOGIES: ANALYSIS AND RECOMMENDATIONS FOR PUBLIC POLICY 96 (1998).

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

212. 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 tbl.2 (2004). Even for children on Medicaid, the unmet needs were low. Somewhat more than twelve percent of Medicaid recipients lacked access to mobility aids or devices, and less than nine percent lacked access to hearing aids or hearing care. *Id.*

213. INDIANA UNIVERSITY, *supra* note 205.

214. *Id.*

215. BRITT, *supra* note 116, 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 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).

216. Nat'l Conference of State Legislatures, State Laws Related to Insurance Coverage for Infertility Treatment (May 2009), http://www.ncsl.org/programs/health/50infert.htm.

217. *See* CAL. HEALTH & SAFTEY CODE § 1374.55 (West 2008); CAL. INS. CODE § 10119.6 (West 2005); TEX. INS. CODE ANN. §§ 1366.001–.007 (Vernon 2009).

218. CAL. HEALTH & SAFTEY CODE § 1374.55 (West 2008); CAL. INS. CODE § 10119.6 (West 2005); N.Y. INS. LAW § 3216 (13), 3221 (6) and 4303 (McKinney 2006).

insurers to cap lifetime benefits for IVF at $15,000.[219] 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.[220]

The limited success of 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.[221]

Public health plans are no different. Consider, for example, the Oregon Health Plan ("Oregon Plan"). The Oregon Plan represented a major effort to provide health care to all Oregon 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.[222] In other words, instead of providing Cadillac care to some indigent people, Oregon hoped to provide Chevrolet care to all of its poor.[223] 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.[224] 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.[225] 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.[226] 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 intra-fallopian transfer (GIFT).[227] Medicaid

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219. 054-00-001 ARK. CODE R. § 6 (Weil 2008).

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

221. *See infra* Part III. D.

222. Jonathan Oberlander, *Health Reform Interrupted: The Unraveling of the Oregon Health Plan*, 26 HEALTH AFF. 96, 97 (2007), *available at* http://content.healthaffairs.org/cgi/reprint/26/1/w96.

223. *Id.* at 97. The Plan never realized its goal. At its height, the Plan reduced the number of uninsured by one-third. *Id.* at 97. However, within a decade of its implementation, Oregon had the same percentage of uninsured residents that it had before the Plan was adopted. *Id.* at 99.

224. *Id.* at 97.

225. OR. HEALTH SERVS. COMM'N, PRIORITIZED LIST OF HEALTH SERVICES (May 1, 2002), *available at* http://www.oregon.gov/OHPPR/HSC/docs/PList5-02.pdf.

226. *Id.*

227. *Id.* With IVF, a fertility specialist combines a woman's egg and a man's sperm in the laboratory to create an embryo. Van Voorhis, *supra* note 84, at 380. After a couple of days, the embryo is inserted into the woman's uterus. *See id.* GIFT is much like IVF except the fertility specialist places the embryo into the woman's fallopian tube. *See* Ricardo H. Asch, Linda R. Ellsworth, Jose P. Balmaceda & Peng C. Wong, *Pregnancy After Translaparoscopic Gamaete Intrafallopian Transfer*, 324 LANCET 1034, 1034 (1984); *see also* M. Ranieri, V.A. Beckett, S.

programs in other states typically exclude coverage for IVF and other infertility treatments as well.[228]

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.

2. Infertility May Even Be Seen as Enabling

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 they "like the freedom."[229] And she prefers to call herself "childfree" rather than "childless" because childfree suggests the absence of something undesirable.[230] Another woman said that she and her husband did not care to have children interfere in their relationship.[231] A man reported that he "simply did not want the troubles and commitment associated with raising children."[232] 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."[233] A private life without children allows them more time with their partner for "love, intimacy, and enjoyable pursuits."[234]

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

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Marchant, A. Kinis & P. Serhal, *Gamete Intra-Fallopian Transfer or In-Vitro Fertilization After Failed Ovarian Stimulation and Intrauterine Insemination in Unexplained Infertility?*, 10 HUM. REPROD. 2023, 2023–25 (1995) (comparing GIFT to IVF).

228. Elena N. Cohen, *Reproduction and Reproductive Genetics*, *in* 5 TREATISE ON HEALTH CARE LAW § 22.04, at 22–74 (2008); NAT'L. HEALTH LAW PROGRAM & NAT'L. ASS'N. OF CMTY. HEALTH CTRS., ROLE OF STATE LAW IN LIMITING MEDICAID CHANGES 1, 24–48 (2007), http://www.healthlaw.org/library/item.100796.

229. MAY, *supra* note 109, at 181.

230. *Id.* at 181–82.

231. *Id.* at 196.

232. *Id.*

233. *Id.* at 185.

234. *Id.* at 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, Michael Pratt, Bruce Hunsberger & Margo Gallant, *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).

responsibility, and the greater opportunities for self-fulfillment without children.[235] 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.[236] A woman spoke of the independence she enjoyed and the freedom from the constraints of parenthood.[237]

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 mentioned in *The Good Food Guide* boldly advise parents to "leave under-fourteens and dogs at home" . . . .
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> . . . .
>
> . . . 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. . . .[238]

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.[239]

Scholarship on reproductive issues reflects 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

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235. McAllister & Clarke, *supra* note 145, 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).

236. McAllister & Clarke, *supra* note 145, at 223.

237. *Id.* at 222.

238. GREER, *supra* note 18, at 3–4; *see also* MAY, *supra* note 109, 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).

239. It may be 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 cost 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.

> [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.[240]
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> . . . .
>
> 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. . . .[241]
>
> . . . .
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> . . . 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.[242]

Rubenfeld further indicates his view of parenting when he provides his basic understanding of privacy rights:

> 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.[243]

Rubenfeld's view of parenting—that it creates a "singular and normalized" society and 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, Rubenfeld would consider it of greater constitutional concern if the state were to ban abortion than if the state were to prohibit parents from having more than two children.[244]

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.[245] In Kukla's view, ovarian tissue preservation is problematic

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240. 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 would commandeer women to become pregnant and bear children. *See id.*

241. *Id.* at 791.

242. *Id.* at 796.

243. *Id.* at 784 (emphasis in original).

244. *Id.* at 796–97.

245. *See* Rebecca Kukla, Presentation at the Annual Meeting of the Am. Soc'y of Bioethics & Humanities: The Oncofertility Project: Ethics at the Intersection of Reproductive Medicine

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."[246]

Janice Raymond warns of the dangers of technological advances like IVF that allow infertile women to have children.[247] Raymond writes, "[n]ew reproductive arrangements are presented as a woman's private choice. But they are publicly sanctioned violence against women."[248] Raymond also says this about IVF: "Represented as expanding women's choices, IVF technology . . . actually narrows the life choices of women who consume the technology."[249]

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.[250] For Kukla, it is more problematic to preserve a girl's future reproductive capacity than to let her become infertile.[251] Raymond sees more danger to women in giving them the opportunity to procreate when infertile than in withholding new reproductive options.[252]

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

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and Pediatric Care (Oct. 2008).

246. *Id.*

247. JANICE G. RAYMOND, WOMEN AS WOMBS: REPRODUCTIVE TECHNOLOGIES AND THE BATTLE OVER WOMEN'S FREEDOM (1993).

248. *Id.* at ix; *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 eds., 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, slightly more than sixty-nine percent of coronary artery bypass surgery patients were men, and slightly more than sixty-nine percent of patients who received coronary artery stents were men. AM. HEART ASS'N & AM. STROKE ASS'N, HEART DISEASE AND STROKE STATISTICS: 2008 UPDATE AT-A-GLANCE 36 (2008), 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 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 (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 (2008).

249. RAYMOND, *supra* note 247, at 86.

250. *See supra* text accompanying note 240.

251. *See supra* text accompanying note 245.

252. *See supra* text accompanying notes 247–49.

casebooks,[253] and it is one of the most frequently referenced among law review articles, with more than 438 citations since it was published as the lead article in a 1989 issue of the *Harvard Law Review*.[254] Clearly, the article and its reasoning resonate 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 161 times.[255]

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.[256] This stigma is particularly present for persons with cultural backgrounds that highly value procreation.[257] And there have been articles and books in both popular and academic publications that praise assisted reproduction for infertile persons.[258] 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,[259] arguably people with more influence in shaping public policy. Indeed, past changes in attitude about family and procreation have been driven by a

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253. PAUL BREST, SANFORD LEVINSON, JACK M. BALKIN, AKHIL REED AMAR & REVA B. SIEGAL, 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., *supra* note 44, at 854.

254. Rubenfeld, *supra* note 240 (shepardized on LexisNexis for number of citations on September 4, 2009).

255. Sunstein, *supra* note 3 (shepardized on LexisNexis for number of citations on September 4, 2009). An important *Harvard Law Review* foreword by Judge Frank Easterbrook of the U.S. Court of Appeals for the Seventh Circuit on the role of economic analysis in judicial decision making has been cited only seven more times than Rubenfeld's, even though it was published four and one-half years earlier. Frank H. Easterbrook, *The Supreme Court, 1983 Term: Foreword: The Court and the Economic System*, 98 HARV. L. REV. 4 (1984) (cited 445 times by law review articles). 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 *The Supreme Court, 1982 Term: Forward: Nomos and Narrative*, 97 HARV. L. REV. 4 (1983), have been cited more than 1,000 times. *See generally* Fred R. Shapiro, *The Most-Cited Law Review Articles Revisited*, 71 CHI.-KENT L. REV. 751 (1996) (providing a list of frequently cited law journal articles).

256. *See, e.g.*, Charlene E. Miall, *Perceptions of Informal Sanctioning and the Stigma of Involuntary Childlessness*, 6 DEVIANT BEHAV. 383 (1985); Charlene E. Miall, *The Stigma of Involuntary Childlessness*, 33 SOC. PROBS. 268, 271–272 (1986); Diana C. Parry, *Work, Leisure, and Support Groups: An Examination of the Ways Women with Infertility Respond to Pronatalist Ideology*, 53 SEX ROLES 337, 342 (2005) (reporting on infertile women who felt that they were "considered lacking, incomplete, or inadequate").

257. *See* Bagenstos, *Subordination, Stigma, and Disability*, *supra* note 61.

258. *See* 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) (analyzing narrative articles about assisted reproduction in women's magazines); JOHN A. ROBERTSON, CHILDREN OF CHOICE 29–42 (1994).

259. Cahn & Carbone, *supra* note 128, at 2.

small part of the population. In the nineteenth century, the newly developing urban middle class led the way in the decline of fertility rates.[260]

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 anticaste 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 a disability came in surprising form in *Bragdon v. Abbott*,[261] the Supreme Court's first decision interpreting the ADA.[262] 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 involved a claim of discrimination brought by Sidney Abbott, a woman with an asymptomatic human immunodeficiency virus (HIV) infection, who received dental care from Randon Bragdon in 1994.[263] During his examination, Dr. Bragdon discovered a dental cavity.[264] 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.[265] Under the policy, Ms. Abbott would have been responsible for the costs of using the hospital's facilities.[266] Ms. Abbott thereupon sued Dr. Bragdon under the ADA.[267]

The case presented two key issues for the Supreme Court: (1) 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?[268] (2) 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?[269]

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260. *Id.* at 10.

261. 524 U.S. 624 (1997).

262. The ADA is codified at 42 U.S.C. §§ 12101–12213 (2006). The Court had previously decided cases involving discrimination on the basis of disability under the Rehabilitation Act of 1973. *See, e.g.*, Se. Cmty. Coll. v. Davis, 442 U.S. 397 (1979).

263. *Bragdon*, 524 U.S. at 628–29.

264. *Id.* at 629.

265. Abbott v. Bragdon, 107 F.3d 934, 937 (1st Cir. 1997), *vacated*, 524 U.S. 624.

266. *Bragdon*, 524 U.S. at 629.

267. *Id.*

268. *Id.* at 628.

269. *See id.*

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.[270] Under the ADA, a disability is "a physical or mental impairment that substantially limits one or more . . . major life activities."[271] Thus, the definition of disability encompasses three key criteria: (1) a physical or mental impairment; (2) that substantially limits; and (3) at least one major life activity. The *Bragdon* Court concluded first that HIV infection is a physical impairment;[272] it then decided that an HIV infection substantially limits the major life activity of reproduction.[273]

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, causes damage in those cells, particularly white blood cells, and over time results in serious symptoms, including pneumonias, malignancies, and eventually death.[274] 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."[275]

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 Acquired Immunodeficiency Syndrome (AIDS).[276] In fact, it had not resulted in any of the symptoms that characterize HIV disease, whether fever, nausea, diarrhea, pneumonia, Kaposi's sarcoma, lymphoma, or other symptoms.[277] 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.[278] The Court agreed.[279] 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."[280]

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270. On the second question regarding Dr. Bragdon's justification for his infection-control policy, the Court remanded the case for further proceedings. *Id.* at 655. On remand, the court of appeals concluded that Dr. Bragdon had not offered evidence sufficient to overcome a motion for summary judgment on the issue of whether he was justified in refusing to fill Ms. Abbott's cavity in his office. Abbott v. Bragdon, 163 F.3d 87 (1st Cir. 1998), *cert. denied*, 526 U.S. 1121 (1999). The court found that the universal precautions recommended by the United States Centers for Disease Control and the American Dental Association 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. *Id.* at 89–90.

271. 42 U.S.C. § 12102(2)(A) (2006).

272. *Bragdon*, 524 U.S. at 636–37.

273. *Id.* at 641.

274. *Id.* at 636–37.

275. *Id.* at 637.

276. *Id.* at 628.

277. *Id.* at 628, 636.

278. *Id.* at 637–38.

279. *Id.* at 638.

280. *Id.*

Moreover, the Court found that HIV infection *substantially limits* a person's ability to reproduce.[281] 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—twenty percent, according to data cited by the Court.[282] Their child would also be at risk of infection—twenty-five percent of babies born to an HIV-infected mother also became infected with HIV if the mother went without treatment.[283] Even with treatment to prevent HIV transmission, a child faced an eight percent risk of infection.[284] While these risks don't make reproduction impossible, wrote the Court, they do make it "dangerous to the public health," which is sufficient to satisfy the demands of the substantial limitation requirement.[285]

Under *Bragdon*, then, infertile persons would appear to enjoy protection from denials of health care under the ADA. To an important extent, infertile persons do have this protection. If a doctor refused to provide dialysis or remove an inflamed appendix 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 primary 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 IVF or other technologies to assist reproduction, and even when insurance provides coverage, it typically is inadequate.[286] 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.[287]

B. The Failure to Recognize Infertility as a Disability Under the Law

Although *Bragdon* held that infertility is a disability under the ADA, lower courts have held that insurers do not violate the ADA when they fail to cover the costs of IVF

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281. *Id.* at 639.

282. *Id.*

283. *Id.* at 640.

284. *Id.* at 639–40.

285. *Id.* at 641. Since the Court's decision, the risk of transmission from mother to child has dropped to less than one percent if transmission-prevention treatments are followed. COMM. ON PEDIATRIC AIDS, AM. ACAD. OF PEDIATRICS, *HIV Testing and Prophylaxis to Prevent Mother-to-Child Transmission in the United States*, 122 PEDIATRICS 1127, 1129 (2008).

286. Daar, *supra* note 90, at 36; *see also supra* Part II.D.1.

287. 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) (holding that plaintiff stated a cognizable claim for sex discrimination when she alleged that she had been fired for taking time off from work to undergo IVF); LaPorta v. Wal-Mart Stores, Inc., 163 F. Supp. 2d 758 (W.D. Mich. 2001) (holding that plaintiff stated a viable claim under the ADA and analogous state laws when she alleged that she had been fired for working a restricted schedule while undergoing IVF).

or other treatments for infertility.[288] 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.[289]

Saks v. Franklin Covey Co.[290] illustrates this point well. In that case, Rochelle Saks received health insurance benefits through her employer, the Franklin Covey Company.[291] Because of infertility, Ms. Saks underwent numerous tests and tried various drugs and procedures to become pregnant, including intrauterine insemination (IUI) and IVF.[292] When Franklin Covey refused to cover the costs of her infertility care, Ms. Saks sued under the ADA to recover those costs,[293] but the district court found no ADA violation.[294] The court observed:

> 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*, . . . the Court of Appeals [for the Second Circuit], 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.[295]

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 *EEOC v. Staten Island Savings Bank*,[296]

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288. *See, e.g.*, Saks v. Franklin Covey Co., 117 F. Supp. 2d 318 (S.D.N.Y. 2000).

289. 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. Conn. Gen. 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).

290. 117 F. Supp. 2d 318 (S.D.N.Y. 2000).

291. *Id.* at 320.

292. *Id.*

293. Ms. Saks 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. Saks v. Franklin Covey Co., 316 F.3d 337 (2d Cir. 2003). Those claims failed, said the Court of Appeals for 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. *Id.* at 345–49. For a discussion of the current failure of these antidiscrimination statutes to protect infertile persons and observations for how antidiscrimination claims might succeed in the future, see Pendo, *supra* note 14, at 317–25; Brietta R. Clark, Erickson v. Bartell Drug Co.: *A Roadmap for Gender Equality in Reproductive Health Care or an Empty Promise?*, 23 LAW & INEQ. 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).

294. *Saks*, 117 F. Supp. 2d at 323.

295. *Id.* at 326–27 (discussing *EEOC v. Staten Island Savings Bank*, 207 F.3d 144 (2d Cir. 2000)).

296. 207 F.3d 144 (2d Cir. 2000).

mentioned by the *Saks* court, 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.[297] For all disabilities, benefits were available for persons who became disabled before the age of sixty, and benefits would cease when the person reached age sixty-five.[298] 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 eighteen or twenty-four months.[299] 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*,[300] the Court upheld Tennessee's cap on hospital coverage of fourteen days per year, even though it disfavored persons with disabilities, on the ground that the disabled still had meaningful access to hospital coverage.[301] 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.

The *Saks* court also cited the insurance provisions of the ADA to reject Ms. Saks's disabilities discrimination claim.[302] 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).[303] Because 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.[304]

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.[305] The ADA withdraws the

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297. *Id.* at 146–47.

298. *Id.*

299. *Id.* (describing two plans, one with an eighteen-month limit and the other with a twenty-four-month limit).

300. 469 U.S. 287 (1985).

301. *Id.* at 301. The fourteen-day cap disfavored persons with disabilities since they were more likely to require more than fourteen days of hospital care in a given year. *Id.* at 289–90.

302. Saks v. Franklin Covey Co., 117 F. Supp. 2d 318, 327–28 (S.D.N.Y. 2000).

303. 42 U.S.C. § 12201(c)(3) (2006). Under ERISA, private-employee benefit plans are subject to a uniform regulatory structure administered by the federal government. Aetna Health Inc. v. Davila, 542 U.S. 200, 208 (2004). The Act also preempts many state-benefit-plan regulations, including regulation of health-care plans. HALL ET AL., *supra* note 204, at 1031–1032. 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).

304. *Saks*, 117 F. Supp. 2d at 327–28.

305. § 12201(c)(1).

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.[306]

In sum, although infertile persons experience widespread discrimination when it comes to access to medical care for their infertility, they cannot turn to antidiscrimination 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 and 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 anticaste principle fails to reach the infertile. Rather, principles of judicial review explain why antidiscrimination 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 ADA 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.[307]

The judicial review argument draws on the work of John Hart Ely and his important procedural theory of judicial authority.[308] 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.[309] 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.[310] But sometimes, the political process operates in an unfair manner.[311] 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.[312] 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.[313] 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 because they enjoy sufficient influence in

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306. *Saks*, 117 F. Supp. 2d at 328.

307. Recall the earlier discussion about the role of the anticaste principle in understanding both the Equal Protection Clause and the ADA. *See supra* Part I.

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

309. *Id.* at 7, 87.

310. *Id.* at 102.

311. *Id.* at 103.

312. *Id.*

313. *Id.* at 102–03.

the political process.[314] 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.[315]

While initially appealing, the judicial review argument ultimately fails. As Rao recognizes, infertility crosses racial and economic lines.[316] In fact, blacks and other minorities are more likely than whites, and the poor are more likely than the wealthy, to be infertile.[317] 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.[318] Reproductive policies in the United States have long favored procreation by whites and wealthier persons and disfavored procreation by minorities and poor individuals.[319] When health-care insurance does not cover infertility treatments and couples (or individuals) must pay out of pocket, then the significant costs of these treatments mean that they tend to be reserved for wealthier, white couples who can pay for them 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.[320] 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.

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314. Coleman, *supra* note 193, at 68–69; Rao, *supra* note 193, at 1478.

315. Coleman, *supra* note 193, at 68–69; Rao, *supra* note 193, at 1478.

316. Rao, *supra* note 193, at 1478.

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

318. *Id.*; *see also* Daar, *supra* note 90, at 40, 80–81; Deborah L. Steinberg, *A Most Selective Practice: The Eugenic Logics of IVF*, 20 WOMEN'S STUD. INT'L F. 33 (1997).

319. *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, 1436–50 (1991) (discussing the history of public policies in the United States that devalued black motherhood).

320. Daar, *supra* note 90, at 38–43; Inhorn & Fakih, *supra* note 317, at 845–47; Dorothy E. Roberts, *Race and the New Reproduction*, 47 HASTINGS L.J. 935, 937–42 (1996).

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.[321] While it is true that (1) an average IVF cycle costs between $10,000 and $15,000,[322] (2) many couples will need multiple cycles of IVF before they give birth to a child,[323] and (3) many other couples will never reproduce with IVF,[324] the costs and benefits actually seem quite reasonable. Although success rates have not been high in the past,[325] they have improved considerably. According to the most recent national report, using 2006 data, a live birth resulted from 28.6% of IVF cycles using fresh embryos.[326] If each cycle costs between $10,000 and $15,000, and 28.6% of cycles are successful, then it costs between $35,000 and $52,500 for each live birth from IVF.[327]

To put that figure in perspective, consider the use of the quality-adjusted life year (QALY)[328] to measure the cost effectiveness of health care. The QALY approach takes into account improvements in both length of life and quality of life.[329] For example, one QALY equals an additional year of life at 100% quality (1 x 1.00). One QALY also results from an increase in the quality of life from 80% to 90% that lasts for ten years ((0.90-0.80) x 10).[330] While researchers often consider health care cost effective

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321. Neumann, *supra* note 201, at 1219 (referencing argument made by others).

322. David S. Guzick, Editorial, *Should Insurance Coverage for In Vitro Fertilization Be Mandated?*, 347 NEW ENG. J. MED. 686, 687 (2002); *see also* Cost of IVF at the Advanced Fertility Ctr. of Chi.: High Quality, Low Cost IVF, http://www.advancedfertility.com/ivfprice.htm; Mark Perloe, *Duration, Cost of IVF Treatment*, YOUR TOTAL HEALTH, http://yourtotalhealth.ivillage.com/duration-cost-ivf-treatment.html.

323. Beth A. Malizia, Michele R. Hacker & Alan S. Penzias, *Cumulative Live-Birth Rates After In Vitro Fertilization*, 360 NEW ENG. J. MED. 236, 237 (2009).

324. *Id.* at 240 (finding that at least twenty-eight percent of women who undergo IVF will not give birth to a child via IVF).

325. RAYMOND, *supra* note 247, at 9–11 (reporting live birth rates below ten percent from IVF).

326. CTRS. FOR DISEASE CONTROL AND PREVENTION, 2006 ASSISTED REPRODUCTIVE TECHNOLOGY SUCCESS RATES: NATIONAL SUMMARY AND FERTILITY CLINIC REPORTS 19 (2008), http://www.cdc.gov/ART/ART2006/508PDF/2006ART.pdf [hereinafter, CDC, 2006 ART REPORT]. "Fresh" embryos are distinguished from cycles in which the embryos have been frozen and thawed before transfer to the woman's uterus. Success rates with frozen, nondonor embryos are lower than with fresh embryos. *Id.* at 54.

The likelihood of success is much higher for a woman younger than thirty-five years of age than for a woman who is forty or older. With fresh embryos, thirty-nine percent of women younger than thirty-five have a live birth from an IVF cycle, while only eleven percent of women who are forty-one or forty-two and four percent of women older than forty-two have a live birth. *Id.* at 30.

327. If each cycle costs $10,000 to $15,000, then 100 cycles will cost $1 million to $1.5 million. Of those 100 cycles, 28.6 will result in a live birth. Thus, the cost of a successful cycle is $1 million to $1.5 million divided by 28.6, or $35,000–$52,500.

328. QALY is pronounced like "kwallee."

329. *See* David C. Hadorn, *The Oregon Priority-Setting Exercise: Quality of Life and Public Policy*, HASTINGS CENTER REP., May–June 1991, 11, 13.

330. *Id.* at 13. QALYs are a widely used measure in health care. The United Kingdom, for example, uses QALYs as its measure of cost effectiveness in deciding whether to provide

when it can provide one QALY for less than $50,000, some experts deem medical care cost effective up to $100,000 for an extra year of life, and data suggest that the public may support even higher costs per QALY.[331] Thus, if a live birth from IVF were to produce at least one QALY, it would be deemed cost effective according to current views.

There are two ways in which reproduction produces additional years of high-quality life. First, for the parents, there will be an increase in their quality of life.[332] If reproduction restores an infertile woman's mental health, then for many years thereafter, her quality of life will be higher. Second, reproduction produces additional QALYs through the lives of the children it creates. One could say that the birth of a healthy child yields one QALY for every year of the child's life as long as the child remains healthy, and less than one QALY for each year in which the child is ill or injured.[333]

Data from Massachusetts also indicate that IVF coverage is an affordable component of health-care insurance policies.[334] In 1987, Massachusetts enacted its mandate for coverage of infertility services, including IVF.[335] Researchers who examined the impact of the mandate on insurance premiums through 1993 found that the costs of coverage for infertility services accounted for no more than about four-tenths of a percent of total expenditures for health care by insurers in the state.[336] Experience in other countries illustrates the affordability of coverage for IVF. France provides full coverage for IVF,[337] and Israel has also shown that IVF can be covered with a much smaller budget for health care.[338] In Israel, the national health service covers IVF (and other assisted reproductive services) for all women up to age forty-

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coverage for a new treatment as part of its national healthcare plan. Michael D. Rawlins & Anthony J. Culyer, *National Institute for Clinical Excellence and Its Value Judgments*, 329 BRIT. MED. J. 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, *supra* note 329, at 13–16. Also, QALYs can disfavor persons with disabilities. Philip G. Peters, Jr., *Health Care Rationing and Disability Rights*, 70 IND. L.J. 491, 500–05 (1995).

331. *See* Richard A. Hirth, Michael E. Chernew, Edward Miller, Mark Fendrick & William G. Weissert, *Willingness to Pay for a Quality-Adjusted Life Year: In Search of a Standard*, 20 MED. DECISION MAKING 332, 333, 339–40 (2000).

332. Recall the high levels of depression in infertile women. *See supra* Part II.A.

333. To be sure, this second claim is more controversial since the new child's life does not exist when the costs of IVF are incurred. Moreover, for someone who believes that the world is overpopulated, more children have a negative social value. Nevertheless, society cannot exist without procreation, and that demonstrates a positive social value for children. Skinner v. Oklahoma, 316 U.S. 535, 541 (1942) ("Marriage and procreation are fundamental to the very existence and survival of the race.").

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

335. *Id.* at 23.

336. *Id.* at 27.

337. L. Garceau, J. Henderson, L.J. Davis, S. Petrou, L.R. Henderson, E. McVeigh, D.H. Barlow & L.L. Davidson, *Economic Implications of Assisted Reproductive Techniques: A Systematic Review*, 17 HUM. REPROD. 3090, 3090 (2002).

338. *See* Birenbaum-Carmeli & Dirnfeld, *supra* note 171.

five, until a woman has had two children with her current partner.[339] 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.[340] Israeli women also enjoy generous child support payments and maternity leave benefits.[341]

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.[342] As discussed, 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,[343] 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 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,[344] or ten times the cost of infertility coverage in Massachusetts after private insurers were required to cover infertility treatment.[345] 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. The existence of such claims, however, 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. And, as discussed, economic and other considerations have

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339. *Id.* at 182–83.

340. *Id.* at 184.

341. *Id.* 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.* For more information about the abortion committee process, see Delila Amir & Orly Biniamin, *Abortion Approval as a Ritual of Symbolic Control*, 3 WOMEN & CRIM. JUST. 5 (1992).

342. 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. John V. Jacobi, *Parity and Difference: The Value of Parity Legislation for the Seriously Mentally Ill*, 29 AM. J.L. & MED. 185, 192–93 (2003). 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. *Id.*

343. *See supra* notes 215–19 and accompanying text.

344. Tami L. Mark, Katharine R. Levit, Jeffrey A. Buck, Rosanna M. Coffey & Rita Vandivort-Warren, *Mental Health Treatment Expenditure Trends, 1986–2003*, 58 PSYCHIATRIC SERVICES 1041, 1043 (2007).

345. *See* Griffin & Panak, *supra* note 334.

led people to view childlessness as much more desirable than it was viewed in previous generations.[346] 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.[347] 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.[348]

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. For example, many women are infertile because of scarring from a ruptured appendix, a pelvic infection, or endometriosis.[349] In addition, most users of IVF are thirty-five years or younger, and more than eighty percent are forty years of age or younger.[350] If couples are being blamed for their infertility, one would expect such blame to be reserved for couples over age forty. Also, studies of infertile persons do not find that expressions of blame from others are prominent.[351] Finally, if denial of coverage were driven primarily by bias against couples that have delayed childbearing, then we would expect to see IVF covered until a specific age cutoff (whether thirty-five, forty, or another age), just as Israel covers infertility treatments only until a woman reaches age forty-five.[352]

CONCLUSION

The anticaste 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 anticaste principle falls short as an antidiscrimination 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

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346. *See supra* Part II.C.

347. GREIL, *supra* note 187, at 127.

348. Alison Chapple, Sue Ziebland & Ann McPherson, *Stigma, Shame, and Blame Experienced by Patients with Lung Cancer: Qualitative Study*, 328 BRIT. MED. J. 1470 (2004).

349. *See supra* Part II.A.

350. CDC, 2006 ART REPORT, *supra* note 326, at 25.

351. *See supra* Part II.D.1.

352. Birenbaum-Carmeli & Dirnfeld, *supra* note 171, at 183.

persons are dismissive of their complaints,[353] and individuals whose functioning is hampered by depression may be told to stop whining and pull themselves together.[354]

Currently, antidiscrimination law does not provide adequate protection against discrimination on the basis of dismissiveness. The failure of antidiscrimination 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 antidiscrimination 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 antidiscrimination theory and doctrine, both under the Equal Protection Clause and statutes like the Americans with Disabilities Act.

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

354. 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.