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Citation: 33 Whittier L. Rev. 27 2011-2012

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WHAT SHOULD INSURANCE INSURE IN THE *PPACA* AGE? ON PAYING FOR OTHER PEOPLE'S REPRODUCTIVE DECISIONS AND AMBITIONS

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I. TITLES: WHAT THEY REVEAL BY WHAT THEY HIDE (AND VICE VERSA).

Think of the title of *The Patient Protection and Affordable Care Act* (“*Act*” or “*PPACA*”).¹ It is tendentious, as legislative titles often are. Its characterizations assume much of what is contested within the major issues it purports to address. With a title like *PPACA's*, the constituent labels may not only beg the major questions, they may affirmatively hide matters of strong interest. Under this *Act*, who is protecting whom from what? Are we indeed being protected, or placed at risk, or both? In what respects? Exactly what risks are we talking about? Affordable care of what sort? Affordable to whom? Why should one person or group pay for another person's or group's care?

One can get too fundamental for the occasion. I am not going to ask why anyone should ever care about anyone else, or debate why things should ever be taken from one person and given to another.

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1. *Patient Protection and Affordable Care Act*, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 42 U.S.C), available at <http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/html/PLAW-111publ148.htm>.

Within the confines of this space, I assume much of the world as it is: We compromise each other's liberty and property to promote overall welfare—an overall welfare that *itself includes* (we hope) greater liberty and property. Attacking/defending the minimal state² is beyond the scope of this Article. All I say here is that the new *Act* is an occasion (and perhaps even embeds an obligation) for us to rethink aspects of insurance—the basic concept, its application to health care, and, in this portion of the Whittier Health Care Symposium, whether and how it should embrace reproductive decisions—which, after all, are largely driven by our inclinations to procreate, not to promote our health.³ (All parents know there is an inverse link between the two.)

Rethinking insurance in the reproductive context is somewhat difficult to do via the *Act*, at least in any specific way, because reproductive rights and stem cell research are only obliquely addressed within it.⁴ But this symposium is more than a matter of line-by-line analysis of the *Act*; it is an occasion to ask after the nature and purpose of health insurance. We are presented with a somewhat garbled, strangled shout-out in this *Act*, and we ought to study the properties of this national but very fractured and uncertain commitment. It is no surprise we are of different minds—even within a given person—about the *Act*, because it seeks to bridle nearly (or completely) intractable moral and political disputes. The *Act* is less a lens through which we examine ourselves than a bent mirror. But it is what we have and we should use it for reanalysis and clarification of our views.

2. John Hasnas, *Reflections on the Minimal State*, 2 POL., PHIL. & ECON. 115, 116 (2003), available at http://faculty.msb.edu/hasnasj/GTWebSite/06_Hasnas.pdf.

3. For a more extensive effort (but which does not directly address reproductive issues), see Allison K. Hoffman, *Three Models of Health Insurance: The Conceptual Pluralism of the Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1873, 1873 (2011) (discussing models of health promotion, financial security from health risks, and a “brute luck” approach that stresses unavoidable risks “that do not arise from individual behavior”).

4. The Independent Payment Advisory Board, established in section 3403 of the *Act*, might address these issues. For a discussion of the Board, see Henry J. Aaron, *The Independent Payment Advisory Board—Congress’s “Good Deed,”* 364 NEW ENG. J. MED. 2377 (2011). On the *Act*’s treatment of abortion, see Roy G. Spece, Jr., *The Purpose Prong of Casey’s Undue Burden Test and its Impact on the Constitutionality of Abortion Insurance Restrictions in the Affordable Care Act or its Progeny*, 33 WHITTIER L. REV. 77.

II. INTRODUCTION

One general question about health care insurance concerns what it in fact *does* cover, whether this is determined by a government insurance plan (as in Medicare), the private market, or by some interplay between government direction and the insurance market. The linked general question is of course what it *should* cover.

The latter question leads to more particular inquiries about whether medical insurance should cover reproduction and related matters. To pursue these inquiries, I comment on several overlapping considerations: the role of disorder models within the insurance domain generally, and their particular application to reproduction and infertility; the significance of the drive to procreate and how it fares against scarce resource constraints; and arguments for and against insurance coverage for infertility treatments—including the anti-insurance argument that we should avoid objectification caused by technologized reproduction, the pro-insurance argument that we should avoid the “dismissal” of the infertile, and another pro-insurance stance holding that reproduction benefits the unconceived, thus avoiding a “genesis” problem. There are also discussions comparing infertility treatment to technological enhancement of human traits, and asking whether constitutional constraints on state action apply to some private insurance actions and to some government inaction in that field.

To begin: not all reproductive matters involve decisions within the disorder model—the justificatory scheme that is the most persuasive for insurance coverage. The decision to have a child is not a medical decision to cure a disorder or repair an injury. But making such a decision generally involves the broader “medical” model because professionals are necessarily involved—medically, as in childbirth, or legally, as in artificial insemination by donor (“AID”).⁵ (Even there, genetic and medical screening is required.) Health care insurance is certainly expected to cover pregnancy-related illnesses, and in fact it generally covers even the normal medical expenses of pregnancy and childbirth, even though most pregnancies are elective and to be pregnant is not automatically to be in a disease state

5. In California, for example, it is necessary to comply with statutory requirements for the physician’s role in order to assure proper assignment of parentage, anonymity, etc. See, e.g. CAL. FAM. CODE § 7613 (West Supp. 2011).

(although it may seem that way to some pregnant women and those nearby).

But what about technologically assisted reproduction and the possibly unusual interpersonal relationships that may be involved with it? If someone is missing a uterus, should insurance cover the costs of egg extraction, fertilization, and the surrogate gestator's pregnancy and the delivery of the child? What about In Vitro Fertilization ("IVF") in multiple cycles? Sooner or later we will be faced with artificial wombs, and, even more spectacularly, germ line enhancement and cloning. Assuming for the sake of argument that they are not banned (and it is not clear constitutionally that this would be valid across the board), what should the insurance profile be? These mechanisms aren't going to be do-it-yourself projects; medical and "bioengineering" services will be indispensable.

Insurance, of course, is not the only way in which we communally assist and threaten each other. We collect funds and redistribute them to provide safety nets for retirement (perhaps a form of insurance against longevity), to build and maintain roads, and to finance official government Fourth of July celebrations. This isn't about insurance, and it is well to understand that denying that some need or preference is medically insurable does not entail that it is not otherwise insurable, or if not insurable, then subject to community financing. We pay taxes to have trash collected and, for the most part, do not worry over the fact that some persons who cannot afford private trash collection are benefiting from other people's money being taxed and spent. (Perhaps the externalities of trash uncollected from the less affluent may have something to do with this.) Thus, we may well decide that enhancing the abilities of a nondisordered person has no direct connection with disorder and should not be publicly funded via "health insurance," but we can still envision its funding through other systems of public support. Whether it is appropriate to refer to this as some sort of "social insurance" I leave aside.

III. INSURANCE: A CENTRAL PARADOX.

Insurance is a way to protect ourselves by *assisting each other* through sharing risks. Because this involves paying things into a pool, the very process of assisting each other also entails that we have to *protect ourselves against each other* by controlling what risks we insure against and thus limiting how much we have to pay for them in

premiums and other costs. We necessarily both threaten and benefit each other through insurance; this is intrinsic to the institution. We could in theory pool risks to protect ourselves against practically anything, but this would be prohibitively expensive and complex: imagine insurance against having a bad day, or against contracting a bad marriage.

In any case, insurance involves multiple reciprocities: it is a social mechanism in which others both protect you (they pay premiums to cover your health) and endanger you (some of them get really sick and your premiums are high because of that).

We thus need to ask a focused set of questions: With insurance, who are we protecting against what—and whom? Again, when we talk about insurance, part of what we necessarily address is protecting ourselves against each other’s “excessive” needs, medical or otherwise. But with health insurance in particular, how much does the “otherwise” cover? Which needs or wants do we *not* want “health insurance” (or perhaps *any* insurance or any social program) to cover?

To set up the nature of our choices here in a simple way, review some terse but serviceable definitions:

Insurance: “A contract whereby, for specified consideration, one party undertakes to compensate the other for a loss relating to a particular subject as a result of the occurrence of designated hazards.”⁶

Health insurance: “Insurance against loss by illness or bodily injury. Health insurance provides coverage for medicine, visits to the doctor or emergency room, hospital stays and other medical expenses. Policies differ in what they cover, the size of the deductible and/or co-payment, limits of coverage and the options for treatment available to the policyholder.”⁷

One critical indeterminacy in the idea of health insurance of course rests on what “health” covers, and this is related in complex ways to the familiar set of related (but not necessarily synonymous) terms: disease, disorder, sickness, ailment, illness, affliction, disability,

6. THE FREE DICTIONARY, <http://legal-dictionary.thefreedictionary.com/insurance> (last visited Dec. 31, 2011).

7. INVESTERWORDS.COM, http://www.investorwords.com/2289/health_insurance.html#ixzz1IuLDkHo9 (last visited Dec. 31, 2011).

defect, injury, trauma, etc. (I offer no theory of linkage among these concepts.) “Health care insurance” could in theory be primarily about medical needs that affect daily economic *functionality*—doing *at least* what we need to survive and earn a living. Or it could also embrace a kind of *medical implementation insurance* that goes beyond the health or medical or disorder model and insures against needs that require medical mechanisms but do not derive from disorder or disorder-like conditions. For example, insurance that covers physician attendance and antibiotics for strep throat is straightforward medical insurance, but insurance that covers the medical costs of normal pregnancy and childbirth is medical implementation insurance. Insurance that covers cosmetic surgery for aging rather than injury-caused disfigurement is medical implementation insurance (unless we decide to place all age-related changes within the disorder mantle). Insurance that covers difficulties in reproduction often straddle the disorder/nondisorder line. Think, for example, of IVF for a couple who cannot conceive and no individual anomaly, disorder or not, is detectable. *Something* is wrong—a “mating anomaly?”

A central aspect of many reproductive difficulties is that although medical problems may make reproduction difficult or impossible, inability to reproduce does not by itself mean that one is unhealthy in the sense of not being able to function in society.⁸ Nor does the underlying pathology ordinarily make one less fit for daily functioning. How should this affect insurability issues concerning medical implementation of reproductive plans? One can function without being a parent and without having a fully intact reproductive system. But reproduction is linked, with or without medical implementation, to overall human thriving—as is just plain health care. (To be sure, inability to reproduce may have serious, adverse psychological effects that may constitute disorders. It does not follow, however, that assisting reproduction should be an insurable “therapy” of choice.)

8. But note that inability to reproduce is considered a disability under the *Americans with Disabilities Act*, 42 U.S.C. § 12102(2) (2006), *amended by ADA Amendments Act of 2008*, Pub. L. No. 110-325, § 3(2)(B), 122 Stat. 3553, 3555 (2008). See *infra* note 51 and accompanying text.

IV. WHY IS HEALTH INSURANCE SUCH A BIG DEAL? BECAUSE IT COSTS SO MUCH. WHY DOES IT COST SO MUCH? BECAUSE HEALTH CARE IS SO EXPENSIVE. WHY IS IT SO EXPENSIVE?

“The question thus presented is, we think, of great importance, but not of much difficulty.”⁹

Rethinking health insurance generally, as well as its application to reproduction, benefits from being clear on why health care expenses have risen so far and so fast over the decades. This rather impressive escalation of costs is the dominant reason that insurance is so urgently needed—a nice irony, since insurance has greatly contributed to cost inflation. There is a monumental cycling involved here in which certain factors drive up costs, inspiring the need for insurance, which in turn accelerates the inflation.

Of course, it doesn’t tell us that much to say that the uncertainty, amount, and incidence of health care costs account in part for the explosive growth of health care insurance. Medical cost increases didn’t just arise *ex nihilo*. What happened, exactly?

It would take a highly trained economist or other relevantly trained “quant” to give a full and rigorous (if uncertain) account of why health care costs so much, but the bones of the analysis are clear enough:¹⁰

1. Largely because of scientific advances and technological implementation, medicine *works* in ways it did not prior to mid-twentieth century. Even when it doesn’t work well, its potential may seem impressive. (No broad claims made here on medical

9. *Barron v. Mayor & City Council of Baltimore*, 32 U.S. 243, 247 (1833).

10. See generally PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 259-61 (1982); VICTOR R. FUCHS, *THE HEALTH ECONOMY* 17-22, 257-59, 281-86 (1986) (discussing growth of consumer income and the “technological imperative”, the impact of insurance on demand for health care services, and, “Imperfectly Competitive Markets”); JOHN G. CULLIS & PETER A. WEST, *THE ECONOMICS OF HEALTH: AN INTRODUCTION* 259 (1971) (discussing the impact of insurance and restrictions on size of the medical profession); PHILIP JACOBS, *THE ECONOMICS OF HEALTH AND MEDICAL CARE: AN INTRODUCTION* 87, 116 (1980), mentioning insurance and the “moral hazard” of “increased quantity demanded”, and discussing technological innovations and the need for capital investment in equipment, and, for expenditures on highly trained personnel to operate them); CAM DONALDSON & KAREN GERARD, *ECONOMICS OF HEALTH CARE FINANCING: THE VISIBLE HAND* 26-48 (1993) (“Market Failure in Health Care”); *What Drives Up Health Care Costs?*, THE REGENGE GROUP, <http://www.regence.com/transparency/regence-and-reform/what-drives-up-health-care-costs.jsp> (last visited Dec. 31, 2011).

effectiveness.) So, the demand for medical care soared. Before the vast acceleration of scientific medicine, few people worried about insurance because medical care was less expensive, and you got pretty much what you paid for, which was very little, unless it involved relatively longstanding forms of treatment (lancing boils, setting broken bones). Physicians might be able to tell you what you suffered from and what to expect by way of suffering and dying, but offer no effective treatments beyond minor palliatives. I suppose this was a comfort to many.

2. Demand grew, and grows, faster than supply, for many reasons, including

- the physician/professional monopoly;
- the time requirements and costs, financial and otherwise, of medical/scientific training;
- the costs and time required for gathering and distributing medical services, and manufacturing and distributing medical tools, including pharmaceuticals and machines.

3. The technology itself is expensive. Investors must recoup costs, manufacturers and materials must be secured and paid for, workers and distributors must be compensated, etc. The need for hospitalization may increase with some technologies and decline with others.

4. Per capita income has grown, allowing demand for health care to rise, both absolutely and proportionally.

5. The very system of insurance called for by the costs of health care further—and hugely—drives up costs because of the incentive effects of the three-party institution. Third party payment skews and skews much of the incentive logic that could otherwise keep medical costs down. Patients have lesser incentives to reduce their calls for health care services, or to try to reduce their very need for such services by choosing healthier lifestyles, and physicians continue to have incentives to resolve doubts in favor of providing costly services. Insurance companies earn their livings by maintaining such incentives. Of course, incentives may be perverse in pure fee-for-service contexts too: physicians have strong incentives to increase the number of patient visits, although this might be countered by a penalty/bonus system for keeping costs down in managed care contexts. The only rational goal is to find the least-worst system.

6. Within the insurance system, the insurer's incentives are to insure the healthy and reject the unhealthy and those at risk for becoming so, thus relegating many of the uninsured to emergency or urgent care services, which are generally more costly. The healthy have an incentive not to insure at all, which pushes premium costs up for the insured—both the healthy and the less healthy who manage to acquire insurance.¹¹ Of course, altering these incentives is part of the very rationale of the *Act*.

7. There are substantial and often inevitable costs of maintaining the huge institutional bureaucracy of insurance and the accompanying needs for screening, verification, documentation, and so on.

8. The delivery of health requires substantial facilities and investments in them—offices, hospitals, clinics, and the like, and they also generate bureaucratic costs.

9. Murphy's law (if anything can go wrong it will) and variants of Parkinson's law (work expands to fill the time—and opportunities—available) are all still on the books, and heavily enforced. So is the Peter Principle (workers are promoted to their level of incompetence). Thus, things tend to be run stupidly and inefficiently.

So, we have insurance because we need it, and having it makes us need it all the more. A positive feedback loop of this sort is not necessarily a paradox, but in this instance it is troublesome enough whatever we call it.

V. HEALTH INSURANCE AND THE MEDICAL DISORDER MODEL.

A. IN GENERAL.

By “model,” I mean an abstract template or guide in pursuing some task, whether descriptive, evaluative, or of the how-to-do-X variety. By “disorder model,” I refer to a justificatory guidance system that authorizes or rejects certain physical or behavioral interventions into human physiology or conduct, where the justification is based on

11. See *Adverse Selection and Cream Skimming*, HEALTHINSURANCE.INFO, <http://www.healthinsurance.info/HISEL.HTM> (last visited Dec. 31, 2011) (for an everyday definition of “adverse selection”). A small terminological point: persons who are at risk for becoming unhealthy might be said to be already unhealthy, but not flordily so.

the supposed presence or risk of disorder, disease, illness, injury, trauma (etc.).¹²

What explains the model's moral and political governance?

To probe deeply into the exact formulation and evaluation of such models would be to enter a scholarly wormhole. I avoid this and simply illustrate the idea. Cutting someone with a sharp instrument to remove a diseased appendix follows a disorder model, while doing so to exact revenge or just for the hell of it does not. (The basic notion of a disorder model does not embed autonomy and informed consent considerations. They appear in more complex models of how to implement disorder models.) The moral analysis of disorder models will come up, somewhat obliquely, in the next section, when we explore its limits in health insurance. For now, accept the point that the medical disorder model underlies health insurance in the sense that we insure against the harms of disorder, illness, injury, and the like, and not against the general misfortunes of life. That is another area of insurance, if there is to be insurance at all, or of social redistributive measures to promote overall welfare.

There are obvious questions about the scope and limits of the disorder model. It is not clear what should be considered "disordered" as opposed to simply "varying from the norm." Is myopia a disorder or just an "anomaly" of natural variation? Does it depend on the setting? Does disorder always involve some compromise of human functioning?¹³ In assessing human needs, we sometimes use a standard of adequate functioning and well-being, and institute some degree of insurability for natural variations, sometimes without precise diagnostics. (Think of insurance for certain learning disabilities.) If health insurance coverage for vision tests and spectacles promotes traffic safety and economic efficiency (having lots of people being able

12. For example, a memory pill for an Alzheimer patient would operate within a disorder model; a memory pill for a person of ordinary intelligence and memory would operate within a pure enhancement model, not a disorder model. Someone who used infertility treatments because of a medical problem interfering with reproduction might justify this within a disorder model; someone who used it because of a desire for triplets rather than singletons could not do so.

13. The literature on the nature of disease is quite extensive. *See, e.g.*, CONCEPTS OF HEALTH AND DISEASE: INTERDISCIPLINARY PERSPECTIVES (Arthur L. Caplan, H. Tristram Engelhardt, Jr., & James J. McCartney, eds., 1981).

to read is good for the economy), we move in that direction, although with eyes and eyeware, insurance remains pretty uncertain.¹⁴

There are many examples of insurance coverage for conditions that do not themselves threaten health but are disorder-connected and affect lifestyle, our sense of well-being, or even our national economic health—e.g., common learning disabilities. Think also, for example, of breast reconstruction measures following surgical treatment for cancer. Amelioration of scarring after burns or injuries is another illustration. Surgery to transform one’s look from one ethnicity to another is not. Treatment—when it becomes available—that significantly improves impaired mental functioning caused by various age-related dementias, or by intelligence-impairing disorders (Down syndrome, fragile-X syndrome, head injuries) is clearly within the disorder model. Enhancements that simply raise performance abilities, mental or physical, are clearly not. One overarching question of course is whether disorder models *ought* to be invoked to limit our rights to secure enhancement.¹⁵ There is strong sentiment against such personal augmentation, partly because it seems to make conceptual and moral hash of the ideas of disorder and health. But if we are to have an enhancement regime at all, another dominating question is whether some system of public financing should make such enhancements available. Such financing, however, doesn’t seem to be a matter of health insurance as such.

B. THE MORAL CONTENT OF THE DISORDER MODEL.

As we saw, it’s easy to illustrate, if not to explain, the moral pull of the disorder model. It is also easy to misuse the model, partly because of that pull. Here is a headline from a Los Angeles Times editorial: “*Ban the circumcision ban: If cities such as San Francisco were allowed to determine which medical procedures were acceptable and which ones weren't, we'd be left with a ridiculous patchwork of*

14. See, e.g., *Insurance Coverage For Eye Exams*, TOTAL FOCUS: KINGSWAY OPTOMETRY, <http://www.kingswayoptometry.com/insurance-coverage-eye-exams/> (last visited Dec. 31, 2011) (no routine coverage for eye exams for adults from ages 19 – 64. However, specific insurance for vision assistance is available); *Eyesight Insurance coverage – Do You Need It?*, UFVENTURE.COM (May 22, 2011), <http://www.ufventure.com/articles/eyesight-insurance-coverage-do-you-need-it.php>.

15. “Enhancement” in this context refers to technological enhancement.

rules.”¹⁶ Of course, the driving force behind most circumcisions is not preventive health, although such benefits are touted. It is pursued in significant part, though far from exclusively, within religious traditions.¹⁷ The justification for requiring the surgical procedure to be performed by a trained professional (not necessarily a physician/surgeon) is ordinarily linked to the disorder model only because of implementation risks, which of course arise only after the threshold stage of deciding on whether to circumcise at all. The implementation stage deals with what might be called an engineering model designed to avoid medical disasters: *If you want to X (say, peel a foreskin) then do Y, with the constraint that doing Y requires someone properly trained.*¹⁸ Whether you *should* want X is an entirely different question, influenced by different models. (I have no model for choosing models.) The procedure thus requires expert intervention as a second-stage matter, but not a disorder-model-based justification for the first stage. When at the first stage, of course, rational actors would consult experts, and if they forecast serious trouble, this would spill over into whether the initial non-medical justification could be defeated by implementation risks. The threshold and implementation stages aren’t conceptually walled-off from each other.

The foundational moral grounds underlying the disorder model cannot be fully explored here, but one major component concerns the benefit-harm tradeoffs for intruding into body and mind. These comparisons are informed by moral considerations and cultural norms. Cutting people open is not generally good for them, but it is worth the risk if the point is to control injury or disorder. And we *ought* to

16. Editorial, *Ban The Circumcision Ban: If Cities Such As San Francisco Were Allowed to Determine Which Medical Procedures Were Acceptable and Which Ones Weren't, We'd Be Left With a Ridiculous Patchwork of Rules*, L.A. TIMES, June 24, 2011, available at <http://articles.latimes.com/print/2011/jun/25/opinion/la-ed-circumcision-20110525>.

17. *Sexual Conditioning Health Center: Circumcision Basics*, WEBMD, <http://www.webmd.com/sexual-conditions/guide/circumcision> (last visited Dec. 31, 2011); *History of Circumcision*, http://www.historyofcircumcision.net/index.php?option=com_content&task=category§ionid=9&id=74&Itemid=53 (last visited Dec. 31, 2011) (the primary religious groups involved are Jews and Muslims); Editorial, *supra* note 16.

18. See generally Ezekiel J. Emanuel & Linda L. Emanuel, *Four Models of the Physician-Patient Relationship*, 267 JAMA 2221 (1992) (exploring models of physician-patient relationships).

control injury or disorder on a variety of moral grounds, both consequentialist and nonconsequentialist.

We are now set up to begin the inquiry into health insurance and reproduction.

VI. THE FERTILE AND REPRODUCTION

We can start with an ultimately doomed effort at simplicity. Try out this claim: Human reproduction, being inspired by matters having no direct connection to health and disease, is simply beyond the scope of health insurance. Certainly, the costs of monitoring and addressing the “normal ills” (not an oxymoron) of pregnancy, childbirth, and neonatal care are not a matter of “health” insurance. As for problem pregnancies and births—the progenitors-to-be assumed the risks. However, in the interests of consistent use of a disorder model and in deference to our strong drives to reproduce, perhaps we can insure, at most, serious medical problems induced by reproductive efforts.

But we don’t generally go this far in excluding reproduction from the insurance sphere; we don’t *only* insure against medical problems in pregnancy and childbirth. Health insurance policies generally cover the costs of both normal and impaired pregnancies, of childbirth simple and complex, and of various post-childbirth needs, both disorder and nondisorder-based.¹⁹ Why should this be? Of course, it is a bad thing to come down with shingles, and a catastrophe to come down with pancreatic cancer. But if we come down with pregnancy? Why are we paying premiums for someone else’s decisions—not to get medical care for disease or injury—but to have children? Having children is not appropriate therapy for the disorder of desiring to reproduce. To be sure, one can be overcome to the point of madness with obsession over procreation—or anything else—but it seems far-fetched to think that all but a few who resort to IVF or AID or surrogacy suffer from obsessive-compulsive disorder. In any case, people with OCD have procreative interests and rights too.

How do we explain why we operate within a conceptually mixed-up system of reproductive insurance? One answer seems to be that we

19. See generally Karen Pollitz, Mila Kofman, Alina Salganicoff & Usha Ranji, *Maternity Care and Consumer-Driven Health Plans*, KAISER FOUNDATION (June 2007), available at <http://www.kff.org/womenshealth/upload/7636.pdf>. Insurance coverage concerning pregnancy is addressed in the *Patient Protection and Affordable Care Act*, Pub. L. No. 111-148, §§ 10211-10214, 124 Stat. 119, 931-35 (2010).

don't live entirely by a pristine disorder model, but under a broader model embracing the idea that important enterprises inevitably trigger the need for serious medical intervention. Reproduction is about as natural an enterprise as humans engage in (true even when we didn't know how reproduction came about), and although no individual act of reproduction is (at the moment) necessary for human survival, some reproduction does seem required at some point if humankind is to continue. (Even for completeness, I'm not going to discuss the moral merits of humanity's continued existence.) Whether humanity's survival is worth striving for is not on point. The fact is that most of us will reproduce and, assuming affordability (a big "if"), doing so without *some* professional health care assistance would generally be ill-advised. Widespread offerings of health insurance for the medical costs of even non-complex pregnancy and childbirth are thus no surprise, even though the justification for such insurance doesn't strictly follow as a logical deduction simply from premises about the importance and (mixed) popularity of procreation.²⁰ Moreover, most of us do not view reproduction as an unfortunate necessity, but as something both desirable and the result of a human impulse that is in general not going to be resisted. For present purposes, the possibility that any given act of reproduction is irrational is irrelevant.

Still more, the right to reproduce is widely believed to be a basic human right, although this is highly qualified in some cultures.²¹ For the most part, the protection of a fundamental right entails that

20. See generally *Female Reproductive Health Coverage*, <http://www.arhp.org/uploadDocs/HealthcareAccessSurvey.pdf> (last visited Dec. 31, 2011) (arguing that, "[a] national survey of benefits managers reveals that reproductive health coverage in many US companies is broad, but not deep. While common products such as oral contraception are almost universally covered, newer products are less likely to be available and benefits managers are relatively uninformed about advances in reproductive health. Moreover, benefits managers believe that their reproductive health coverage is excellent or good, yet there is a clear gap in coverage between new procedures and the traditional, more common procedures.").

21. Population and Family Planning Law of the People's Republic of China (Order of the President No.63)(promulgated by the Standing Comm. of 9th Nat'l People Cong., Dec. 29, 2001, effective Sept. 1, 2002) 2001 STANDING COMM. NAT'L PEOPLES CONG., available at http://www.gov.cn/english/laws/2005-10/11/content_75954.htm; *No Relaxation of Chinese 'One Couple, One Child' Policy: Official*, PEOPLE'S DAILY ONLINE (Sept. 2, 2002), http://english.peopledaily.com.cn/200209/01/eng20020901_102440.shtml.

government actors are not to inquire into the rationality of the decision to exercise the right, whether at all or in certain ways.

Reproduction is not the only field in which we support health insurance for medical interventions *not* occasioned by decisions taken within a disorder model. Any socially important activity posing serious medical risks is nevertheless likely to be encouraged and ratified by providing *some* mechanism for dealing with health impairments. Without begging any questions about the quality of care, we can point to post-service treatment of (at least) war-related injuries of veterans. We might even point to insurability against road accidents: motorized locomotion is both dangerous and important. We are far less likely to complain of noncoverage for persons like Evel Knievel, the late daredevil.²²

So, all things considered, it's presumptively desirable, normal and species-necessary to have children. Even if pregnancy isn't a disorder, we apply for medical insurance to deal with it.

VII. THE INFERTILE²³ AND REPRODUCTION

A. *THE DISORDER FILTER.*

In this short work, my approach is, in part, to explain what something is by examining what it is not. We learn more about why we insure against adverse health events by examining why we do not insure against certain non-health mishaps. We are now at the point, within the framework of this presentation, where the limiting and authorizing aspects of the disorder model face off. Health insurance is meant to filter claims for insurance payoffs through the disorder model gate—but it is far from a simple screening mechanism. The standards

22. See *Evel Knievel*, WIKIPEDIA, http://en.wikipedia.org/wiki/Evel_knievel (last visited Dec. 31, 2011) (stating that Knievel reported difficulties in securing life and accident insurance, and hospitalization coverage).

23. "(In)fertility" designates a variety of conditions and degrees of seriousness. To some extent, whether certain forms and levels of burden on procreation are rightly considered matters of infertility is a value or policy issue. "There are degrees of infertility. The majority of infertile couples are actually sub fertile – they produce eggs and sperm but have difficulty conceiving due to disorders such as hormone imbalances and problems of the reproductive tract. Cases of total infertility – where no eggs or sperm are produced – are rare." Shae-Lee McArthur, *Infertility*, ABC (May 30, 2007), <http://www.abc.net.au/health/library/stories/2007/05/30/1919840.htm>.

affecting the filter are perhaps more determinate than those used by a night club doorman, but the comparison does come to mind.

If we apply the disorder model to reproductive ills, how ill is the fit? Assume that a couple is unable to reach pregnancy or that the woman is unable to carry a fetus safely to term. The reasons for this I will assume are roughly specifiable within a disorder model. (If a woman is unable to maintain a safe pregnancy solely because, say, her partner beats her or she ingests toxic agents, then, absent a role for mental disorder or other pathology, I will assume that nothing about this reproductive failure is insurable.)

Trying to justify insurability for the couple's procreational problems is not like trying to justify health insurance for deleting a craving for crême brûlée, or for the dish itself. If we are *already* willing to set up health insurance to cover both normal and medically challenged pregnancies and births, why isn't it *a fortiori* appropriate to fund efforts to *get* pregnant in the face of infertility challenges? We have *already* decided to insure both normal and disordered pregnancy and childbirth because of the importance and inevitability of reproduction, and because it is fraught with physical and mental dangers, including the death of mothers and children in childbirth, and post-partum mental disorders.

But, for several reasons, health insurance for infertility is not taken as an *a fortiori* matter following from our insuring of reproduction. Infertility means that reproduction is no longer inevitable. The have-children ethic in the United States is strong, but not as strong as in some places, although it may be overwhelming as a cultural, moral or religious expectation within various communities. There are of course persons who feel extremely burdened by being unable to reproduce—a point raised by those arguing that the infertile are targets for discrimination.²⁴

One reason for rejecting an easy move from pregnancy-childbirth insurance to insurance for infertility treatment is that people are going to keep reproducing in great numbers. There is no keep-humanity-going imperative operating when particular persons cannot reproduce. The human race as a whole is sufficiently prolific.

The second (and perhaps more prominent) reason for hesitating to move toward broad infertility insurance is that, despite the pathology-

24. See *infra* text accompanying notes 44-45 and 54.

based causes of infertility, it seems generally to pose no threat to health that compromises daily economic and social functionality. Thus, many have raised objections to viewing infertility as a disorder.²⁵ Of course, this rests entirely on what we mean by “disorder,” *and*, in particular, on distinguishing between a bottom line condition as such—infertility *simpliciter*—and its causes. Determining the causes of infertility is difficult, but it generally involves diagnosable pathologies: impaired ova, low sperm count, disordered reproductive organs, etc.²⁶ If the variations from the norms are great enough to block reproduction, there is no good reason to refuse to call the underlying conditions disorders, defects, or injuries.²⁷

But it is too simple to acknowledge without more that infertility alone does not bear on daily on-the-job or intrafamilial functionality. The difficulty is that we are not talking about functionality generally—which is indeed not impaired by fertility *simpliciter*—but about a kind of *relational* impairment: functional individuals with no apparent sense of illness or disorder are unable to create another human being. So what? So this: Disorder or injury is impairing a characteristic function of the species.²⁸ (Here I include “incompatibility” between male sperm

25. See, e.g., Esther B. Fein, *Calling Infertility a Disease, Couples Battle with Insurers*, N.Y. TIMES (Feb. 22, 1998), <http://www.nytimes.com/1998/02/22/nyregion/calling-infertility-a-disease-couples-battle-with-insurers.html>; Leslie King & Madonna Harrington Meyer, *The Politics of Reproductive Benefits: U.S. Insurance Coverage of Contraceptive and Infertility Treatments*, 11 GENDER & SOC'Y 8, 10 (1997), available at <http://www.jstor.org/stable/190223> (noting that “[l]ike the need for contraception, infertility problems have historically been dismissed as social or moral rather than health issues”); Ann C. Hwang, David A. Grimes & Wayne C. Shields, Editorial, *Universal Insurance Coverage for Contraceptives: A Public Health Imperative*, 70 CONTRACEPTION 357, 357 (Nov. 2004), available at <http://www.arhp.org/uploadDocs/journaleditorialnov2004.pdf> (referring to “spotty” coverage for contraception).

26. Mayo Clinic Staff, *Infertility*, MAYO CLINIC, <http://www.mayoclinic.com/health/infertility/DS00310/DSECTION=causes> (last visited Dec. 31, 2011).

27. Although it doesn't solve the moral-analytic problem, some variations from the norm can be designated “handicaps” without calling them disorders. Think, for example, of very short stature not caused by any diagnosable physiological impairment, such as pituitary disease. See David B. Allen & Norman C. Fost, *Growth Hormone Therapy for Short Stature: Panacea or Pandora's Box*, 117 J. PEDIATRICS 16, 18-19 (1990).

28. For more extensive exploration of the concept of normal species functioning see generally NORMAN DANIELS, JUST HEALTH CARE 28 (Daniel I. Wilker ed., 1985).

and cervical mucus—another “relational” disorder, affecting “couples.” Because human coupling is a standard social arrangement, it seems appropriate to view the doubleton as impaired within the meaning of a comprehensive disorder model.)

To be sure, there is functioning and functioning, whether of individuals or reproductive pairs. We generally have no difficulty in assigning disorder status to various impairments that compromise our ability to survive, earn a living, be self-sufficient, and, at least at a basic level, to interact with others. But we are not going to get health insurance payoffs for not being smart enough to write good novels, even if we might be more successful for conditions that keep us from learning to read and write altogether. No one is shut out of subsistence and even thriving as a direct result of infertility. (If someone is expelled from a group for failing to reproduce, that’s something else.)

Third, and perhaps somewhat paradoxically, there is some hostility toward striving to reproduce in the face of great difficulties. People who spend lots of money on *in vitro* fertilization (IVF), or who break the “genetic integrity” of a marriage through artificial insemination by donor are suspect in some eyes. The most common “reason” offered for this animus—that such persons are “selfish”—makes little sense, and in some cases may be a trope for other things: an anti-technology bent generally, or a strong aversion to anything outside the norm of healthy and easy in reproduction. In the procreational realm especially, many do not want to pay for other persons’ ills or even hear about them. Of course this is oversimplified. But it is lame to argue that wanting to have a child in the face of serious difficulties is more “selfish” than what is reflected in normal parenthood efforts. Why does *anyone* want to reproduce? We don’t berate parents who easily and efficiently have children normally for being selfish because they seek fulfillment in raising children. Run a simple thought experiment. Your friends tell you they are going to try to have a child. You ask “Why?” What do you suppose the reaction will be? To be sure, there are situations in which the question seems called for: the couple is about to go into combat; one or both have the Huntington’s gene; they live on the streets and have no prospects; and

On the dysfunctionality of the mating *couple*, see A. Krzemirski, R. Sikorski & M. Bokiniec, *Sperm Penetration Through Cervical Mucus In Infertile Couples In Relation To Selected Cervical Factors*, 3 HUMAN REPRODUCTION 353 (1988), available at <http://humrep.oxfordjournals.org/content/3/3/353.full.pdf>.

so on. That aside, they will sputter and say something like, “Well, we’re married and we want a family.” You respond, “OK, I’ll rephrase: why do you want a family?” “We want the experience of raising a child—it’s what people do, after all, and we want to add to the sum of human happiness—we’re total-utility utilitarians.” The exchange is goofy.

Perhaps those who complain about the selfishness of persons who spend \$50,000 on IVF don’t care for children that much and don’t understand why any effort other than sexual intercourse is worth it. Perhaps they are overwhelmed by the prospect of overpopulation. Or—somewhat more plausibly—they think that heavy monetary and psychic investment may lead to undue pressures on the child, promoting a kind of “objectification”—a point I get to shortly.²⁹ They may also harbor an anti-technology sentiment that reinforces their hostility toward efforts at relieving infertility, but I have not specifically encountered that view in the context of health insurance. There is, however, no shortage of critical commentary on the use of technologically assisted reproduction.³⁰

What is the dominant reason for the unrefined, incoherent ascription of “selfishness” to procreative efforts requiring serious infertility remedies? It may concern an unwillingness by the community (whether privately or through government) to further what it views as primarily individual self-regarding preferences that are unrelated to basic functionality and not clearly linked to the general good. We assign great value to *humanity’s* procreational efforts. However, we usually see much less merit in struggles by specific persons to become parents when this would require beyond-the-baseline medical resources—at least if it’s not necessary for species

29. As I have argued, this is a vastly inflated claim in most current contexts, and is beset by a customary failure to explain what is meant by “objectification.” See generally Michael H. Shapiro, *Illicit Reasons and Means for Reproduction: On Excessive Choice and Categorical and Technological Imperatives*, 47 HASTINGS L.J. 1081, 1180-99 (1996) [hereafter *Illicit Reasons*]. See also *id.* at 1110-41 for a critique of the selfishness argument, and noting confusion among claims of selfishness as opposed to irresponsibility.

30. See, e.g. generally PAUL LAURITZEN, PURSUING PARENTHOOD: ETHICAL ISSUES IN ASSISTED REPRODUCTION (David H. Smith & Robert M. Veatch eds., 1993) for a balanced view of the issues concerning use of IVF and other reproductive technologies. Lauritzen describes his difficulty in resisting “the goal-oriented ‘production’ mentality that pervades infertility treatment,” suggesting that “[t]he very ability of the technology appears to exert a sort of tyrannical pressure to use it.” *Id.* at xiv-xv.

survival, and pregnancy is not already underway. On this view, not being a parent is neither itself a disordered state of being nor is it based on impaired socioeconomic functionality, so there is no call for social assistance when procreation is difficult.

If, however, you are participating in species-necessary activity that—as a species-wide matter—is easily pursued and medically risky, then insurance is justified and perhaps required. This is so even though the activity—here, procreation—is not the result of a medical decision. (What this would cover beyond procreation I leave aside.) On the other hand, if in individual cases the activity is blocked by some form of individual or couples pathology, it won't affect the species and concerns only you. Indeed, given the circumstances, perhaps it's all the better if reproduction doesn't occur. The infertility might have a genetic component and failing to reproduce would act as a sink for the bad genes. Moreover, under current conditions, multiple births are a frequent result of infertility treatments, and this is risky for children.³¹

B. HEALTH INSURANCE AND THE SOCIAL ROLE OF REPRODUCTION.

There are opposing vectors within our reproductive preferences: we want to have children and need to for species survival, but it can be overdone. Given scarce resources, having children may not be worth the effort and risks to push it, either for individuals or society. All these tensions are at work whether we deal with fertility or infertility.³²

31. American Society for Reproductive Medicine, *Patient Fact Sheet: Fertility Drugs and the Risk of Multiple Births*, http://www.asrm.org/uploadedFiles/ASRM_Content/Resources/Patient_Resources/Fact_Sheets_and_Info_Booklets/fertilitydrugs_multiplebirths.pdf (last visited Dec. 31, 2011).

32. See generally Lance Gable, *Reproductive Health as a Human Right* (June 16, 2011) (unpublished Legal Studies Research Paper Series No. 10-20 Wayne State University Law School) available at <http://ssrn.com/abstract=1865841>. The author addresses reproductive health as something more than an entailment of the right to health care. "The right to reproductive health should be recognized as a distinct human right and not merely as a subcomponent of the right to health or as one of several rights included within a generalized collection of reproductive rights." (Quoting from the abstract.) See also Lance Gable, *Reproductive Health as a Human Right*, 60 CASE W. RES. L. REV. 957 (2010) (the accompanying paper). The Department of Health and Human Services has implemented the *Act* by authorizing coverage for at least some forms of contraception as preventive health. See Allison Bell, *PPACA: Feds Add Contraception to Preventive Care Package*, LIFEHEALTHPRO (Aug 1, 2011), <http://www.lifehealthpro.com/2011/08/01/ppaca-feds-add-contraception-to-preventive->

This is partially illustrated by our insurance practices concerning contraception. Here too our traditions are fragmented, as might be expected. Not all health insurance policies cover contraception extensively.³³

Where traditions are conflicted, one thinks about rethinking them. A call for questioning the hostility to reproductive assistance in this area may seem relatively benign, but exactly how would we implement such a review and what are its likely results? Here are several points to address; they cut in multiple ways.

First, the right to reproduce in the sense of being free from interference in pursuing parenthood is well established culturally and legally. Exactly how far it extends is not that well established. It is easy to ascribe too much punch to *Skinner v. Oklahoma*.³⁴ one cannot move all that easily from its protection against coerced termination of reproductive abilities to, say, protection of surrogate motherhood, germ line augmentation, or cloning. It is quite clear, however, that the scope of the right and our overall interest in reproduction are not exhausted simply by generating a child, with no presumed rights to the companionship of the child; it is about family formation and its enduring associations. This is, at least in terms, entirely at war with the absurd suggestion of the New Jersey Supreme Court in *In re Baby M*. that the right to procreate is, in effect, a purely physiological matter involving no more than an anemic interest that is fully vindicated simply by creating a child.³⁵ We do not operate within a social system

care-pa?page=2. (discussing coverage for contraception).

33. See, e.g., *In re Union Pac. R.R. Emp't Practices Litig.*, 479 F.3d 936, 942-43 (8th Cir. 2007) (ruling that failure of an employee health insurance plan to cover all contraception was legal under the *Pregnancy Discrimination Act* and Title VII); See generally *Birth Control and Health Insurance*, HEALTHINSURANCERATES.COM, <http://www.healthinsurancerates.com/56-birth-control-and-health-insurance.html> (last visited Dec. 31, 2011).

34. *Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942) (invalidating a law authorizing sterilization of certain convicted felons, using an equal protection theory that rested on triggering strict scrutiny through finding procreation to be a basic right).

35. *In re Baby M*, 537 A.2d 1227, 1253 (N.J. 1988). Although companionship/family formation is not technically within the purely biological act of procreation, it is not true that, as the New Jersey court put it, “[t]he right to procreate very simply is the right to have natural children . . . it is no more than that. Mr. Stern has not been deprived of that right. Through artificial insemination of Mrs. Whitehead, Baby M is his child. The custody, care, companionship, and nurturing that follow birth are not parts of the right of procreation[.]” *Id.*

of the sort Plato envisioned, in which children at birth are routinely taken to be raised by an Elite and families as we know them are annulled.³⁶

Second, infertility treatments and assisted reproduction remain quite expensive (\$10,000 to \$15,000 for a single cycle of IVF, for example).³⁷ The drive to fulfill a felt need or duty to reproduce is countervailed not only by the expense and medical risks (mainly to the prospective mothers and the children) but by the fact that infertility alone does not directly impair the economic standing, productivity, social interactivity and general functionality of infertile persons or couples. The drive to reproduce is also countered by the fact there is no *general* secular imperative requiring efforts to have children.

Of course, “expensive” is normatively ambiguous; it is not simply a matter of fact about how much something costs, whether in dollars, euros, time, or other resources. Whether something is *worth the cost* is a key inquiry. The value placed on life and on creating it is critical, and this varies from person to person and culture to culture. IVF in Israel, for example, is in most cases free to the prospective parents—compensated for by government.³⁸

Third, there are critical problems of rank-ordering in deciding what health insurance ought to cover, given not only scarce medical resources, but scarce resources generally. One can easily come up with examples to display the point. A medication to prevent paralysis during surgery would obviously outrank, on any scale of importance, measures to improve (or decrease) the prospects of reproduction. (Yes, there might be exceptions—e.g., if few persons are left on earth—but this won’t work well if low value is placed on humanity’s continuation.) Moreover, all forms of health care have to compete with

36. PLATO, THE REPUBLIC BOOK V, 151 (Benjamin Jowett trans., rendered into HTML and text by John Roland of the Constitution Society) (c. 360 BCE) available at http://constitution.org/pla/repub_05.htm (last visited Dec. 31, 2011).

37. See, e.g., Rachel Gurevich, *How Much Does IVF Cost?*, ABOUT.COM (updated Aug. 16, 2011), http://infertility.about.com/od/ivf/ivf_cost.htm (last visited Dec. 31, 2011).

38. Dina Kraft, *Where Families Are Prized, Help Is Free*, N.Y. TIMES, July 17, 2011, http://www.nytimes.com/2011/07/18/world/middleeast/18israel.html?_r=1&hp. How free “free” is I don’t know. There seems to be a religious component to this public policy. See Vardit Ravitsky, *Culture as Shaping Public Policy: Public Funding of IVF in Israel*, Health Innovations in Context, <http://www.hinnovic.org/culture-as-shaping-public-policy-public-funding-of-ivf-in-israel/> (last visited Jan. 11, 2012).

the need to allocate resources to food, shelter, education, and keeping bridges from collapsing.

C. *DOWNPLAYING DISORDER AND EMPHASIZING SCARCE RESOURCES:
WANTING THINGS TOO MUCH GIVEN THE CIRCUMSTANCES.*

1. *Two Stages of Health Care Decisions; Threshold and Implementation Matters.*

This account may oversimplify, but this seems appropriate, if not necessary. As I suggested, some needs for health care occur at a threshold that is clearly informed by the disorder model. Pain moving from the navel to the lower right abdomen, nausea, and an elevated temperature yield an easy decision: get checked for appendicitis, and if that's what it is, get treated for it. The threshold and implementation measures are squarely within the disorder model. A decision to reproduce or to change one's appearance from Asian to Western (or, with Asia's growing influence, the reverse) has no direct link to that model. Implementing it, however, requires medical services because the decision to treat infertility, and the processes of pregnancy and childbirth necessarily put our health at risk. These conditions overlap disorder-based medical needs and their similar therapeutic measures. Altering a nose to change ethnic appearance requires much the same medical/surgical measures (though not the same game plan) as repairing a nose that is broken.

2. *The Coverage Considerations*

I have suggested that although infertility may be disorder-based and impairs a significant species function, it generally affects no other functions. Economic productivity and general functionality are intact, although some communities may react negatively to the infertile. On any plausible ordering of social and personal needs, remedying reproductive failure is easily outranked. I do not at all deny that for some persons, reproductive failure is a personal disaster that blights life, but even from this perspective, death, maiming, and serious compromise of one's ability to subsist and survive seem worse *in general*. Promoting fertility, at least where health care and other resources are very scarce, may simply not be worth the effort.

From this perspective, funding even “simple” IVF, never mind reproductive efforts that go beyond it, doesn’t generate much support. These other assisted reproductive technologies (ARTs) might not be physiologically more complex, but they occasion category-busting interpersonal relationships that can and do go wrong. The most obvious example is surrogacy, gestational or traditional: the fees for the surrogate don’t provide much of a case for insurability, although pregnancy and childbirth costs should be just as insurable in surrogacy as in standard reproduction. (Insurable pregnancy costs would cover the medical supervision needs of the surrogate, but her fee wouldn’t seem to have anything to do *either* with the threshold nonmedical reproduction decision, *or* with medical monitoring of the progress and vagaries of pregnancy and childbirth.) Another example is AID: because of the serious risks from using diseased semen or sperm with adverse genetic characteristics that can be screened for, insurability for some AID-related procedures would make sense, although coverage is unclear.³⁹

These conflicting pulls and pushes are of course the stuff of which political compromise is made, and one might argue that where the moral analytics are uncertain, “moral compromise” (perhaps ill-named) is in order.⁴⁰ Insurance is not all-or-nothing; we can and do select partial insurance (X% of the cost) plus significant deductibles for various health care services.⁴¹

39. This is somewhat complex conceptually. One would expect that the costs of physician services in diagnosing fertility and recommending anti-fertility procedures would be covered, but it seems that for the most part, the costs of obtaining the donor sperm, sperm screening, and the insemination procedure itself are unlikely to be covered. My research is incomplete on this point. *See, e.g., What Artificial Insemination Costs Today*, ARTIFICIALINSEMINATIONCOST.COM, <http://artificial-insemination-cost.com/what-artificial-insemination-costs-today> (last visited Dec. 31, 2011) (noting that, “[w]hile many insurance policies will cover dr.’s [sic] visits, most will not cover artificial insemination itself. This procedure can cost those with health insurance coverage around 10-30\$ a visit. However, those without insurance that covers fertility treatment will have to pay out of pocket. The cost of the procedure ranges from 300-800\$. This price varies greatly by clinic and state.”) Some plans may cover it. *See* Costhelper, *How Much Does Artificial Insemination Cost?*, COSTHELPER.COM, <http://www.costhelper.com/cost/health/artificial-insemination.html> (last visited Dec. 31, 2011).

40. *See generally* David B. Wong, *Coping with Moral Conflict and Ambiguity*, 102 ETHICS 763 (1992).

41. A number of state laws require some coverage for infertility treatments. *State Mandated Insurance Coverage*, FERTILITY LIFELINES,

D. *THE ARGUMENT FROM DISMISSAL OF THE INFERTILE (FAVORING INSURABILITY), OBJECTIFICATION OF PERSONS (OPPOSING IT), AND "GENESIS" OF FAMILIES (GOING BOTH WAYS).*

The "argument from dismissal" is, put briefly, that failure to insure and otherwise encourage infertility treatments constitutes a dismissal and stigmatization of the infertile as lesser persons. This harm, it is said, can be partially rectified by mandating reproductive insurance. The argument from objectification draws us the other way: the technologized effort to reproduce, together with the anomalous personal relationships it creates, promotes the descent of persons to objects. It reduces women, children, and possibly everyone to things for mere use.

The two arguments are not precisely inconsistent: we could simply be faced with a dilemma. To avoid objectification caused by overtechnologizing life, we must endure the dismissal of the infertile as lesser persons (which is perhaps a form of objectification too). Or maybe it's the other way around, depending on what we view as the worse harm. I do not agree with either the descent-to-thinghood or the dismissal arguments. Both rest in part on difficult and dubious empirical claims concerning how we perceive each other as persons. (There is an extensive literature on the cognitions involved in "person perception."⁴²)

Finally, there are "genesis" arguments about whether persons should or should not be created under given circumstances.⁴³ These include "arguments from harm." The most obvious one is that infertility treatments and ARTs may damage the resulting children and that therefore we should generally (if not always) avoid these modes of creation. Another argument from harm, somewhat more hidden, is that *failing* to bring persons into existence may harm them, and therefore we ought to create them.

<http://www.fertilitylifelines.com/payingfortreatment/state-mandatedinsurancelist.jsp> (last visited Dec. 31, 2011); See, e.g., CAL. HEALTH & SAFETY CODE § 1374.55 (West 2008); CAL. INS. CODE § 10119.6 (West 2005) (specifying insurance for certain forms of infertility treatment, but not IVF).

42. See generally DAVID J. SCHNEIDER ET AL., PERSON PERCEPTION 116-69, 267-69 (2d ed., 1979); PERSONALITY AND PERSON PERCEPTION ACROSS CULTURES (Yueh-Ting Lee et al. eds., 1999); ROBERT A. STEWART ET AL., PERSON PERCEPTION AND STEREOTYPING 14-15 (1979).

43. See generally DAVID HEYD, GENETHICS: MORAL ISSUES IN THE CREATION OF PEOPLE 1-2 (1992).

None of these three kinds of argument, in this context, works very well.

1. *Dismissal.*

This argument has been offered by Professors Orentlicher and Daar in separate works. The idea is that there is disrespect entailed in failure to accommodate the insurance needs of infertile persons and couples, and that this constitutes creating a caste of the dismissed. It is thus a form of discrimination. They also stress the disparate impact of lack of access on minority groups. In particular, the failure to recognize infertility as a disability reflects, performs, and compounds the disdain.

I think, however, that it is a normative/conceptual error to shoehorn the insurance and disability exclusion of infertility into the antidiscrimination, anticaste realm we associate with race, ethnicity, gender, and sexual orientation.

Here is one formulation of the claim, from Professor Orentlicher:

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.⁴⁴

44. David Orentlicher, *Discrimination Out of Dismissiveness: The Example of Infertility*, 85 IND. L.J. 143, 144 (2010). Elsewhere, Professor Orentlicher states:

[I]t 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.

....

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.

....

Professor Daar argues:

The first group [harmed by lack of access to assisted reproductive technologies] consists of infertility patients, who suffer in a number of ways from the denial of services, arguably the most problematic of which is harm to dignity.

....

[L]imiting access to reproductive technologies harms society by expressing an attitude that stigmatizes those who are unable to achieve parenthood via heterosexual intercourse. . . .⁴⁵

These claims have the virtue of calling attention to instructive connections we may not have made, even if they are not fully persuasive on a given issue. But connections don't entail *material* similarities. Everything is similar to everything else in some respect (to quote my contracts professor, Malcolm Sharp—not in writing as far as I know), but that doesn't get us very far. As an empirical matter,

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.

Id. at 145, 180, 185.

45. Judith F. Daar, *Accessing Reproductive Technologies: Invisible Barriers, Indelible Harms*, 23 BERKELEY J. GENDER L. & JUST. 18, 22-23 (2008). Daar also argues:

One source of hope for reducing racial and ethnic disparities in access to ART can be found in state insurance mandates, which hold out the promise that at least one group of patients, those with private insurance, will have equal access to fertility treatments.

....

If women of color anticipate a physician will respond to their infertility by either subtly or explicitly suggesting that women of certain racial and ethnic backgrounds do not "need" to birth any more children, one can understand why these women shy away from seeking treatment.

....

Access barriers to ART services affect four main groups: patients, providers, children, and society. Depriving an individual the right to procreate, or creating a substantial obstacle to the exercise of that right, is as much an affront to the affected individual as it is to the third party actors involved in ART access.

Id. 40, 41, 48.

what support is there for the claim that failure to provide insurance adds any *incremental* stigma we assign to the infertile? (Many do suffer some stigma. Some may think the infertile are being punished by God for their sins. Or they might be pitied, and view themselves as stigmatized simply by being pitiable.)⁴⁶ It is not at all clear that, whatever stigma was experienced by the infertile at other times and places, modern American society seriously believes that the infertile are inferior or terminal losers. They may be objects of sympathy, which is often not far removed from being viewed with scorn. Still, I see no dismissal or caste creation. (Although it is not fully clear what to make of it, it is said that more persons are opting for voluntary—and hard-to-reverse—sterilization.⁴⁷) So, the terms “dismissal” and “caste” seem to me to be tendentious descriptions without adequate empirical or conceptual support.

Three key questions for empirical investigation—I’m not recommending we actually pursue this—are (a) whether lack of insurance for infertility treatment, including access to expensive assisted reproductive technologies (ART), contributes to dim and dimmer views of the infertile; (b) whether having a condition that is considered less worthy of insurance than, say, treatment for cancer or heart failure is widely viewed as dismissive of *the person* with the noninsurable condition; and (c) whether declining to characterize a condition as a disorder entails some moral castigation or stigmatization. (The last is a possibility in some cases. Perhaps some forms of addiction are examples.)

46. *Infertility, Quick Reference Counseling Keys*, HOPE FOR THE HEART, http://www.hopefortheheart.org/site/DocServer/OLQR_Infertility.pdf?docID=356 (last visited Dec. 31, 2011) (describing, but not endorsing the view).

47. *See generally* Malcolm Potts, *Birth Control: Voluntary Sterilization*, BRITANNICA CONCISE ENCYCLOPEDIA, <http://www.britannica.com/EBchecked/topic/66704/birth-control/9596/Voluntary-sterilization> (last visited Dec. 31, 2011). Vasectomies are usually covered by health insurance; *see How Much Does Vasectomy Cost?*, VASECTOMY.COM, <http://www.vasectomy.com/ArticleDetail.asp?siteid=V&ArticleId=10> (last visited Dec. 31, 2011). Tubal ligations for woman cost much more than a vasectomy procedure. *How Much Will This Cost?*, VASECTOMY.COM, http://www.vasectomy.com/articles/popup_1.html#TUBAL (last visited Dec. 31, 2011); *See also* Susan L. Peck, *Voluntary Female Sterilization: Attitudes and Legislation*, 4 THE HASTINGS CENTER REPORT 8 (1974), available at <http://www.jstor.org/stable/3560700>.

To say that someone's disorder offers a lesser case for insurance coverage than someone else's condition depends on situational variables that foreclose blunt conclusions about dismissal, discrimination, and caste formation. For example, singling out sickle cell anemia as not worth treating or insuring has a near-facial racial component to it that may well "express" hostility, especially to black persons. To say that mental disorders are not worth treating or insuring against reflects an empirical, conceptual and moral error that may well embed moral devaluation of the persons affected. And it remains controversial and morally fraught whether alcoholism and addictions are to be viewed as disorders.⁴⁸

It is a major leap, however, to make these negative inferences when *managing scarce resources* whose best uses may be to treat persons too impaired to function. Even assuming the well-known infirmities of human cognition, and absent a clear link between exclusion and disfavored groups or behaviors, how could excluding a condition from insurance (not treatment itself) rationally be seen to reflect the personal dismissal that characterizes hostile discrimination? Indeed, a conceptual error lurks in the equivocal use of the term "dismissal." The "dismissal" or low-rank-ordering of a condition for insurance purposes may or may not support an inference of personal or group "dismissal." Such an inference, as I said, rests on many factors, and they are not as densely present in the no-insurance-for-ART case as they are in many other circumstances—e.g., no insurance for sickle cell disorder or for mental health problems. Nor is being infertile at all like having cancer, which was (and sometimes still is) viewed as stigmatizing.⁴⁹ Put otherwise, it is unconvincing to argue that failure to recognize infertility as a compensable disorder or disability effects a reduction in the human value of the infertile.⁵⁰

48. See generally HERBERT FINGARETTE, *HEAVY DRINKING: THE MYTH OF ALCOHOLISM AS A DISEASE* (1988).

49. See A. Lazare, *The Stigma of Cancer*, 24 *CANCER DETECTION AND PREVENTION*, (2000) available at <http://www.cancerprev.org/Journal/Issues/24/101/121/3823>.

50. This is not to say that it cannot be a disability within the meaning of various existing laws. See, e.g., *Saks v. Franklin Covey Co.*, 117 F. Supp. 2d 318, 324, 326, 328 (S.D.N.Y. 2000), *aff'd in part and remanded in part*, *Saks v. Franklin Covey Co.*, 316 F.3d 337 (2d Cir. 2003) (ruling that infertility is a disability within the meaning of the *Americans with Disabilities Act*, but that an employee health benefits plan did not violate that *Act*, the *Pregnancy Discrimination Act*, or Title VII in failing to cover certain infertility treatments); *Bragdon v. Abbott*, 524 U.S. 624, 638 (1998) (ruling that reproduction is a major life activity, and thus its impairment may be a disability under

I do not deny some infertile persons and observers will take insurance exclusion in this way, but it is entirely unlike declining to find mental disorder to be a disorder, which arguably relegates crazy behavior to moral fault and/or to some weak characterization such as “problems in living.”⁵¹ Whether or not such failures to absorb a condition or situation into a disorder model are morally/conceptually justified, they might well be linked to some moral censure and stigmatization. The fallout of not considering mental conditions and addictions as disorders may thus go beyond inability to secure insurance. Whether these fallouts promote a case for changing our no-disorder characterizations is another issue.

No such drives are currently at work in infertility and ART: the infertile are not, in their infertility, addicted to anything (although some of them may, as noted, be taken to task for “wanting children too much,” whatever that means). I suppose those who cannot secure insurance for their conditions are viewed by some as losers, and this is worse than being the loser who doesn’t make the team. In an odd symmetry, some who succeed in the world against all odds might be viewed as arbitrary beneficiaries of dumb luck—as in having special natural abilities—and despised and dismissed for that reason. Some people put down Lance Armstrong not just because they believe he doped, but because some of his physiological capacities are exceptionally high. How dare he be that good?⁵²

Nor do the demoralizing effects of infertility make for dismissal into a lesser caste of persons. These emotional hurts do not render insurance exclusion akin to racial, gender, religious, or sexual orientation discrimination, nor is it creation of some inferior social order. One can of course place anything at all in a defined set, but being in a set (all persons over six feet tall) doesn’t entail being in a *caste*. If we are told that the ills of our disorder are simply outweighed by other disorders, we are members of a class of losers, but not

the ADA). The Second Circuit acknowledged that “[i]nfertility is a medical condition. . . .” *Saks*, 316 F.3d at 346.

51. See generally THOMAS S. SZASZ, *THE MYTH OF MENTAL ILLNESS: FOUNDATIONS OF A THEORY OF PERSONAL CONDUCT* xi, 25 (rev. ed. 1974).

52. C.f. Elizabeth Quinn, *What is VO2Max? VO2 Max Measures Aerobic Fitness and Maximal Oxygen Uptake*, ABOUT.COM, http://sportsmedicine.about.com/od/anatomyandphysiology/a/VO2_max.htm (last updated July 18, 2011) (discussing athletic capacities and noting Lance Armstrong’s very high VO2 max results).

(necessarily) a discriminated-against caste. To claim otherwise is to use “discrimination” too loosely. Losing out in the competition for scarce resources is experienced by absolutely everyone. These losses are not universally caused by bigotry, nor do they always inspire it. Public policy in many arenas rests in part on recognizing and accepting this.

[W]e agree with the other circuits to have addressed the issue that the plain language of Title I of the ADA “does not require equal coverage for every type of disability” and that “such a requirement, if it existed, would destabilize the insurance industry in a manner definitely not intended by Congress when passing the ADA.”⁵³

Thus, failure to provide for insurability is *generally* more about allocating scarce resources—by denying them to some—than about putting people down. What is being put down is the relative importance of X and Y (X is, say, IVF and Y is, say, treatment of paralysis), not of the persons involved nor of their impaired enterprises. If there are spillover stigmatizing effects, so be it. We can’t do everything for everyone. Not all stupid mistakes are rectifiable, and even if they were, it would probably be vastly too expensive to do so. “If it’s broke, fix it” holds only for some damaged items.

One response is that it may not always be too expensive to do so, a point suggested by Professor Orentlicher concerning IVF. I don’t directly dispute this, but I note that adding up a bunch of small numbers can yield a fairly large one.⁵⁴

53. *E.E.O.C. v. Staten Island Sav. Bank*, 207 F.3d 144, 152 (2d Cir. 2000) (quoting *Ford v. Schering-Plough Corp.*, 145 F.3d 601, 608 (3d Cir. 1998)). The Second Circuit held that under Title I of the ADA, different long-term benefits for mental and physical disabilities are not generally barred. *Id.* at 152-53.

54. Orentlicher, *Discrimination Out of Dismissiveness*, *supra* note 44, at 182-85 (arguing that “[u]pon close examination...the claims that infertility treatments cost too much money are not persuasive.”). *But cf.* Marketdata Enterprises, *Press Release: U.S. Fertility Clinics & Infertility Services Market Tops \$4 Billion, But Recession Damps Demand*, Aug. 4, 2009, <http://www.marketdataenterprises.com/pressreleases/FertilityClinicsPR-08-04-2009.pdf> (stating that, “Marketdata analysts estimate that the U.S. infertility services market reached \$4.04 billion in 2008.”). The article also states that “ART now produces more than 50,000 babies per year in the U.S. via 142,000 IVF procedures (nearly tripled since 1999), and demand is growing from the ranks of 7-plus million infertile women.” Their figures apparently include some surrogacy costs. For another estimate from 2004 see DEBORA L. SPAR, *THE BABY BUSINESS: HOW MONEY, SCIENCE,*

Nor does it boost insurability to say that failure to insure “deprives” the infertile of the right to procreate, thus disrespecting them. It is simply too much to say that we are thereby creating a stock of losers, akin to what we do when we discriminate in truly odious ways against minorities or persons with certain viewpoints or those with independently (if irrationally) stigmatized disorders, such as psychotic conditions.⁵⁵ Sometimes failure to fund constitutes a deprivation, but hardly always, and not here. (Perhaps one illustration of possible stigmatization from nonfunding would be failure to insure for medical/surgical treatment for gender disorders.)

2. *Objectification.*

The argument from objectification, as applied here, can be invoked to oppose insurance coverage for infertility and ART—and indeed for pursuing those projects at all, insured or not. The risk of objectification is thought to be run by the children created, the progenitors—women especially—and society generally. In various forms, the risk of objectification is in excessively wide use as an objection to technology across the board, as well as to many other forms of human interaction.⁵⁶

Even a modest beginning at unscrambling the idea of objectification and its cognates would be out of place here; I simply note a few points.⁵⁷

There is an entangled triad of terms often invoked to describe and evaluate human behavior, and they are especially favored (and often ill-used) in assessing technologies—biological technologies in particular: objectification (commodification is its commercial form); reduction; and, mere use of persons (in the Kantian sense).⁵⁸

AND POLITICS DRIVE THE COMMERCE OF CONCEPTION 3 (2006)(presenting in Table 1-1 a total just under \$2.9 billion).

55. For a review of the stigma associated with mental disorders, see Nava R. Siltan et al., *Stigma in America: Has Anything Changed?: Impact of Perceptions of Mental Illness and Dangerousness on the Desire for Social Distance: 1996 and 2006*, 199 J. NERVOUS & MENTAL DISEASE 361 (2011).

56. Cf. Jacques Ellul, *THE TECHNOLOGICAL SOCIETY* 6 (1964) (stating that “[w]hen technique enters into every area of life, including the human, it ceases to be external to man and becomes his very substance.”).

57. See *supra* text accompanying note 29.

58. “ ‘Act in such a way that you always treat humanity, whether in your own person or in the person of any other, never simply as a means but always at the same

Objectification and reduction refer both to processes and results. All the terms are ambiguous in the sense that they do not, on the face of it, tell us what the role of state of mind (intention, purpose) is, either for the objectifier or the objectified, or whether objectification can be identified simply by observing the behavior of the parties in question. To the extent that these terms involve how we *view* as well as *treat* people, then objectification heavily depends on human perception, cognition and inference—all of which vary from situation to situation and person to person, and which are in theory alterable: the terms of perception are not always *given* or invariant.

The core idea of objectification is that of treating persons as mere things or objects. This does not entail gross physical or mental mistreatment. Slavery is an obvious form of objectification, although slaves are not always tortured or beaten. (It does sound oxymoronic to refer to “well-treated slaves.”) But slavery is nevertheless the clearest form of commodification, reduction, and mere use of humans. To a slaveholder, slaves are in many ways more like machines operating on their own than persons.

What could any of this have to do with insuring infertility treatments? I will not consider how objectification could result from the mere use of technology (IVF, artificial insemination), a topic that is peripheral, although not entirely unrelated to, the fertility insurance issue. Nor do I discuss the triad’s application to creation of unusual relationships, commercial or otherwise, as in the use of anonymous gamete or embryo donors, surrogate motherhood, or in germ line modification or cloning. (The argument from objectification is at least worth thinking about in the latter two enterprises, partly because of the relationships of *use* created—but not necessarily *mere* use.) I suppose the central idea of objectification in the *intrafamilial* fertility context (especially with germ line modification and cloning) is that any departure from the most natural forms of reproduction represents the intrusions of planning and investment, and those who plan and invest are generally bent on realizing their benefits. If we plan a child’s traits by germ line manipulation—as opposed to everyday mate selection, which may or may not involve planning or even forecasting a child’s traits—there is obviously a possibility of overly intrusive child-rearing.

time as an end.’ ” THOMAS E. HILL, JR., DIGNITY AND PRACTICAL REASON IN KANT’S MORAL THEORY 38–39 (1992). This is the second formulation of Kant’s Categorical Imperative.

But that very risk is instinct with the possibility of increasing the child's autonomy and general satisfaction by matching her preferences to her (supposedly) considerable abilities. It is hard to find one's way amidst the conflicting forces of trying to vindicate our children's "right to an open future," as Joel Feinberg put it.⁵⁹

But pure pro-fertility measures do not involve the construction of human traits or the assembly of persons, as these terms are usually understood. To be sure, they do involve significant commitments of money, time, emotional investment, and physical pain and risk for the woman. And if we spend all that money and time and endure pain and distress to have this kid, he/she had damn well better be worth it (even if not monetarily), right? No doubt some parents will think this way, or at least some children will think their parents think this way. Is there evidence that children born of infertility treatments or ARTs have been harmed by intrusive parenting that has compromised their right to an open future? (The absence of evidence does not entail there is no evidence, or that the hypothesis is false.)

The force of this argument-from-investment is not entirely unidirectional, however. One could argue that the pro-fertility commitment involves parents who may become particularly inspired to do the best job of parenting they can, maneuvering between the paths of rigid tracking and letting the children fend for themselves in the wild. I complained earlier (and in prior work) about the coherence of the idea that intense efforts to reproduce evidence selfishness.⁶⁰ The common desire to have children for personal enjoyment and fulfillment might (ill-advisedly) be taken as a form of selfishness, but it is obviously to be paired with wanting to create an (eventually) independent life for one's offspring. It combines both conceptual and empirical error to assimilate all beyond-the-baseline procreational efforts into a selfishness framework. An interesting question to be put to cognitive psychologists: how did this warped use of "selfishness" come into use? What ideological postulates lead to this depiction?

59. JOEL FEINBERG, FREEDOM AND FULFILLMENT: PHILOSOPHICAL ESSAYS 76-77 (1992).

60. See *Illicit Reasons*, *supra* note 29, at 1110-41.

3. “Genesis” Arguments for and Against Insurability: Arguments From Harm to the Children.

As we saw in the preceding subsection, objectification—and any other adversities that befall the children born of infertility treatments—is a form of harm. So, as some argue: We do not want to harm children, so we should not use pro-fertility technologies. The risks are too great. They should not be brought into existence at all, because of the prospect of harm. In this way, the objectification and genesis argument (in one form) are linked. (The other genesis argument is that it is harmful *not* to bring otherwise unimpaired children into existence—an argument I try to refute later in this section.)

This argument—I think few offer it in this form—is very weak. The main point in its support rests on the risks of a procedure going so badly that the severely injured person born would prefer, from her rational viewpoint, nonexistence to her life. For present purposes, leave germ line modification aside; if that were accomplished, the selfsame child could complain that her specific genome was tampered with. (Such modifications, however, can’t properly be rejected simply by stipulating that tampering with nature in certain ways constitutes harm by definition.)⁶¹ The argument from harm fails in the usual ART context because the children born of infertility treatments and ARTs *had no other options for life*. Even if they are at special risk for the ills of reduction and mere use, it is irrational to assume that their lives will be so fraught with misery that, from their viewpoints, life would rationally be dispreferred to nonexistence.⁶² They suffer no harm by coming into existence and living thereafter. True, as mentioned, the

61. James J. Delaney, *Possible People, Complaints, and the Distinction Between Genetic Planning And Genetic Engineering*, 37 J. MED. ETHICS 410, 410 (2011) (“This paper provides a principle that can salvage the popular view, which stresses that offspring from genetic engineering practices have grounds for complaint because they are identical to the pre-enhanced embryo, whereas offspring who are the result of genetic planning have no such grounds.”) “Genetic planning” refers, in Delaney’s article, to mating measures, such as sperm selection, not to germ line modification. A parallel point applies when comparing the modification of existing entities after germ line alteration is no longer possible—embryos past the early embryo stage, fetuses, and born persons—with genetic planning at the mate or gamete selection stage.

62. The idea of rationally dispreferring one’s existence under certain conditions is not a simple idea. It does not rest solely on particular subjective states. Thus, if a cloned offspring became suicidal, it would not follow that her life was rationally dispreferred to nonexistence, even if she felt otherwise at a given time.

risk of accidents may produce children whose lives are, in their own eyes, worse than nonexistence. A person might, especially in the early days of cloning, be so beset with disorders and malformations that she would rationally prefer nonexistence. Think of Ellen Ripley's failed clones (all portrayed by Sigourney Weaver) in *Alien Resurrection*.⁶³

As many have noted, this objection to arguments based on avoiding harm to children does *not* prove too much. It does not at all establish that we are duty-bound to propel all "unconceived entities" into existence. To assert that individual human existence is usually preferable to its nonexistence, from the living person's perspective, does not entail that we must move as many of the nonexistent into existence as we can. This is a plain *non sequitur*. All that the no-harm argument says is that *if* you want to have children under circumstances X, Y, . . . , then it is usually not a sound argument against doing so to say that they will suffer in certain ways because of X, Y, It all depends on the what X, Y, . . . are. The harm argument works if and only if the resulting life is rationally dispreferred, by the one living, to not existing at all. That simply does not hold here, at least not across the board. It may hold, in contrast, for most cases of Tay-Sachs in infants, but not to being born of infertility treatment. True, there are certain physiological risks from multiple and premature births, and no one is obliged to create children at such risk. From *society's* viewpoint, we may well think that, at least on consequentialist grounds, the fewer impaired children the better; we are not obliged to choose to have impaired children. Whether we should or shouldn't is another question.⁶⁴

On the other side, favoring funding, there is a related but also unconvincing genesis argument. It is closely akin to the *reductio ad absurdum* argument just criticized—that if we reject the harm-to-children argument for those born of infertility treatments or ARTs, we are obliged to create more children nonstop. The idea here is that children who could have been born but were not, for lack of funding, are harmed by remaining in limbo and not getting to live lives.⁶⁵ I do

63. *ALIEN RESURRECTION* (20th Century Fox 1997).

64. Cf. George F. Will, *Jon Will's Aptitudes*, *THE DAILY BEAST* (May 2, 1993, 8:00 PM), <http://www.thedailybeast.com/newsweek/1993/05/02/jon-will-s-aptitudes.html>. ("Because of advancing science and declining morals, there are fewer people like Jon [his son, who has Down syndrome] than there should be.")

65. Daar, *supra* note 45, at 69, 71 (stating: "But if human existence is assumed to be

not think this position, argued by Professor Daar, can be maintained. The harms are exclusively to the living—the persons who want to reproduce but cannot or who find it extremely difficult and/or financially burdensome.

A more plausible moral argument is that the addition of happy lives in place of no life promotes overall utility and is thus the right thing to do. But such reasons sound in utilitarianism, not in the specific rights or interests of the unconceived. One might present a version of utilitarianism under which increasing the total amount of net happiness or satisfaction is (presumptively) obligatory, but there are some *reductio ad absurdum* arguments here (fatal or not) that must be dealt with. For example, this position suggests that there is a duty to increase population up to the point where marginal gains in the net good equal the marginal losses associated with having too many people around. Here, a total utility approach has to be compared with an average utility standard.⁶⁶

So, the case for *fully* funding infertility treatments (never mind all forms of ART) is not frivolous, but it is not overwhelming either. And the argument against funding it insofar as it is based on objectification or other harms is even less persuasive.

VIII. COMPARING THE INFERTILE WHO DESIRE OFFSPRING WITH NON-DISORDERED PERSONS WHO DESIRE ENHANCEMENT

Why make this comparison, aside from the fact that it is there? “Light, more light.”⁶⁷ Then again, too much light is blinding, especially for the photophobic.

The point of this space-limited Article is to view the *Act* as an opportunity to illuminate what we think insurance is supposed to do, but to do so by also inquiring into what it is *not* supposed to do. This

less than good, or at least equivocal, then it is less certain that its denial can cause harm.” “When one considers the potential benefit to such children, it no longer makes sense to conclude that the never born suffer no harm from ART barriers.”)

66. See, e.g., Walter Sinnott-Armstrong, *Consequentialism*, in STANFORD ENCYCLOPEDIA OF PHILOSOPHY (MAY 20, 2003) (substantive rev. Feb. 9, 2006), <http://plato.stanford.edu/entries/consequentialism/> (discussing total and average utility approaches). Of course, there are other important distinctions made within utilitarian analysis.

67. This is a variation on what some claim were Goethe’s last words. Christopher Orlet, *Famous Last Words*, UTNE READER (July/August 2002 Issue) <http://www.utne.com/print-article.aspx?id=10592>.

limited inquiry requires us to describe certain foundational matters, but to avoid deeply probing them. Earlier I used the comparison between standard-case health care issues and infertility treatments to delineate the analysis of insurability. I now add another layer of comparison to see what else we can learn.

First, I make clear that I do not suggest that infertility remedies as we now know them are a form of enhancement, although the importance of procreation to one's sense of self and social position may be important. Having many or few children might be a matter of high status in different cultures.⁶⁸ If the reaction to inability to procreate is severe, a disorder model might be implicated, but for the most part neither disorder nor enhancement would be involved.

When we discuss the increasingly popular and timely topic of enhancement (physical or mental, as with steroids or memory boosters), we have to address several critical matters. The threshold issue concerns whether and when technological enhancement should be pursued at all, never mind encouraged, mandated, discouraged, or forbidden.⁶⁹ Part of this analysis requires examining whether we should move beyond disorder-based justifications for physiological interventions into the human body and mind. The next—and unavoidable—issue is scarcity: allocation of resources to creating enhancement mechanisms and determining final distribution. The more mundane issue of insurability of infertility treatments and ART mechanisms also requires us to enter the distributional dimension, and we have done this to some extent by asking about hierarchies of insurable conditions. The distributional issues, so far, have concerned choosing between reproductive funding and other health care and non-health care matters. At this, point, however, we need to ask forthrightly why some people should have greater access to these pro-fertility measures than others by virtue of being able to afford them,

68. Muddling Along, *Is Having More Than Two Children The Ultimate Status Symbol?* MUDDLING ALONG MUMMY BLOG (Jan. 13, 2011), <http://www.muddlingalongmummy.com/2011/01/13/is-having-more-than-two-children-the-ultimate-status-symbol/>.

69. I do not define or describe such enhancement here. See generally Michael H. Shapiro, *The Technology of Perfection: Performance Enhancement and the Control of Attributes*, 65 S. CAL. L. REV. 11 (1991); Michael H. Shapiro, *Who Merits Merit? Problems in Distributive Justice Posed by the New Biology*, 48 S. CAL. L. REV. 318 (1974).

either out-of-pocket or via insurance. Of course, a classical liberal would then ask: Why not?

So, should the relatively better off be able to gain access to reproductive technologies while others cannot, for lack of funds or insurance? Looking at this as a competition among persons for a scarce resource reminds us of the complexity of distributive justice; there is no escape from evaluating, from some value template, the importance of such access to persons and groups.

For some observers, there are no significant issues here. Processes and outcomes are to be governed by the natural lottery, the luck of the draw, arbitrary environmental variables, all working through the market. Ability, diligence, courage—whether they are fixed by nature-and-nurture or not—and market mechanisms are the default morally correct mode of addressing “Who gets what?” But it is a fact that, for better or worse, we do not rigorously adhere to this moral framework. Whatever mixed (or mixed-up) framework we have, we work within it, and I do not address whether it should be dismantled or remantled. But clearly we need to ask just what we are to do if we do not rely entirely on free markets. If we use wealth transfers to redistribute various opportunities, how do we decide what commodities to (dis)favor for wider or narrower distribution? In any case, even for free marketeers, things are *quite* different when we deal with enhancements because of the special risks of rigid economic and social stratifications, which I describe later in this section.

Now, what specifically does referring to steroids, human growth hormone, intellect-enhancing mechanisms—germ line or non-germline—add to our analysis of reproductive insurance? For one thing, it reemphasizes that we cannot escape having to parse and evaluate disorder models of justification. Think first of the immense importance of our personal packets of prowess to our prospects of getting through life decently. Then note the role of positional (dis)advantage in our efforts to survive and thrive. This is not just about adding to our store of personal possessions or wealth, and it goes beyond the accumulation of education (to which enhancement nevertheless bears strong analogies). Why, then, should matters of disorder play any role in determining who gets resources for human augmentation? What difference does it make whether we are talking about bringing the truly impaired up to normal planes of intelligence, or allowing those who are normal-but-marginal (most of us) to either gain or maintain positional advantages in the face of the enhancement

gains of others (however they acquired them)? Why would disorder be important in deciding whether air traffic controllers or combat pilots should have to be teched up.

On the other hand, how could we possibly afford to fund everyone's need or preference for enhancement? It's hard to see how we could do this via "health insurance," of course, since we are by hypothesis outside the disorder model, which served to limit claims to disorders, such as Alzheimer's disease, congenital disabilities, and injuries. Whether any form of pooled private or public funding for enhancement should be called "insurance" is another question. Perhaps it is insurance against the risk of being not capable enough across many situations. Are annuities and pensions a form of insurance for the contingency of living a long life? For our purposes, however, nothing much turns on this.

But if we do not pursue frank redistribution of resources—resources that increase the very power to secure more (and more) resources—how can we prevent the *compounding* of wealth and power? (The structural analogy to compound interest is obvious.) Any initial distribution of these elite-creating and elite-entrenching resources may ratchet the changes in social and economic position, and create truly irreversible stratifications beyond anything we now know. The social, economic and political gulfs may lock themselves in for good.

I deal with these and related issues more fully in other works, past and in progress. In some fields involving serious questions about whether a given enterprise is (im)permissible from the get-go, distributional issues are occasionally put down as of lesser importance because they skirt what are deemed the main issues.⁷⁰ After all, the moral permissibility / obligatoriness / forbiddenness of use is "logically prior." If we decide that use—an infertility treatment or other ART—should be banned, why think about distribution of the nondistributable?

The problem in downplaying distributional issues here is twofold. First, things that are not supposed to be distributed are often distributed

70. See, e.g., Arthur Caplan, *Good, Better, Best?*, U. OF PA, SCHOLARLY COMMONS NEUROETHICS PUBLICATIONS, CENTER FOR NEUROSCIENCE & SOC'Y 195, 196 (DEC. 1, 2008) available at http://repository.upenn.edu/cgi/viewcontent.cgi?article=1041&context=neuroethics_publications (stating that "equity arguments do not show what is inherently wrong with the desire to use biotechnology to improve ourselves and our children

anyway—think street drugs, steroids, weapons of mass destruction. Biological weapons may be banned, but if Upper Paregoric can have them, why can't Nusquamia? Even if the possession, use or production of some commodity is illegal, then, the distributional (and other) problems cannot be dismissed. There is no assured way, at present, of adequately enforcing the world-wide ban on enhancements in sports.⁷¹

Second, the threshold issue of whether certain actions are allowed, mandatory or forbidden is often unclear, as both the enhancement and fertility/ART domains show. If you are *certain* that technological enhancement of existing persons, germ line alteration to suit future persons for specific tasks, and cloning are *always* wrong or right, you are almost certainly wrong. But when moral uncertainty affects the threshold decision of whether something is to be done at all, we may well look to supposedly “secondary” issues to resolve doubts. Distribution is one such issue. There is a distinctively *distributional* risk in delivering enhancement resources because they are immensely powerful resource attractors that draw in, at least after the early accumulation stages, a large proportion of (arguably) unearned wealth. Complaints about such “unearned” gains are often made in denouncing the morality of technological enhancement.

If it turns out, then, that the distributional pitfalls in enhancement are truly formidable—the risk of sociopolitical entrenchment; the ratcheting of changes in positional advantage; the general compounding and locking in of “merit,” wealth and power—it is easy to see that this might trump the threshold stage. If we cannot figure out a *non-catastrophic* (not just a marginally unjust) distributional scheme and cannot enforce a full ban, that may be enough to rule out even the toleration of enhancement. The substantive merits of using enhancements *at all* will always be relevant, but may pale in importance because of looming distributional wars.

So, even if one establishes the permissibility or desirability of enhancement, the distributional costs may outweigh the benefits. Of course, if a successful ban on enhancement is unlikely across the board, we are in for hard times (as we generally have been in every arena of human endeavor).

In any case, the distributional issues of access to infertility treatments and ARTs (not involving enhancement or cloning) pose far

71. See *Doping Tests*, <http://www.faqs.org/sports-science/Ce-Do/Doping-Tests.html> (last visited Dec. 31, 2011) (discussing testing difficulties).

lesser risks of stratification/inegalitarian calamities; the insure-it-or-not issue is hard, but not nearly as fraught. (To be sure, enhancement is not the only field in which social stratifications might harden from uneven distribution. Think, for example, of limited access to care necessary for economic and other basic functioning.)

IX. ONE CONSTITUTIONAL ISSUE—THE *ACT* AND STATE ACTION:
DOES AN ENTERPRISE BECOME A PUBLIC FUNCTION IF GOVERNMENT
FORMALLY STATES THAT IT UNDERTAKES RESPONSIBILITY FOR
PURSUING IT FOR EVERYONE'S BENEFIT? ARE WE STATING THIS
THROUGH THE *ACT*?

For present purposes, I will have to assume general familiarity with certain doctrinal basics in constitutional law. The only points I raise here concern state action. Choosing this issue is not a random act of malevolence: the insurability problems embedded in the *Act* are considered by many to involve not only individual rights as worked out within moral theory, but legal rights that are enforceable in courts. In American constitutional law, however, whatever those rights are, they hold against government action, not private conduct (except under the Thirteenth Amendment). I'm not violating your constitutional free speech rights when I turn off the microphone to end your mindless rant, whatever torts or crimes I'm committing, and quite apart from whether law enforcement is constitutionally culpable for failing to protect you.

There are those who think that the state action doctrine is doctrinally incorrect and unsound as a matter of political philosophy. I do not agree with either of these points, but here the issue at the entrance of the wormhole ends up at a black hole, and is thus particularly to be avoided.

For us, the state action problem arises because private sector health care insurance is indeed *private*, even though regulated by government in various ways. On the face of it, if insurance companies generally don't cover a particular condition or procedure—say, reproductive problems or abortion—there is no constitutional violation despite the significant constitutional status of the underlying individual interests when pitted against government interference. The only avenues to government liability are finding that the private insurance companies are engaging in government action because of entanglements with the government or because health care insurance is considered a public or government function. One theoretical public

function argument rests on a government's announced or implied politico-economic philosophy in some field of action—a stance that might entail an overarching state duty in the area. On this view, some private insurance conduct and some government inaction concerning the insurance conduct could amount to government action. As I will suggest, this is far-fetched in the current context. (I do not discuss the questionable claim that government is required to provide or encourage health insurance when it doesn't exist in the private sector; there may be particular circumstances in which it must be extended, however, given preexisting programs.) The dominating point is that private insurance, not being government action, is not constrained by the Constitution (unless some insurance practices constitute slavery or involuntary servitude under the Thirteenth Amendment).⁷²

The standard criteria for attributing putatively private conduct to the state are often said to consist of two nodes; they purport to be exhaustive (though not exclusive) but probably are neither, depending on one's understanding of the concepts.⁷³ One is whether the private conduct is marbled or intertwined with government so strongly that we should either attribute it to government, or say that it *appears* to be attributable to it, and acknowledge that appearance may be of constitutional dimension.⁷⁴ This is the nexus or entanglement approach. The second track of state action analysis rests on the idea that private parties are performing functions traditionally and (possibly) exclusively associated with the government—as in taking on substantial roles in elections.⁷⁵ Government functions of this sort

72. See ERWIN CHERMERINSKY, *CONSTITUTIONAL LAW: PRINCIPLES AND POLICIES* 507-39 (3d ed. 2006).

73. See, e.g., *Brentwood Acad. v. Tenn. Secondary Sch. Athletic Ass'n*, 531 U.S. 288, 288 (2001).

74. See generally *Burton v. Wilmington Parking Auth.*, 365 U.S. 715, 726 (1961) (holding that a private restaurant's discrimination against black persons could be ascribed to the state, from which it leased its premises and secured various important benefits; the Court noted, *id.* at 720, that the lease did not contain a nondiscrimination provision). This is not a straightforward recognition of the constitutional impact of appearances, however— a tricky subject in constitutional law. See also *Marsh v. Alabama*, 326 U.S. 501, 502-03 (1946), where what appeared to be a town like other towns was a "company" town owned entirely by a private entity—which operated it in much the same way a town government would. In effect, under *Marsh*, if it appears to be a town like all other towns, it is. That is not all there was to the case, but more discussion is not required here.

75. See, e.g., *Terry v. Adams*, 345 U.S. 461, 463, 469 (1953) (one of *The White*

cannot be (entirely) delegated away to private parties.⁷⁶ This is the public function criterion. On this theory, putatively private conduct would be considered government action, and so also would government failure to intervene because of its duties to control public functions.

Whether it reflects a third approach or is an aspect of the public function argument, there are some other questions one might ask about this approach. How did a given enterprise, pursued by government, come to be traditionally, perhaps exclusively associated with government? It could, of course, be a matter of the very concept of a governmental entity, or at least a governmental entity of certain sorts. There do seem to be some basic minima in the modern world for constituting a government. Governments in republics are responsible for the election institutions and practices that yield our elected representatives and executive officers. I suppose they are responsible for government succession generally. Similarly for defining crime and punishing it (although religion may operate in parallel as a nongovernmental or quasi-governmental enterprise). But governments sometimes do and sometimes don't do things—like run urban railway systems. Running a transportation system isn't intrinsic to government. Sometimes government simply undertakes certain tasks, and in many cases presumably can divest itself of these tasks.⁷⁷

Suppose a government, federal or state, declares straightforwardly that “We acknowledge as a moral duty the promotion of human flourishing, and we implement this through our establishment of universal health insurance coverage for all persons legally present in the United States and its territories, possessions [etc.]. This is a matter of political and moral philosophy.”

Has this assertive government wildly expanded the range of its constitutional state duties?

Primary Cases).

76. *Richardson v. McKnight*, 521 U.S. 399, 401 (1997) (“The issue before us is whether prison guards who are employees of a private prison management firm are entitled to a qualified immunity from suit by prisoners charging a violation of 42 U.S.C. § 1983. We hold that they are not.”).

77. There are limits here. A government pursuing racial discrimination in operating an enterprise may not be able entirely to quit the operation and leave it for private operators. In some cases, this divestment may amount to a delegation, leaving the government responsible. For an example of ultimately successful divestment, see *Evans v. Abney*, 396 U.S. 435, 436-37 (1970) (concerning racial discrimination in a park).

Here I insert a major caution: the *Act* is currently quite opaque on most reproductive issues, abortion aside. On the one hand, government, acting for the community, has not taken a forthright stand that it is responsible for those aspects of human thriving that require successful reproduction. On the other hand, one could—stretching things—take the current fabric of federal and state health financing, health care, and public health laws as evidence of a comprehensive commitment to American health, and the thin spots are just details to be filled in. And some policies pull on both hands at once. Medicaid may cover some reproductive ventures even though they are not currently included within the benefits private parties must purchase under the individual mandate.⁷⁸ All things considered, the government/societal “statement” made by the *Act* and by other major health care undertakings is quite equivocal, to say the least.

One could argue—unsuccessfully—that the *Act*, taken together with much earlier legislation enacting the Medicare/Medicaid systems, reflect such a global undertaking. Because of the general scope of the *Act*, one could further say that the range of government “inaction”—a familiar concept in denying state action—is progressively limited when the government recognizes a *duty* to act. All lawyers know that omissions coupled with a duty are loosely taken to be actions in many contexts. One is not liable for failing to pursue even an easy rescue of a stranger, but one is indeed liable for such a failure to rescue one’s own children.⁷⁹ Here, one is nested within a network of duty relationships.

Moreover, the more important the enterprise—either objectively or in the government’s or the community’s view—the stronger the perceived and possibly actual duty, and the lesser the “action” component need be. One example is racial discrimination: this is an arena in which rights/interests claims are particularly strong, and so the call to recognize government duties is correspondingly greater. The stronger the abstract right, the lighter the burden of establishing the threat to it in a given case (the expected disutility goes up with the

78. Usha Ranji & Alina Salganicoff, *State Medicaid Coverage of Family Planning Services: Summary of State Survey Findings*, THE KAISER FAMILY FOUNDATION at 3-5 (Nov. 2009) available at <http://www.kff.org/womenshealth/upload/8015.pdf> (last visited Aug. 27, 2011).

79. *E.g.*, *Barber v. Superior Court*, 195 Cal. Rptr. 484, 490 (Cal. App. 1983) (citing 1 Witkin, CAL. CRIMES § 67 (1974) (“There is no criminal liability for failure to act unless there is a legal duty to act.”)).

status of the right). And as a constituent part of this, the easier is it to prove government action (omission + duty) in the face of what seems to be inaction or a hands-off stance. So, in matters of race, one would expect to find more state action in doubtful cases—although this varies with the times.⁸⁰

Thus, as the argument continues, in adopting a particular philosophy embracing specified courses of action, the government (in the hypothetical, and to some extent under the *Act*) undertook certain duties. Through its course of *conduct* it occupied and preempted for its own a large field. If someone dies, at least because of health denied or misapplied, government is responsible. If so, government's failure to control the inappropriate actions of private entities—where such actions would have been unconstitutional if done through concededly government action—is constitutionally culpable. One could add to this some variant of the nexus / entanglement argument: the marbling of government action and policy with private conduct. Sometimes this latter maneuver works and sometimes not; this is not quite as arbitrary as it sounds, but to try to reconcile the cases would be a huge effort.⁸¹

80. *See, e.g.,* *Reitman v. Mulkey*, 387 U.S. 369, 380-81 (1967) (state action found where state constitutional amendment removed legal blockade against private sellers' discrimination). The enactment purported simply to recognize default private rights:

“Neither the State nor any subdivision or agency thereof shall deny, limit or abridge, directly or indirectly, the right of any person, who is willing or desires to sell, lease or rent any part or all of his real property, to decline to sell, lease or rent such property to such person or persons as he, in his absolute discretion, chooses.”

Id. at 371 (quoting CAL. CONST. ART. I §26, *amended by* Proposition 14 (1964)(repealed)).

The Court also referred to “the necessity for a court to assess the potential impact of official action in determining whether the State has significantly involved itself with invidious discriminations.” *Id.* at 380.

81. *Compare* *Blum v. Yaretsky*, 457 U.S. 991, 1012 (1982) (finding no state action where nursing homes were said to have discharged or transferred residents without notice and hearing, despite a network of extensive government regulation and funding), *with* *Brentwood Acad. v. Tenn. Secondary Sch. Athletic Ass'n*, 531 U.S. 288, 288 (2001) (finding state action where supposedly private athletic association, which had imposed sanctions on private academy, was extensively linked to state officials within the association's structure). *See also* *Rendell-Baker v. Kohn*, 457 U.S. 830, 837 (1982) (ruling that there was no state action where a private school discharged a teacher, although the school was substantially funded by government); and *NCAA v. Tarkanian*, 488 U.S. 179, 182 (1988) (holding that the NCAA's suspension of a basketball coach wasn't state action despite its interactions with the state). I do not address whether these cases are consistent. *See generally* *Jackson v. Metro. Edison*

Whether adoption of the Act, along with other government action, constitutes this kind of self-fulfilling performative utterance, thus instituting a new tradition-to-be, is questionable, but not entirely implausible. To be sure, it is not like a sweeping announcement that “This government hereby embraces (Herbert Spencer’s Social Statics) (Ayn Rand’s objectivism) (Trotskyism).” And even if the issue were raised within our narrow hypothetical undertaking, the result might well be as it was in *American Manufacturers Mutual Insurance Company, et al. v. Sullivan*, where the Court held that:

[T]he issue we address, in accordance with our cases, is whether a *private insurer’s* decision to withhold payment for disputed medical treatment may be fairly attributable to the State so as to subject insurers to the constraints of the Fourteenth Amendment. Our answer to that question is ‘no.’⁸²

Despite the regulatory context, which involved specific legal authorization for the private employer to withhold payment pending utilization review, no state action was found.⁸³

It is easy to run wild with this suggested framework and claim that every time government enters a field, it is at least implicitly undertaking to gather it all unto itself and accept responsibility for the fate of everyone affected in that realm of government action. But enacting *PPACA*, though a clear (if equivocal) step beyond Medicare and Medicaid, did not, in fact, reflect a moral and philosophical

Co., 419 U.S. 345, 358-59 (1974) (holding that there was no state action when a heavily regulated private utility cut off service).

82. *Am. Mfrs. Mut. Ins. Co. v. Sullivan*, 526 U.S. 40, 51 (1999) (emphasis in original). The context is roughly indicated by the Court’s opening remarks:

Under Pennsylvania’s Workers’ Compensation Act, once an employer becomes liable for an employee’s work-related injury—because liability either is not contested or is no longer at issue—the employer or its insurer must pay for all “reasonable” and “necessary” medical treatment. To assure that only medical expenses meeting these criteria are paid, and in an attempt to control costs, Pennsylvania has amended its workers’ compensation system to provide that a self-insured employer or private insurer (collectively insurer) may withhold payment for disputed treatment pending an independent “utilization review,” as to which, among other things, the insurer files a one-page request for review with the State Workers’ Compensation Bureau (Bureau), the Bureau forwards the request to a “utilization review organization” (URO) of private health care providers, and the URO determines whether the treatment is reasonable or necessary.

Id. at 40.

83. *Id.* at 51.

commitment by government to accept responsibility for everyone's health. The ascription of state action would hold, if at all, for a more limited sub-field of health; state responsibility under the *Act* doesn't quite rise to following the fate of all sparrows, rich and poor.

The case for finding state action in the context of the *Act's* insurance decisions is thus shaky under existing precedent,⁸⁴ but I think the argument, resting on "public function by transformative philosophical declaration," is one way to provoke evaluation of the presuppositions of the *Act*. The United States is (despite alarms raised at various times) decidedly nowhere near the vision of Plato in *The Republic*, where the very distinctions between the public and the private and between government and nongovernment are in question (from our perspective, if not from that of the Republic's residents).⁸⁵

Examining state action, of course, is an issue joined with the task of determining whether any seriously protected constitutional right is at stake at all. Because there is no doctrine clearly supporting the idea of a fundamental right or liberty interest in health, most of the constitutional analysis in this field rests on addressing discriminatory exclusions *within governmental systems that did not have to be created as a matter of constitutional obligation*.

I will assume for the sake of argument—not implausibly—that there is some significant protection against interference with reproductive decisions under the Constitution. It may well be that the Court will eventually have to fragment the idea of reproductive liberty and recognize different levels of protection. This may range from strict scrutiny of government roles in nonvoluntary sterilization or forced reproduction, through progressively less intense scrutiny of

84. It is particularly vulnerable if the *Act* is viewed as simply an extension of Medicare.

85. See *supra* note 36; See Eric Brown, *Plato's Ethics and Politics in The Republic*, STANFORD ENCYCLOPEDIA OF PHILOSOPHY § 4.2 (Apr. 1, 2003, substantive rev. Aug. 31, 2009), available at <http://plato.stanford.edu/entries/plato-ethics-politics/> ("One of the most striking features of the ideal city is its abolition of private families and sharp limitation on private property in the two guardian classes.") For a brief commentary, see *Machiavelli and Plato*, <http://www.emachiavelli.com/Mach%20and%20Plato.htm> (last visited Dec. 31, 2011) ("There was no distinction between private life and public life, as there is today. There was no such concept as the 'invasion of privacy,' perhaps because no Athenian felt that he had a private life that was to be kept distinct from his public life." (This seems an overstatement, but I do not press the point.)); See generally Ruth Gavison, *Feminism and the Public/Private Distinction*, 45 STAN. L. REV. 1, 12 (1992).

government regulation of access to (for example) IVF, posthumous rights to control reproduction, surrogacy, germ line modification, and cloning.⁸⁶ I have already argued that failure to require a system of insurance for reproductive needs, including infertility treatment, does not entail any form of unconstitutional discrimination. Still, it is likely that various forms of discrimination and equality violations generally will occur as the *Act* is implemented (human malfeasance has long been omnipresent; why would it stop now?), so the discussion of state action seems well within the ballpark.

X. CONCLUSION

One purpose for this Symposium was to rethink, under the pressure of the *Patient Protection and Affordable Care Act*, the reasons for health insurance generally and for its use in certain specific realms. The arguments I reviewed here sound both in policy and constitutional analysis concerning the insurability of infertility treatments and assisted reproduction generally. Infertility in some ways fits awkwardly into disorder-based justifications for medical intervention and for insurance coverage, but it is not at all like urging health insurance coverage for enhancement of human traits not impaired by disorder, defect or injury. (I am not claiming that such enhancement is inappropriate for some other kind of public funding. Just don't call it health insurance.) The decisions to be made over time will probably rest less on what is or isn't a disorder but on gradations of harm that we associate with being unable to reproduce, on how these harms compare with more direct threats to economic and social functionality, on assessment of particular forms of health care and their comparative costs, and on calls for allocating scarce resources to non-health measures. The study of these gradations suggests that insurability is not in all cases an all-or-nothing matter. I also argued that failure to insure fertility and ARTs is not a violation of constitutional constraints on discrimination or inconsistent with an anticaste principle, and that

86. For an extensive analysis, see JOHN A. ROBERTSON, CHILDREN OF CHOICE: FREEDOM AND THE NEW REPRODUCTIVE TECHNOLOGIES (1994); Michael H. Shapiro, *I Want a Girl (Boy) Just Like the Girl (Boy) That Married Dear Old Dad (Mom): Cloning Lives*, 9 S. CAL. INTERDISC. L.J. 1, 238-292 (2000) (discussing some constitutional issues in cloning); Radhika Rao, *Equal Liberty: Assisted Reproductive Technology and Reproductive Equality*, 76 GEO. WASH. L. REV. 1457 (2008) (presenting a skeptical view of the scope of procreational autonomy).

pursuing claims based on constitutionally recognized forms of discrimination would encounter the state action barrier.