

Reply

A Response to Appleton and Pollak

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We view Professor Appleton and Professor Pollak's response to our article, *Trading-Off Reproductive Technology and Adoption: Does Subsidizing IVF Decrease Adoption Rates and Should It Matter?*, as "complementary" in two senses.¹ First, they are extremely generous with their praise for our project, which is particularly gratifying given how important their own work has been in the field. Second, and perhaps more importantly, they suggest a number of new tangents and ideas prompted by our project. We first summarize those contributions and how we think they fit with our Article. We then very briefly discuss a few instances where we might characterize what we have said differently than they do.

Appleton and Pollak add a number of distinct contributions to what we have said. They nicely suggest that the rhetorical and legal relationship between embryo adoption and child adoption is worth further study.² While one of us has written extensively about reproductive technologies and the legal and ethical issues they raise,³ neither in this paper nor in that prior

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1. See I. Glenn Cohen & Daniel L. Chen, *Trading-Off Reproductive Technology and Adoption: Does Subsidizing IVF Decrease Adoption Rates and Should It Matter?*, 95 MINN. L. REV. 485 (2010).

2. Susan Frelich Appleton & Robert A. Pollak, *Exploring the Connections Between Adoption and IVF: Twibling Analyses*, 95 MINN. L. REV. HEADNOTES 60, 66–69 (2011), http://www.minnesotalawreview.org/wp-content/uploads/2011/05/Appleton-Pollak_PDF.pdf.

3. See, e.g., I. Glenn Cohen, *Beyond Best Interests*, 96 MINN. L. REV. ___ (forthcoming 2012) (proposing substitutes for BIRC analysis); I. Glenn Cohen, *Intentional Diminishment, The Non-Identity Problem, and Legal Liability*, 60 HASTINGS L.J. 347 (2008) (discussing tort liability for parents who use reproductive technologies to intentionally produce disabled children); I. Glenn Cohen, *Regulating Reproduction: The Problem with Best Interests*, 96 MINN. L. REV. 423 (forthcoming 2011) (problematising best-interests-of-the-resulting-child (BIRC) analysis by examining it within the context of modern reproductive technologies); I. Glenn Cohen, *The Constitution and the Rights Not to Pro-*

work have we examined embryo adoption—although its omission in this paper is, in part, a function of the inability to distinguish it within the CDC data set with which we conduct our empirical work. In any event, we wholeheartedly agree with Appleton and Pollak that it deserves considerable further study.

At the end of our Article we frame a research agenda based on our results: “[W]hy do complete mandates *not* reduce nonrelated domestic or international adoptions?”⁴ We then offer some “speculative possibilities that might be investigated in further work, econometric or other,” and suggest that “[m]uch more work should be done to examine these (and other) possibilities . . .”⁵ We are thus delighted to see the game-theoretic modeling in Part II of Appleton and Pollak’s response, which attempts to provide exactly such a possible explanation.⁶ We view this kind of modeling as a beneficial and necessary compliment to empirical testing, whereby models are suggested, then tested, then dismissed or refined, and so on.

Third, Pollak and Appleton highlight an important assumption in our Article. As they explain, for our “challenge to this theory to have maximum traction, adoption must be a positive institution with benefits for individual children, society, or both. Otherwise, no one would care that IVF subsidies might decrease adoptions—the substitution theory would not matter.” Additionally, they note our discussion of some arguments against international adoption and the absence of an equivalent discussion of why reduced domestic adoptions might be a positive thing.⁷ They are certainly correct that if one thinks that domestic adoptions in the U.S. are a bad thing, a possible effect where IVF insurance mandates reduce domestic adoptions will not be troubling—indeed, perhaps a reduction in domestic adoptions will be welcomed! We viewed the work we did in our Article as an attempt to meet those pressing the substitution theory within their own framework (that views domestic adoption as a good thing), granting them their own assumptions and trying to show that, as normative and empirical mat-

create, 60 STAN. L. REV. 1135 (2008) (arguing against a constitutional right not to be a genetic parent); I. Glenn Cohen, *The Right Not to be a Genetic Parent?*, 81 S. CAL. L. REV. 1115 (2008) (developing a legal framework for analyzing the right not to be a genetic parent).

4. Cohen & Chen, *supra* note 1, at 575.
5. *Id.* at 575–76.
6. See Appleton & Pollak, *supra* note 2, at 72–80.
7. *Id.* at 63–65.

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ters, their claims against subsidizing IVF may not follow. For those who, perhaps like Pollak and Appleton (who do not take ownership of this argument, just raise it), accept a more external critique that domestic adoption is not a good thing, the case against funding IVF is obviously weaker still. Their game-theoretic modeling also posits that IVF mandates can have income effects, which can lead to an increase in adoption rates.⁸ This argument further reduces the case against funding IVF, even as an internal critique.

Thus, we think very highly of Appleton and Pollak's response and think it adds to and extends the research agenda we have tried to initiate with our Article. We hope that many others follow suit.

For the sake of crystallizing the issues, though, we shall briefly identify a few places where we would characterize our argument differently from Appleton and Pollak.

First, Appleton and Pollak write that we say "nothing to challenge the common understanding of adoption as a 'second choice' or even 'last resort' path to parenthood" and that "in explaining their findings, [we] hypothesize that prospective parents will try IVF before turning to adoption."⁹ They appear to be referring to a few pages of our Article where we discuss why the substitution theory has seemed plausible to its proponents by reviewing parts of the existing qualitative literature to "show that infertility, and prior attempts at fertility treatments, are associated with considering adoption or actually adopting."¹⁰ Their critique culminates with a quotation of Professor Appleton's own work, noting that she has "aptly observed in interpreting and summarizing the results of these kinds of studies" that "most couples turn to medical treatment when first experiencing a fertility problem, reinforcing the 'second best' or 'last resort' status of adoption."¹¹ It seemed quite clear to us that these pages discuss a common descriptive claim in the literature that Appleton has herself endorsed, and we are not in any way offering the point as a normative argument. Indeed, in a different passage, we are explicit on the issue:

There is also a further question of whether the preference for genetic children carries forward *after* adoption, or, as has been demonstrated

8. *Id.* at 75–80.

9. *Id.* at 68.

10. Cohen & Chen, *supra* note 1, at 534.

11. *Id.* at 535 (quoting Susan Frelich Appleton, *Adoption in the Age of Reproductive Technology*, 2004 U. CHI. LEGAL F. 393, 426).

with quality of life measures related to disability, whether individuals instead “adapt” their evaluations to some extent. Does that adaptation occur for all potential adopted children, or is it less likely to occur with, for example, special needs children? If preference “adaptation” does take place to some extent, which set of preferences should policy makers “count,” the adapted or unadapted ones? An analogous problem has proven perplexing in the context of allocation debates for scarce health resources to prevent disability, that is, whether we should allocate resources based on unadapted or adapted quality of life estimates for people with disabilities. Finally, there is the question of whether the negative effects of being denied genetic reproduction could successfully be reduced by widespread attempts to de-emphasize the importance of the genetic connection in parenting. Given the long history of this preference and its centrality in many religious traditions, we think such preference reprogramming is unlikely in the foreseeable future.¹²

Second, at several junctures, Appleton and Pollak take issue with our consideration of whether IVF falls within normative conceptions of health and the state’s obligations to promote it. Most notably, they state that:

By portraying infertility as a health impairment (“deviations [from] species-typical normal functioning”), Cohen and Chen naturalize conception, pregnancy, childbirth, and reproductivity itself. Although this move helps them arrive at their narrow normative destination, this notion of “normal functioning” undercuts arguments for insurance subsidies for contraception, which have encountered some notable pushback in recent times. And, of course, the legal status of abortion, not to mention abortion subsidies, remains highly contested.¹³

We think this misses our argument in two ways. First, Norman Daniels’s theory of an obligation to promote health as defined as species-typical functioning is offered by us as one of five different rationales for covering IVF, alongside Martha Nussbaum’s Capabilities Theory, welfarist-consequentialist moral theories, disability-rights theories, and narrower health outcomes and dollars and cents approaches.¹⁴ Thus, one can easily support IVF insurance mandates or even a conception of infertility as a health care need without necessarily subscribing to the species-typical functioning approach. Indeed, we are explicit about this in our normative discussion of the substitution

12. *Id.* at 518; *see also id.* at 506 (noting the argument “that government programs to expand access to IVF have the problematic expressive effect of reinforcing the centrality of biological ties for family, or will further undermine the self-worth of infertile women who try IVF and fail”).

13. Appleton & Pollak, *supra* note 2, at 71–72 (quoting Cohen & Chen, *supra* note 1, at 517).

14. Cohen & Chen, *supra* note 1, at 501–05.

theory where we run the argument twice.¹⁵

Moreover, even if one *were* committed to the species-typical functioning approach it is not clear that it problematically “naturalize[s] conception, pregnancy, childbirth, and repronormativity itself” or that it necessarily creates problems for Pollak and Appleton’s preferred policy outcomes for abortion and contraception.¹⁶ Without giving a full articulation or defense of Daniels’s approach, we note at one point in the paper that whether some people want or do not want a procedure does not determine whether that procedure is truly a health need, nor does it affect our obligation to make it available to those who do want it.¹⁷ It is true that Daniels has acknowledged in earlier work that, under his theory, “[n]on-therapeutic abortions do not count as health-care needs, since unwanted pregnancy is not a disease,” such that “if medicaid has as its only legitimate function the meeting of health-care needs of the poor, then we cannot argue for funding abortions as we do for funding other medical procedures which treat diseases.”¹⁸ However, as Daniels writes, “if Medicaid should serve other important goals, like ensuring that poor and well-off women can equally well control their bodies, then there is justification for funding these abortions,” as well as an argument that not funding these abortions “will contribute to other health problems induced by illegal abortions or by the lack of adequate prenatal care for poor, teenaged girls.”¹⁹ This rationale for funding these abortions makes eminent sense when understood against Daniels’s larger theory: that protecting health is important as a way of furthering the larger goal of ensuring that all have access to the “normal opportunity range” that is “the array of life plans reasonable persons are likely to develop for themselves.”²⁰

Third, in a few places Appleton and Pollak suggest we have failed to acknowledge important drawbacks to subsidizing IVF. They write that we “assume—in [their] view, rather too readi-

15. See *id.* at 509–26; see, e.g., *id.* at 518 (“Now suppose one rejects the classification of infertility treatment as part of ‘health,’ or—contrary to Daniels, Nussbaum, and others—rejects the premise that government has any special obligations to further the health of its citizens.”).

16. Appleton & Pollack, *supra* note 2, at 71–72.

17. Cohen & Chen, *supra* note 1, at 515–16.

18. NORMAN DANIELS, JUST HEALTH CARE 31–32 (1985).

19. *Id.* at 32.

20. NORMAN DANIELS, JUST HEALTH: MEETING HEALTH NEEDS FAIRLY 43–46 (2008).

ly—that establishing that a procedure promotes health suffices to make the case for public subsidies or mandates, without considering cost as well as benefit,” that “[s]trengthening the theoretical foundation for access to IVF, without attending to questions of contraception and abortion, profoundly threatens gender equality, which even liberal feminism embraces.”²¹ They claim that “[t]hese are serious problems for women that extend well beyond what Cohen and Chen describe as ‘radical feminist critiques of IVF.’”²²

In fact, we do, at several places in our Article, discuss the costs of subsidizing IVF apart from effects on adoption. We are most explicit in doing so in the portion where we discuss the large number of possible reasons other than the substitution theory that one might offer against subsidizing IVF. Indeed, the last words of the Article are, “the concern about effects on adoption is but one reason to oppose these mandates, and we leave full examination of other possible reasons to oppose these mandates for further work.”²³ In the Article itself, we set out seven other critiques of subsidizing IVF: (1) that children born from IVF are less healthy; (2) that government programs to expand access to IVF have the problematic expressive effect of reinforcing the centrality of biological ties for family or will further undermine the self-worth of infertile women who try IVF and fail; (3) that on some religious views, IVF problematically separates the unitive and the procreative elements of reproduction within a marriage and/or may lead to embryo destruction; (4) that subsidizing health care is inappropriate on libertarian grounds; (5) that including IVF in a mandate problematically increases health insurance costs and prices some out of the market; (6) that satisfying infertility-related needs is inappropriate when other health care needs judged more important go unmet; and (7) that IVF mandates confuse a health care need with the satisfaction of a lifestyle choice.²⁴ We are also very clear that we do not think this list is exhaustive.²⁵ Instead, as we state fairly directly,

[f]or the purpose of this Article we self-consciously put each of these objections to one side, acknowledging that if the argument we offer here succeeds, these objections will nonetheless persist and their persuasiveness will have to be evaluated in further work in order to de-

21. Appleton & Pollak, *supra* note 2, at 62, 72.

22. *Id.* at 72 (quoting Cohen & Chen, *supra* note 1, at 506).

23. Cohen & Chen, *supra* note 1, at 577.

24. *Id.* at 505–09.

25. *Id.* at 509 (“There may be other kinds of objections as well.”).

termine the ultimate question of whether expanding IVF access through insurance mandates is desirable.²⁶

We go on to say that “[h]ere we instead focus on an objection from a perspective otherwise open to promoting access to health care goods and reducing inequality—the objection that focuses on the negative effects these mandates have on adoption.”²⁷ Thus, Appleton and Pollak’s concerns as to equity with contraception and abortion—which, we should hasten to add, not every reader will find troubling—are, in our view, simply an additional set of arguments to be evaluated before reaching an all-things-considered view of subsidizing IVF.

Finally, Appleton and Pollak, in the game-theoretic portion of their response, suggest we do not acknowledge the possibility of heterogeneous responses to IVF subsidies. They argue that “[a] proper analysis of the effect of IVF mandates requires us to recognize that infertile couples are heterogeneous in their resources and their preferences and, hence, heterogeneous in their responses to IVF mandates.”²⁸ In our conclusion, we suggest just such a possibility, writing: “there may be . . . a ‘two solitudes’ effect: individuals have preferences for or against domestic adoption that are independent of IVF’s availability such that they will either adopt or refuse to adopt regardless of whether or not they have a substitutive method of having children.”²⁹ We note that this “is in tension with much of the qualitative empirical literature reviewed earlier on adoption decisionmaking.”³⁰ Thus, we view Appleton and Pollak’s excellent game theoretic formalization of our suggestion on this score as once again complimentary rather than critical. This is exactly the kind of future empirical and theoretical work that we have hoped our work will launch.

Small differences in characterization about our project should not distract from what we said at the outset: we are thrilled by the praise of such leading figures in our fields and we think the response beautifully adds to and extends the research agenda we have tried to initiate with our Article. We hope that many others follow suit with work as outstanding as that of Professors Appleton and Pollak.

26. *Id.*

27. *Id.*

28. Appleton & Pollak, *supra* note 2, at 72–73.

29. Cohen & Chen, *supra* note 1, at 576.

30. *Id.*