BOOK REVIEW

Review of *The New Eugenics: Selective Breeding in an Era of Reproductive Technologies*. By Judith Daar (Yale University Press, 2017. 288 p, $40.00).

In *The New Eugenics*, Judith F. Daar compellingly documents how the eugenics movement of old—intended to limit reproduction among ‘undesirables’—has far from disappeared.1 Rather, the eugenics methods have evolved hand in hand with advances in medicine and reproductive technology. Daar’s book provides a careful and easily digestible map of the ways that law, medicine, and, especially, money have perpetuated selective reproduction by placing limits on who has access to assisted reproductive technology (ART)2 to treat infertility. The same characteristics that motivated earlier eugenicists to deem someone unfit to reproduce—including socioeconomic status, race or ethnicity, marital status, disability, and sexual orientation—now underlie deprivation of access to reproductive technologies. Put simply, she writes ‘both eugenics and ART extract control over reproduction from the closed universe of the progenitors and deliver it to a world of procreative strangers’.3

What I found particularly interesting is that, in addition to the usual suspects such as doctors, these procreative strangers now include the policymakers and corporations who determine what insurance will pay for. They hold the purse strings for reproduction in an age of ART, and their decisions shine a light on ways that insurance both reflects and shapes social norms about ‘good’ reproduction and parentage.

Daar artfully distills a complicated set of factors that results in differential access to reproduction and the various reasons why ART is inaccessible for the ‘less wealthy, less white, less traditional and less-abled bodied’.4 She starts by distinguishing sources of infertility as either medical or social in origin, ‘with medical infertility caused by the

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1 Judith Daar, *The New Eugenics: Selective Breeding in an Era of Reproductive Technologies* (2017).
2 Daar uses ‘ART’ to refer to the full range of reproductive technologies, including artificial insemination of semen to in vitro fertilization (IVF) where an embryo is created outside the body and then transferred to the uterus, and gestational surrogacy where a third party gestates the fetus and sometimes provides genetic material.
3 Daar, *supra* note 1, at 3.
4 Id. at xiiv
absence or malfunction of reproductive organs, and social infertility a product of the
social structure in which a person lives his or her life.\(^5\) This clear distinction helps her
expose how laws and practices that consider only medical infertility have eugenic re-

\[5\] Id. at xiii.

\[6\] Id. at 129–30.

\[7\] Id. at 96–9.

\[8\] Id. at 92.

\[9\] Id. at 172–74.

\[10\] Id. at 57.

\[11\] Id. at 59 (citing data from California Cryobank’s website).

results. As one example, she describes how the law protects only some people’s parent-
age. Laws in many states provide parental recognition for those who have a child with
the help of gestational surrogacy. But in many states, these laws only recognize some of
those who intend to be a child’s legal parent.\(^6\) For example, some states’ laws require
the intended parents be married, discouraging surrogacy by single people. Others pro-
vide parental recognition only when an intended parent is a woman who was unable to
bear a child, meaning that men, single or in a same-sex marriage, lack legal protection if
they have a child by surrogate.

Daar identifies many non-legal barriers as well. In chapter 4, she documents barriers
to ART by race, including the location of ART clinics in wealthier areas and the imagery
of ART over-representing white babies and parents.\(^7\) She describes how, especially with
respect to race, the legacy of past eugenic practices and stereotypes that connect their
fertility and worth deter women of color from seeking out treatment for infertility.\(^8\) In
chapter 6, she explains how biases against people with disabilities may cause doctors
to deny access to ART, even when those disabilities pose no danger to the prospective
parent or the future child. Likewise, chapter 5 addresses physicians as gatekeepers
more broadly, recounting the story of a doctor refusing to provide IVF care for a lesbian
couple, Guadalupe Benitez and Joanne Clark. The couple successfully litigated a claim
of sexual orientation discrimination under the California Unruh Civil Rights Act.\(^9\) The
recounting of each of these different barriers eloquently reveals the tools of power and
influence in the new eugenics movement.

Yet, Daar rightfully identifies that the threshold barrier for many people is money.
Very few people can afford the cost of ART and thus do not even get far enough to
discover these other roadblocks created by law, medicine, and personal psychology.
She writes:

Cost limits access to intimate IVF and correspondingly stratifies the medically infertile
along socioeconomic lines. Stratified reproduction—in which demographic features cre-
ate a hierarchy that determines one’s ability to access infertility treatment—has been de-
scribed as the ’eugenic logic of IVF’ because cost barriers disparately impact low-income
individuals and couples who are primarily of color.\(^10\)

Daar documents why ART is unaffordable for most American families. At the
less expensive end of the range, sperm for artificial insemination by donor can cost
$595 per vial for home use.\(^11\) Costs rise steeply from there. A cycle of IVF for a couple
using their own gametes costs on average $12,000 and has a 33 per cent success rate, and
the cost of a successful delivery with IVF ranges from $66,667 to as much as $800,000,
depending on the age of the couple and how many IVF attempts they have made.\textsuperscript{12}
Donated eggs cost up to $20,000 and birth by a surrogate costs between $75,000 and $150,000.\textsuperscript{13}

Of course, these costs would be less of a barrier if ART were covered by insurance. For the most part, it is not, which raises the question of why—a question that runs as a subcurrent throughout the book and is the focus of the rest of this review. This book elucidates how insurance and its coverage of ART has become another stage for conflicts over norms regarding reproduction and family.

In 2016, more Americans than ever, around 90 per cent, carried health insurance.\textsuperscript{14} A majority of people ages 18–64 have insurance through an employer-based plan,\textsuperscript{15} where the employer typically has discretion whether to cover ART and to what degree; according to a survey from 2006, only 20 per cent of employers covered infertility treatment.\textsuperscript{16} Twenty per cent of people age 18–64 have public health insurance, such as Medicaid or military coverage, which generally does not pay for infertility services.\textsuperscript{17} A minority of insured are covered by a private individual plan that they purchased on their own from an insurer or through a health insurance exchange established by the Patient Protection and Affordable Care Act (ACA). Even though the ACA mandated a comprehensive set of benefits that these exchange plans must cover, this list excluded infertility treatment.

Without a federal mandate, private plans are only required to cover fertility treatment to the extent that a state mandates it (and even if a state has a mandate, it only applies to some employer plans). Daar documents the mandates that exist in 15 states, but even in these states, the mandates are often limited in scope. In fact, Daar argues that the laws themselves reproduce eugenic selectivity by, for example, statutorily limiting mandated coverage of infertility treatment to married couples with a history of infertility, defined as an inability to conceive over some period of months or years, which I’ll discuss further below.\textsuperscript{18} The bottom line is that for most prospective parents, insurance will not cover ART.

Why does health insurance neglect to cover ART? It seems anachronistic with the importance of reproduction to people’s health, families, and roles in society. As Daar describes, the law recognizes reproduction as a major life activity and it is the most meaningful life activity for many people (the book dedication to her husband and four sons suggested the personal meaning to the author). She writes:

\begin{quote}
As human beings, in the main we have a natural inclination to reproduce and to value the products of our reproductive efforts. Ask virtually any parent about the relative value of his or her life’s experiences and you will most often hear, ‘The most significant and meaningful thing I have done in my life is parent my child(ren).’ Because of the central importance of
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\textsuperscript{12} Id. at 56.
\textsuperscript{13} Id. at 61–62.
\textsuperscript{14} ROBINA. COHEN ET AL., DIVISION OF HEALTH INTERVIEW STATISTICS, NATIONAL CENTER FOR HEALTH STATISTICS, HEALTH INSURANCE COVERAGE: EARLY RELEASE OF ESTIMATES FROM THE NATIONAL HEALTH INTERVIEW SURVEY (2017).
\textsuperscript{15} Id.
\textsuperscript{16} Mercer Health & Benefits, Employer Experience With, and Attitudes Toward, Coverage of Infertility Treatment 2 (2006) (noting that ‘20 of all employers currently provide coverage for assisted reproductive technologies’).
\textsuperscript{17} Daar, supra note 1, at 64.
\textsuperscript{18} Id. at 64–9.
parenthood to the human experience, denial of the opportunity to procreate—through refractory infertility, lack of resources, provider unwillingness or government restrictions on ART—strikes at the core of how we see ourselves and our place in the world.19

She describes barriers to procreation as a dignitary affront and a challenge to a person’s value as an independent moral agent.20

The puzzle of the exclusion of ART from most insurance coverage comes into clearer relief when viewed in the larger social context. One part of the story might be the quasimedical nature of ART. For cases of medical infertility, ART falls squarely within the narrow definition of medical need. For cases of social infertility, including, for example, surrogacy for a couple of married men, the services are arguably outside the realm of their medical needs. Health insurance—both public and private—has long excluded or deprioritized services that can be characterized as non-medical, including long-term care and caregiving generally.21 Social infertility may be perceived as one such non-medical need. But even if that were the case, it can only be part of the story since treatment for medical infertility is also excluded from most insurance policies.

Insurance reflects social values. When medical items or services are covered by insurance, they become part of a social compact among insured to share in their costs. The more insurance covers, the more health-related costs are collectively funded in a society and among insureds. The less insurance covers, the more individuals must shoulder the burden of financing their own medical needs, or going without needed care if they cannot afford it on their own. In most countries, the notion of a right to health care and a concomitant social compact to finance it is given. In the USA, the question of who has a right to what types of medical care and, in turn, the content of health insurance coverage is constant battleground for values conflict.

Take an example that should be easy: insurance coverage of pregnancy, including prenatal care, delivery, and postnatal care. It should be in the collective interest to promote healthy births and babies. In accord with this idea, the ACA included coverage of pregnancy as one of the ‘essential health benefits’ that insurers selling policies in the state exchanges must cover. This requirement set off a maelstrom, inducing prompting Republican Representatives Rob Blum and John Shimkus to express their disbelief that men, especially old men, must pay young women’s pregnancies.22 These types of arguments resonate with many Americans. They imply that someone should only pay his own ‘fair’ share, with fair defined based on the medical care he might use individually. This line of thinking is inconsistent with the very purpose of health insurance, which is to spread the costs of healthcare, including expensive care that would undermine someone’s financial security. It is, however, consonant with and implicates a long history of battles over the law’s treatment of pregnancy, women’s reproductive labor, and family roles and choices.23

19 Id. at 153.
20 Id. at 166.
21 See EILEEN BORIS & JENNIFER KLEIN, CARING FOR AMERICA (2012).
22 Julia Manchester, Illinois Congressman Voices Objection to Men Purchasing Prenatal Care, CNN POLITICS (March 10, 2017, 3:41 PM), http://edition.cnn.com/2017/03/10/politics/shimkus-prenatal-care-comments/index.html (accessed Aug. 7, 2017).
23 For example, Linda Greenhouse & Reva B. Siegel, Before (and After) Roe v. Wade: Questions about Backlash, 120 YALE L.J. 2028 (2011) (describing the Supreme Court as only one player in the ‘polarizing conflict’ over abortion).
As a society, if we cannot agree to pay for the basic costs of pregnancy, it comes as no surprise that we lack consensus to cover more expensive therapies to aid in procreation. Even more, when such coverage would disproportionately benefit groups such as single parents, same-sex couples and LGBT people, or people of color (who Daar explains face higher rates of medical infertility), it is unsurprising that solidarity breaks down.24

Yet, such views are not set in stone. This book tells a story of rapid progress. It was not even 40 years ago that the first ‘test tube’ baby was born, and today we can screen individual embryos for over 250 genetic conditions before implantation.25 The face of reproduction is changing dramatically in ways that put these technologies in higher demand. The Centers for Disease Control and Prevention recently reported that in 2016, for the first time, the birth rate for women ages 30–34 outpaced that of women in their late 20s.26 As Daar notes, 40 per cent of US births are to unmarried women, as compared to one per cent in 1920.27 And social understanding and regulation of same-sex relationships and families has gone through a sea change in the past two decades. Now 62 per cent of Americans (and 74 per cent of Millennials) favor gay marriage, in contrast to only 35 per cent in 2001.28 A Supreme Court decision like *Obergefell v Hodges*,29 which explicitly recognizes a constitutional right to gay marriage, was unimaginable just 15 years ago, when I was a law student.

This type of social change may usher in a more capacious understanding of ‘good’ reproduction, and could undermine the narrower conceptions that motivate and fuel eugenics movements—both old and new. Social and legal norms shift first, and institutions like social and private insurance follow, sometimes quite slowly.

As I write this review, the Trump Administration and Congress attempt to dismantle the ACA. The Senate’s efforts were guided by 13 white men behind closed doors. Perhaps it seems naïve at this moment to imagine a world where social mores would evolve to the point that heteronormative views on reproduction were no longer dominant and where insurance would cover ART so that everyone has equal access to parenthood, regardless of fertility status or ability to pay for ART out of pocket.

Yet, even as formal institutions of federal power regress, social evolution continues on the ground. The legal protection of same-sex marriage, in fact, already begins to rewrite Daar’s eugenics story and may continue to do so.30 Take the example Daar gives about state insurance mandates that exclude social infertility, such as Rhode Island’s law. This law requires insurers to cover diagnosis and treatment of infertility,

24 Notethat coverage of IVF is spotty in other countries that embrace a robust right to health, suggesting that even if the USA had greater health solidarity, shifts in other social values would need to occur to lead to insurance coverage of IVF. See Donna Ferguson, *IVF and the NHS: the Parents Navigating Fertility’s Postcard Lottery, The Guardian* (May 10, 2014). In addition, for some people, opposition to IVF might be because it undermines adoption. *Elizabeth Bartholet, Family Bonds: Adoption, Infertility, and the New World of Child Production* (1999).

25 Daar, *supra* note 1, at 138.

26 National Center for Health Statistics, Centers for Disease Control and Prevention, *Natality Dashboard, Age Specific Birth Rates* (2017), https://www.cdc.gov/nchs/products/vsrr/natality-dashboard.htm# (accessed Aug. 7, 2017).

27 Daar, *supra* note 1, at 37.

28 Pew Research Center, Changing Attitudes on Gay Marriage (June 26, 2017), http://www.pewforum.org/fact-sheet/changing-attitudes-on-gay-marriage/ (accessed Aug. 7, 2017).

29 135 S.Ct. 2584 (2015).

30 See Douglas NeJaime, *Marriage Equality and the New Parenthood*, 129 Harv. L. Rev. 1185, 1191 (2016) (considering whether marriage equality and extension of parentage rights to same-sex families could legitimate surrogacy).
but then defines ‘infertility’ as based on a ‘healthy married individual who is unable to conceive or sustain pregnancy during a period of one year’. Obergefell instantly changes the meaning of Rhode Island’s law and also renders it meaningless in part. What does it mean for a same-sex married couple to be unable to conceive? Are they presumptively unable to conceive and thus ‘infertile’ for purposes of the law? Or do they need to attempt ART for a year to qualify as infertile? The law defines infertility in terms that imply the presence of a woman, who could in theory become pregnant. Even if the law might be read to extend to coverage for same-sex married women, it is harder to read the law to extend to same-sex married men, since neither of them could ‘conceive or sustain pregnancy’. Obergefell reveals the embedded assumptions of an opposite-sex couple underlying the law. It could also make the law vulnerable to legal challenge if read to apply to same-sex married women but not same-sex married men.

Thus, changes in technology came first. Changes in social and legal norms on marriage, families, and parenthood and antidiscrimination are going through tectonic shifts now. This evolution is captured dramatically in court cases like Obergefell and more subtly in shifting policies and regulatory interpretations. For example, Daar cites the American Medical Association Code of Medical Ethics’ statement of nondiscrimination, preventing refusal of treatment based on ‘race, color, religion, national origin, sexual orientation, gender identity or any other basis that would constitute invidious discrimination’. Even if largely symbolic, it is a bold statement of inclusion from a notoriously conservative organization. The ACA’s prohibitions on sex discrimination and regulations interpreting them include discrimination based on sexual orientation or gender identity as elements of sex discrimination. These policies capture changing values.

Changes in insurance will, undoubtedly, come last and slowly. Even if social norms evolve to bless a more capacious conception of reproduction, a willingness to pay for others’ reproduction—especially when their reproduction is expensive—may not follow as quickly. When asked if they believe in health insurance for all Americans by a New York Times/CBS News Poll, about 60 per cent Americans say they do. When asked if they are willing to pay higher taxes to ensure that right for others, the number drops off—although, interestingly, it still hovers around 50 per cent.

If the scales do tip toward greater reproductive solidarity and a willingness to pay its costs, those social norms still must percolate into institutions that design the payment structures. The leaders of private insurance companies and the legislators making decisions about insurance mandates tend not to be at the cutting edge. Yet, eventually insurance policies and products evolve. Employees, especially in companies who

31 Daar, supra note 1, at 125 (quoting Rhode Island law).
32 See generally Douglas NeJaime, The Nature of Parenthood, 126 YALE L.J. 2260, 2285-2314 (2017) (discussing more broadly the inconsistent legal recognition of parenthood for children born from use of ART).
33 See generally NeJaime, supra note 30 (describing the evolution of a more functional definition of parenthood that recognizes non-traditional family structures); NeJaime, supra note 32 (showing how the law of parenthood is still evolving to accommodate new norms of gender and sexual-orientation equality).
34 Daar, supra note 1, at 167.
35 See Patient Protection and Affordable Care Act § 1557; Department of Health and Human Services, Nondiscrimination in Health Programs and Activities, 45 C.F.R. 31387 (May 18, 2016).
36 New York Times CBS News, Poll on Health (June 12–16, 2009), https://int.nyt.com/data/int-shared/nytdocs/docs/155/155.pdf (accessed Aug. 7, 2017).
37 Id.
are looking to attract and retain top talent, will increasingly expect coverage of ART in their insurance plans. The Millennials will reproduce and parent in ways wholly different than their grandparents, and their desires to couple and reproduce as they wish will drive political decision making and markets.

To be sure, insurance coverage of ART will not end the new eugenics. It will simply dissolve the first barrier, affordability, and make the other social and cultural barriers more pronounced. As Daar describes, even when controlled for income, people of color access less care for infertility. Thus, when financial barriers dissolve, other barriers remain, and these barriers will likely produce even greater disparate effects. The financial barriers to ART may affect the different populations Daar describes indiscriminately, but social barriers will vary as some groups (eg same-sex couples) are socially sanctioned and others (eg people with disabilities) do not enjoy similarly rapidly improving social status.

The final chapter of this book left me mildly unsatisfied because of its lack of focus on this interrelation between social norms and their evolution and the new eugenics movement. Daar ticks through a variety of solutions that would increase access to ART, including efforts to make ART more affordable—state mandates, tax relief for out-of-pocket costs, innovation to reduce costs, charity care—and more accessible—expanded supply in underserved areas and efforts to reduce discrimination in delivery settings. Even though these efforts are all laudable and necessary, they are insufficient to unseat a new eugenics movement. More fundamental changes are necessary to reshape the many forces that explicitly and implicitly lead to limits on procreation for some groups of people, more than others.

In the last paragraphs, Daar gestures to this fact, by discussing in a couple of sentences the shifting racial demographics and the marriage equality revolution in the USA. She writes: ‘Even if no such reforms are taken up, I remain hopeful that external factors will coalesce to incrementally widen access to reproductive technologies. Global and national changes that, in some instances, are seemingly unrelated to ART will usher in an era of greater availability and access to reproductive assistance.’ In my view, the greatest potential for ending the perpetuation of eugenic beliefs and practices lies in these changes in social composition mentioned only briefly. No degree of regulation or education could counter the many powerful strategies used to limit who can procreate, which this book vividly recounts. Its very purpose is to show that when people want to limit others’ reproduction, they will find new tools to do so. The key, then, must be to address the animus and misunderstanding that produces eugenics moments—old and new—in the first place.

I found this book thought provoking, insightful, and well worth reading.

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38 Daar, supra note 1, at 82–3.
39 Id. at 205.