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EVALUATING THE LEGALITY OF AGE-BASED CRITERIA IN HEALTH CARE: FROM NONDISCRIMINATION AND DISCRETION TO DISTRIBUTIVE JUSTICE

GOVIND PERSAD

EVALUATING THE LEGALITY OF AGE-BASED CRITERIA IN HEALTH CARE: FROM NONDISCRIMINATION AND DISCRETION TO DISTRIBUTIVE JUSTICE

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Abstract: Recent disputes over whether older people should pay more for health insurance, or receive lower priority for transplantable organs, highlight broader disagreements regarding the legality of using age-based criteria in health care. These debates will likely intensify given the changing age structure of the American population and the turmoil surrounding the financing of American health care. This Article provides a comprehensive examination of the legality and normative desirability of age-based criteria. I defend a distributive justice approach to age-based criteria and contrast it with two prevailing theoretical approaches to age-based criteria, nondiscrimination and discretion. I propose a detailed normative framework for the use of age-based criteria in health care, the *lifetime justice approach*, that considers the future life patients can gain from treatment and the past years of life they already have experienced.

INTRODUCTION

In 2017, proposals to weaken the Affordable Care Act's (ACA) limits on health insurance premiums for older purchasers faced opposition from the American Association for Retired Persons (AARP), which exhorted its members to help "ax the age tax."[1] A proposed 2011 change in kidney allo-

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[1] *Ax the Age Tax—AARP*, AARP, http://videos.aarp.org/detail/video/5349644641001/ax-the-age-tax-aarp [https://perma.cc/CU4C-W6FP]; *see also* Patrick Caldwell, *Watch This Squirrel Explain the GOP's New "Age Tax,"* MOTHER JONES (Mar. 7, 2017), http://www.motherjones.

cation guidelines that would have given organs from younger donors to younger recipients was defended on the basis that, under current policy, "there are years of life being left on the table."[2] These debates demonstrate the importance and currency of this Article's topic: whether *age-based* criteria for access to medical treatment should be legal.

I define age-based criteria for access to medical treatment as the use of an individual's chronological age as a factor for determining access to medical care.[3] The following examples, based on real-life scenarios or proposals, illustrate the use of such criteria:

1. Anne, fifty-five, is charged higher premiums for health insurance than Bashirah, twenty-five, because Anne is actuarially predicted to need more treatment.[4]
2. Charlotte, sixty-five, is assigned lower priority for kidney transplantation than younger candidates because she already has enjoyed many years of life and likely has fewer future years of life.[5]
3. Deepa, forty-five, is refused infertility treatment because providers believe her prospect of conception is so low that treatment would be futile.[6]
4. Eric, seventy-five, is not encouraged to get a colonoscopy because the evidence base for colonoscopy in his age group is lacking.[7]

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com/politics/2017/03/pissing-off-old-people-seems-like-a-fabulous-plan/ [https://perma.cc/BC2Z-49RU] (discussing AARP's opposition to changes to the ACA).

[2] Luis Fábregas, *Kidney Allocation Plan Could Discriminate Against Older People,* TRIB. LIVE (Feb. 25, 2011), http://triblive.com/x/pittsburghtrib/lifestyles/health/s_724572.html?printerfriendly=true [https://perma.cc/N7FY-XSVH] (reporting on the United Network for Organ Sharing ("UNOS") proposal and statement by physician Trent Tipple, who is himself a transplant recipient); *see also Mission, Vision, and Values*, UNOS, https://unos.org/about/mission-values/ [https://perma.cc/L3YM-JX7W] (providing an overview of UNOS and the organization's mission of connecting organ donors with donees).

[3] This Article focuses on age-based criteria that apply to adults because of the special challenges presented by minors' psychological capacities and the scope of parental authority. *Cf.* Dep't of Civil Rights v. Beznos Corp., 365 N.W.2d 82, 87–88 (Mich. 1984) (holding that although state antidiscrimination laws protect minors, the laws do not require "identical treatment of children and adults in every situation," and observing that the contrary conclusion would dramatically disrupt contract law, social norms, and the parent-child relationship).

[4] *Cf.* Caldwell, *supra* note 1 (discussing the proposal to weaken limits on health insurance premiums for older purchasers).

[5] *See* Lainie Friedman Ross et al., *Equal Opportunity Supplemented by Fair Innings: Equity and Efficiency in Allocating Deceased Donor Kidneys*, 12 AM. J. TRANSPLANTATION 2115, 2115–16 (2012) (describing the kidney allocation system proposed by UNOS).

[6] *See* Robert L. Klitzman, *How Old Is Too Old? Challenges Faced by Clinicians Concerning Age Cutoffs for Patients Undergoing in Vitro Fertilization*, 106 FERTILITY & STERILITY 216, 217 (2016) (reporting on the American Society for Reproductive Medicine's ("ASRM") recommendations against providing infertility treatment to women over a certain age).

5. Francisco, eighty-five, receives poorer quality long-term care because caregivers find it repulsive to care for older people.[8]
6. Gail, fifty, is refused infertility treatment by a provider who believes it is unnatural for older women to give birth.[9]

The two prevailing theoretical approaches to age-based criteria are what I call *nondiscrimination* and *discretion*. The nondiscrimination approach identifies with the use of "heightened scrutiny" in equal protection doctrine.[10] Under this approach, age-based criteria are viewed with great skepticism, analogous to race-based criteria: they are permissible—if at all—only when they advance the interests of disadvantaged groups.[11] The nondiscrimination approach would prohibit the use of age-based criteria in many of the above cases, with the possible exception of Eric's; even in Eric's case, this approach would likely grant him a right to individualized review if he sought a colonoscopy. In contrast, the discretion approach, identified with the use of highly deferential versions of "rational basis" scrutiny in equal protection doctrine, views age-based criteria as broadly permissible and gives wide leeway to medical professionals' judgments.[12] This approach would likely permit the use of age-based criteria in all the above cases, with Gail's case presenting the closest question.

Rather than adopting either the nondiscrimination or the discretion approach, or engaging in an *ad hoc* balancing of these approaches, this Article defends a *distributive justice* approach to age-based criteria. Instead of viewing age as a personal characteristic akin to race or sex, the distributive justice approach regards age as relevant in two ways to the distribution of an extremely valuable and widely desirable good, namely years of life. First, age establishes how much life someone has already enjoyed. Second, age indicates (though imperfectly) how much more life a person is likely to gain

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[7] *See* U.S. PREVENTIVE SERVS. TASK FORCE, USPSTF A AND B RECOMMENDATIONS (2018), https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ [https://perma.cc/8AQD-AXLJ] (recommending that colorectal cancer screening start at age 50 and end at age 75).

[8] *See* Tova Band-Winterstein, *Health Care Provision for Older Persons: The Interplay Between Ageism and Elder Neglect*, 34 J. APPLIED GERONTOLOGY NP113, NP120–21 (2013).

[9] *See* Melissa Reynolds, Note, *How Old Is Too Old? The Need for Federal Regulation Imposing a Maximum Age Limit on Women Seeking Infertility Treatments*, 7 IND. HEALTH L. REV. 277, 295 (2010) (arguing that providing infertility treatment to post-menopausal women is "unethical").

[10] *See infra* notes 64–94 and accompanying text.

[11] *See* J. Grimley Evans, *Rationing Health Care by Age: The Case Against,* 313 BMJ 822, 823 (1997) (analogizing age-based criteria to race- and sex-based criteria); John Harris, Editorial, *It's Not NICE to Discriminate*, 31 J. MED. ETHICS 373, 375 (2005) (arguing that the "principle of equality applies as much in the face of discrimination on the basis of chronological age . . . as it does to discrimination on the basis of gender, race, and other arbitrary features").

[12] *See infra* notes 64–94 and accompanying text.

from treatment. A distributive justice approach also differentiates justifications grounded in distributive considerations—such as the higher predicted costs of treating older patients—from justifications grounded in animus or false stereotypes about older patients.[13] The former can be justifiable, but the latter never are, and a distributive justice approach would therefore reject the rationales offered in Francisco's and Gail's cases. The distributive justice approach is therefore aligned with the emerging animus-focused approach to antidiscrimination law.[14] The distributive justice approach does better than the discretion approach at addressing genuine unfairness faced by older people, and it does better than the nondiscrimination approach at avoiding reliance on intrusive, costly, and divisive individualized judgments or the adoption of simplistic distributive frameworks that waste precious resources and ignore the compelling moral claims of younger people.[15] The distributive justice approach, however, requires abandoning simple rhetoric, like the claim that "charging older people more" for health insurance is obviously wrong, in favor of more nuanced positions, such as the stance that age-rated premiums can be appropriate but must be designed to be fair to people in different age groups.[16]

Justifications for using age-based criteria can be grouped into at least four different categories: (1) those grounded in the interests of older patients themselves, (2) those grounded in the interests of medical care providers, (3) those grounded in the interests of society as a whole, and (4) those grounded in factors other than interests. I call these justifications "patient-based," "provider-based," "societal," and "non-interest." Patient-based justifications typically involve safety or harmful side effects.[17] They can also involve patients' financial interests, especially when treatments have higher costs or lower efficacy in older patients. Provider-based justifications can also reflect safety fears: a physician may refuse to be complicit in inflicting

[13] *See infra* notes 95–170 and accompanying text.

[14] *See generally* Dale Carpenter, Windsor *Products: Equal Protection from Animus*, 2013 SUP. CT. REV. 183 (discussing animus).

[15] *Cf.* Peter H. Schuck, *The Graying of Civil Rights Law: The Age Discrimination Act of 1975*, 89 YALE L.J. 27, 90–93 (1979).

[16] *See* Rebecca Savransky, *Senate Dem: Graham-Cassidy Is an "Intellectual and Moral Garbage Truck Fire,"* HILL (Sept. 18, 2017), http://thehill.com/policy/healthcare/351200-senate-dem-graham-cassidy-an-intellectual-and-moral-garbage-truck-fire [https://perma.cc/D7FN-GGV8] (reporting on Senator Chris Murphy's tweet).

[17] *See, e.g.*, Warren v. State, 778 S.E.2d 749, 763 (Ga. 2015) (noting expert agreement on the heightened risks of antipsychotic medications in older patients); Coombes v. Florio, 877 N.E.2d 567, 574 (Mass. 2007) (concluding that patients' age can make harmful side effects more likely and severe).

harm even on a willing patient.[18] They can also reflect concerns about futility or inefficacy.[19] More controversially, they may involve providers protecting their own financial interests by, for instance, refusing to perform risky procedures on older patients because a failed procedure would hurt their success rates and thereby lower their reimbursements.[20] Societal justifications for age-based criteria typically reflect concerns about the fair distribution of medical resources, especially resources that are scarce (such as transplantable organs) or expensive (such as chemotherapy medications or intensive care beds). These justifications often appeal to the ethical principles that scarce and expensive resources should go to individuals who (1) have a greater prospect of benefit, or (2) are at risk of dying young if they are not helped.[21] Last, non-interest justifications aim to prevent "free-floating evils" that do not implicate interests at all.[22] Table 1 categorizes the above examples using this schema.

Table 1: Categorizing Justifications for Age-Based Criteria

Patient-Based	Provider-Based	Societal	Non-Interest
Eric	Deepa Anne (private insurer) Francisco	Charlotte Anne (government insurer)	Gail

Disputes about age-based criteria in medicine often have deeply personal stakes: many of us fear the prospect of ourselves, or our parents, be-

[18] *See, e.g.*, Teneille Ruth Brown, *Medical Futility and Religious Free Exercise*, 15 FIRST AMEND. L. REV. 43, 56 (2016) (observing that "nurses and physicians . . . resist feeling complicit in 'torturing' a patient with ventilators, pokes, and tracheotomies"). An excellent discussion of complicity that distinguishes provider-based and patient-based concerns can be found in Seana Valentine Shiffrin, *Paternalism, Unconscionability Doctrine, and Accommodation*, 19 PHIL. & PUB. AFF. 205, 227–30 (2000).

[19] *See* Brown, *supra* note 18, at 56 (observing that physicians "do not want to be 'indentured servants' or 'grocers,' required to provide whatever treatment their patients and surrogates want"); Thaddeus Mason Pope, *Medical Futility Statutes: No Safe Harbor to Unilaterally Refuse Life-Sustaining Treatment*, 75 TENN. L. REV. 1, 16 (2007) (stating that "many health care providers do not consider the practice of medicine to include measures aimed solely at maintaining corporeal existence and biologic functioning").

[20] *See* Bjorg Thorsteinsdottir, Keith M. Swetz & Jon C. Tilburt, *Dialysis in the Frail Elderly—A Current Ethical Problem, an Impending Ethical Crisis*, 28 J. GEN. INTERNAL MED. 1511, 1511 (2013) (discussing the refusal of services to older patients for financial reasons). The permissibility of at least some self-serving choice by physicians is defended in Paul Litton, *Physician Participation in Executions, the Morality of Capital Punishment, and the Practical Implications of Their Relationship*, 41 J.L. MED. & ETHICS 333, 341 (2013) (arguing that "a physician's personal interests, unrelated to promoting health, represent legitimate limits to the duty of patient loyalty").

[21] *See* Govind Persad, *Priority Setting, Cost-Effectiveness, and the Affordable Care Act,* 41 AM. J.L. & MED. 119, 136–37 (2015).

[22] *See* JOEL FEINBERG, HARMLESS WRONGDOING 17–20 (1988) (introducing the concept of a "free-floating evil").

ing assigned lower priority for medical treatment in old age. Although I do not expect to defuse controversy, a few clarifications can help avert potential misinterpretations. First, the distributive justice approach regards the use of age-based criteria that may disadvantage some older patients as a fallback option. Treating everyone, if it can be done without sacrificing anything of moral importance, is ethically preferable to denying beneficial treatment to some. That some treatments are less effective in older patients, which supports a patient-based justification for the use of age-based criteria, should also motivate a search for treatments that are effective in all population groups.[23] Similarly, when evaluating societal justifications grounded in resource scarcity, the first option should always be to assess whether genuine scarcity exists, rather than treating scarcity as fixed or unchangeable.[24] Scarcity exists on a spectrum, ranging from conflicts over access to organs (where increasing supply is difficult) to conflicts over access to medicines (where the only barrier is money). Older people's claims to scarce treatment, even if weaker than the claims of younger people, may be stronger than wealthy people's claims to retain wealth that could be used to ameliorate scarcity.[25] But even though scarcity frequently stems from background injustice and resource misallocation, the need to allocate scarce resources fairly persists. Last, because the distributive justice approach appeals to scarcity, it differs from the approach taken by Daniel Callahan and others, which regards the provision of life-extending treatment to older adults as undesirable even in the absence of scarcity.[26]

Second, the distributive justice approach is not committed to the view that age must be the decisive factor in every decision. Hypotheticals that compare deserving older people to undeserving younger ones, or greater numbers of older people to lesser numbers of younger ones, are therefore beside the point.[27] Such hypotheticals do not show that age is irrelevant, but only that it can be outweighed by other considerations. This Article's goal is

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[23] *Cf.* Klitzman, *supra* note 6, at 217 (reporting on the ASRM's recommendations against providing infertility treatment to women over a certain age).

[24] *Cf.* Ezekiel J. Emanuel & Govind Persad, *The Ethics of Expanding Access to Cheaper, Less-Effective Treatments—Authors' Reply*, 389 LANCET 1008, 1008 (2017) (arguing that the cost and availability of medical resources are variable and impacted by social and political decision making).

[25] *Cf.* Frank Pasquale, Book Review, 32 J. LEGAL MED. 529, 535–36 (2011) (reviewing M. GREGG BLOCHE, THE HIPPOCRATIC MYTH (2011) and arguing that "[t]he current scarcity of care for the least well off is not a natural feature of the world; rather, it is epiphenomenal of repeated decisions not to impose certain tax burdens today").

[26] DANIEL CALLAHAN, SETTING LIMITS 116 (1987); *see also* Nancy S. Jecker, *Disenfranchising the Elderly from Life-Extending Medical Care*, 2 PUB. AFF. Q. 51, 64–65 (1988) (explaining that Callahan's view and a similar view defended by Alasdair MacIntyre do not rely on scarcity).

[27] *See, e.g.*, Michael M. Rivlin, *Several Other Markers of Fairness Exist, Besides Age*, 314 BMJ 514, 514 (1997) (presenting hypotheticals).

not to offer a complete theory of justice in health, but to defend the proposition that age-based criteria can be part of a just health care system.

Part I of this Article explains that age discrimination statutes, as well as the Equal Protection Clause and similar state constitutional provisions, permit the use of age-based criteria when those criteria have a rational grounding and do not appeal to animus or bias.[28] These laws therefore leave room open for the use of a distributive justice approach. Part II argues that the conceptual underpinnings of antidiscrimination law do not support the enactment of new law, or the adoption of new interpretations of existing law, that would reject the use of age-based criteria.[29] Part III proposes a detailed normative framework for the use of age-based criteria in health care, the *lifetime justice approach*, that considers the future life patients can gain from treatment and the past years of life they already have experienced.[30] The lifetime justice approach also includes a principle of nonabandonment, which supports the continued provision of supportive medical care to older people in need.[31] Part III then defends this framework against objections—most prominently, the objection that it disregards the moral equality of older people.[32] Part IV applies the analysis offered in the earlier Parts to age-based criteria employed in various areas of medical practice and health policy, including the examples of transplantation and health insurance discussed at the outset.[33]

I. THE LEGALITY OF AGE-BASED CRITERIA: DOCTRINE

In this Part, I consider whether federal and state antidiscrimination statutes or equal protection provisions in the federal Constitution and many state constitutions support a limitation on the use of age-based criteria for access to medical treatment.[34]

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[28] *See infra* notes 34–94 and accompanying text.
[29] *See infra* notes 95–170 and accompanying text.
[30] *See infra* notes 171–242 and accompanying text.
[31] *See infra* notes 202–209 and accompanying text.
[32] *See infra* notes 210–242 and accompanying text.
[33] *See infra* notes 243–296 and accompanying text.
[34] *See infra* notes 35–94 and accompanying text. Outside of the employment context, where age discrimination can sometimes support common-law wrongful discharge actions, there are few avenues for bringing common-law age discrimination claims.

A. Antidiscrimination Statutes

1. Federal Statutes

Section 1557 of the ACA includes language proscribing age discrimination.[35] This language has been welcomed by commentators and advocates who believe that age-based criteria should be analyzed using an antidiscrimination framework and should frequently be rejected as unacceptable.[36] Rather than crafting an entirely new approach to age discrimination or borrowing the approaches used for race, sex, or disability discrimination, § 1557's prohibition on age discrimination adopts and extends the approach taken in the Age Discrimination Act of 1975 ("Age Act").[37] The Age Act specifies that "no person in the United States shall, on the basis of age, be excluded from participation in, be denied the benefits of, or be subjected to discrimi-

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[35] *See* Valarie K. Blake, *An Opening for Civil Rights in Health Insurance After the Affordable Care Act*, 36 B.C. J.L. & SOC. JUST. 235, 269 (2016) (describing a Connecticut court's reliance, in part, on § 1557 to remove an age limit for infertility treatment); Andrew C. Stevens, *Patient Discrimination Litigation Under Section 1557 of the ACA: A Sleeping Giant?*, 9 J. HEALTH & LIFE SCI. L. 111, 116 (2016) ("It is clear that this sleeping giant of patient discrimination litigation is beginning to wake. Will the health care industry be ready?"); Sidney D. Watson, *Section 1557 of the Affordable Care Act: Civil Rights, Health Reform, Race, and Equity*, 55 HOW. L.J. 855, 880 (2012) (noting novelty and breadth of § 1557). The ACA contains additional provisions that explicitly direct when age may be used in medical decision making, which I discuss in other work. *See* Persad, *supra* note 21, at 136–38, 140–46 (2015).

[36] *See* NAT'L WOMEN'S LAW CTR., STATE OF WOMEN'S COVERAGE: HEALTH PLAN VIOLATIONS OF THE AFFORDABLE CARE ACT 19 (2015), https://www.nwlc.org/wp-content/uploads/2015/08/stateofcoverage2015final.pdf [https://perma.cc/C5NP-CRZQ] (criticizing insurers that limit coverage for reproductive health services based on age); Blake, *supra* note 35, at 270; *see also* Community Catalyst, Comment Letter on Proposed Rule on Nondiscrimination in Health Programs and Activities (Sept. 9, 2015), https://www.govinfo.gov/content/pkg/FR-2016-05-18/pdf/2016-11458.pdf [https://perma.cc/3Q9Z-MKFQ] (arguing that DHHS should prohibit "[p]lacing age limits on certain types of reproductive health services based on the age of the recipient"); Letter from M. James Kaufman, Vice President, Public Policy, Children's Hosp. Ass'n, to Jocelyn Samuels, Dir., Office for Civil Rights., U.S. Dep't of Health & Hum. Servs. (Nov. 9, 2015), https://www.childrenshospitals.org/-/media/Files/CHA/Main/Issues_and_Advocacy/Key_Issues/Medicaid/Letters_and_Testimony/2015/CCH_Comments_1557_Nondiscrimination_Proposed_Rule11,-d-,09,-d-,2015.pdf [https://perma.cc/PU4N-GWG3] (arguing that the DHHS should clarify that insurers cannot impose "arbitrary age" limits).

[37] *See* The Age Discrimination Act of 1975, 42 U.S.C. §§ 6101–6107 (2012) ("Age Act") (listing the regulations that prohibit age-based discrimination in any program or activity that receives federal funds). The Health Security Act (HSA) proposed during the 1990s also would have incorporated the Age Act's provisions. *See* Vernellia R. Randall, *Does Clinton's Health Care Reform Proposal Ensure (E)qual(ity) of Health Care for Ethnic Americans and the Poor?* 60 BROOK. L. REV. 167, 193 n.127 (1994).

nation under, any program or activity receiving Federal financial assistance."[38]

There is no published precedent either prohibiting the use of an age-based criterion in health care under § 1557 or upholding the use of such a criterion. Valarie Blake reports that Connecticut modified its age-based criteria for reimbursing infertility treatments in light of § 1557, although it also relied on new medical evidence, leaving ambiguous whether age-based criteria were universally barred, or whether the new evidence in this particular situation made the difference.[39] The Age Act itself also has not generated precedent in the health context, although the Obama administration's Department of Health and Human Services (DHHS) raised informal concerns that proposals, such as the proposal discussed in the introduction, to "age-match" organs for transplantation—i.e. to provide organs from donors of a given age to recipients in roughly the same age bracket—would violate the Age Act.[40] Transplantation scholars argued that a well-designed age-matching proposal should be legal when impacts on individuals over their entire lifetimes are considered, and DHHS apparently conceded that age-based criteria can be acceptable when age is not the sole factor considered in determining eligibility, or when age-based cutoffs are supported by a detailed justification.[41]

The modest academic literature on the Age Act's applicability to medicine has reached little consensus. Some commentators assert that the use of age cutoffs for access to medical procedures would violate the Age Act, others claim that the Age Act offers little protection in practice against the allocation of resources by age, and another concludes that the question is a

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[38] 42 U.S.C. § 6102. The applicability of the Age Discrimination in Employment Act (ADEA) to health insurance designs that differentiate beneficiaries based on age has also generated some litigation. *See, e.g.*, Am. Ass'n of Ret. Pers. v. EEOC, 489 F.3d 558 (3d Cir. 2008).

[39] Blake, *supra* note 35, at 269.

[40] Ross et al., *supra* note 5, at 2115–16 (noting the HHS's concerns that the kidney allocation proposal's age-matching formula is arbitrary); *see also* David L. Weimer, *Stakeholder Governance of Organ Transplantation: A Desirable Model for Inducing Evidence-Based Medicine?* 4 REG. & GOVERNANCE 281, 291 (2010) (observing that, after the introduction of a proposal for organ allocation in 2009, "HHS staff who sit ex officio on the committees . . . expressed concern that, because the proposal uses age as a factor in predicting net benefits, the HHS Office of Civil Rights might object on the basis of age discrimination").

[41] Richard N. Formica, John J. Friedewald & Mark Aeder, *Changing the Kidney Allocation System: A 20-Year History,* 3 CURRENT TRANSPLANTATION REP. 39, 40 (2016) (reporting that the Office of Civil Rights advised that age could be used to determine kidney allocation if it is not the sole factor and that "if age was to be used as a single metric, there must be a rationale as to why 15 versus 14 versus 16 years was chosen"); Ross et al., *supra* note 5, at 2118 (arguing for an allocation system that equalizes treatment for individuals at different life stages).

close one.[42] Some also suggest that the use of age as one factor among many is more legally defensible than the use of age as a sole factor.[43]

I will argue that two major exceptions in the Age Act—those for (1) age-based criteria explicitly adopted in law and (2) the "normal operation" of programs—leave ample room for distributive justice considerations. First, the Age Act does not apply to criteria that are themselves explicitly adopted in federal, state, or local law or that are necessary for the achievement of objectives adopted in such law.[44] This exemption is consonant with the distributive justice approach: it allows legislative bodies, which are the proper actors to make population-level distributive judgments, to consider age.[45] That the Age Act permits age-based criteria that are explicitly approved under state law supports the view that Connecticut's decision to change its infertility reimbursement guidelines was motivated by new empirical evidence, rather than by a broad § 1557 prohibition on the use of

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[42] *See* Howard Eglit, *Health Care Allocation for the Elderly: Age Discrimination by Another Name?* 26 HOUS. L. REV. 813, 873–74 (1989) (discussing the administrative challenges of implementing the Age Act); Thomas D. Overcast & Roger W. Evans, *Technology Assessment, Public Policy and Transplantation: A Restrained Appraisal of the Massachusetts Task Force Approach*, 13 LAW MED. & HEALTH CARE 106, 109 (1985) (explaining that the exceptions in the Age Act that permit using age as a factor weaken the likelihood that the Age Act will be used to challenge an age discrimination claim); Jessica Dunsay Silver, *From Baby Doe to Grandpa Doe: The Impact of the Federal Age Discrimination Act on the "Hidden" Rationing of Medical Care*, 37 CATH. U. L. REV. 993, 1070 (1988) (asserting that a health care provider who continually refuses to treat patients due to their age could be subject to the Age Act); *see also* Patrick R. Grady, *You've Got to Have (a) Heart: Allocating Hearts for Transplantation: Should Age Make a Difference?*, 7 EXPERIENCE 12, 14 (1997) (noting that the applicability of the Age Act to Medicare and Medicaid is uncertain); Haavi Morreim, *Should Age Be a Basis for Rationing Health Care?: Commentary 1*, 16 VIRTUAL MENTOR 339, 341 (2014) (arguing that an age cutoff for access to medical treatment would likely violate the Age Act); Karen DeBolt, Comment, *What Will Happen to Granny? Ageism in America: Allocation of Healthcare to the Elderly & Reform Through Alternative Avenues*, 47 CAL. W. L. REV. 127, 166 (2010) (noting that the Age Act does little to protect older persons from Medicare's "rationing of heart transplants"); Benjamin Eidelson, Comment, *Kidney Allocation and the Limits of the Age Discrimination Act*, 122 YALE L.J. 1635, 1645 (2013) (stating that the convergence of the Age Act's purpose and its application presents "difficult questions").

[43] Silver, *supra* note 42, at 1070 (arguing that the use of age as one factor among others enables fairness, individualized examinations, and provides practical advantages); *see also* Eidelson, *supra* note 42, at 1650 (arguing that a "compound longevity estimate" including non-age factors may be more legally defensible).

[44] 42 U.S.C. § 6103 (listing the exemptions to the Age Act). As one case puts it, "[t]he Age Discrimination Act differs somewhat from the other civil rights statutes in that the Age Discrimination Act itself specifies certain categories of age discrimination which will be considered permissible." NAACP v. Wilmington Med. Ctr., Inc., 491 F. Supp. 290, 316 (D. Del. 1980), *aff'd sub nom.* NAACP v. Med. Ctr., Inc., 657 F.2d 1322 (3d Cir. 1981).

[45] *Cf.* Peter M. Gerhart, *The Tragedy of TRIPS*, 2007 MICH. ST. L. REV. 143, 159 (arguing that "[l]egislatures can reflect the kind of basic values and shared goals that allow distributive policies to be enacted and sustained").

age-based criteria.[46] Had Connecticut wanted to continue using age-based criteria for reimbursement, it could have done so by passing legislation. The distributive justice approach can also explain why age-based criteria adopted by administrators rather than legislators remain subject to the Age Act; although some have questioned "how an age distinction can be discriminatory when adopted by program administrators and not discriminatory when enacted by legislators," administrative discretion allows more room for biased judgments than an explicit legislative enactment does.[47]

The "normal operation" exception also allows for distributive considerations and rejects a pure nondiscrimination approach. The permissibility of taking age into account as a factor necessary for the normal operation of a program is judged by a four-part test: (1) age must be used as a measure of some other characteristic, (2) the other characteristic must itself be important to the normal operation or statutory objective of the activity, (3) age must be a reasonable proxy for the other characteristic, and (4) direct measurement of the other characteristic must be impractical.[48] This exception would allow the use of age as a proxy for future life expectancy. It also could allow the use of age as a comparative measure of past years of life lived, even while prohibiting the use of approaches that set an absolute age cutoff. Although knowing a person's age also tells you how many years of life a person has lived, the fact of age in itself is different from the number of years someone has already enjoyed (to which the distributive justice approach appeals).[49]

Section 1557, following the Age Act's framework, also requires complainants to exhaust administrative remedies, including mediation, before filing suit.[50] During the rulemaking process, some advocates argued that § 1557 should be interpreted to drop the Age Act's administrative exhaustion requirement, resulting in age discrimination claims being treated identically to race or sex discrimination claims, where exhaustion is not re-

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[46] *Cf.* Blake, *supra* note 35, at 269 (stating that the court's reasoning was ambiguous).

[47] Silver, *supra* note 42, at 1035; *see* 45 C.F.R. § 90.13 (2018) (defining normal operation as the "operation of a program or activity without significant changes that would impair its ability to meet its objectives").

[48] 45 C.F.R. § 90.14 (listing the four exceptions to the prohibition on using age as a factor).

[49] *Cf.* Espen Gamlund, *What Is So Important About Completing Lives? A Critique of the Modified Youngest First Principle of Scarce Resource Allocation*, 37 THEORETICAL MED. & BIOETHICS 113, 123 n.18 (2017) (distinguishing "the moral relevance of age simpliciter" from the significance of age as "an important indicator of the degree of completion of a life").

[50] *See* 45 C.F.R. §§ 91.42-44, 91.50 (explicitly requiring exhaustion of administrative remedies); Phoebe Weaver Williams, *Age Discrimination in the Delivery of Health Care Services to Our Elders*, 11 MARQ. ELDER'S ADVISOR 1, 33–35 (2009) (describing the Age Act's administrative procedural requirements).

quired.[51] The final rules, however, maintained the administrative exhaustion requirement.[52] The choice to maintain the administrative exhaustion requirement is consistent with the distributive justice approach in that mediation and administrative remedies may be appropriate for a distributive disagreement, whereas proceeding directly to litigation is more appropriate where an inherently objectionable criterion such as race or sex is at issue.[53]

2. State and Local Statutes

State civil rights statutes often proscribe age discrimination in public accommodations.[54] (Some, however, contain explicit exemptions for age-based criteria targeting minors, for reasonable consideration of age in general, or for laws that disadvantage people under forty.) [55] Some state statutes specific to the operation of health programs, such as clinical research or sterile injection

[51] *See* Healthcare and Equal. Experts, Comment on Proposed Rule on Nondiscrimination in Health Programs and Activities (Nov. 8, 2015), https://law.yale.edu/system/files/documents/pdf/Solomon/healthcareequalitylawexpertsltr.pdf [https://perma.cc/U5GU-LBST] (describing the requirement for administrative exhaustion of age discrimination claims as an "absurd consequence[]" given that sex discrimination claims do not require administrative exhaustion); *cf.* Rumble v. Fairview Health Servs., No. 14-CV-2037, 2015 WL 1197415, at *11 (D. Minn. Mar. 16, 2015) (rejecting the "illogical result" of having different procedural requirements apply whether the § 1557 plaintiff's claim is due to "race, sex, age, or disability"); Watson, *supra* note 35, at 880 (noting that § 1557 plaintiffs "appear to have their choice of process").

[52] *See* Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,441 (May 18, 2016) (to be codified at 45 C.F.R. pt. 92) (providing that "[m]ediation and exhaustion of administrative remedies will still be required for age discrimination allegations in complaints, but not for allegations of other covered types of discrimination").

[53] *Cf.* Schuck, *supra* note 15, at 63 (contrasting the Age Act with Title VI, which prohibits discrimination on the basis of race or ethnicity).

[54] *See* Nat'l Conf. of State Legislatures, State Public Accommodation Laws (2016), http://www.ncsl.org/research/civil-and-criminal-justice/state-public-accommodation-laws.aspx [https://perma.cc/RA5Q-57GJ] (listing nineteen states that prohibit "age-based discrimination in areas of public accommodation").

[55] *See, e.g.*, CONN. GEN. STAT. ANN. § 46a-64 (2018) (exempting minors from the prohibition against age discrimination); 775 ILL. COMP. STAT. ANN. § 5/1-103 (2018) (excepting apprenticeship programs from the definition of age as, "the chronological age of a person who is at least 40 years old"); LA. STAT. ANN. § 51:2231 (2018) (stating that the age discrimination prohibitions "in connection with public accommodations shall be limited to individuals who are at least forty years of age"); MONT. CODE ANN. § 49-2-304 (2017) (permitting consideration of age when "based on reasonable grounds"); N.D. CENT. CODE ANN. § 14-02.4-02 (West 2018) (defining age as at least forty years); OR. REV. STAT. ANN. § 659A.406 (2018) (limiting the prohibition against age discrimination to persons at least 18 years of age); VA. CODE ANN. § 2.2-3902 (2018) (permitting age distinctions "where the program, law or activity constitutes a legitimate exercise of powers of the Commonwealth for the general health, safety and welfare of the population at large"); *see also* OHIO REV. CODE ANN. § 4112.02 (2018) (permitting mandatory retirement ages for police and firefighters).

programs, also contain language barring age discrimination.[56] Local ordinances can also contain protections for older people, including protections against age discrimination.[57]

There is no case law examining how state and local law might limit the use of age-based criteria, and there is little scholarly analysis of the topic. The one exception is a student comment criticizing a recent Oklahoma statute for potentially requiring "transplant centers in Oklahoma to perform organ transplants on patients who may not only fail to qualify as candidates but also to survive the procedure itself due to age or illness."[58] The statute proscribes medical decisions that are grounded in any view that regards "extending the life of an elderly, disabled, or terminally ill individual as of lower value than extending the life of an individual who is younger, nondisabled, or not terminally ill."[59] A distributive justice approach, however, need not claim that extending an elderly person's life has "lower value" for that person or for society; instead—analogous to some arguments for progressive taxation—it can claim that an elderly person has less need for an extra year of life and therefore less entitlement to that year, even though the year has the same value for her as it would for someone else.[60] It therefore may not fall afoul of the statute. Additionally, the statute's placement of age alongside disability suggests that the statute's aim is to prohibit the assignment of a lower "quality weight" to life extension for elderly or disabled people, rather than to prohibit the consideration of how many years some-

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[56] *See, e.g.*, ARIZ. REV. STAT. ANN. § 36-3005 (2018) (stating that domestic violence service providers may not receive federal funds if they discriminate on the basis of age); HAW. REV. STAT. ANN. § 334E-2 (2018) (providing that patients in psychiatric facilities are not to be subject to "discriminatory treatment" due to age); MINN. STAT. ANN. § 148F.17 (2018) (requiring providers who "teach, evaluate, supervise, or conduct research" to not "discriminate on the basis of . . . age" against research subjects); NEV. REV. STAT. ANN. § 439.994 (2017) (prohibiting age discrimination in any "sterile hypodermic device program"); OR. REV. STAT. ANN. § 659.875 (2018) (prohibiting age discrimination by "any health benefit plan issued or delivered in this state"); S.C. CODE ANN. § 44-69-80 (2018) (prohibiting age discrimination by home health agencies "in the recruitment, location of patient, acceptance or provision of goods and services to patients or potential patients").

[57] *See* Israel Doron & Kim Dayton, *"Thinking Locally": Law, Aging, and Municipal Government: Findings from a National Survey*, 21 TEMP. POL. & C.R. L. REV. 365, 372 (2012) (discussing more than one thousand local ordinances that potentially implicated rights of the elderly).

[58] Kendra Norman, Comment, *Live and Let Die: The Consequences of Oklahoma's Nondiscrimination in Treatment Act*, 68 OKLA. L. REV. 585, 608 (2016) (arguing that the statute prevents medical providers from making important quality of life "value judgment[s]"). The statute was based on model legislation written by an interest group, the National Right to Life Committee, which suggests that similar statutes are likely to be proposed elsewhere. *See id.* at 600.

[59] OKLA. STAT. ANN. § 3090.3 (2018).

[60] I distinguish the *value* of additional life to a person from the *entitlement* that person has to additional years of life at *infra* note 190 and accompanying text.

one has enjoyed.[61] The statute also does not require that providers be indifferent to the number of years a patient can gain from treatment. Finally, the statute's reference to "elderly" individuals, rather than to age as such, makes it inapplicable to age-based criteria that differentiate younger people from middle-aged people.[62]

Going beyond the distinctive language of the Oklahoma statute, most state statutes prohibit age "discrimination," rather than using the broader Age Act language that prohibits exclusion from programs or denial of benefits. This language leaves more room for distributive justice considerations because not all cases where age-based criteria *disadvantage* a patient necessarily constitute age *discrimination*.[63] Recognizing a difference between disadvantage and invidious discrimination could harmonize state statutory law with equal protection law, which I discuss next.

B. Equal Protection

Discussions of a constitutional prohibition on age discrimination have focused on the Fourteenth Amendment's Equal Protection Clause.[64] In 1976, in *Massachusetts Board of Retirement v. Murgia*, the Supreme Court determined that older adults are not a group akin to racial or national-origin groups, observing that age discrimination—even against the elderly—has not been as severe as racial discrimination, and that "old age does not define a 'discrete and insular' group . . . in need of 'extraordinary protection from the majoritarian political process,'" but only "marks a stage that each of us will reach if we live out our normal span."[65] Accordingly, the Court con-

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[61] *See* OKLA. STAT. ANN. § 3090.

[62] *See id*.

[63] *Cf.* Persad, *supra* note 21, at 147–48 (differentiating between various concerns including: (1) varying treatment of individuals with differing health statuses; (2) whether "designs systematically disadvantage" people due to their belonging to an "illness-based class"; and (3) whether insurance disadvantages people who belong to a "non-illness-based class[]").

[64] See U.S. CONST. amend. XIV, § 1 (stating that "[n]o state shall make or enforce any law which shall . . . deny to any person within its jurisdiction the equal protection of the laws"). Beyond the Fourteenth Amendment itself, there is a small scholarly literature, but no published precedent, concerning whether the Twenty-Sixth Amendment's prohibition on abridging the voting rights of people over eighteen should be "read back" into the Fourteenth Amendment's antidiscrimination guarantee to decisively establish a prohibition on age discrimination. *Compare* Eric S. Fish, Response, *Originalism, Sex Discrimination, and Age Discrimination*, 91 TEX. L. REV. SEE ALSO 1, 2–3 (2012), http://texaslawreview.org/wp-content/uploads/2015/08/Fish-91-TLRSA-1.pdf [https://perma.cc/AU6U-X426] (rejecting the view that the Twenty-Sixth Amendment supports a prohibition on age discrimination outside the voting rights context), *with* Michael C. Dorf, *Equal Protection Incorporation*, 88 VA. L. REV. 951, 995 (2002) (arguing that the Twenty-Sixth Amendment supports the position that "age discrimination should be presumptively invalid").

[65] Mass. Bd. of Ret. v. Murgia, 427 U.S. 307, 313–14 (1976) (per curiam).

cluded that, under the Equal Protection Clause, classifications that disadvantage older people do not require the strict scrutiny applied to classifications on the basis of race or national origin, but rather only require a rational basis.[66] Individualized assessment of older people's capacities is not required.[67]

In dissent, Justice Marshall agreed that age-based classifications differ from race- or sex-based classifications because older people are not "isolated in society, and discrimination against them is not pervasive but is centered primarily in employment."[68] Focusing on the importance of employment, he would have concluded that "to sustain the legislation appellants must show a reasonably substantial interest and a scheme reasonably closely tailored to achieving that interest."[69] Marshall also would have concluded that automatic employment termination on the basis of age, without individualized testing, is irrational.[70]

The Supreme Court has subsequently reaffirmed and extended the approach taken in *Murgia*, most recently by adopting the position that "[s]tates may discriminate on the basis of age without offending the Fourteenth Amendment if the age classification in question is rationally related to a legitimate state interest."[71] This language makes explicit that a rational basis test applies to age-based criteria that disadvantage middle-aged or younger people, as well as to those that disadvantage older people.

Some commentators have asserted that *Murgia* and its progeny rest on factual mistakes or invidious stereotypes and should be overturned.[72] More innovatively, Nina Kohn has argued that the use of age-based criteria in specific contexts, such as medical decision making, can be subject to heightened legal scrutiny even if *Murgia* and subsequent cases remain good law.[73] Kohn asserts that the "case for heightened scrutiny in the health care context would

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[66] *Id.* at 314–15.

[67] *Id.* at 316.

[68] *Id.* at 325 (Marshall, J., dissenting).

[69] *Id.*

[70] *Id.* at 327 (finding "no reason at all for automatically terminating those officers who reach the age of 50; indeed, that action seems the height of irrationality").

[71] Kimel v. Fla. Bd. of Regents, 528 U.S. 62, 83 (2000).

[72] *See* Julie R. Steiner, Comment, *Age Classifications and the Fourteenth Amendment: Is the* Murgia *Standard Too Old to Stand?,* 6 SETON HALL CONST. L.J. 263, 293 (1995); *see also* Nina A. Kohn, *Rethinking the Constitutionality of Age Discrimination: A Challenge to a Decades-Old Consensus*, 44 U.C. DAVIS L. REV. 213, 247 (2010).

[73] *See* Kohn, *supra* note 72, at 260. Kohn relies on the work of another scholar, Julie Nice, who identifies a "third strand" of equal protection case law that addresses situations where important rights are denied on the basis of "class-based distinctions," such as age distinctions. *See* Julie A. Nice, *The Emerging Third Strand in Equal Protection Jurisprudence: Recognizing the Co-Constitutive Nature of Rights and Classes*, 1999 U. ILL. L. REV. 1209, 1211 (articulating the "third strand" approach to equal protection analysis).

be most compelling where the government uses age-based classifications to deny older adults the right to obtain a certain procedure regardless of need or ability to pay," as with a hypothetical "policy that stated that no person over a certain age could receive a certain type of organ transplant regardless of his or her need or ability to pay."[74] Heightened scrutiny of such a policy is warranted because "the government would be denying a very important interest (that in a vital organ) to a very vulnerable population (older people in need of such an organ)."[75] This approach, as Kohn observes, combines equal protection and fundamental rights analyses. Kohn likewise argues that age-based reimbursement criteria for back surgery should receive heightened scrutiny, though she acknowledges that the case here is weaker.[76] Kohn concedes, however, that age-based criteria for the provision of financial benefits would likely not receive heightened scrutiny.[77] This conclusion would support the constitutionality of age-rated insurance premiums.

I disagree with Kohn's defense of applying heightened scrutiny to age-based medical criteria. Although receiving a vital organ may be crucial to a particular individual's survival, federal constitutional law does not recognize the right to *receive* medical treatment—in contrast to the right to *refuse*—as fundamental. As Kohn admits, the Supreme Court has "never recognized access to health care as a fundamental right" and, moreover, has expressly rejected the equation of rights to refuse medical treatment with rights to receive such treatment.[78] The same is true in lower federal courts and in state courts.[79] Courts have also rejected the effort to use *Roe v. Wade*

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[74] Kohn, *supra* note 72, at 273–74.

[75] *Id.* at 274; *cf.* Basile J. Uddo, *The Withdrawal or Refusal of Food and Hydration as Age Discrimination: Some Possibilities*, 2 ISSUES L. & MED. 39, 58–59 (1986) (arguing that *Murgia*'s use of a rational basis test may not apply to the denial of life-prolonging health care because "[a] compelling argument can be made that a person's right to his own life, and the medical treatment necessary to sustain it, is as fundamental as a right can be," and that therefore "the Court may scrutinize more closely challenged government actions that could result in someone's death").

[76] Kohn, *supra* note 72, at 275.

[77] *Id.* at 276 (considering a hypothetical in which "the government reversed current policy and provided social security payments to the middle-aged instead of the old").

[78] *Id.* at 273; *see* Washington v. Glucksberg, 521 U.S. 702, 725–26 (1997) (rejecting the view that "the right to refuse unwanted medical treatment could be somehow transmuted into a right to assistance in committing suicide"); *cf.* O. Carter Snead, Response, *Unenumerated Rights and the Limits of Analogy: A Critique of the Right to Medical Self-Defense*, 120 HARV. L. REV. F. 1, 2 (2009), https://harvardlawreview.org/wp-content/uploads/pdfs/snead.pdf [https://perma.cc/JXR5-VYVX] (rejecting a fundamental constitutional right to "medical self-defense"). These arguments apply even more strongly in the case of non-lifesaving treatment.

[79] *See* Mitchell v. Clayton, 995 F.2d 772, 775 (7th Cir. 1993) (observing that "most federal courts have held that a patient does not have a constitutional right to obtain a particular type of treatment or to obtain treatment from a particular provider if the government has reasonably prohibited that type of treatment or provider"); Mont. Cannabis Indus. Ass'n v. State, 286 P.3d 1161, 1166 (Mont. 2012) (concluding that "in pursuing health, an individual does not have a fundamen-

and related cases that focus on family-planning and reproductive rights to support a general right to receive the medical care of one's choice.[80] Additionally, older people in need of an organ and younger people in need of an organ are equally vulnerable to the threat of death from organ failure, which indicates that transplantation is an area of life where older people are not at special risk.[81]

The scant precedent on age-based criteria for transplantation provides no affirmative support for Kohn's theory that heightened scrutiny is warranted. The only published case considering an equal protection suit by a plaintiff seeking organ transplantation affirmed the dismissal of the plaintiff's complaint as factually unsubstantiated, without settling the question of how age discrimination law applies to organ allocation.[82] In a more recent, highly publicized case, lawyers for ten-year-old Sarah Murnaghan asserted that organ transplantation rules that limit children's ability to receive organs from adult donors constitutes age discrimination.[83] Murnaghan secured a temporary restraining order and obtained a transplant soon afterward, but the restraining order did not resolve the substantive legal issues.[84]

Courts' refusal to apply heightened scrutiny to transplantation decisions is consistent with the distributive justice approach I defend. If courts viewed the right to receive scarce treatments like transplants as fundamental, this would make systematic allocation of scarce medical resources—such as the UNOS allocation systems for organs—difficult to employ.[85] Recognizing a fundamental right to *refuse* medical treatments, in contrast, does not present

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tal affirmative right of access to a particular drug"); *see also* Smith v. Shalala, 954 F. Supp. 1, 3 (D.D.C. 1996) (rejecting the view that the "government has an affirmative obligation to set aside its regulations in order to provide dying patients access to experimental medical treatments").

[80] People v. Younghanz, 156 Cal. App. 3d 811, 816 (Ct. App. 1984) (rejecting an analogy to family-planning cases and observing that "[t]he right to seek a particular form of medical treatment as a cure for one's illness, however, has not been recognized as a fundamental right in California"). *Contra* Kohn, *supra* note 72, at 273 & n.291 (citing family-planning cases as examples of legally protected health care decisions).

[81] *Cf. Murgia*, 427 U.S. at 325 (Marshall, J., dissenting) (differentiating employment discrimination from other discrimination on the basis of age).

[82] Wheat v. Massachusetts, 994 F.2d 273, 276 (5th Cir. 1993).

[83] Scott D. Halpern, *Turning Wrong into Right: The 2013 Lung Allocation Controversy*, 159 ANNALS INTERNAL MED. 358, 358–59 (2013) (describing Sarah Murnaghan's case). Interestingly, Murnaghan's attorneys omitted any Age Act claims from their pleadings, focusing solely on constitutional equal protection claims and other administrative law claims. *See* Complaint for a Temporary Restraining Order and Preliminary and Permanent Injunctive Relief at 16–18, Murnaghan v. Dep't of Health & Human Servs., No. 13-CV-03083 (E.D. Pa. June 5, 2013), https://www.courtlistener.com/recap/gov.uscourts.paed.477750.1.0.pdf [https://perma.cc/BU8L-KXXH].

[84] *See* Supplemental Memorandum at 1–2, *Murnaghan*, No. 13-CV-03083, https://www.courtlistener.com/recap/gov.uscourts.paed.477750.12.0.pdf [https://perma.cc/9T3U-R5HS].

[85] *See infra* notes 140–153 and accompanying text.

similar distributive issues, because refusals do not generate competing distributive claims to a scarce good.

A rational basis test that emphasizes that the state's interest must be legitimate—the approach taken in in *City of Cleburne v. Cleburne Living Center*—is a better way of reviewing age-based criteria than the heightened scrutiny for which Kohn advocates.[86] In *Cleburne*, the Court struck down a city council decision that treated a home for mentally disabled adults disadvantageously, concluding that the city's decision responded primarily to the negative attitudes of community members toward mentally disabled people, and that "mere negative attitudes, or fear" could not be used to support the council's decision.[87] The Court, however, declined to conclude that classifications disadvantaging the mentally disabled should receive heightened scrutiny in general.[88] In doing so, the *Cleburne* Court read *Murgia* as supporting the principle that legislative consideration of personal characteristics such as age in furtherance of distributive purposes should not be subject to heightened scrutiny.[89] This principle is consonant with the distributive justice approach.

Notably, the *Cleburne* approach, unlike Kohn's approach, does not depend on the importance of the right at issue, but on the irrationality of the government's justification for denying the right. The *Cleburne* approach would therefore be more likely to protect Francisco's interest in not being subjected to substandard nursing care, or Gail's interest in not being denied infertility treatment on the basis that it is "unnatural," than to vindicate Charlotte's efforts to obtain an organ transplant, even though transplantation is a lifesaving intervention. More generally, the *Cleburne* approach favors the overturning of decisions on an as-applied basis over the complete rejection of a developed legal framework.

Many state constitutions also contain equal protection provisions: some closely parallel the federal Constitution, and others substantially di-

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[86] City of Cleburne v. Cleburne Living Ctr., 473 U.S. 432 (1985).

[87] *Id.* at 448.

[88] *Id.* at 469–70.

[89] *Id.* at 441–42. In *City of Cleburne v. Cleburne Living Center*, Justice White stated:

> The lesson of *Murgia* is that where individuals in the group affected by a law have distinguishing characteristics relevant to interests the State has the authority to implement, the courts have been very reluctant, as they should be in our federal system and with our respect for the separation of powers to closely scrutinize legislative choices as to whether, how, and to what extent those interests should be pursued.

Id.

verge.[90] State courts interpreting these provisions in age discrimination contexts have typically followed the *Murgia* approach, frequently with little explicit acknowledgement that state constitutional interpretation need not follow the Supreme Court's interpretation of the U.S. Constitution, but sometimes on the basis that the reasoning in *Murgia* and its progeny is persuasive.[91] Some state courts, however, particularly those interpreting provisions that differ meaningfully from the Equal Protection Clause, have applied more searching scrutiny to certain age-based classifications.[92] Another state court has invalidated age-based criteria as irrational even under a rational basis test.[93]

This willingness to invalidate some age-based criteria as irrational leaves open the possibility—which I discuss in Part II.E—that there may in fact be a case for invalidation of age-based criteria that disadvantage younger, rather than older, people.[94]

II. THE LEGALITY OF AGE-BASED CRITERIA: ANTIDISCRIMINATION PRINCIPLES

In Part I, I argued that current law does not support a broad prohibition on the use of age-based criteria in medical decision making, although the lack of extensive precedent means that many questions remain unresolved. This description of the law does not settle whether such a broad prohibition *should* exist. The analysis of Part I might be read to indicate a need for new federal or state legislation; for regulatory or judicial interpretations that ex-

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[90] *See* Jeffrey M. Shaman, *The Evolution of Equality in State Constitutional Law*, 34 RUTGERS L.J. 1013, 1014–17 (2003) (discussing the spectrum of equal protection provisions in state constitutions).

[91] Shaman, *supra* note 90, at 1078 (stating that state courts usually follow the rational basis standard articulated in *Murgia* to evaluate claims of age-based discrimination); *see, e.g.*, Landers v. Stone, 496 S.W.3d 370, 377 (Ark. 2016) (stating that age is not a suspect classification under the Equal Protection Clause); Nagle v. Bd. of Ed., 629 P.2d 109, 113 (Haw. 1981) (concluding that the rational basis test is the "proper" test to apply); Cruz v. Chevrolet Grey Iron, Div. of Gen. Motors Corp., 247 N.W.2d 764, 768 (Mich. 1976) (similar); O'Neil v. Baine, 568 S.W.2d 761, 765 (Mo. 1978) (similar); *cf.* Shaman, *supra* note 90, at 1019 (observing that during the 1970s, "[i]n interpreting their own equality provisions," many "state courts obediently followed the federal framework for putting the Equal Protection Clause into effect").

[92] *See, e.g.*, Badgley v. Walton, 10 A.3d 469, 481 (Vt. 2010) (rejecting the rational basis standard for an age discrimination claim under the Vermont Constitution); *cf.* Power v. City of Providence, 582 A.2d 895, 901 & n.6 (R.I. 1990) (declining to decide the standard of scrutiny for an age discrimination claim under the Rhode Island Constitution).

[93] Jaksha v. Butte-Silver Bow Cty., 214 P.3d 1248, 1254 (Mont. 2009) (concluding that the "age limitation of 34 years" for firefighters is not rational).

[94] *See infra* notes 163–170 and accompanying text. *Contra* Kohn, *supra* note 72, at 276 (arguing that "chronological age criteria that discriminate on the basis of younger age are . . . less likely to be granted heightened scrutiny than those that discriminate on the basis of old age").

plicitly foreclose the use of age-based criteria; or even for federal or state constitutional amendments. Defending my contrary conclusion requires normative analysis. This normative analysis can also feed back into doctrine because age discrimination law relies on contested normative concepts like reasonableness, making normative analysis particularly relevant.[95] Furthermore, the lack of case law applying many of the statutes discussed above to health care leaves ample room for doctrinal development.

In this Part, I discuss five proposed limits on the consideration of age that reflect antidiscrimination concerns:

1. The *animus/bias* principle prohibits medical care decisions that rely on unjustifiable biases or animus.
2. The *anticlassification* principle takes the position that age is an impermissible group-based classification.
3. The *individualized judgments* principle rejects age-based criteria that use formulae, rather than individualized judgments, to decide what benefits people receive.
4. The *plus-factor* principle prohibits the use of age as a sole factor, but permits its use alongside other factors.
5. The *antisubordination* principle takes the position that no person should be subordinated on the basis of age.

I argue that the animus/bias principle can support the invalidation of some age-based criteria, and that the anticlassification principle is not applicable to age-based criteria. The other three principles are sometimes applicable to age-based criteria; however, they are better understood as parts of a broader account of distributive justice than as bright-line rules against using age-based criteria. The antisubordination principle in particular bridges antidiscrimination and distributive justice concerns.

A. Age as a Trigger for Animus and Bias

In a study of physician bias, Mary Crossley reviewed empirical evidence that physicians consider age when treating patients; Crossley reports that "[o]ne study found that among seriously ill, hospitalized adults, older patients were more likely than younger patients to have treatments such as surgery, dialysis and ventilator support withheld, even after adjusting for patients' preferences for life-extending care."[96] Another survey of physicians that

[95] *Cf.* Michael S. Moore, *Liberty and the Constitution,* 21 LEGAL THEORY 156, 159 (2015) (arguing that judgments of reasonableness in law require normative analysis).

[96] Mary Crossley, *Infected Judgment: Legal Responses to Physician Bias*, 48 VILL. L. REV. 195, 231–32 (2003) (footnotes omitted).

Crossley discusses "revealed that a significant proportion of the respondents concurred in judgments to treat an older patient less aggressively than a younger patient, even when those patients' likelihoods of survival were identical."[97]

Not all differential treatment is unjustified bias. In many cases, older patients' prospect of benefit is drastically limited by their life expectancy. This remains true even if patients have the same likelihood of surviving a procedure or have equally strong preferences to receive care. A Florida court implicitly conceded this point when it approved, in the calculation of damages, the use of mortality tables that use age as a factor in predicting future life expectancy.[98] Differential treatment can also be justified based on need rather than prospect of benefit: older patients have already experienced many years of life and are not in danger of dying young.[99]

Many cases of differential treatment, however, are grounded in unjustifiable biases. I classify these biases into three categories: factual mistake, nonrational bias, and animus.[100] I also discuss a fourth basis for differential treatment, which appeals to controversial conceptions of a good human life.

Factual mistakes are the simplest to identify and criticize: they are well-captured by Crossley's concern about physicians relying on an "*erroneous* belief that older patients are more likely to suffer poor outcomes or are less likely to benefit from aggressive treatment."[101] Factual mistakes lead to worse medical and societal outcomes, and efforts to counter their effects through regulation and education are normatively warranted. A good example of a factual mistake in a legal context would be a mathematical error in a document used to ground a policy: even under rational basis review, mathematical errors are proper grounds for reversal.[102]

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[97] *See id.*

[98] Sainz v. Bucelo, 527 So. 2d 911, 912 (Fla. Dist. Ct. App. 1988) (holding admissible "mortality tables which considered the health, age and physical condition of the 64 year-old [plaintiff], giving him a projected life expectancy of 13.9 years").

[99] *Cf.* Martínez-Álvarez v. Ryder Mem'l Hosp., Inc., No. 09-2038, 2010 WL 3431653, at *7 (D.P.R. Aug. 31, 2010) (asserting that although "losing a family member before their time is always tragic, losing a parent of a somewhat advanced age is different from cases involving the untimely death of a young parent or the death of a child").

[100] The categories of nonrational bias and animus overlap, but some nonrational bias involves no animus, and some animus operates at a subconscious rather than conscious level. *See* Amelia M. Wirts, Note, *Discriminatory Intent and Implicit Bias: Title VII Liability for Unwitting Discrimination*, 58 B.C. L. REV. 809, 830, 833–35 (2017) (describing unconscious bias and how animus may not be evident even when there is bias).

[101] Crossley, *supra* note 97, at 232 (emphasis added).

[102] *Cf.* Holmes v. Farmer, 475 A.2d 976, 987–88 (R.I. 1984) (describing a policy grounded in mathematical error as not supported by a "legitimate state purpose").

A second category of unjustifiable biases are nonrational responses based on age. Psychological studies indicate that information about age often induces implicit, unconscious responses (sometimes termed "implicit biases").[103] Some nonrational or preconscious responses—like the instinctive urge to assist a crying child—are normatively justifiable upon reflection because they serve legitimate individual or societal interests.[104] But other implicit biases, in particular reflexive disgust or aversion toward members of an outgroup, are more difficult to normatively justify.[105] One way of countering implicit bias is to use a guideline or checklist that slows down and channels deliberation.[106] In Part II.C, I argue that this concern supports the use of systematic frameworks rather than individualized judgments.

A third category of unjustifiable biases comprises age-based criteria that are justified by bare moral disapproval, hostility, or revulsion, such as the refusal to provide infertility treatments to post-menopausal women because bearing children after menopause is "unnatural."[107] A rejection of animus or bare revulsion arguably undergirds several Supreme Court precedents, from *Department of Agriculture v. Moreno* to *United States v. Windsor*, that strike down policies that disadvantage specific groups as irrational without invoking heightened scrutiny.[108] Normative justifications for the rejection of disgust or bare moral disapproval as a basis for law often rely on John Stuart Mill's "harm principle," which rejects prohibitions on conduct that imposes no harm on others.[109]

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[103] *See, e.g.*, Jordan R. Axt, Charles R. Ebersole & Brian A. Nosek, *The Rules of Implicit Evaluation by Race, Religion, and Age*, 25 PSYCH. SCI. 1804, 1809–1812 (2014) (reporting the results of a study in which the participants implicitly ranked children highest, followed by young adults, middle-aged adults, and lastly older adults); *cf.* Marshall B. Kapp, *De Facto Health-Care Rationing by Age: The Law Has No Remedy*, 19 J. LEGAL MED. 323, 333 (1998) (discussing health care providers' "unconscious bias and prejudice regarding the elderly").

[104] *See* Govind Persad*, When, and How, Should Cognitive Bias Matter to Law?* 32 LAW & INEQ. 31, 43–58 (2014); *see also* Gregory Mitchell, *Taking Behavioralism Too Seriously? The Unwarranted Pessimism of the New Behavioral Analysis of Law,* 43 WM. & MARY L. REV. 1907, 1996–2002 (2002).

[105] *See* Persad, *supra* note 104, at 60–61 (discussing "indefensible" implicit biases).

[106] *See* L. Song Richardson & Phillip Atiba Goff*, Self-Defense and the Suspicion Heuristic*, 98 IOWA L. REV. 293, 307 (2012).

[107] Reynolds, *supra* note 9, at 295.

[108] *See* United States v. Windsor, 570 U.S. 744, 770–72 (2013) (concluding that the exclusion of same-sex couples from marriage was rooted in animus and bias); U.S. Dep't of Agric. v. Moreno, 413 U.S. 528 (1973) (asserting that statute was rooted in bias against "hippies"); Carpenter, *supra* note 14, at 230–31 (noting that both *Moreno* and *Windsor* use anti-animus principles, allowing for greater legislative decision making).

[109] *See* FEINBERG, *supra* note 22, ch. 30 (discussing the "harm principle" in both law and moral philosophy); JOHN STUART MILL, ON LIBERTY 22–23 (1871) (arguing that "the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others"); *cf.* Carlos A. Ball, *The Proper Role of Morality in*

In recent work, the psychologist Jonathan Haidt argued that some individuals recognize both disgust and ingroup preference as proper foundations for moral judgments.[110] Haidt's work might be used to argue that disgust and ingroup loyalty can be proper bases for law, and therefore to support, for instance, the refusal of reproductive medical treatments to older women or the denial of optimal nursing care to "repulsive" elderly patients.[111] This strategy faces two problems. First, Haidt's psychological research describes what people believe; it does not tell us what is right or wrong.[112] That many people ground moral judgments in disgust responses does not make doing so correct. There are compelling reasons to reject disgust as a proper basis for moral judgments.[113] Additionally, even if disgust were a defensible basis for moral judgments, it might remain an inappropriate basis for legislation.[114]

Age-based criteria that are justified by appeal to controversial conceptions of what a good human life consists of, rather than to either distributive justice principles or psychological biases, present perhaps the most challenging questions.[115] An exemplar of such a justification is Daniel Callahan's defense of an age cutoff for access to life-extending care even in the absence of scarcity. Callahan's argument appeals to a conception of the proper meaning of old age, rather than to concerns about harms to older patients, distributive unfairness to younger patients, or overall societal ben-

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State Policies on Sexual Orientation and Intimate Relationships, 35 N.Y.U. REV. L. & SOC. CHANGE 81, 93 (2011) (distinguishing "two . . . types of morality-based government actions: those grounded in empirical evidence and those that are not"); Peter M. Cicchino, *Reason and the Rule of Law: Should Bare Assertions of "Public Morality" Qualify as Legitimate Government Interests for the Purposes of Equal Protection Review?*, 87 GEO. L.J. 139, 140 (1998) (stating that "'[b]are public morality' arguments defend a law by asserting a legitimate government interest in prohibiting or encouraging certain human behavior without any empirical connection to goods *other than* the alleged good of eliminating or increasing . . . the behavior at issue").

[110] *See* Courtney Megan Cahill, *Abortion and Disgust*, 48 HARV. C.R.-C.L. L. REV. 409, 427 & n.100 (2013) (reviewing Haidt's research). *See generally* JONATHAN HAIDT, THE RIGHTEOUS MIND: WHY GOOD PEOPLE ARE DIVIDED BY POLITICS AND RELIGION (2012) (presenting empirical research on moral judgment).

[111] *See, e.g.*, Maggie Gallagher & William C. Duncan, *The Kennedy Doctrine: Moral Disagreement and the "Bare Desire to Harm,"* 64 CASE W. RES. L. REV. 949, 962 (2014) (using Haidt's view to support laws that exclude same-sex couples from marriage).

[112] *Cf.* Persad, *supra* note 104, at 64–67 (arguing that whether a belief is defensible or corrosive is a question that cannot be answered by behavioral science alone).

[113] *See generally* MARTHA NUSSBAUM, HIDING FROM HUMANITY: DISGUST, SHAME, AND THE LAW (2004).

[114] Cahill, *supra* note 110, at 454–55.

[115] *See generally* JOHN RAWLS, POLITICAL LIBERALISM (1993) (exploring "public reason," which proposes limits on the use of "comprehensive" religious and philosophical doctrines in political argument and public policy).

efits.[116] Approaches like Callahan's have been criticized for grounding moral claims in controversial conceptions of a good life that are anathema to many people in a pluralistic society.[117] Some have argued that law similarly should not be based on such controversial conceptions.[118]

In contrast to Callahan's view, the lifetime justice approach I advocate in Part III does not appeal to any controversial conception of a good human life. Instead, it proposes a framework for understanding and balancing widely accepted values, such as providing greater benefits and giving priority to the least advantaged. Although the interpretation and ordering of these values is likely to be controversial, the values themselves are not.[119]

B. Age as a Forbidden Classification

As the medical literature discussed in Part I indicates, age is frequently a reliable proxy—though imperfect, as all proxies are—for the prospect of medical benefit.[120] Nevertheless, some have taken the position that age is a fundamentally objectionable group classification, akin to race.[121] This stance represents what legal scholars have called an *anticlassification* approach, which regards age as a "forbidden trait" whose consideration is proscribed in the provision of health care.[122] Anticlassification approaches are willing to accept some social costs to avoid forbidden classifications—to repurpose

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[116] *See* CALLAHAN, *supra* note 26.

[117] *See, e.g.*, Jecker, *supra* note 26, at 64–65 (criticizing Daniel Callahan and Alasdair MacIntyre for relying on the argument that older people's requests for medical treatment are fundamentally unwise, rather than on the argument that their requests should be assigned a lower priority when resources are scarce).

[118] *See, e.g.*, Lawrence B. Solum, *Public Legal Reason*, 92 VA. L. REV. 1449, 1469 (2006); *cf.* Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 850 (1992) ("Some of us as individuals find abortion offensive to our most basic principles of morality, but that cannot control our decision. Our obligation is to define the liberty of all, not to mandate our own moral code."). *But see* David Enoch, *The Disorder of Public Reason*, 124 ETHICS 141, 141 (2013) (arguing against "public reason" approaches).

[119] *Cf.* John Rawls, *The Idea of Public Reason Revisited*, 64 U. CHI. L. REV. 765, 777 (1997) (arguing that policies should not be grounded in controversial conceptions of the good life).

[120] *See* Crossley, *supra* note 96, at 204 (noting that "a committee of the Institute of Medicine took the stance that demographic characteristics may sometimes be reliable proxies for factors such as patient preferences or anticipated outcomes of care").

[121] *See* Schuck, *supra* note 15, at 30, 50–53, 82 & n.272 (providing examples); *see also* Evans, *supra* note 11, at 823 (analogizing age-based criteria to race- and sex-based criteria); Harris, *supra* note 11, at 375 (arguing that the "principle of equality applies as much in the face of discrimination on the basis of chronological age . . . as it does to discrimination on the basis of gender, race, and other arbitrary features").

[122] *See* Bradley A. Areheart, *The Anticlassification Turn in Employment Discrimination Law*, 63 ALA. L. REV. 955, 960–67 (2011). Areheart's article provides an excellent overview of this approach, its contrast with antisubordination approaches, and the extensive legal scholarship on antisubordination and anticlassification.

some of Seana Shiffrin's terminology, anticlassification approaches accommodate (at public expense) people's claim not to be categorized according to certain characteristics.[123]

Employing anticlassification approaches requires providing a normative justification for limiting or forbidding the use of certain categories.[124] I will argue that age differs from race and sex in important ways that make classification by age much less objectionable. One clear difference between age and these other categories, as is stated in *Murgia* and as I discuss in Part II.E, is that older age is not a basis for systematic subordination.[125] Even under an anticlassification approach that does not rely on antisubordination considerations, age remains different from race or sex because age is not as conceptually or empirically central to individuals' identities. Conceptually, race and gender serve to systematically structure many individuals' long-term life plans in a normatively defensible way.[126] Even though religion is not always externally identifiable and can more easily change, it plays a similar role.[127] In contrast, although the passage of time and the fact of aging certainly do structure our life plans, the transitory facts of age and age-group membership lack the same long-term significance. There is also more evidence that race, gender, and religion are more subjectively important identities than age.[128] Although age-correlated identities, such as "parent" or "retiree," may be important, it is difficult to imagine someone regarding being fifty-three years old as central to their life plan or self-concept, and

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[123] *Cf.* Shiffrin, *supra* note 18, at 236–45 (explaining that accommodation can impose costs on the public).

[124] *See* Areheart, *supra* note 122, at 963 (stating that "[a]nticlassification principles . . . require normative input on the front end to determine what traits are, for decision-making purposes, forbidden traits").

[125] *See* Mass. Bd. of Ret. v. Murgia, 427 U.S. 307, 313–14 (1976) (per curiam) (concluding that "old age does not define a 'discrete and insular' group"); *cf.* Areheart, *supra* note 122, at 963 (arguing that antisubordination principles can be used to establish which principles should be forbidden bases for classification).

[126] *See* Anthony Appiah, *"But Would That Still Be Me?" Notes on Gender, "Race," Ethnicity, as Sources of "Identity,"* 87 J. PHIL. 493, 499 (1990) (claiming that disregarding one's race or gender amounts to "ignoring . . . social reality").

[127] *See* David A.J. Richards, *Sexual Preference as a Suspect (Religious) Classification: An Alternative Perspective on the Unconstitutionality of Anti-Lesbian/Gay Initiatives*, 55 OHIO ST. L.J. 491, 508 (1994) (stating that "[t]he constitutional protection of religion never turned on its putative immutable and salient character . . ., but on the traditional place of religion in the conscientious and reasonable formation of one's moral identity in public and private life"). As a normative matter, as opposed to a description of current legal doctrine, Richards' argument also offers a compelling case for the centrality of sexual orientation. *See id.* (arguing that "normative claims by lesbian and gay persons today have exactly the same ethical and constitutional force" as claims grounded in religious identity).

[128] Kay Deaux, *Reconstructing Social Identity*, 19 PERSONALITY & SOC. PSYCH. BULL. 4, 10 (1993) (discussing empirical research).

only marginally easier to imagine someone regarding being "in their fifties" in that way.

Another difference between age and race or sex is that people move through age categories over time.[129] Further, age changes inexorably, unlike characteristics such as economic status or geographical location that commonly change over time but are not guaranteed to do so.[130] Aging is also a continuous process, rather than a transition between discrete categories.[131]

The inexorableness of aging might be used, however, in defense of an anticlassification approach: the process of growing older—unlike moving geographically or becoming wealthier—is entirely outside our control.[132] That age is outside our control may explain why some case law classifies age as immutable—although age mutates, it is not mutable by us.[133] It might also support a "luck egalitarian" or "choice-sensitive" case against age-based criteria, which takes the position that how individuals fare in society should depend solely or primarily on chosen characteristics.[134]

The choice-sensitive approach faces at least three problems. First, when we consider individuals over their lifetimes rather than at a given moment,

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[129] *See, e.g.*, Hamilton v. Caterpillar Inc., 966 F.2d 1226, 1227 (7th Cir. 1992) ("Age is not a distinction that arises at birth. Nor is age immutable . . . ."); Norman Daniels, *Justice Between Adjacent Generations: Further Thoughts*, 16 J. POL. PHIL. 475, 475 (2008) (arguing that the inevitability of aging, in part, merits different treatment of different age groups); Judith A. Howard, *Social Psychology of Identities*, 26 ANN. REV. SOC. 367, 380 (2000); *see also* EEOC v. Univ. of Tex. Health Sci. Ctr., 710 F.2d 1091, 1097 (5th Cir. 1983) (Higginbotham, J., concurring) (observing that "race, sex, and national origin describe an immutable status while age is a dynamic progression").

[130] *See* United States v. Tsarnaev, 53 F. Supp. 3d 443, 449 (D. Mass. 2014) ("[A] person's age is in a constant state of change. A 71 year old is a former 69 year old (and 30 year old) in a way, for example, that an African-American is not a former white person."); Kubik v. Scripps Coll., 173 Cal. Rptr. 539, 542 (Ct. App. 1981) (observing that although age is determined by one's date of birth, everyone progressively grows older over time).

[131] Goldstein v. Manhattan Indus., Inc., 758 F.2d 1435, 1442 (11th Cir. 1985) (noting that "age is a continuum" involving "subtle and relative" distinctions); *cf.* Adam J. Kolber, *Smooth and Bumpy Laws*, 102 CAL. L. REV. 655, 659–61 (2014) (distinguishing continuous from discrete variables in legal contexts).

[132] *See* DeNovellis v. Shalala, 124 F.3d 298, 314 (1st Cir. 1997) (listing age among the "immutable characteristics that a person does not choose and cannot change"); *cf. Tsarnaev*, 53 F. Supp. 3d at 449 (stating that "[a]ge is immutable only in the sense that a person cannot change her age").

[133] United States v. Escalante, No. 92-10363, 1993 WL 97510, at *2 (9th Cir. Mar. 22, 1993) (characterizing age as immutable); Arnett v. Aspin, 846 F. Supp. 1234, 1241 (E.D. Pa. 1994) (similar); Travelers Indem. Co. of Am. v. Commonwealth, Ins. Dep't, 440 A.2d 645, 646 (Pa. Commw. Ct. 1981) (referencing "immutable characteristics such as age and race").

[134] *Cf.* Schuck, *supra* note 15, at 33 (discussing criticism of age-based criteria on the basis that age is something "over which the individual has no control and for which he or she therefore cannot be held morally responsible"). *See generally* Richard J. Arneson, *Luck Egalitarianism Interpreted and Defended,* 32 PHIL. TOPICS 1 (2004) (providing a survey of the extensive literature on this topic).

age-based classifications do not subject people to differential good or bad luck. Each person will benefit from these classifications at some point; for some people, the benefit is in the past, although for others, it is in the future.[135] Age-based criteria therefore differ from random allocations of benefits and burdens, such as the draft lottery used for the Vietnam War, which give equal chances to participants but allow brute luck to affect how individuals fare over their lifetimes.[136] Second, choice-based approaches face two pressing normative criticisms. One charges that choice-based accounts are too willing to abandon people who make unwise choices.[137] The other argues that what counts as an appropriate basis for allocating benefits and burdens is underdetermined by the idea of choice-sensitivity because different ways of understanding choice-sensitivity correspond to different rules for distribution.[138] Although these objections question whether *chosen* characteristics are fair criteria for assigning benefits and burdens, as opposed to establishing that *unchosen* characteristics like age can be fair, they put pressure on the coherence of the choice-based account. Third, choice-sensitive accounts are often regarded as distinctively inappropriate for the distribution of health care.[139]

C. Age and the Right to an Individualized Judgment

Deciding who will receive an important medical benefit might seem to require an exhaustive, individualized examination of each candidate's situation. This argument recalls an objection offered to lottery-based allocation, namely that an inherently insignificant factor—such as the matching of a name to a random number—should not be the sole determinant of a very

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[135] A crucial and often-overlooked exception to the claim that everyone will benefit from age-based classifications is that people who die young will not benefit from age-based classifications that benefit older people. *See* Daniels, *supra* note 129, at 475 n.2. But this exception does not support an anticlassificationist view; rather, it recommends the use of age-based criteria that favor younger people. I return to this issue in Parts II.E and III. *See infra* notes 168–247.

[136] *See* SHLOMI SEGALL, HEALTH, LUCK, AND JUSTICE 45–57 (2010) (discussing "all-luck egalitarianism," which objects even to fair lotteries).

[137] Elizabeth S. Anderson, *What Is the Point of Equality?*, 109 ETHICS 287, 296 (1999).

[138] *See generally* Susan Hurley & Richard Arneson, *Luck and Equality*, 75 PROC. ARISTOTELIAN SOC'Y 51 (2001) (discussing the ambiguity of choice-sensitivity).

[139] *See* Oscar W. Clarke et al., *Ethical Considerations in the Allocation of Organs and Other Scarce Medical Resources Among Patients,* 155 ARCHIVES INTERNAL MED. 29, 32–33 (1995) (critiquing the use of a patient's contribution to a disease in health care resource allocation); E. Feiring, *Lifestyle, Responsibility and Justice*, 34 J. MED. ETHICS 33 (2008). *But see* SEGALL, *supra* note 136, at 74–86 (defending a luck egalitarian view that takes voluntary choices into account).

important outcome.[140] Instead, it might seem that the exhaustiveness of the process should match the significance of the outcome.

Although I agree in Part II.D that it can be important to consider multiple factors when making a health care decision, I disagree that a detailed, individualized judgment about a patient's situation is required.[141] As a descriptive matter, the American legal system now agrees, at least where the distribution of benefits (as opposed to the imposition of burdens) is concerned.[142] During the brief heyday of the "irrebuttable presumption" doctrine, individuals excluded from a benefit on the basis of a categorical rule were entitled to make an individualized case for an exception.[143] As a relevant example, a policy that categorically excluded individuals over seventy-five from organ transplantation would have violated the irrebuttable presumption doctrine, even if the policy was a rational effort to efficiently allocate organs without generating administrative burden.[144] Instead, each individual denied an organ would be entitled to make a case for an exception. In contrast, after the demise of the irrebuttable presumption doctrine, irrebuttable presumptions based on age are broadly permitted.[145]

Some have called for reviving the right to an individualized judgment, and the American Medical Association's ethics guidelines defend the desirability of individualized judgments in health care.[146] Although a profession-

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[140] *Cf.* Carol Necole Brown, *Casting Lots: The Illusion of Justice and Accountability in Property Allocation*, 53 BUFF. L. REV. 65, 70 n.10 (2005) (discussing the objection that "[l]ottery allocation or decision-making undermines human dignity and diminishes the individual by attacking the very basis of individuality (that is, being considered as a person with attributes, rather than a cipher, in the decision process)").

[141] *Accord* Schuck, *supra* note 15, at 34–35 (stating that age categories can be easily administered because age is "highly objective" and an "easily measured characteristic"); *see also infra* notes 154–161 and accompanying text.

[142] *See, e.g.*, Weinberger v. Salfi, 422 U.S. 749, 754, 772 (1975); *see also* Robert A. Kagan, *Inside Administrative Law*, 84 COLUM. L. REV. 816, 827 (1984) (noting that "[t]he courts are not ready to construct statutory or due process rights to individualized treatment when citizens complain of overly mechanical application of regulations that are otherwise 'rational'").

[143] James M. Binnall, *Sixteen Million Angry Men: Reviving a Dead Doctrine to Challenge the Constitutionality of Excluding Felons from Jury Service*, 17 VA. J. SOC. POL'Y & L. 1, 5–14 (2009) (providing an overview of the irrebuttable presumption doctrine).

[144] *Cf. id*. at 11–12 (discussing application of irrebuttable presumption doctrine to age-based classifications).

[145] *See* Nagle v. Bd. of Ed., 629 P.2d 109, 119 (Haw. 1981) (permitting irrebuttable presumption based on age); *see also* Palmer v. Ticcione, 576 F.2d 459, 463 (2d Cir. 1978) (upholding a statute mandating retirement of teachers at age seventy and observing that when "the statutory classification is sustainable as rationally based, then it should not fall because it might also be labeled a presumption").

[146] *See, e.g.*, Emily Toler, Comment, *"Without Good Cause": The Case for a Standard-Based Approach to Determining Worker Qualification for Unemployment Benefits*, 89 WASH. L. REV. 559, 592–93 (2014) (arguing that "when people are governed by rigid rules, they have an important interest in proving that those rules do not adequately address their situations" and that

al norm of having physicians make individualized assessments of their patients' needs rather than relying on population-based guidelines has both advantages and disadvantages, an enforceable legal right to individualized medical judgments presents more serious problems.[147] Such a right would likely generate an explosion of litigation that undermines any effort to set coherent health care priorities across society. The recognition of enforceable fundamental rights to health has been criticized for producing such a result.[148]

A recent commentary by a group of distinguished health policy scholars, building on the work of the World Health Organization's Consultative Group on Equity and Universal Health Coverage, rejects the idea that courts should be the arbiters of access to health care.[149] They evaluate a hypothetical system that involves "reliance on the judiciary to make decisions about specific individuals' claims to services that were initially excluded from the government-provided package," and conclude that judicial decision-making about access to health care has major disadvantages: (1) an inability to "systematically take account of cost-effectiveness" or clinical effectiveness, which leads to courts approving "expensive services that offer limited or highly uncertain benefits" and thereby reducing "the funds available to provide proven, more cost-effective services"; (2) exacerbating inequalities in access to health services, due to the financial and educational resources litigation requires; and (3) being poorly placed to "weigh evidence of medical efficacy" or "evaluate the impact of an isolated decision on the fairness of resource allocation in a health system."[150] For these reasons, they conclude that "[p]riority setting by a dedicated institution—establishing an independent mechanism or body that sets priorities in an accountable and transparent

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"where individual circumstances vary wildly and the need for benefits is often acute, it is theoretically unsound and fundamentally unfair to deny claimants the right to a truly individualized adjudication"); Clarke et al., *supra* note 139, at 31 (stating that "[w]hen a duration of benefit criterion is applied, patients should be assessed according to their own medical histories and prognoses, not aggregate statistics based on membership in a group"). Taken literally, this statement would prohibit the use of age-based criteria for screening tests, as well as for transplantation, as these procedures use age to assess patients' prospect of benefit from screening or transplantation.

[147] *See* R.E. Ashcroft, *Current Epistemological Problems in Evidence Based Medicine,* 30 J. MED. ETHICS 131, 132 (2004) (discussing the advantages and disadvantages of individualized assessments and evidence-based guidelines).

[148] *See* Govind Persad*, The Medical Cost Pandemic: Why Limiting Access to Cost-Effective Treatments Hurts the Global Poor*, 15 CHI. J. INT'L L. 559, 582–85 (2015) (summarizing evidence).

[149] Alex Voorhoeve et al., *Three Case Studies in Making Fair Choices on the Path to Universal Health Coverage*, 18 HEALTH & HUM. RTS. 11, 18–20 (2016).

[150] *Id.* at 18–19; *cf.* Halpern, *supra* note 83*,* at 358 (criticizing the court's intervention in the Sarah Murnaghan case on the basis that "legal and political leaders . . . neglected their responsibility to protect the interests of all potential patients" and "bent the rules in favor of a well-resourced family that generated enormous media attention").

manner, based on explicit, reasonable criteria—is morally preferable" to individualized priority-setting by the judiciary.[151]

An additional advantage of a formalized framework that employs explicit criteria over the use of individualized judgments is that a formalized framework can help to forestall the effects of implicit bias.[152] The bias-preventing value of a formalized framework suggests that courts should be more willing to scrutinize the individualized and informal use of age-based criteria, such as the practices of health care providers in a nursing home, than to disapprove the results of formalized frameworks like the UNOS transplantation guidelines.[153]

D. Age as a "Plus Factor"

The plus-factor approach permits the use of age in medical decision making alongside other factors, but prohibits its use as the sole factor.[154] The plus-factor approach is defended in the medical literature, and national policies, including the Age Act and the United Kingdom's age discrimination laws, have been interpreted to support it.[155] Some have interpreted an-

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[151] Voorhoeve et al., *supra* note 149, at 19.

[152] *See* Erik J. Girvan, *Wise Restraints?: Learning Legal Rules, Not Standards, Reduces the Effects of Stereotypes in Legal Decision-Making*, 22 PSYCHOL. PUB. POL'Y & L. 31, 33 (2016) (discussing study results); Antony Page & Michael J. Pitts, *Poll Workers, Election Administration, and the Problem of Implicit Bias*, 15 MICH. J. RACE & L. 1, 33 n.180 (2009) ("[U]nconscious bias is more likely when a decision-maker is applying a standard rather than a bright-line rule.").

[153] *See generally* ORGAN PROCUREMENT & TRANSPLANTATION NETWORK, PUBLIC COMMENT PROPOSAL: FRAMEWORKS FOR ORGAN DISTRIBUTION (2018) https://optn.transplant.hrsa.gov/media/2565/geography_publiccomment_201808.pdf [https://perma.cc/EJH8-6CAR].

[154] Govind Persad, Alan Wertheimer & Ezekiel J. Emanuel, *Principles for Allocation of Scarce Medical Interventions*, 373 LANCET 423, 423 (2009) (differentiating "insufficient" criteria for medical decision making, which are acceptable when used as one factor among many, from "flawed" criteria, which are categorically unacceptable). Plus-factor approaches regard age as an insufficient criterion.

[155] *See* RUSSEL H. PATTERSON, REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS: ETHICAL IMPLICATIONS OF AGE-BASED RATIONING OF HEALTH CARE 1, 4 (1989) (reasoning that "[i]f it is determined that rationing is necessary . . . choices based solely on chronological age are not acceptable"); Formica et al., *supra* note 41, at 40 (discussing the Office of Civil Rights' interpretation of the Age Act to prohibit the use of age as a sole factor in transplant allocation); Kenneth Prager, Op-Ed, *Response 2: Medical Care for the Elderly: Should Limits Be Set?* 10 VIRTUAL MENTOR 404, 408 (2008) (stating that age "should not be used as the sole criterion" to determine distribution of health care resources); Roman Romero-Ortuno & Diarmuid O'Shea, *Fitness and Frailty: Opposite Ends of a Challenging Continuum! Will the End of Age Discrimination Make Frailty Assessments an Imperative?*, 42 AGE & AGEING 279, 279 (2013) (observing that "[i]n the UK, from 1 October 2012, older people will have the right to sue if they have been denied health and/or social care based on age *alone*"); *cf.* Eyal Katvan et al., *Age Limitation for Organ Transplantation: The Israeli Example*, 46 AGE & AGEING 8, 10 (2016) (discussing the minority position in the Israeli committee on transplant allocation, which "argued that chronological

tidiscrimination provisions in the Affordable Care Act (ACA) as supporting a plus-factor position.[156] Notably, the plus-factor approach has been adopted for race-based classifications in university admissions, which suggests that plus-factor approaches have appeal when a classification is normatively concerning but implementing it can produce substantial social benefits.[157]

Despite the plus-factor approach's popularity, the normative case for it is difficult to identify.[158] Whenever a decision is a close call, many factors—including "plus factors"—are but-for causes, such that the decision would not have been reached had those factors not been considered.[159] Furthermore, the plus-factor approach only makes normative sense where a classification serves antisubordination goals, as I discuss next. It would be normatively intolerable to regard whiteness, for instance, as a "plus factor" for access to medical treatment, even alongside other criteria.

A better argument for the plus-factor approach would look beyond an antidiscrimination paradigm toward an account of fair distribution.[160] If distributing health resources fairly requires looking to multiple ethical values, then no single factor—whether age, prognosis, or severity of illness—will be sufficient on its own to resolve distributive questions.[161] Plus-factor approaches will therefore frequently be warranted. Because assessing whether resources are distributed fairly requires considering the health care system

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age should be considered as one, of many, allocation considerations," rather than being—as the majority argued—entirely ignored).

[156] *See, e.g.*, Nicholas Bagley, *Bedside Bureaucrats: Why Medicare Reform Hasn't Worked*, 101 GEO. L.J. 519, 574 (2013) (reasoning that an ACA provision supports Medicare's reliance on multiple factors); Persad, *supra* note 21, at 133 (arguing that an ACA provision permits consideration of cost-effectiveness and level of disability to determine priority).

[157] Grutter v. Bollinger, 539 U.S. 306, 334 (2003) (employing plus-factor approach); *see* Persad, *supra* note 21, at 133–34 (discussing the plus-factor approach); *cf.* Areheart, *supra* note 122, at 963 n.32 ("Does a policy violate the anticlassification principle if group membership is one of several criteria?").

[158] *See* Eidelson, *supra* note 42, at 1644 (questioning "why . . . encasing age in a compound measure of longevity" should "redress, or even mitigate" concerns that age-based criteria are invidiously discriminatory).

[159] *Id.* (claiming that "even under the revised plan, there will still be candidates who would have qualified for a better kidney if they had been only one year younger"); *cf.* Ogden v. Bureau of Labor, 699 P.2d 189, 191 (Or. 1985) ("If the word 'solely' . . . were given its literal meaning, forbidden age discrimination would occur only if age were the 'sole factor' in an employment decision . . . . The commissioner is not bound to so limited a view of the law."); Persad, *supra* note 21, at 133–34 (discussing the challenges for the plus-factor approach).

[160] *See* Schuck, *supra* note 15, at 84–93 (contrasting "allocative" and "nondiscrimination" approaches to social problems); *cf.* Mark Kelman, *Market Discrimination and Groups*, 53 STAN. L. REV. 833, 892 (2001) (contrasting "simple discrimination" with "reasonable accommodation" claims, and observing that the latter involve distributive issues).

[161] *See* Persad et al., *supra* note 154, at 426 (arguing that "no principle is sufficient on its own to recognize all morally relevant considerations").

as a whole rather than each medical transaction individually, the use of age as a sole criterion may be appropriate in some circumstances, such as the provision of screening tests. I return to this issue in Part IV.[162]

E. Age, Disadvantage, and Subordination

An antisubordination approach to antidiscrimination, unlike an anti-classification approach, aims fundamentally to forestall and remedy the oppression of disadvantaged groups.[163] Accordingly, it countenances the use of classifications to remediate past subordination, or to prevent subordination by private actors.[164] Although some argue that current Supreme Court precedent disfavors antisubordination approaches, such approaches can possess a compelling link to fundamental values like equality of opportunity.[165]

Antisubordination approaches, properly understood, do not disfavor the use of age-based criteria, and often even favor their use when they assist disadvantaged individuals. To understand how antisubordination approaches evaluate age-based criteria, it is useful to disentangle older age from the increased frailty that commonly accompanies it.[166] Older age, absent frailty, is not inherently disadvantaging. Rather, given that enjoying more years of life is a valuable outcome, older age is an advantage akin to greater wealth. Accordingly, just as antisubordination approaches support special concern for poorer people, who are not guaranteed to become wealthier, they support special concern for younger people, who are not guaranteed to enjoy the years of life that older people have already enjoyed.[167] Several authors rightly note that not all younger people will live to older ages, but mistakenly conclude that age-based criteria that deny benefits to older people are therefore worse than those that disadvantage the young.[168] This is mistaken:

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[162] *See infra* notes 243–291 and accompanying text.

[163] Areheart, *supra* note 122, at 965.

[164] *Id.* at 964.

[165] *Id.*

[166] *Cf.* Rebecca S. Starr & Mihaela S. Stefan, *Perioperative Assessment of and Care for the Elderly and Frail*, 5 HOSP. MED. CLINICS 224, 231 (2016) (explaining that "[a]lthough the prevalence of frailty increases with age, people can age without frailty or can be frail without being old").

[167] *Cf.* Jensen v. Franchise Tax Bd., 100 Cal. Rptr. 3d 408, 414 (Ct. App. 2009) ("Wealth generally confers benefits, and does not require the special protections afforded to suspect classes.").

[168] *See, e.g.*, Howard Eglit, *Of Age and the Constitution*, 57 CHI.-KENT L. REV. 859, 888–89 (1981) (noting that dying young is a "worse alternative" to aging, but nonetheless arguing that "laws which impose disadvantages for being too old" are "permanently inescapable" for the old, and therefore more objectionable than laws that disadvantage younger people); John F. Kilner, *Age as a Basis for Allocating Lifesaving Medical Resources: An Ethical Analysis*, 13 J. HEALTH POL. POL'Y & L. 405, 411 (1988) (arguing that age-based criteria are unfair because "many people

because living to an older age is a highly valued outcome, we should be especially concerned about age-based criteria for lifesaving medical treatments that favor individuals who have already lived to an older age over individuals who are not guaranteed to do so. An antisubordination perspective also counsels concern about facially neutral rules that fail to address the disadvantage of dying at a younger age. Such rules include criteria for the distribution of life-saving resources, such as first-come, first-served approaches, that give equal chances to younger and older people despite the fact that older people have already accumulated more years of life.[169] Ultimately, although frailty sometimes provides a basis for special concern about the interests of older people, older age decreases their claim to additional life-extending treatment.[170]

III. AN AFFIRMATIVE CASE FOR AGE-BASED CRITERIA

Part II rejected a variety of arguments that the use of age-based criteria necessarily constitutes wrongful discrimination. This Part defends the claim that age-based criteria are not merely *permissible*, but normatively *preferable*. The normative considerations I identify apply to a variety of actors who make decisions about age-based criteria, including patients, providers, public and private payers, and governments.[171] These actors, however, are subject to other obligations that may pull in different directions from the age-

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are born with congenital, genetic, or environmental conditions which ensure that they will not live as long as most"); *see also* Felix v. Milliken, 463 F. Supp. 1360, 1373 (E.D. Mich. 1978) ("[I]t is interesting to note that while discrimination against the elderly at a particular age imposes a disability that is never removed, drawing lines that affect young people has only a temporary effect."); *cf.* Michael K. Gusmano, *Is It Reasonable to Deny Older Patients Treatment for Glioblastoma?*, 42 J.L. MED. & ETHICS 183, 185 (2014) (claiming that young voters support "social insurance commitments" that assist the elderly because they will be recipients of such programs in the future).

[169] *Cf.* Javorsky v. W. Athletic Clubs, Inc., 195 Cal. Rptr. 3d 706, 718 (Ct. App. 2015) (holding that a discount for customers 18 to 29 years of age was not wrongful age discrimination because of evidence that individuals in that age range "have a lower economic position than persons age 30 and older"). *Contra* Eglit, *supra* note 168, at 905 (arguing that "the unfairness of deprivation imposed because of an immutable characteristic is tempered by the fact that youngsters will outgrow their age-based disabilities").

[170] *See infra* notes 202–209 and accompanying text. The nonabandonment principle proposed in Part III.C.1 can be seen as a response to frailty. *See infra* notes 183–209 and accompanying text.

[171] *Cf.* Dan W. Brock, *Ethical Issues in the Use of Cost-Effectiveness Analysis for the Prioritization of Health Care Resources*, *in* MAKING CHOICES IN HEALTH: WHO GUIDE TO COST-EFFECTIVENESS ANALYSIS 289, 291 (T. Tan-Torres Edejer et al. eds. 2003), http://www.who.int/choice/publications/p_2003_generalised_cea.pdf [https://perma.cc/MJX4-LY3U] (stating that research on "substantive issues of equity in health care . . . should inform the deliberations" of decisionmakers using fair procedures to make health policy choices).

related considerations I identify. For instance, a provider may regard her obligations to specific patients or her own conception of professional integrity as prior to societal considerations: a geriatrician may provide expensive treatments to her own patients even if the money spent on these treatments would be better spent, from a societal perspective, on other physicians' younger patients.[172] In contrast, a societal decisionmaker (like a legislator) should regard societal justifications as paramount: although a patient or provider may promote her own interests or those of her "nearest and dearest" at the expense of the greater good, a legislator may not.

A. Patient-Based Justifications

Turn first to patient-based justifications. These should be normatively desirable when they improve the health of most older patients, even if they do not improve *each* older person's health. Consider the example of Eric, from the Introduction.[173] Most people over seventy-five will be better off if doctors do not recommend colonoscopies to them. But some people over seventy-five—perhaps those with particularly aggressive cancers that would have responded well to treatment—will be worse off. Yet, given the need for some default rule, not recommending colonoscopies is the correct one to adopt, because the alternative—recommending testing—would leave a greater number of patients worse off. Where we must choose between helping more people and helping fewer, giving the smaller group an equal chance at assistance, rather than immediately assisting the larger group, is normatively untenable.[174] The lesson of this example is that not all decisions that disadvantage some people on the basis of group membership unfairly subordinate them.[175] A policy that helps more people should not be regarded as on a par with one that helps fewer people merely because the two policies help *different* people.

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[172] See the discussion in Mark A. Hall, *Rationing Health Care at the Bedside*, 69 N.Y.U. L. REV. 693, 703–05 & nn.31–32 (1994). Hall observes that a common view, which he rejects, "advocates that from the physician's perspective literally any marginal medical benefit, no matter how small, is worth absolutely any price because doctors in their role as healers should behave as if each of our lives is priceless." *Id.* at 705.

[173] *See supra* note 7 and accompanying text.

[174] *See* David Wasserman & Alan Strudler, *Can a Nonconsequentialist Count Lives?*, 31 PHIL. & PUB. AFF. 71, 71–73 (2003) (explaining the consequentialist proposition that numbers have moral significance); *cf.* Daniel Sharp & Joseph Millum, *Prioritarianism for Global Health Investments: Identifying the Worst Off*, 35 J. APPLIED PHIL. 112, 118–19 (2018) (providing examples). *But see* John M. Taurek, *Should the Numbers Count?*, 6 PHIL. & PUB. AFF. 293, 294 (1977) (defending the view that group size is irrelevant to which group should be saved).

[175] *Cf.* Henry S. Richardson, *Discerning Subordination and Inviolability: A Comment On Kamm's* Intricate Ethics, 20 UTILITAS 81, 89 (2008) (supporting the proposition that not all subordination is unfair).

What sorts of patient-based justifications for age-based criteria are objectionable? The best examples involve bias and animus. Even if—somehow—a policy grounded in animus against the old helped more older patients than it hurt (for instance, if an animus-motivated policy of denying fertility treatments to older women saved those women from spending money on futile care), the animus would remain objectionable. Rather than eliminating the policy, the solution would be to adopt the policy without the animus.[176] So long as they are not grounded in animus, however, patient-based justifications for the use of age criteria are normatively acceptable even if age is used as a sole factor, without the capacity for an individualized rebuttal.

B. Provider-Based Justifications

As a threshold matter, classifications grounded in providers' implicit biases, or in animus, are objectionable for the reasons offered above. Classifications grounded in controversial accounts of the good life, meanwhile, present the same difficult questions discussed in Part II.A. For instance, a provider's invocation of Callahan's theory of the meaning of old age as a justification for not providing a treatment to an older patient would present serious moral problems.[177] These problems parallel those raised when providers refuse to provide treatments on religious or cultural grounds.[178]

Putting animus to one side, even though providers cannot impose unwanted treatment on patients, they enjoy some degree of "personal prerogative," as well as some degree of "professional prerogative," to not provide requested treatments.[179] Their professional prerogative may also extend to

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[176] *See* Jeff McMahan, *Intention, Permissibility, Terrorism, and War*, 23 PHIL. PERSP. 345, 354–56 (2009) (examining in detail whether a "wrongful intention can make an act impermissible"); *cf.* Am. Civil Liberties Union of Tenn. v. Rutherford Cty., 209 F. Supp. 2d 799, 808 (M.D. Tenn. 2002) (discussing policy that was invalidated because it was adopted on the basis of an improper religious purpose, and efforts to cure that purpose).

[177] *See supra* notes 116–117 and accompanying text.

[178] *See generally* Robin Fretwell Wilson, Essay, *The Limits of Conscience: Moral Clashes Over Deeply Divisive Healthcare Procedures*, 34 AM. J.L. & MED. 41, 41–42 (2008) (detailing examples of providers' refusals on religious or moral grounds to provide emergency contraceptives, birth control, or abortions).

[179] Schloendorff v. Soc'y of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914); *see* Litton, *supra* note 20, at 341. For a discussion of personal prerogatives not to do what is in others' interest, see G.A. COHEN, RESCUING JUSTICE AND EQUALITY 10 (2008) ("The prerogative grants each person the right to be something other than an engine for the welfare of other people."); *cf.* Bruce A. Green, *The Role of Personal Values in Professional Decisionmaking*, 11 GEO. J. LEGAL ETHICS 19, 25 (1997) (arguing that "a lawyer generally may rely on" her own moral and religious commitments "in deciding whom not to represent").

persuading patients to select some options over others.[180] Providers are permitted to use age-based criteria to pursue a legitimate prerogative, such as not providing futile care: the use of age-based criteria does not render impermissible an otherwise permissible objective.

Both patients' interests and societal interests set ethical limits on provider-based justifications for the use of age-based criteria. When providers' use of age-based criteria runs counter to the interest of patients or of society, providers' prerogative to use such criteria can be overridden. Importantly, the interests of patients and of society also set limits on providers' *refusal* to use age-based criteria: even if providers may prefer to engage in individualized analyses instead of following evidence-based recommendations, whether for reasons of "defensive medicine" or because of a distaste for age-based criteria, patients' medical interests quickly become normatively decisive. The same is arguably true when societal interests clash with providers' interests.[181] Furthermore, a prerogative's strength may depend on its basis—the goal of seeking personal financial gain may support only a weak prerogative, whereas a provider's understanding of her professional role may support a stronger one.[182]

C. Societal Justifications

Societal justifications implicate a richer set of normative issues than patient-based or provider-based justifications. In this Subpart, I propose an approach to evaluating societal justifications for age-based criteria that I call the *lifetime justice approach* and consider objections to that approach.

1. The Lifetime Justice Approach

The lifetime justice approach incorporates two principles that are widely agreed to be normatively attractive and that support the use of age-based criteria: providing greater medical benefits and assisting those who will be worst off if not treated.[183] It also contains a third principle, that of

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[180] Ezekiel J. Emanuel & Linda L. Emanuel, *Four Models of the Physician-Patient Relationship*, 267 J. AM. MED. ASS'N 2221, 2223 (1992) (describing the rise of "patient sovereignty" in health care where the physician provides information regarding treatment options to enable the patient to make a choice).

[181] *See* Hall, *supra* note 172, at 721–22 (providing examples of health care providers' duties to the state, law, public health goals, and the public good).

[182] *See* Mark R. Wicclair, *Conscientious Objection in Medicine,* 14 BIOETHICS 205, 221–25 (2000).

[183] *See* Derek Parfit, *Equality and Priority,* 10 RATIO 202, 213 (1997); *cf.* Sharp & Millum, *supra* note 174, at 112–14 (proposing that more weight should be given to benefitting the worst off).

not abandoning patients. In some cases, these principles align; in others, they pull against one another. Although the lifetime justice approach provides no precise algorithm for balancing these principles, its open texture is a virtue, not a vice.[184]

a. Providing Greater Benefits

The importance of providing greater medical benefits largely speaks for itself. Although some have argued that providers should entirely ignore patients' prospect of long-term survival when deciding whom to treat or what to do, the goal of helping patients live longer and healthier lives is widely agreed to be an important one for medicine.[185] Even many critics of age-based criteria are willing to permit their use as a proxy for a patient's prospect of benefit, when used in an empirically accurate way alongside other proxies.[186] Especially when decisions are being made at institutional or societal levels, indifference to the fact that some patients have better prospects of benefit leads to unpalatable results. For instance, an insensitive approach to the prospect of benefit would entail the absurdity that a hospital should be indifferent between including a drug in its formulary that will produce ten years of life for some patients and including a different drug that will produce six months of life for other patients. A more plausible view—the one the lifetime justice approach adopts—is that achieving better outcomes for patients is an important goal of medicine, although not the only goal.

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[184] *Cf.* Govind Persad, Alan Wertheimer & Ezekiel J. Emanuel, *Standing by Our Principles: Meaningful Guidance, Moral Foundations, and Multi-Principle Methodology in Medical Scarcity,* 10 AM. J. BIOETHICS 46, 46 (2010). *Contra* Samuel J. Kerstein & Greg Bognar, *Complete Lives in the Balance,* 10 AM. J. BIOETHICS 37, 41–43 (2010) (stating that the system put forth by Persad, Wertheimer, and Emanuel "fails to help us in reaching an allocation decision in a variety of instances").

[185] *See, e.g.*, Harris, *supra* note 11, at 373; *cf.* Persad, *supra* note 21, at 138–39 (discussing "length-insensitive" approaches). This argument was endorsed by the majority of the Israeli committee on transplantation. *See* Katvan et al., *supra* note 155, at 9.

[186] *See, e.g.*, Kilner, *supra* note 168, at 416 (stating that consideration of age is acceptable as part of "the medical assessment required by a medical-benefit criterion"); Silver, *supra* note 42, at 1070 (similar); *see also* Katvan et al., *supra* note 155, at 10 (describing the minority position on the Israeli committee, which would have permitted the use of age in part on the basis of the "significance of the number of years the donated organ, as a public resource, will serve its recipient"); *cf.* Leslie Pickering Francis & Anita Silvers, *Bringing Age Discrimination and Disability Discrimination Together: Too Few Intersections, Too Many Interstices,* 11 MARQ. ELDER'S ADVISOR 139, 146 (2009) (raising concerns that age-based criteria will underestimate older people's prospect of benefit, but not denying that age can in principle be a proxy for prospect of benefit).

b. Assisting the Least Advantaged

The idea that assisting the least advantaged patients should have moral priority is attractive, but it is frequently understood to support giving priority to the patients who are currently sickest.[187] In contrast, the lifetime justice approach understands disadvantage as a matter of lifetime deprivation. Consider a case parallel to that of Charlotte, from the Introduction: a hospital must choose to provide a scarce organ to a twenty-five-year-old patient whose kidneys are projected to fail in a few months, or to a seventy-five-year-old patient currently in acute kidney failure. The older patient is sicker right now, but is more advantaged from a lifetime perspective: facing death at twenty-five is a far worse outcome than facing death at seventy-five, after one has enjoyed many years of life.[188] Although the lifetime justice approach agrees that medicine should also give some priority to those who are currently very sick, it grounds priority to the sick in a principle of nonabandonment, discussed in the next Subpart, rather than in the principle of priority to the least advantaged.[189]

The lifetime justice approach bases the case for giving priority to younger people on the principle of giving priority to the least advantaged, rather than on any claim about older people's subjective well-being. As such, it does not rely on the claim that an individual's seventh decade of life will be less *good* for her than her second decade was; rather, it asserts that an individual's *entitlement* to receive scarce or expensive resources needed to live through her seventh decade is less than her entitlement to receive those resources needed to live through her second decade.[190] The lifetime justice approach therefore need not take a position on the question of whether years lived later in life have diminishing marginal utility to the person living them, have greater marginal utility, or neither.[191]

Because younger age is typically a proxy for better prognosis, the use of age-based criteria usually both achieves better outcomes and assists the least advantaged. Assisting the least advantaged, however, can come apart

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[187] *See* Persad et al., *supra* note 154, at 424–25 (describing "sickest-first" allocation).

[188] *See* RONALD DWORKIN, LIFE'S DOMINION 85 (1994); Persad et al., *supra* note 154, at 425. That tort law authorizes compensation for shortened life expectancy reflects the value of living to an older age. *See, e.g.*, Alexander v. Scheid, 726 N.E.2d 272, 280 (Ind. 2000) (collecting cases).

[189] *See infra* notes 202–209 and accompanying text.

[190] To use some terminology from ethical theory, the lifetime justice view makes *deontic* claims (i.e. claims about what a person is entitled to receive) rather than *axiological* claims (i.e. claims about what is good for a person). *See* Persad, *supra* note 21, at 131. *Cf.* JOHN RAWLS, A THEORY OF JUSTICE 28 (rev. ed. 1999) (discussing the "priority of the right over the good").

[191] *See* Maria Knoph Kvamme et al., *Increasing Marginal Utility of Small Increases in Life-Expectancy? Results from a Population Survey*, 29 J. HEALTH ECON. 541, 547 (2010) (reporting the results of a study that attempts to measure the marginal utility of added life expectancy).

from providing greater benefits, as in cases where an older patient, despite her age-limited life expectancy, is nevertheless likely to gain more from treatment than a younger person can. In such cases, unlike John Rawls' famous "difference principle," which requires that we maximize the position of the least advantaged before considering what course of action provides greatest overall benefits, the lifetime justice approach engages in a rougher balancing of assisting the least advantaged and achieving better outcomes.[192]

The lifetime justice approach differs from an approach that Daniel Callahan has defended, which employs a "cut-off" age above which people lose entitlement to life-extending treatment.[193] Callahan's approach is "sufficientarian": it assumes that there is a specific threshold of advantage above (and below) which fine-grained differences are irrelevant.[194] Sufficientarianism faces the criticism that it ignores morally significant differences above and below the threshold.[195] Rather than setting a threshold at seventy-five, it is preferable to recognize that it is more disadvantageous to live to only seventy-five than to live to eighty-five, or to live only to fifty-five than to live to sixty-five.[196] Recognizing the importance of these differences better fits with the fact that even a single additional year of life is enormously valuable. The use of cutoffs and thresholds, however, can sometimes be justifiable on administrability grounds: setting a threshold for cancer screening at age seventy-five is easier for providers to implement and patients to under-

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[192] *Compare* RAWLS, *supra* note 190, at 277–85 (sympathetically considering, but ultimately rejecting, an approach that intuitively balances improvements in the general good against the interests of the least advantaged)*, with* Persad et al., *supra* note 154, at 429 (defending a balancing approach), *and* Parfit, *supra* note 183, at 213 (arguing that "benefits to the worse off could be morally outweighed by sufficiently great benefits to the better off [and] [i]f we ask what would be sufficient, there may not always be a precise answer").

[193] *See* CALLAHAN, *supra* note 26, at 116 (arguing for the imposition of an age limit to receive life-extending treatment despite the presence of sufficient resources).

[194] *See id.*; Paula Casal, *Why Sufficiency Is Not Enough,* 117 ETHICS 296, 299–300 (2007).

[195] Casal*, supra* note 194, at 313–18 (critiquing the sufficientarian view); *see also* Kolber, *supra* note 131, at 684–85 (arguing that "sharp discontinuities" in policy fail to treat similarly situated individuals similarly).

[196] What about living to fifteen versus living to five? Cases involving children generate additional complexities. I have argued that even though providing greater benefits and giving priority to the least advantaged favor young children, the fact that older children are more invested in their future plans counterbalances the age-based priority that younger children should receive. Persad et al., *supra* note 154, at 425 (claiming that the a twenty-year old's death is "intuitively worse" than the death of a two-month old); *cf.* DWORKIN, *supra* note 188, at 88 (suggesting that the death of an adolescent is worse than an infant because the adolescent "made a significant personal investment in his own life"). But I believe that reasonable people can disagree on this point. *See* Govind Persad, *Public Preferences About Fairness and the Ethics of Allocating Scarce Medical Interventions*, *in* INTERDISCIPLINARY PERSPECTIVES ON FAIRNESS, EQUITY, AND JUSTICE 51, 56 (Meng Li & David Tracer eds. 2017) (discussing the reasonableness of differing allocation systems).

stand than a more complex algorithm would be.[197] An administrability justification for an age cutoff, however, is much less normatively concerning than Callahan's grounding of an age cutoff in a tendentious view about the moral meaning of old age.[198]

The lifetime justice approach also differs from Norman Daniels' prudential lifetime account, which defends age-based criteria on the basis that they are in the anticipated interest of each individual in society because everyone expects to live through many stages of life.[199] Because Daniels grounds his approach in the idea of individual prudence rather than in principles of distributive justice, his view is more willing to allow the interests of particular individuals to override the provision of greater benefits to society, but his approach may also be more willing to allow individuals to risk dying young in exchange for the chance to live to an older age.[200] Additionally, the lifetime justice approach, by incorporating a nonabandonment principle, can justify helping older people even when a policy of abandoning them might be in their self-interest *ex ante*. In contrast, Daniels' view finds it difficult to explain why it would not be prudent to agree to be abandoned in old age in exchange for a greater chance of living to old age.[201] In many cases, however, the lifetime justice approach will reach the same verdict as Daniels' approach.

c. Nonabandonment

Even if someone has already enjoyed a great deal of life and/or has poor prospects of gaining more life from treatment, her claims to assistance still possess moral force. This reflects the importance of nonabandonment and social inclusion—although I conceive of nonabandonment as part of

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[197] *See* Schuck, *supra* note 15, at 34 ("[A]ge classifications can be administered more easily than those dependent upon criteria that are difficult to measure directly or that require individualized determinations."); *see also* Kolber, *supra* note 131, at 687 (observing that thresholds allow for lower costs and ease of administration).

[198] *See supra* notes 116–117 and accompanying text.

[199] *See generally* Daniels, *supra* note 129 (arguing that the inevitability of aging, in part, merits different treatment of different age groups).

[200] *See id.* at 475 n.2; *cf.* RAWLS, *supra* note 190, at 24–25 (arguing that goodness and rightness are distinct).

[201] *See* Kilner, *supra* note 168, at 411 (arguing that Daniels's prudential lifespan view would "impose constraints on liberty and welfare during the elderly stage of life that would probably be experienced as unbearably harsh even if they were in fact objectively prudent"); *cf.* F.M. KAMM, MORALITY, MORTALITY: VOLUME II: RIGHTS, DUTIES, AND STATUS 303 (1996) (arguing that we sometimes cannot enforce agreements to be harmed against people, even when those agreements were *ex ante* reasonable to accept). *But see* Michael Otsuka, *Kamm on the Morality of Killing*, 108 ETHICS 197, 203, 206–07 (1997) (arguing that such agreements should be enforced). I discuss this issue and its relevance to law in Govind C. Persad, Note, *Risk, Everyday Intuitions, and the Institutional Value of Tort Law*, 62 STAN. L. REV. 1445, 1468–69 (2010).

what justice requires, others see it as a value different from, or orthogonal to, justice.[202] The nonabandonment principle implies that older people should not be entirely excluded from the benefits of the health care system, and that they retain claims to assistance insofar as they can benefit from medical interventions.

Within the broader lifetime justice approach, claims grounded in nonabandonment must be balanced against the goals of providing greater benefits and giving priority to the least advantaged. Determining how far nonabandonment should constrain the pursuit of the latter two principles is challenging.[203] There are compelling arguments grounded in fairness for regarding individuals' claims to assistance in avoiding early death as categorically more important than their claims to assistance later in life.[204] In contrast, nonabandonment claims remain compelling where an older person is threatened by severe pain. Even though the older person has already enjoyed many years of life, the moral urgency of severe pain could swamp differences in future prospects or past benefit that would otherwise justify favoring younger people.[205]

Another relevant example where nonabandonment claims are compelling involves prevention and psychological support services for serious mental deterioration, such as dementia. Severe dementia can undermine the narrative coherence of a person's life, and can make basic participation in

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[202] *Compare* Anderson, *supra* note 137, at 295–96 (arguing that choice-based accounts are too willing to abandon people who make unwise choices), *and* Axel Gosseries, W*hat Makes Age Discrimination Special? A Philosophical Look at the ECJ Case Law*, 43 NETH. J. LEGAL PHIL. 59, 67–68 (2014) (discussing a "continuist approach to what justice requires" which requires the provision of basic needs regardless of age), *with* SEGALL, *supra* note 136, at 58–73 (grounding the wrongness of abandonment in solidarity rather than moral equality)*, and* G.A. COHEN, WHY NOT SOCIALISM? 37–38 (2009) (contrasting claims grounded in justice with claims grounded in the "ideal of community").

[203] *See* Juliana Bidadanure, *In Defense of the PLA,* 13 AM. J. BIOETHICS 25, 26 (2013).

[204] *Cf.* RAWLS, *supra* note 190, at 155 (criticizing an approach that asks the "less fortunate . . . to accept the greater advantages of others as a sufficient reason for lower expectations over the whole course of . . . life" for being "an extreme demand").

[205] *See* Gosseries, *supra* note 202, at 67–68 (concluding that the case for age-based criteria is weaker when older people's "ability to cover their basic needs" is in jeopardy); Kerstein & Bognar, *supra* note 184, at 38 (arguing that "the alleviation of severe, debilitating pain has special moral urgency"); *cf.* Amy Gutmann, *For and Against Equal Access to Health Care*, 59 MILBANK Q. 542, 547 (1981) (proposing a "precept of egalitarian justice that physical pains of a sufficient degree be treated similarly, regardless of who experiences them"); Robert M. Veatch, *Justice and the Economics of Terminal Illness*, 18 HASTINGS CTR. REP. 34, 38 (1988) ("For the terminally ill cancer patient in excruciating agony who could be treated cheaply with morphine, or the terminally ill person in need of clean sheets and compassionate nursing support, the fact that he or she has experienced a long, happy life seems irrelevant.").

community life impossible.[206] An older person who has enjoyed a long life could therefore offer credible justifications for dementia prevention and supportive care, even though that care consumes resources also needed by younger people whose prospects of living a long life are still uncertain.

In contrast, although a nonabandonment principle can support claims to pain relief and psychological support in the dying process, it does not support claims to additional years of life. Death certainly renders participation in community life impossible; however, death is not painful in itself, and does not undermine the narrative of a person's life, but simply ends that narrative. Thus, for instance, the nonabandonment principle would entitle a seventy-five-year-old cancer patient to palliative care and psychological counseling, even when such care would consume medical resources that could have been used to benefit younger patients, but would not entitle that patient to an equal opportunity to receive expensive chemotherapy. To the extent that chemotherapy could extend her life, the principle of providing greater medical benefits would support her case, but the principle of priority to the least advantaged would count strongly against it. Of course, many interventions have both pain-relieving and life-extending elements, which makes the task of balancing nonabandonment against other values more complex. It should be easy, however, to reject nonabandonment claims to treatments that simply improve nonessential aspects of function.[207]

Two final points on nonabandonment are important. First, I understand nonabandonment as one value that must be balanced against others, rather than as a deontological constraint that stands prior to, and potentially forecloses the consideration of, other values. This is because, *inter alia*, the abandonment of a patient is a failure to aid rather than an active deprivation; an abandoned older person is not used as a means to others' good, even though she is left below a threshold of basic decency.[208] Second, the nonabandonment principle is grounded in individuals' rights, which do not always track their subjective preferences. Even if an individual would be willing to sacri-

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[206] *See* DWORKIN, *supra* note 188, at 231. On the capacity to participate, *see* Ezekiel J. Emanuel, *Where Civic Republicanism and Deliberative Democracy Meet*, 26 HASTINGS CTR. REP. 12, 13 (1996) (arguing that health services that "ensure full and active participation by citizens in public deliberations —are to be socially guaranteed as basic"); *see also* Edmund G. Howe & Christopher J. Lettieri, *Health Care Rationing in the Aged: Ethical and Clinical Perspectives*, 15 DRUGS & AGING 37, 42 (1999) (describing loss of the "capacity to enjoy meaningful interactions" as a loss "worse than many or all others").

[207] *See* Gutmann, *supra* note 205, at 546 (using dentistry as an example of equal access to functionally equivalent treatments that are "aesthetically or socially" different).

[208] *Cf.* Richardson, *supra* note 175, at 89 (discussing cases where a person's "being harmed is a causal means to the greater good"). This implies that, for instance, patients may be abandoned on the basis of age in tragic situations where some patients must unavoidably be left below a threshold of basic decency. *Id*.

fice her claim to dementia support in exchange for a greater chance at life-extending care, society's responsibility is to prevent social exclusion, not to provide the medical outcomes that a patient might prefer.[209]

2. Objections

a. Moral Equality

The most common criticism of age-sensitive approaches, like the lifetime justice approach, contends that respecting older people's fundamental moral equality requires providing health care without regard to age.[210] The lifetime justice approach has an easier time addressing these concerns than other defenses of age-based criteria do because it rejects animus and bias, eschews reliance on tendentious accounts of the meaning of old age, and incorporates a nonabandonment principle that addresses the concern that older people's interests will be categorically ignored. Once these issues have been put to one side, there is a compelling case in support of considering the fact that older people have enjoyed more life and have less life to gain.[211] Although criteria other than age may also be important, these factors establish a case in support of age-based criteria. Such criteria parallel similar policies that impose comparative disadvantages on wealthy, socially advantaged, or well-educated people on the basis that these people have already enjoyed more of a good and can gain less from further assistance. Consider, for instance, policies that give special financial assistance, or admissions priority, to students pursuing their first undergraduate degree.[212] These policies are normatively justifiable on the basis that those who already have an undergraduate degree have already enjoyed more education and can gain less from further education. Contrary to the reasoning that undergirds the moral

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[209] *See* Gutmann, *supra* note 205, at 551; *cf.* Leo Katz, *Harm and Justification in Negligence*, 4 THEORETICAL INQUIRIES L. 397, 405–08 (2003) (arguing that medical care ought to be distributed according to patients' objective claims rather than according to its effect on their subjective well-being).

[210] *See, e.g.*, Eidelson, *supra* note 42, at 1646 (arguing that antidiscrimination claims that reject age-based criteria are a way of "insisting on the public recognition of people's equal worth and dignity"); Katvan, *supra* note 155, at 9 (claiming that age-based criteria involve "a decision that some people are 'worth more' and some are 'worth less'"); Kilner, *supra* note 168, at 414 ("A person's life arguably should be preserved simply because it is a human life. In this perspective, the age attached to that life would be irrelevant. Otherwise, one's right to life would diminish with every day that one lives.").

[211] *Cf.* A.B. Shaw, *In Defence of Ageism*, 20 J. MED. ETHICS 188, 191 (1994) ("Older people have enjoyed more life and have less life left to enjoy.").

[212] *See, e.g.*, Hunter v. Univ. of Wash., 2 P.3d 1022, 1024 (Wash. App. 2000). Another parallel is assistance for first-generation college students—a group that, like age groups, is defined by an unchosen characteristic. *See, e.g.*, 42 U.S.C. § 13504(b)(1) (2012).

equality objection, such policies do not disrespect the moral worth of the college-educated or create a situation where one's right to education diminishes with each class one attends.[213] Rather, giving priority to those pursuing a first undergraduate degree recognizes that what it takes to respect someone's moral equality depends on their circumstances, and that differential receipt of benefits does not imply differential moral worth. Provisions that favor undergraduates pursuing their first degree do not suggest that the right to education itself diminishes as one becomes more educated, but rather that claims to assistance in fulfilling that right depend on one's circumstances and prior advantages.[214] The same is true for older people and the right to life-extending medical care.

Similarly, the assertion that the "distinction—between a person's worth and the worth of saving her life—is very thin indeed" and that by "consigning the aged to a lower-priority class for access to lifesaving treatment, we risk conveying and fostering the attitude that they are simply of lesser value as persons" goes wrong by ignoring the differential capacity of medical care to help different people.[215] The act of saving someone's life is simultaneously the act of extending that life, and ignoring the difference between extending one life by five years and extending another by twenty-five years, or providing one person the chance to live through their second decade rather than providing another the chance to live through their seventh, is morally indefensible given the value of each year of life.[216] Consider the following pair of examples:

1. Including Drug A in a formulary will only enable doctors to delay one patient's death by a year, whereas including Drug B will enable them both to delay a different patient's death by a year and to delay a third patient's death by twenty years. In this example, we should include Drug B rather than Drug A; doing so does not regard the first patient as having lesser value, but instead appropriately recognizes the great importance of extending the third patient's life by twenty years.
2. Including Drug A in a formulary will enable doctors to delay one death for a year, whereas including Drug B will enable them to delay another patient's death by twenty-one years. The case for including Drug B remains clear; even though the benefits of Drug B now go to only one pa-

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[213] *Cf.* Kilner, *supra* note 168, at 414 (providing an argument for the moral equality objection that all human life has intrinsic worth).

[214] *Contra id*.

[215] Eidelson, *supra* note 42, at 1647.

[216] *See* Richard Yetter Chappell, *Against 'Saving Lives': Equal Concern and Differential Impact*, 30 BIOETHICS 159, 159 (2016).

> tient, choosing Drug B still does not regard the first patient as having lesser value than the second, but instead appropriately recognizes the great importance of extending the second patient's life by twenty-one years.

Even though both Drug A and Drug B "save a life," Drug B can do far more good than Drug A can. The moral equality objection goes wrong when it overlooks the moral importance of doing more good rather than less, particularly where a valuable good like years of life is at stake.

Understanding that the provision of differential benefits is consistent with equal moral worth also undermines a moral equality objection that Leslie Francis and Anita Silvers offer.[217] Francis and Silvers believe that defenders of age-based criteria wrongly "transmute equality into a quantum of something, often welfare or the like," and "adopt a distributive rather than a procedural understanding of equality."[218] I agree with Francis and Silvers that equal respect should be understood as procedural rather than distributive. Their argument, however, more properly applies to *critics* of age-based criteria. Such critics frequently contend that recognizing older people as morally equal requires a distributive undertaking—namely, providing them the same quantum of medical resources that younger people receive.[219] In contrast, the lifetime justice approach concludes that recognizing the moral equality of older people is a matter of procedural fairness (exemplified by, for instance, avoidance of animus and bias), and that once procedural fairness is achieved, it is acceptable to provide older people a lesser quantum of resources. It is critics, not defenders, of age-based criteria who mistakenly understand equal respect as requiring the provision of equally sized benefits.

Moral equality arguments can also take an empirical form, charging that age-based criteria will spur demeaning attitudes against older people or undermine social cohesion.[220] Such claims cannot be resolved by pure normative or legal reasoning, but only by evidence about the empirical effects

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[217] Francis & Silvers, *supra* note 186, at 144.

[218] *Id.*

[219] *See, e.g.*, Eidelson, *supra* note 42, at 1646; Katvan, *supra* note 155, at 9; Kilner, *supra* note 168, at 414 (noting a critique of using age as a criterion, namely that age is irrelevant because all human life has value and "[o]therwise, one's right to life would diminish with every day that one lives").

[220] *See, e.g.*, Eidelson, *supra* note 42, at 1649 (asserting that "[s]tate-sanctioned medical rationing that expressly disfavors older people is troubling because of the real risk that it will be understood to reflect judgments of comparative worth, and that it will thereby lend renewed credibility to . . . demeaning attitudes toward older people"); Kilner, *supra* note 168, at 414–15 ("An age criterion may be disrespectful of the elderly as persons . . . . In the process of showing disrespect to an entire group of people, society itself can become brutalized.").

of these policies and of alternative arrangements. Furthermore, even if the use of age-based criteria proves to have some negative effects on older people or on social cohesion, this would still have to be balanced against the advantages of using age-based criteria. I will nonetheless yield to temptation and offer one brief speculation: age-based criteria could potentially *strengthen*, rather than weaken, social cohesion between the young and the old by demonstrating to the young that the old recognize the advantages they have experienced and are willing to sacrifice further gains so that others can enjoy similar advantages. In the same way, for example, progressive taxation or preferences for first-generation college students might strengthen cohesion between the advantaged and disadvantaged rather than undermining cohesion. This hypothesis—like the contrary hypotheses proposed by critics of age-based criteria—warrants empirical research.

A fascinating cousin to the moral equality argument is advanced by Derek Parfit, who argues that a person's status as the same person over time is a continuous variable (like age) rather than an all-or-nothing fact.[221] What Parfit calls the "Reductionist View" of personal identity counsels against giving moral weight to a person's past advantages, because these advantages, seen from their present vantage point, are no longer fully their own.[222] The Reductionist View would undermine efforts to justify age-based criteria on the basis of priority to the least advantaged, because from an older person's current perspective, the earlier years of life "she" enjoyed are not so vividly *her own* as her last few years of life—those early years are similar to years of life someone else might have enjoyed in the past.[223] Adopting the Reductionist View, however, would make such simple questions as who someone's friends or family are, or what property they own, extremely difficult to answer.[224] Furthermore, although the Reductionist View undermines the principle of priority to the least advantaged, it also does not lend support to a principle of nonabandonment or provision of equal benefits. Rather, Parfit argues that we should "aim for the least possible suffering, whatever its distribution."[225] Ultimately, adopting the Reductionist View would support only the principle of providing greater benefits, and would require abandoning both nonabandonment and priority to the least advantaged.

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[221] DEREK PARFIT, REASONS AND PERSONS 275–82 (1984).

[222] *See id.*

[223] *Cf. id.* at 333–34, 341 (proposing that "subdivisions within lives" are akin to "divisions between lives"). Richard Posner has used Parfit's approach to defend the position that older people have rights against their "younger selves." RICHARD POSNER, AGING AND OLD AGE 84–94 (1995).

[224] *See generally* ALLEN E. BUCHANAN & DAN W. BROCK, DECIDING FOR OTHERS (1989).

[225] PARFIT, *supra* note 221, at 341.

b. Alternative Currencies of Distributive Justice

Some argue that years of life are the wrong "currency" of advantage to focus on when distributing the benefits of health care.[226] Instead, they contend that it is more coherent to focus on fairly distributing individuals' *opportunity* to enjoy a given number of years of life.[227] This line of argument often goes on to conclude that a focus on fairly distributing opportunities is nevertheless normatively mistaken because it would require tallying up the total cost of the medical care each person has received.[228] Less often, this argument is used to recommend shifting to a strategy of equalizing opportunity.[229]

In contrast, Daniel Sharp and Joseph Millum argue that rather than giving priority to those who have enjoyed the fewest life-years, we should widen our lens and give priority to those who have enjoyed the least lifetime advantage more generally.[230] In many cases, such as the moral requirement to give priority to ill children, the lifetime justice approach and Sharp and Millum's view reach the same verdict.[231] The lifetime justice approach, however, gives priority to those at risk of dying prematurely, and Sharp and Millum's view gives priority to those at risk of enjoying less overall advantage.

I argue that years of life are a more important criterion for the distribution of health care than either opportunity to enjoy life or lifetime advantage, for both pragmatic and fundamentally normative reasons. Pragmat-

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[226] I borrow the "currency" terminology from G.A. Cohen, *On The Currency of Egalitarian Justice*, 99 ETHICS 906, 906 (1989).

[227] *See, e.g.*, Kilner, *supra* note 168, at 409 (arguing that if a young person has received more medical care than an elderly person, "[i]t may not be accurate to say that the younger person should be saved because she or he has not been given as great an opportunity to live as the older person," but rather the elderly person should be saved).

[228] *See* Francis & Silvers, *supra* note 186, at 144 (providing that "[a]n analogy would be to lifetime caps on health insurance payments, with the elderly having consumed their share over their lifespan"); *cf.* Council on Ethics and Judicial Affairs, *supra* note 139, at 33 (rejecting the view that patients' past access to and use of scarce medical resources gives them lower priority than others).

[229] *See* Kilner, *supra* note 168, at 411–12; *see also* Gusmano, *supra* note 168, at 184–85 (questioning whether the elderly have used their "fair share of public resources" and asking "[i]s it fair to limit curative care that may be beneficial to an 80-year-old patient if she received relatively little care earlier in life . . . ?").

[230] Sharp & Millum, *supra* note 174, at 124 (claiming that the worst off are people "who have the least lifetime advantage, where advantage is understood in terms of a plurality of valuable dimensions"). This approach is criticized in Kerstein & Bognar, *supra* note 184, at 38 (arguing that being denied treatment for pain due to being "too well off overall to have an urgent medical need" would be "invidious"), and in Evans, *supra* note 11, at 825 (suggesting that the "early turning off of the rich and fortunate in favour of the poor and deprived" is an "an intellectually charming reductio ad absurdum").

[231] *See* Sharp & Millum, *supra* note 174, at 124 ("Virtually no one who makes it to age 50 will be as badly off over her lifetime as someone who dies at age five. Non-health factors are unlikely to make a difference to this result.").

ically, as Sharp and Millum concede, measuring age is easier than measuring lifetime advantage.[232] More fundamentally, focusing on life-years has three advantages. First, assessments of either opportunity to enjoy life or of overall advantage will likely be objectionably intrusive, whereas age assessments will not.[233] Second, years of life have many of the qualities associated with other widely accepted currencies of distributive justice, such as the "primary goods" Rawls discusses: additional years of life, like wealth, health, or opportunity, "normally have a use whatever a person's rational plan of life."[234] Third, health care providers are ill-placed to assess patients' overall advantage, but well-placed to assess age.[235]

c. Disparate Impact on Protected Classes

Some critics charge that age-based criteria indirectly disadvantage women, who make up a greater share of the oldest age groups.[236] This consequence of age-based criteria is, on its face, normatively objectionable. It could also render age-based criteria legally vulnerable, although recent changes in law have weakened disadvantaged groups' protection against disparate impact.[237]

In an unequal society where advantage and disadvantage (including life expectancy) correlate with socially defined categories, the problem of indirect disadvantage is pervasive. The use of age-based criteria will indirectly disadvantage women, who are already disadvantaged in many ways by social arrangements.[238] This disadvantage, however, occurs in the context of life expectancy, where women are advantaged rather than disadvantaged.[239] This, at the very least, makes the use of age-based criteria less ob-

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[232] *Id.* at 117.

[233] *See* Schuck, *supra* note 15, at 33–35.

[234] RAWLS, *supra* note 190, at 54.

[235] *See* Clarke et al., *supra* note 139, at 33 (noting that medicine is ill-placed to assess patients' access to factors that impact health including "income, education, and access to primary care").

[236] *See* Howe & Lettieri, *supra* note 206, at 41 (discussing the argument that "discrimination against the elderly disproportionately discriminates against women" because women have longer lifespans than men); Kapp, *supra* note 103, at 328 (contending that age-based criteria have an "inherently sexist impact" on women).

[237] *See* Areheart, *supra* note 122, at 993–95; *cf.* Nungesser v. Columbia Univ., 169 F. Supp. 3d 353, 363 (S.D.N.Y. 2016) (finding that "courts have held that a private right of action based on the alleged disparate impact of a policy on a protected group is not cognizable under Title IX").

[238] *See, e.g.*, Roberts v. U.S. Jaycees, 468 U.S. 609, 626 (1984).

[239] SEGALL, *supra* note 136, at 106–07.

jectionable than a policy that further disadvantages women in contexts where they are already disadvantaged.[240]

Attention to intersectional identity further weakens the basis for concern about indirect disadvantage. Many younger women will experience no disadvantage from the use of age-based criteria and will even experience advantages from the use of such criteria: any disadvantage will fall on older women who have already enjoyed more years of life. Additionally, because of correlations between wealth, race, and life expectancy, those older women are more likely to be well-off and less likely to be African-American.[241] If imposing indirect disadvantage on women as a group remains a concern, one strategy would be to direct some of the resources saved via the use of age-based criteria to programs that aim to assist women at younger ages—for instance, using the resources saved by adopting an age cutoff for transplantation to fund health literacy efforts that target younger women.

A related, but less compelling argument charges that using older age as a proxy for future life expectancy logically entails the use of race as a proxy. Because life expectancy is lower on average for African-Americans, this would entail the direct disadvantaging of African-Americans.[242] This concern can be addressed with relative ease. Because living to old age is an advantageous outcome, using old age as a proxy for low future life expectancy disadvantages members of a generally advantaged group (people who have already lived to old age). In contrast, using race as a proxy for future life expectancy would impose additional disadvantage on an already disadvantaged group.

IV. EVALUATING AGE-BASED CRITERIA IN PRACTICE

In this Part, I apply the analysis offered in the preceding Parts to age-based criteria that are in use, or have been proposed, in medical practice and health policy. These areas include transplantation, reproductive medicine, disease screening, medical research, and the provision of health insurance.

A. Transplantation

The details of age-based criteria for access to transplantation depend both on the organ being transplanted and on the local norms of specific

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[240] *See, e.g.*, Bridget J. Crawford & Carla Spivack, *Tampon Taxes, Discrimination, and Human Rights*, 2017 WIS. L. REV. 491, 493 (discussing a "tampon tax," which increases a financial burden that already falls disproportionately on women).

[241] *See generally* S. Jay Olshansky et al., *Differences in Life Expectancy Due to Race and Educational Differences Are Widening, and Many May Not Catch Up*, 8 HEALTH AFF. 1803 (2012) (reporting correlations between race, education, and life expectancy).

[242] *See* Morreim, *supra* note 42, at 341.

transplantation centers. Age-based criteria are frequently used in the allocation of lung transplants, kidney transplants, liver transplants, and heart transplants.[243] Some medical and bioethical commentators nonetheless worry that the use of age-based criteria in transplantation is unfair age discrimination.[244] These concerns may have motivated prohibitions in other countries on the use of age-based criteria in transplantation.[245] For example, Israel has prohibited any consideration of age in organ allocation, including approaches where age is only one factor among many.[246]

The lifetime justice approach is not a detailed proposal for allocating organs.[247] It does, however, provide guidance for the development of organ allocation policy. Most importantly, it counsels that the adoption of a policy like Israel's, which categorically prohibits the use of age in allocation, would be a tragic and unfair waste of valuable medical resources. Age-based criteria can help providers direct organs toward patients who have a greater prospect of benefiting from the organs, and can address the tragedy of early death. Patients, providers, hospitals, regulators, and judges should

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[243] Katvan et al., *supra* note 155, at 8–9 (discussing the historical use of age limits for heart transplantation in Israel); Francesco Tona & Carlo Dal Lin, *Clinical Indications for Heart Transplantation*, *in* THE PATHOLOGY OF CARDIAC TRANSPLANTATION 33, 35–36 (Ornella Leone et al. eds. 2016) (stating that wait list consideration for heart transplants is usually capped at 75 years); Suzanne R. Sharpton et al., *Combined Effects of Recipient Age and Model for End-Stage Liver Disease Score on Liver Transplantation Outcomes*, 98 TRANSPLANTATION 557, 557, 560 (2014) (observing that some age cut-offs for liver transplantation have been set around 65 or 70 years but arguing that age should not be used as a sole criterion for transplantation); Paul L. Tso, *Access to Renal Transplantation for the Elderly in the Face of New Allocation Policy: A Review of Contemporary Perspectives on "Older" Issues*, 28 TRANSPLANTATION REVS. 6, 9–10 (2014) (describing a study concluding that "deceased donor transplantation is attractive for senior patients up to ages 65–70 at centers with wait times up to 2 years, and living donor transplantation is reasonable for patients up to age 80," as well as describing kidney transplantation guidelines in several countries); Eric S. Weiss, Christian A. Merlo & Ashish S. Shah, *Impact of Advanced Age in Lung Transplantation: An Analysis of United Network for Organ Sharing Data*, 208 J. AM. C. SURGEONS 400, 400 (2009) (describing the use of age-based criteria in medical practice and concluding that lung transplantation should not be used in patients age seventy years or older).

[244] *See, e.g.*, K. Ladin & D.W. Hanto, *Rational Rationing or Discrimination: Balancing Equity and Efficiency Considerations in Kidney Allocation,* 11 AM. J. TRANSPLANTATION 2317, 2318 (2011) (observing that experts in the field contend that using age-based criteria to allocate organs "amounts to age discrimination, disadvantaging patients who could benefit significantly from transplantation because of a morally, and often, clinically irrelevant factor such as age").

[245] *See, e.g.*, Liviu Segall et al., *Criteria for and Appropriateness of Renal Transplantation in Elderly Patients with End-Stage Renal Disease: A Literature Review and Position Statement on Behalf of the European Renal Association–European Dialysis and Transplant Association Descartes Working Group and European Renal Best Practice*, 100 TRANSPLANTATION e55, e58–e59 (2016).

[246] Katvan et al., *supra* note 155, at 9–10 (discussing Israel's rejection of age-based criteria).

[247] The detailed kidney allocation proposal offered by Ross et al., *supra* note 5, at 2115–16, would be a good starting point for future work because it recognizes both the importance of providing greater medical benefits and of giving priority to people who have enjoyed less life.

all resist the seductive appeal of simplistic anticlassification arguments that describe age as an arbitrary basis for allocating organs.[248] Relevantly for law, this implies that age-based criteria should not be subject to heightened scrutiny, and that judges should be deferential to evidence-based arguments for the relevance of age to outcomes. A normatively appealing approach to transplantation would use age as one eligibility criterion, alongside other criteria that might predict how likely the transplant is to provide the patient with long-term benefit. Another potential criterion—grounded in nonabandonment considerations—would be whether non-transplant alternatives (or the receipt of less healthy organs) would be likely to subject older patients to unacceptable pain, or instead would merely provide them with fewer expected years of life.

The lifetime justice approach also provides grounds for doubt about the high significance that many allocation systems assign to how long a patient has been on a waiting list for an organ.[249] Under the lifetime justice approach, if a child can gain many years of life from an organ and would be consigned to a vastly shortened life without one, she should receive priority over a middle-aged or older person who may have been waiting for a transplant for longer than the child has been alive. Even if the mere passage of time can cement entitlements to what one already has, it should not support a greater entitlement to what one only hopes to receive.[250] A better approach would create an eligibility pool rather than a waiting list, and would then select patients from the pool without regard to waiting time, except when waiting time predicts a patient's prospect of benefit or predicts how badly they will fare without an organ.

B. Reproductive Medicine

Age-based criteria are common in reproductive medicine. ASRM recommends that "providers should implant embryos in women >50 years only after medical evaluation; and should discourage women >55 years from doing so . . . ."[251] Many providers use even lower age cutoffs.[252] Cryopres-

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[248] *Cf.* Areheart, *supra* note 122, at 996 (contrasting the easy application of anticlassification with the greater nuance required for antisubordination analysis).

[249] *See* Clarke et al., *supra* note 139, at 38 (describing and endorsing the view that waiting time is an appropriate basis for allocation); *see also* Ross et al., *supra* note 5, at 2116 (asserting that "waiting time points have become the primary allocation factor" for deceased-donor kidneys); *cf.* Persad et al., *supra* note 154, at 424 (criticizing "first-come, first-served" allocation of organs).

[250] *Cf.* David A. Super, *A New New Property*, 113 COLUM. L. REV. 1773, 1813 (2013) (discussing the "natural sense of the possessor to treat property as her or his own after the passage of some time").

[251] Klitzman, *supra* note 6, at 217.

ervation procedures are also subject to age limits: practice guidelines recommend against cryopreservation of eggs or ovarian tissue for women over thirty-eight, and only twenty-six percent of providers in a recent survey would provide cryopreservation services to women over forty.[253] Some reproductive clinics also consider the age of all prospective parents—not only the direct patient—when deciding whether to offer treatment.[254] These policies often reflect concerns about children being orphaned:

> By including the father's age in the decision and establishing a maximum cutoff, providers increased the odds that at least one parent would be alive to raise the child. "Generally, their ages have to add up to less than 100. We came up with 100 because we don't want gender bias, but want a parent around to raise the kid" . . . .[255]

Governments also employ age-based criteria when making reimbursement decisions:

> In order to begin to balance the costs to insurers, as well as promote the health and safety of both mother and child . . . New Jersey, Rhode Island, New York, and Connecticut have put age restrictions on their insurance mandates. These states recognized that there must be a balance between comprehensive coverage and the costs associated with high risk pregnancies. New Jersey limits coverage for in vitro fertilization to women forty-five or younger. Connecticut limits its coverage to individuals under the age of forty. Rhode Island's coverage is limited to women between twenty-

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[252] *Id.* at 218 (reporting statement of one physician that age forty-five is the cutoff for women using their own eggs).

[253] Jacques Donnez et al., *Restoration of Ovarian Activity and Pregnancy After Transplantation of Cryopreserved Ovarian Tissue: A Review of 60 Cases of Reimplantation*, 99 FERTILITY & STERILITY 1503, 1504 (2013) (asserting that women over 38 years should be excluded from cryopreservation procedures); ESHRE Task Force on Ethics and Law, *Oocyte Cryopreservation for Age-Related Fertility Loss*, 27 HUM. REPROD. 1231, 1235 (2012) (providing guidelines for cryopreservation); Briana Rudick et al., *The Status of Oocyte Cryopreservation in the United States*, 94 FERTILITY & STERILITY 2642, 2646 (2010) (reporting survey results of providers' likelihood to provide cryopreservation to women ages 38 to 40 years old). *But see* Micah J. Hill & Eric D. Levens, *Elective Egg Freezing: Is 40 Too Old?*, 60 CONTTEMP. OB/GYN 42, 44 (2015) (arguing that well-informed patients, even over 40 years of age, should be allowed to freeze their eggs).

[254] Klitzman, *supra* note 6, at 219 ("One physician reported that '[s]ome clinics won't treat you if your combined age is more than 80. Or 90. Or 110.'").

[255] *Id.* Some providers also consider the prospect of age-related morbidity. *Id.* at 220 (observing that being alive at a later age does not necessarily equate to being "healthy to be an active parent").

> five and forty-two. New York limits its mandate for infertility coverage to women between age twenty-one and forty-four.[256]

Many countries that subsidize assisted reproduction similarly set age cutoffs for reimbursement.[257] Although these reimbursement limits do not constitute a strict bar on access to treatment, their major implications for patients' finances make them more than a mere default rule or nudge.

Societal justifications are the most common basis for defensible age-based criteria in reproductive medicine. Even though assisted reproductive treatments—unlike transplantable organs—are not absolutely scarce, the use of these treatments in older patients may be a low-priority use of scarce resources.[258] Another defensible societal justification, distinctive to assisted reproduction, focuses on concerns about the well-being of the resulting child.[259] These concerns include both risks of genetic abnormality and, as discussed above, being orphaned, being raised by parents who are unable to effectively care for a child, or experiencing the death of a parent during childhood.[260] Assessing the force of these concerns, particularly as regards genetic risks, is complicated by the "non-identity problem"—even if the children of older parents face distinctive risks, these specific children could not have existed with different genetic parents, and are unlikely to have existed with different legal parents; their most likely alternative was not to exist at all.[261] An alternative societal justification, not obviously vulnerable to the non-identity problem, would focus on the burdens imposed on society when children are orphaned, raised by parents who lack capacity, or suffer severe congenital disabilities: we might be able to say that appropriate regulation can make society as a whole better off, even if we cannot say the same for its effects on specific children. Going beyond societal justifications, the most plausible patient-based justification for age-based criteria would be the financial burden on patients who are unlikely to benefit; con-

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[256] Camille M. Davidson, *Octomom and Multi-Fetal Pregnancies: Why Federal Legislation Should Require Insurers to Cover in Vitro Fertilization*, 17 WM. & MARY J. WOMEN & L. 135, 180–81 (2010). Notably, Connecticut has since removed its age restriction due to concerns about age discrimination. *See* Blake, *supra* note 35, at 269.

[257] Eleanor L. Stevenson & Jamie Kanehl, *Utilization of ART Services in Developed Countries and Impact on Cross-Border Reproductive Care, in* FERTILITY AND ASSISTED REPRODUCTIVE TECHNOLOGY (ART): THEORY, RESEARCH, POLICY AND PRACTICE FOR HEALTH CARE PRACTITIONERS 201, 202 (Eleanor L. Stevenson & Patricia E. Hershberger eds. 2016).

[258] *See, e.g.*, Davidson, *supra* note 256, at 180.

[259] *See* Klitzman, *supra* note 6, at 222.

[260] *See id.*

[261] *Id.; see* PARFIT, *supra* note 221, at 359 (coining the term "non-identity problem"); I. Glenn Cohen*, Regulating Reproduction: The Problem with Best Interests*, 96 MINN. L. REV. 423, 426 (2011) (discussing the "non-identity problem").

cerns about futility, meanwhile, could sometimes support provider-based justifications.[262]

Fears of lawsuits can influence reproductive medicine providers' decisions:

> I do not have cutoffs because one clinic's front office received a phone call and the caller said she would like to come in for IVF treatment. The staff member said, "Well, you're passed our cutoff age—you're 48. The doctors won't treat you." The caller was a judge, and filed a federal lawsuit for age discrimination.[263]

Clarifying age discrimination law to differentiate animus and bias from justifications grounded in the legitimate interests of providers, patients, or society might help to clarify providers' obligations and to avoid the practice of defensive medicine. A cutoff age is not obviously objectionable when it is supported by evidence about differential efficacy, rather than by false stereotypes or claims about unnaturalness. Indeed, as I argue in Part II.A, an explicit cutoff age may reduce the risk of implicit bias.[264]

Because assisted reproduction involves procreation, it generates unique legal questions, unrelated to age, that I cannot explore in depth. Although individuals have no established constitutional rights to receive transplants, they do have established constitutional rights to procreate, which might be used to undergird a claim that restrictions on access to reproductive treatment must meet the higher standard of scrutiny associated with restrictions on fundamental rights.[265] But it is unclear whether the heightened scrutiny already

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[262] *See* Klitzman, *supra* note 6, at 217; Note, *Assessing the Viability of a Substantive Due Process Right to in Vitro Fertilization,* 118 HARV. L. REV. 2792, 2811 (2005) (raising concerns about financial exploitation of patients). Compared to transplantation*,* the physical risks of reproductive medicine are minimal. *See* ESHRE Task Force, *supra* note 253, at 1233.

[263] Klitzman, *supra* note 6, at 221. A search of legal databases uncovered no material related to this lawsuit; perhaps Klitzman's survey respondent mistook a threat of suit for a filed suit. *See* Judy E. Stern et al., *Attitudes on Access to Services at Assisted Reproductive Technology Clinics: Comparisons with Clinic Policy*, 77 FERTILITY & STERILITY 537, 540 (2002) (stating that "the decision not to offer a service to an individual or couple because of their advanced age may invite legal action under state or federal laws that prohibit age discrimination in other contexts"); G. William Bates & Susanne R. Bates, *Infertility Services in a Managed Care Environment*, 8 CURRENT OPINION OBSTETRICS & GYNECOLOGY 300, 302 (1996) (observing that in an Illinois health insurance policy, "[n]o age cut-off was established so as not to create an issue of age discrimination").

[264] *See supra* notes 97–119 and accompanying text.

[265] Deborah L. Forman, *When "Bad" Mothers Make Worse Law: A Critique of Legislative Limits on Embryo Transfer*, 14 U. PA. J.L. & SOC. CHANGE 273, 284 (2011) (questioning whether limits on reproductive treatment restrict fundamental rights to procreate); Kimberly M. Mutcherson, *Procreative Pluralism*, 30 BERKELEY J. GENDER L. & JUST. 22 (2015) (arguing that "the fundamental right to procreate as protected by the Constitution includes a fundamental right to use assisted repro-

required where fundamental rights are at stake would be further intensified by the use of age-based criteria, given that age-based criteria do not warrant heightened scrutiny on their own.[266] Meanwhile, because assisted reproduction produces a child, the "best interests" of that child could serve as a counterweight to an older patient's asserted right to procreate.[267]

C. Screening Tests

The United States Preventive Services Task Force (USPSTF), which makes expert recommendations about screening tests, frequently uses age-based criteria in its recommendations.[268] This likely reflects both the impossibility of basing decisions about whether to provide screening tests—which provide detailed information about patients' health risks—on detailed preexisting knowledge of patient health status, and the easy accessibility of patients' age to both patients and providers. The USPSTF's recommendations are not directly legally binding; however, the ACA's regulations incorporate the USPSTF's recommendations, and private parties also rely on them.[269] Perhaps for these reasons, a revision to the USPSTF's mammography guidelines recommending an age-based exclusion of younger women was highly controversial, with the ACA directing federal programs to ignore the recommendations.[270] As with transplantation and reproductive medicine, concerns about legal liability—including liability for discrimination—are likely to discourage the use of age-based criteria, even when tests may be ineffective or harmful for older adults.[271]

A distributive justice approach is consistent with patient-based and provider-based rationales for using age-based criteria that appeal to the risk of overdiagnosis and overtreatment following screening, as well as the risk

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duction"); *cf.* J.R. v. Utah, 261 F. Supp. 2d 1268, 1279 (D. Utah 2002) (suggesting that a statute that purported to prevent access to or "prohibit use of gestational surrogacy as a procreative method" would be legally infirm).

[266] *But see* Kohn, *supra* note 72, at 273–75.

[267] *See* Klitzman, *supra* note 6, at 220; ESHRE Task Force, *supra* note 253, at 1233. *But see* Cohen, *supra* note 261, at 426 (arguing that a best interests analysis is inapplicable in cases where the child could not have existed otherwise).

[268] *See* U.S. PREVENTIVE SERVS. TASK FORCE, *supra* note 7 (recommending age-based criteria for aortic aneurysm, cervical cancer, colorectal cancer, diabetes, gonorrhea, HIV, and lung cancer screening).

[269] *See* Mary Helen McNeal, *Say What? The Affordable Care Act, Medicare, and Hearing Aids*, 53 HARV. J. ON LEGIS. 621, 655 & n. 245, 668 (2016).

[270] *See* 42 U.S.C.A. § 300gg-12(a)(5) (West 2019); Persad, *supra* note 21, at 125 & n.27.

[271] Renee Twombly, *Preventive Services Task Force Recommends Against PSA Screening After Age 75*, 100 J. NAT'L CANCER INST. 1571, 1571 (2008) (observing that "some physicians predict that the USPSTF's revised guideline will generally be ignored—particularly by urologists—for a variety of reasons, including fears of age discrimination").

of direct harm from screening itself.[272] Screening older patients may be a net harm to them, and may implicate providers in the infliction of harm. Using age-based criteria when making screening decisions is also consistent with societal rationales that appeal to resource stewardship—screening older patients may impose high costs on the public fisc while producing few benefits, or consume resources and physician time that could be used to screen patients who are more likely to benefit.[273]

D. Clinical Research

Clinical trials of experimental interventions frequently exclude older adults.[274] Although the obligations involved in the researcher-participant relationship are different from those involved in the physician-patient relationship, recent scholarly literature has criticized the use of age-based exclusion criteria on the basis that they unfairly exclude older people from the benefit of research innovations.[275] Meanwhile, Daniel Callahan has argued for reducing clinical research spending on diseases suffered primarily by older patients.[276]

The lifetime justice approach, in contrast to both of these approaches, supports neither the elimination of age-based criteria nor the categorical exclusion of older people from clinical trials. Rather, it supports stratifying older patients into "elderly-specific" trials; although such stratification has raised concerns about discrimination, it has also helped older patients access better-tailored care.[277] Elderly-specific trials recognize that older patients are not similarly situated to younger patients, and have genuinely different needs and ethical entitlements, but nonetheless have a claim to benefit from research.

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[272] *See* SHANNON BROWNLEE, OVERTREATED 142–74 (2010); *see also* Govind Persad, *Health Theater*, 48 LOY. U. CHI. L.J. 585, 594–600 (2016) (discussing harms caused by health screenings).

[273] *See* Persad, *supra* note 272, at 591–94, 618–21.

[274] Williams, *supra* note 50, at 23.

[275] *See, e.g.*, Sandra J. Carnahan, *Medicare's Coverage with Study Participation Policy: Clinical Trials or Tribulations?*, 7 YALE J. HEALTH POL'Y L. & ETHICS 229, 260 (2007) (noting that clinical trial data "cannot be generalized to the over-sixty-five (Medicare) population as a whole" due to exclusion of older people from clinical trials); Williams, *supra* note 50, at 23.

[276] DANIEL CALLAHAN, WHAT PRICE BETTER HEALTH? HAZARDS OF THE RESEARCH IMPERATIVE 72 (2006).

[277] Aminah Jatoi et al., *Should Elderly Non-Small-Cell Lung Cancer Patients Be Offered Elderly-Specific Trials? Results of a Pooled Analysis from the North Central Cancer Treatment Group*, 23 J. CLINICAL ONCOLOGY 9113, 9114, 9118 (2005) (considering the argument that "[if] elderly cancer patients are recruited to cancer clinical trials that specify advanced age as an eligibility criterion," this could "constitute yet another form of unjustified age discrimination," but ultimately concluding that "elderly-specific trials are providing quality care to elderly cancer patients and are helping to define optimal care").

E. Health Insurance

Moving from medical practice and research to health care financing, whether health insurers should be permitted to use age-based criteria to set premiums has been a prominent issue in the public debate over the future of the ACA. It prohibits plans offered on the state or federal marketplaces from varying their premiums on the basis of age by more than a three to one ratio.[278] The changes proposed as part of a 2017 Republican repeal effort would have raised the ratio permitted by regulation to five to one, although other repeal proposals would have eliminated the regulation entirely.[279] The proposed changes were castigated as an "age tax" and were unpopular in polls.[280] Popular criticisms of the repeal proposals have typically employed simplified anticlassificationist rhetoric. As an example, Senator Chris Murphy described the practice of "charging older people more" for health insurance as part of why one repeal proposal was an "intellectual and moral garbage truck fire."[281] I largely agree with Senator Murphy's assessment of the repeal proposals, but disagree with his anticlassificationist reasoning. Under the lifetime justice approach, age-based criteria that disadvantage older patients compared to younger ones, such as age rating, can sometimes be normatively justified.

Nonetheless, bringing the broader structure of the health care system into view demonstrates the plausibility of Senator Murphy's overall verdict. Those who qualify for Medicare at sixty-five pay a comparatively low premium thereafter for health insurance.[282] The repeal proposals would create a strange cliff-like premium structure, where premiums rise sharply in late middle age and then suddenly plummet at sixty-five. The burdens of such a structure would fall most severely not on the oldest people, but on those between fifty-five and sixty-five.[283] Accordingly, even if it marginally improved equity between the young and the middle-aged, a five to one or un-

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[278] 42 U.S.C.A. § 300gg(a)(1)(A)(iii).

[279] Jane Sung & Olivia Dean, *Impact of Changing the Age Rating Limit for Health Insurance Premiums*, 23 AARP PUB. POL'Y INST. SPOTLIGHT 1 (Feb. 2017), http://www.aarp.org/content/dam/aarp/ppi/2017-01/Final_Spotlight_Age_Rating_Feb7.pdf [https://perma.cc/UR65-KRSP].

[280] *See* Caldwell, *supra* note 1; Memorandum from Save My Care to Interested Parties, Health Care Polling in Nevada, Alaska and West Virginia (June 19, 2017), http://www.savemycare.org/wp-content/uploads/2017/06/Health-Care-Polling.pdf [https://perma.cc/GZ4X-CEN6] (reporting poll results on the popularity of the American Health Care Act in Nevada, Alaska, and West Virginia).

[281] See Savransky, *supra* note 16.

[282] *See Medicare Costs At a Glance*, MEDICARE.GOV, https://www.medicare.gov/your-medicare-costs/medicare-costs-at-a-glance [https://perma.cc/YM6V-VKB6] (listing the costs of different Medicare plans).

[283] Sung & Dean, *supra* note 279, at 1.

limited ratio would seriously violate equity between the middle-aged and the old. Correlations between life expectancy and economic and educational advantage, as well as between race and life expectancy, make this problem even more pressing.[284] As an example, the repeal proposal would have heavily burdened people in economically deprived southern West Virginia, eastern Kentucky, and South Dakota counties where life expectancy at birth is less than sixty-nine years of age, who would pay both high insurance premiums and Medicare taxes without surviving long enough to receive many Medicare benefits; in contrast, people in the wealthy DC suburbs, where life expectancy at birth is over eighty, would be likely to survive past the "cliff" of high premiums and receive substantial Medicare benefits.[285]

The lifetime justice approach also has implications for "Medicare for All" proposals.[286] It suggests that, within Medicare for All, premiums for younger participants should be lower than those for middle-aged participants, which should in turn be lower than those for older participants. This would have both the salutary effect of encouraging younger people to join the system (thereby shoring up its actuarial foundations and protecting younger people from catastrophic expenses), and the normatively desirable effect of preventing early death and medical deprivation among younger people by easing their access to affordable health care.[287] Although some have speculated that age rating constitutes age discrimination,[288] there is no case law reaching this conclusion, and many states explicitly permit insurers to vary premiums based on age.[289] That the ACA permits a three to one difference in premiums

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[284] *Cf.* Olshansky et al., *supra* note 241 (discussing correlations between life expectancy and various dimensions of advantage).

[285] Laura Dwyer-Lindgren et al., *Inequalities in Life Expectancy Among US Counties, 1980 to 2014: Temporal Trends and Key Drivers*, 177 JAMA INTERNAL MED. 1003, 1006–07 (2017) (providing comparative life expectancy data); *cf.* Clark C. Havighurst & Barak D. Richman, *Distributive Injustice(s) in American Health Care*, 69 L. & CONTEMP. PROBS. 7, 48 (2006) (arguing that people with lower incomes receive less value from Medicare because of their shorter life expectancies).

[286] *See* Mary Leto Pareja, *Inviting Everyone to the ACA (Risk) Pool Party: Using Advanceable, Income-Based Tax Credits to Subsidize Purchases*, 20 FLA. TAX REV. 551, 559 n.22 (2017) (discussing Medicare for All).

[287] *Cf.* Tom Baker & Peter Siegelman, *Tontines for the Invincibles: Enticing Low Risks into the Health-Insurance Pool with an Idea from Insurance History and Behavioral Economics*, 2010 WIS. L. REV. 79, 96–97 (proposing a lottery-like program to increase enrollment of younger insureds).

[288] *See, e.g.*, Harold S. Luft, *On the Use of Vouchers for Medicare,* 62 MILBANK Q. 237, 241 (1984).

[289] Ronen Avraham et al., *Understanding Insurance Antidiscrimination Laws*, 87 S. CAL. L. REV. 195, 259 & n.156, 264 (2014) (reporting that 36 states and the District of Columbia permit the use of age in health insurance, 13 impose some restrictions, and only New York prohibits its use).

between older and younger customers further suggests that some differentiation by age is legally allowable.[290]

More generally, the lifetime justice approach highlights a challenge in designing a program like Medicare equitably, namely that insurance is typically designed to indemnify people against the consequences of *bad* luck. Automobile insurance compensates you if your car is totaled in an accident. Homeowners' insurance compensates you if your house is destroyed in a tornado. In contrast, old-age insurance programs like Medicare compensate people when they experience the *good* luck of living long enough to need health care at eighty-five or ninety-five. Medicare's current design therefore makes it similar to a hypothetical insurance program that pays out only after a good event happens—for instance, insurance against one's income dropping below the median level that kicks in only after one's income rises above the median. Such an insurance program is normatively dubious, because it protects the well-off while doing nothing for the worse-off.[291] Regardless of whether age-rating is used, lowering the age cutoff for access to Medicare—as Medicare for All does—helps to address this problem.

CONCLUSION

I have argued that the law neither does nor should adopt a general skepticism toward age-based criteria. The law, however, also should not leave unchallenged the operation of genuinely invidious age bias. Rather, the law should understand the use of age-based criteria as a way of fairly distributing the important good of years of life. I have proposed an account of how that good should be distributed and have applied my approach to several contexts where age-based criteria are currently in use. I hope that some readers who balk at details of the lifetime justice approach have nevertheless come to see the plausibility of a distributive justice approach to age-based criteria, and that the taxonomy I have provided is useful even to readers who disagree entirely with my conclusions.

One goal of this project is to assist those—including judges, administrators, and legislators, as well as providers and private individuals—who are involved in evaluating age-based criteria. Beyond this aim, the lifetime justice approach I propose can serve as a springboard for future research in law, ethics, and social science. Though I have not discussed how the lifetime justice approach might apply to administrative and legislative decisions regarding the social determinants of health, such as decisions about

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[290] *See* 45 C.F.R. § 147.102(a)(1)(iii) (2019). *But see* Blake, *supra* note 35, at 269–70.

[291] *Cf.* Havighurst & Richman, *supra* note 285, at 48–49 (arguing that people with lower incomes receive less value from Medicare because of their shorter life expectancies).

environmental policy or public health surveillance, this area is an important one for further analysis.[292] So is the use of age-based criteria in private law contexts, such as the calculation of tort damages. I have also intentionally bypassed the challenge of incorporating quality of life considerations into the lifetime justice approach. This task requires identifying a way to measure quality of life that does not discriminate against people with disabilities.[293] Although I was too quick in earlier work to dismiss the possibility of a normatively defensible quality-of-life measure that avoids discrimination against people with disabilities, quality of life is a crucial area for future research.[294] Meanwhile, turning to social science, research into the history of the social movements that have pushed to regulate the use of age-based criteria and into the empirical effects of adopting such criteria would be tremendously valuable.

I close by discussing a final concern: some argue that the adoption of age-based criteria is politically impossible, either because of the political power of older voters or because of widespread public distaste for such criteria.[295] As a descriptive matter, the adoption of age-based criteria is not a political impossibility—many age-based criteria are in wide use. More importantly, even if political barriers to adopting age-based criteria exist at present, analyzing their merits is important because political circumstances can and do change. As Joseph Carens argues, "even if we must take deeply rooted social arrangements as givens for purposes of immediate action in a particular context, we should never forget about our assessment of their fundamental character," because "otherwise we wind up legitimating what should only be endured."[296] Changes in the demographics of American society and upheaval in our health care system make the present moment one where changes in existing social arrangements are likely. Careful analysis of the role age should play in those arrangements can help ensure that those changes are steps toward, rather than away from, greater justice.

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[292] *Cf.* Eidelson, *supra* note 42, at 1648 (discussing controversies about the use of age in environmental policy).

[293] A superb recent overview of these issues can be found in DANIEL M. HAUSMAN, VALUING HEALTH: WELL-BEING, FREEDOM, AND SUFFERING (2015).

[294] *See* Persad et al., *supra* note 184, at 47 (criticizing "QALY and DALY metrics that disadvantage disabled people and favor the socially popular"). I offer a proposal for doing this in Govind C. Persad, *Considering Quality of Life While Repudiating Disability Injustice: The Pathways Approach to Priority Setting,* J.L. MED. & ETHICS (forthcoming 2019).

[295] *See* Kapp, *supra* note 103, at 328–29.

[296] JOSEPH H. CARENS, THE ETHICS OF IMMIGRATION 230 (2013).