

COMMENT

Kidney Allocation and the Limits of the Age Discrimination Act

Thousands of people die waiting for a kidney transplant every year in the United States.¹ Less well known, however, is that many people who do receive kidneys from deceased donors gain only a few years of life, because they were relatively old and in poor health to begin with.² Meanwhile, younger people who receive kidneys from older decedents often outlive their new organs, eventually returning to the waiting list for a second transplant.³

After years of planning and consultation, the Organ Procurement and Transplantation Network (OPTN), the government-chartered body responsible for allocating cadaveric organs in the United States, has proposed a new regime to address these misalignments and make better use of the scarce supply of kidneys.⁴ The crux of the proposal, which was released for public comment in September 2012, is straightforward. Rather than simply giving kidneys to the patients who have been waiting the longest, the new system will allocate the highest-quality kidneys to the people for whom a transplant

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1. See Chapter III: *Kidney and Pancreas Transplantation in the United States, 1999-2008: The Changing Face of Living Donation*, in 2009 OPTN/SRTR ANNUAL REPORT: TRANSPLANT DATA 1999-2008, at 3 (2009), http://www.ustransplant.org/annual_reports/current/chapter_iii_forprint.pdf.
 2. See R.A. Wolfe et al., *Calculating Life Years from Transplant (LYFT): Methods for Kidney and Kidney-Pancreas Candidates*, 8 AM. J. TRANSPLANTATION 997, 1007-08 & fig.10 (2008) (estimating life-years from transplant by age and diabetes status).
 3. See Alan B. Leichtman, Keith P. McCullough & Robert A. Wolfe, *Improving the Allocation System for Deceased-Donor Kidneys*, 364 NEW ENG. J. MED. 1287, 1288 (2011).
 4. Organ Procurement & Transplantation Network, *Proposal To Substantially Revise the National Kidney Allocation System*, U.S. DEP'T OF HEALTH & HUM. SERVS. (2012), http://optn.transplant.hrsa.gov/PublicComment/pubcommentPropSub_311.pdf [hereinafter *Proposal*].

promises the most years of additional life.⁵ The OPTN's Kidney Transplantation Committee estimates that this new system of "longevity matching" will wring an extra 8,380 years of life out of the nation's supply of cadaveric kidneys each year.⁶

Critics have charged the plan with age discrimination, since it will deliberately allocate high-quality kidneys to younger candidates at the expense of older candidates with equal or greater medical need.⁷ These allegations raise significant legal and moral questions, and the debate they have sparked offers a revealing vantage point on the ways discrimination is conceptualized within and outside the law.

As a constitutional matter, age discrimination is insulated from judicial scrutiny by the Supreme Court's longstanding conclusion that the aged do not constitute a "suspect class."⁸ Federally funded programs, however, are expressly forbidden from engaging in age discrimination by the Age

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5. Under the proposed system, transplant candidates will be assigned "estimated post transplant survival" (EPTS) scores, calculated on the basis of age, dialysis time, prior transplant history, and diabetes status; and donated kidneys will be assigned "kidney donor profile index" (KDPI) scores that measure organ quality on the basis of the donor's age, height, weight, ethnicity, and other medical characteristics. *See id.* at 10-12. The quintile of adult candidates with the best EPTS scores will receive priority for the quintile of donor kidneys with the best KDPI scores. *Id.* at 7. "If longevity matching proves to be a successful approach for kidney allocation," however, "future policy iterations could expand the number of kidneys and candidates which participate." *Id.* at 12. In addition, although the top-quintile rule will apply only to adult candidates, pediatric candidates—who presently hold priority for kidneys from donors younger than thirty-five—will continue to hold priority for organs that satisfy a KDPI threshold calibrated to "maintain the same level of access that is experienced under the current system." *Id.* at 20.
 6. *Id.* at 32.
 7. *See* Rob Stein, *Who's Next in Line for A Kidney Transplant? The Answer Is Changing*, NPR, (Sept. 20, 2012, 4:31 PM), <http://www.npr.org/blogs/health/2012/09/20/161475405/whos-next-in-line-for-a-transplant-the-answer-is-changing> (recounting criticism). The debate over longevity matching was sparked by an earlier "concept document" published in 2011 and discussed below. For contributions to that discussion, see, for example, J.S. Gill, *An Alternative Kidney Allocation Algorithm: Is It Better, and by What Yardstick?*, 12 AM. J. TRANSPLANTATION 1973, 1973-74 (2012); K. Ladin & D.W. Hanto, *Rational Rationing or Discrimination: Balancing Equity and Efficiency Considerations in Kidney Allocation*, 11 AM. J. TRANSPLANTATION 2317, 2318 (2011); L.F. Ross et al., *Equal Opportunity Supplemented by Fair Innings: Equity and Efficiency in Allocating Deceased Donor Kidneys*, 12 AM. J. TRANSPLANTATION 2115 (2012); and Lainie Friedman Ross & J. Richard Thistlethwaite, *Should Age Be a Factor in the Allocation of Deceased Donor Kidneys?*, 25 SEMINARS DIALYSIS 1 (2012).
 8. *See* *Mass. Bd. of Ret. v. Murgia*, 427 U.S. 307, 313-14 (1976).

Discrimination Act (ADA) of 1975.⁹ Although this statute “has seldom been cited or litigated,”¹⁰ there is little question that the organ transplantation network is subject to its requirements. Indeed, federal officials warned that an earlier version of the OPTN proposal, which would have directly matched candidates with organs of comparable age, could violate the ADA.¹¹ The OPTN responded by scrapping the draft plan, acknowledging that it “may be perceived as age discrimination.”¹² While the new proposal does away with direct pairing of donors and recipients by age, it continues to take account of age in calculating a patient’s “estimated post transplant survival” score, which in turn determines her access to high-quality kidneys.¹³ Some have called for Congress to intervene and exempt the new plan from the ADA altogether if necessary to ensure its legality.¹⁴

In Part I of this Comment, I consider whether this new scheme violates the ADA. This analysis traverses largely uncharted terrain, interpreting a statute that “has been virtually forgotten since its enactment.”¹⁵ My conclusions are correspondingly tentative. What is clear, however, is the narrow conception of wrongful discrimination that animates the law. In essence, the ADA asks how closely a proposed age-based means fits a program’s ends, deeming age classifications impermissibly discriminatory if the fit is too loose.

In Part II, I explore a symbolic dimension to discrimination claims that the ADA therefore fails to squarely confront. As recent scholarship has recognized, to claim that a practice is wrongfully discriminatory is often not to allege that it is instrumentally irrational, but to assert that its public meaning denigrates the equal worth of some persons. Disputes over discriminatory rationing are thus not only about forswearing arbitrary inferences, as the ADA imagines, or about equitable distribution, as many bioethicists seem to suppose, but are also a site of contestation over how to publicly respect people as equals. Considering the new OPTN proposal from this perspective, I argue, sheds valuable light on the concerns it has provoked.

9. 42 U.S.C. §§ 6101-6107 (2006).

10. Peter H. Schuck, *The Golden Age of Aging, and Its Discontents*, 18 *ELDER L.J.* 25, 26 (2010).

11. See *Proposal*, *supra* note 4, at 3, 7.

12. *Id.* at 7.

13. See *supra* note 5.

14. See Editorial, *Discarded Kidneys*, *N.Y. TIMES*, Sept. 24, 2012, <http://www.nytimes.com/2012/09/25/opinion/discarded-kidneys.html>.

15. 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, 994-95 (1988).

Finally, I suggest that the interplay between legal and moral conceptions of discrimination in this unfolding debate may exemplify a phenomenon of broader significance. In codifying our normative commitments, legal categories also shape the terms on which we understand and debate them. The legal regime governing claims of age discrimination therefore threatens to cut short an important conversation about what forms of age-based differential treatment are acceptable, not only as instrumentally rational, but as consistent with our commitment to affirming the equal worth of persons.

I. IS THE PROPOSED SYSTEM CONSISTENT WITH THE AGE DISCRIMINATION ACT?

A. *The Statutory Scheme*

The Age Discrimination Act of 1975 provides 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 discrimination under, any program or activity receiving Federal financial assistance.”¹⁶ This sweeping prohibition applies to the hundreds of transplant centers that comprise the OPTN.¹⁷ The ADA is subject to three broad exceptions, however, which “crystallize the dearth of advantage provided by this law.”¹⁸

First, the statute expressly disfavors disparate impact claims, providing that classifications on the basis of “reasonable factors other than age” cannot constitute age discrimination.¹⁹ Second, certain age-based distinctions are permitted if the program at issue is “established under authority of any law”

16. 42 U.S.C. § 6102 (2006).

17. See *Report to the Board of Directors*, ORGAN PROCUREMENT & TRANSPLANTATION NETWORK 3 (Nov. 14-15, 2011), http://optn.transplant.hrsa.gov/CommitteeReports/board_main_KidneyTransplantationCommittee_11_17_2011_17_29.pdf [hereinafter *Report*] (noting that “transplant centers may be at risk of being sued” under the ADA if an impermissible algorithm is used); cf. Silver, *supra* note 15, at 1057 (“There seems to be little doubt that a hospital that participates in Medicare or receives reimbursement under a state Medicaid program receives federal financial assistance.” (footnotes omitted)). For a list of transplant centers in the OPTN, see *Transplant Centers*, ORGAN PROCUREMENT & TRANSPLANTATION NETWORK, <http://optn.transplant.hrsa.gov/members/search.asp> (last visited Feb. 5, 2013).

18. George J. Alexander, *Schucking Off the Rights of the Aged: Congressional Ambivalence and the Exceptions to the Age Discrimination Act of 1975*, 57 CHI.-KENT L. REV. 1009, 1009 (1981).

19. 42 U.S.C. § 6103(b)(1)(B); cf. *Smith v. City of Jackson*, 544 U.S. 228, 240-43 (2005) (construing a parallel provision in the Age Discrimination in Employment Act to create a defense against disparate impact claims where the nonage factor is reasonable).

that draws the distinctions itself.²⁰ And third, federally funded programs may distinguish on the basis of age if “such action reasonably takes into account age as a factor necessary to the normal operation or the achievement of any statutory objective of such program or activity.”²¹

Since the proposed longevity-matching scheme would differentiate among transplant candidates in part on the basis of age itself, rather than merely on the basis of some other correlated trait, the exception for use of “reasonable factors other than age” is inapposite here. The exception for age distinctions established by “any law” comes closer, but it has been construed to cover only age distinctions drawn by statutes,²² and the statute authorizing the organ transplantation network does not draw any such distinctions.²³ Consequently, the legality of the longevity-matching proposal turns on the question posed by the third exception: whether the proposal “takes into account age as a factor necessary” either to the “normal operation” of the organ transplantation program or to “the achievement of any [of its] statutory objective[s].”

B. Does Longevity Matching Fall Within the Exception?

Although courts have almost never interpreted and applied this provision of the ADA,²⁴ the statutory categories can be construed in light of the implementing regulations promulgated by the U.S. Department of Health and Human Services (HHS).²⁵ These regulations were expressly commissioned by

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20. 42 U.S.C. § 6103(b)(2); see also Peter H. Schuck, *The Graying of Civil Rights Law: The Age Discrimination Act of 1975*, 89 YALE L.J. 27, 60 n.170 (1979) (clarifying the relevant statutory language).
21. 42 U.S.C. § 6103(b)(1)(A).
22. See 45 C.F.R. § 90.3(b)(1) (2012).
23. See National Organ Transplant Act, Pub. L. No. 98-507, 98 Stat. 2339 (1984) (codified as amended in scattered sections of 42 U.S.C.).
24. The eighteen reported ADA cases are cataloged in 1 JOAN M. KRAUSKOPF ET AL., ELDERLAW § 3:11 (2d ed. Supp. 2012). Within this small set, most claims are dismissed on threshold grounds—for example, because of the plaintiff’s failure to exhaust available remedies, or because the defendant is not covered by the Act. However, there has been some occasional, cursory analysis of the reach of the statutory prohibition. For example, one district court has concluded that the NCAA rule limiting collegiate eligibility after age twenty “probabl[y] . . . does not amount to age-discrimination under the statute,” because “in this context, age is simply a shorthand approximation of physical maturity.” *Butts v. Nat’l Collegiate Athletic Ass’n*, 600 F. Supp. 73, 76 (E.D. Pa. 1984), *aff’d*, 751 F.2d 609 (3d Cir. 1984).
25. Congress directed HHS (then the Department of Health, Education, and Welfare) to issue government-wide regulations for implementing the ADA and also instructed

the statute and are therefore entitled to “[g]reat deference.”²⁶ Even with the benefit of the regulations, however, the import of the ADA’s exception for distinctions necessary to a program’s “normal operation” or “statutory objective[s]” remains somewhat opaque.

Specifically, according to the regulations, an otherwise prohibited action is permitted if age is used as a reasonable “measure or approximation” of some other characteristic that is “impractical to measure directly on an individual basis” but nonetheless necessary to approximate “in order for the normal operation of the program or activity to continue, or to achieve any statutory objective of the program or activity.”²⁷ “Normal operation,” the regulations explain, “means the operation of a program or activity without significant changes that would impair its ability to meet its objectives.”²⁸ A “statutory objective,” by contrast, is any purpose that is “expressly stated” in a statute.²⁹

The applicability of the exception to the longevity-matching scheme can thus be analyzed in two stages. The first concerns the degree of fit between the age classification and some given end—here, estimating post-transplant longevity. Second, assuming a sufficiently close fit between ends and means, age-based differentiation is permitted if it is necessary to achieve an explicit statutory objective or if foregoing it would represent a significant change to the program that frustrates its objectives.

As for the first stage, it is apparently true that various medical risks that bear on future life expectancy “can be reasonably measured or approximated by the use of age,” and it may indeed be impractical to assess these risks without taking account of age. An HHS representative thus advised the OPTN policy committee that the use of age in estimating post-transplant survival “was not of concern because the evidence has shown that age is a suitable proxy for variables such as cardiovascular disease which are not available in the OPTN dataset.”³⁰

individual departments—including HHS—to issue agency-specific regulations consistent with these general regulations. 42 U.S.C. § 6103(a) (2006); see 45 C.F.R. § 90 (2012) (government-wide regulations); *id.* § 91 (2012) (HHS-specific regulations).

26. NAACP v. Wilmington Med. Ctr., Inc., 491 F. Supp. 290, 317 (D. Del. 1980), *aff'd*, 657 F.2d 1322 (3d Cir. 1981).

27. 45 C.F.R. § 91.13 (2012).

28. *Id.* § 91.12(a).

29. *Id.* § 91.12(b).

30. *Report, supra* note 17, at 3.

Supposing that is true—and that the OPTN dataset could not readily be expanded to incorporate such variables³¹—the question remains whether estimating post-transplant survival is necessary to the program’s normal operation or to achieving its statutory objectives. The fit between longevity matching and the statutory objectives of the program is unclear, however. The National Organ Transplant Act directs the OPTN to “assist organ procurement organizations in the nationwide distribution of organs equitably among transplant patients,”³² and mandates that the component organizations must “have a system to allocate donated organs equitably among transplant patients according to established medical criteria.”³³ These broad instructions to allocate organs “equitably” do not say whether longevity matching is essential to that purpose or inconsistent with it.

A stronger case for an exception can be made under the “normal operation” prong of the test. According to the HHS regulations governing the OPTN, its allocation policies “[s]hall seek to achieve the best use of donated organs,”³⁴ and must be designed not only to “promote patient access to transplantation,”³⁵ but also to “avoid wasting organs” and “to avoid futile transplants.”³⁶ A task force commissioned by Congress in chartering the OPTN similarly reported that “[t]he prevailing ethos and practice are to allocate organs to the recipient who will live the longest with the highest quality of life.”³⁷ It is therefore at least plausible that foregoing longevity matching would impair the program’s objectives and hence interfere with its “normal operation” within the meaning of the ADA.

Interestingly, when HHS promulgated the government-wide regulations for the ADA, its preamble analyzed a somewhat analogous case by way of example.³⁸ A medical school might turn away applicants ages thirty-five and

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31. The proposal explains that “[w]hile other factors, such as cardiovascular health, affect survival, an objective metric is not currently available in the OPTN database. As the field of transplantation advances, study of additional factors could lead to their incorporation into the dataset and ultimately into allocation policy.” *Proposal, supra* note 4, at 12.
32. 42 U.S.C. § 274(b)(2)(D) (2006).
33. *Id.* § 273(b)(3)(E).
34. 42 C.F.R. § 121.8(a)(2) (2012).
35. *Id.* § 121.8(a)(5).
36. *Id.*
37. U.S. DEP’T OF HEALTH & HUMAN SERVS., ORGAN TRANSPLANTATION: ISSUES AND RECOMMENDATIONS, REPORT OF THE TASK FORCE ON ORGAN TRANSPLANTATION 87 (1986) [hereinafter ORGAN TRANSPLANTATION]. *But see infra* notes 73-74 and accompanying text (discussing the report’s recommendations about age-based rationing in particular).
38. *See* 44 Fed. Reg. 33,768, 33,773-74 (June 12, 1979).

older, the agency explained, and claim that its objective was “the teaching of qualified medical students who, upon graduation, will practice as long as possible.”³⁹ In its model analysis, HHS conceded that age “may be a reasonable measure” of “longevity of practice,” and that it “may be impractical” to measure this property directly.⁴⁰ Nonetheless, it explained, the program could not qualify for the “normal operation” exception because “the basic objectives of the medical school involve training competent and qualified medical school graduates.”⁴¹ “The ‘normal operation’ exception is not intended to permit a recipient to use broad notions of efficiency or cost-benefit analysis to justify exclusion from a program on the basis of age.”⁴²

Does this mean that age-based longevity matching in organ allocation is impermissible as well, since it too is an obvious effort to promote efficiency through a kind of cost-benefit analysis? The preamble takes a more equivocal view, explaining later on that an “explicit age distinction . . . cannot be disqualified or justified because it reflects a cost-benefit consideration.”⁴³ Rather, the distinction must rise or fall with the letter of the “normal operation” test.⁴⁴ This is not very helpful guidance, since in the lead example of *why* something would fail that test, the agency’s conclusion appears to rest on the program’s use of cost-benefit analysis; nothing else is said to explain why the medical school has misunderstood its own objectives. In any case, because a mandate to achieve the “best use” of organs and to avoid “wasting” them is explicit in the regulations governing the OPTN, a plausible case can be made that this sort of rationing is, unlike in the medical school case, an integral part of the program’s scheme of objectives—and hence important to its “normal operation” within the meaning of the regulations and the statute.

Finally, we might seek interpretive guidance in the parallel between the language of the ADA’s “normal operation” exception and the Age Discrimination in Employment Act’s exception for “bona fide occupational qualifications” (BFOQs).⁴⁵ The Supreme Court has described the BFOQ

39. *Id.* at 33,773.

40. *Id.* at 33,774.

41. *Id.*

42. *Id.*

43. *Id.*

44. *Id.*

45. Compare 42 U.S.C. § 6103(b)(1) (2006) (permitting age discrimination if “such action reasonably takes into account age as a factor necessary to the normal operation . . . of such program or activity”), with 29 U.S.C. § 623(f)(1) (2006) (permitting age discrimination “where age is a bona fide occupational qualification reasonably necessary to the normal operation of the particular business”).

exception as “an extremely narrow” one,⁴⁶ and some have argued that the ADA’s similarly worded “normal operation” provision should therefore also be given limited scope.⁴⁷ This comparison is of limited use, however. The Court’s reading of the BFOQ exception relied heavily on the Equal Employment Opportunity Commission’s view that the provision permitted only age distinctions “reasonably necessary to the *essence* of the business.”⁴⁸ By contrast, as we have seen, HHS reads the ADA’s exception to cover classifications that are necessary not to the essence of a program, but merely to its “normal operation,” defined as its operation “without significant changes that would impair its ability to meet its objectives.”⁴⁹ This is a more permissive standard; it evidently refuses to ask funding recipients to make large changes that would compromise their objectives in order to avoid age classifications. Moreover, functional differences between the two statutes warn against imputing equivalent meanings to the exceptions as well.⁵⁰ Whereas the viability of the BFOQ defense in employment cases often turns on whether older candidates can perform the job “safely and efficiently,”⁵¹ for instance, the scheme of objectives that informs the targeting of public programs such as the organ transplantation network is plainly different and likely more complex.⁵²

C. The Puzzle of Direct Age Matching

The central question posed by the ADA, this analysis suggests, is whether a proposed age-based differentiation serves as a rational proxy for some other trait and is instrumental to furthering a program’s objectives. I have suggested that a colorable case can be made that longevity matching in organ allocation satisfies this test, since part of the point of the program is to make the best use of donated organs—with an evident concern for efficiency—and prioritizing on the basis of age arguably furthers that goal. Supposing that is correct, however, it remains something of a mystery why HHS’s Office of Civil Rights objected to a draft proposal that would have *directly* matched donated organs with candidates of comparable age, while apparently acquiescing in a scheme that

46. *W. Air Lines, Inc. v. Criswell*, 472 U.S. 400, 412 (1985) (quoting *Dothard v. Rawlinson*, 433 U.S. 321, 334 (1977)).

47. See Silver, *supra* note 15, at 1036-41.

48. 29 C.F.R. § 1625.6 (2012) (emphasis added); see *Criswell*, 472 U.S. at 412, 416.

49. 45 C.F.R. § 91.12 (2012).

50. See Schuck, *supra* note 20, at 68-70.

51. See *Criswell*, 472 U.S. at 414.

52. See Schuck, *supra* note 20, at 68-69.

uses age as a factor in estimating post-transplant survival, which in turn is used to prioritize candidates.

Under the rejected direct-matching scheme, most kidneys would have been allocated with a preference for candidates within fifteen years of the deceased donor's age.⁵³ In a report to its Board of Directors, however, the OPTN's Kidney Transplantation Committee related the government's advice that, although "age may be used if it is a proxy for medical variables," "the use of age matching within 15 years appeared to be arbitrary in that candidates who are sixteen years older or younger than a donor are not substantially clinically different than those who have 14 years of age difference."⁵⁴ By contrast, the use of age as one factor in calculating post-transplant longevity was thought to be unproblematic because, as noted above, "evidence has shown that age is a suitable proxy for variables such as cardiovascular disease which are not available in the OPTN dataset."⁵⁵

Two possible interpretations of this analysis suggest themselves. One is that the fit between age *alone* and longevity is simply not good enough to qualify as a reasonable proxy under the ADA—dooming the proposal at the first of the two stages identified above. By contrast, the new proposal's compound estimate of estimated post-transplant survival (EPTS)—which takes account of not only age, but also length of time on dialysis, prior transplant history, and diabetes status⁵⁶—is presumably much more accurate.

This may be true, but it does not resolve the puzzle. After all, 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, and it will presumably still be impossible to show that they are "substantially clinically different" from the marginally younger candidates who take their places. If that constitutes impermissible arbitrariness in the context of direct age matching, why should encasing age in a compound measure of longevity redress, or even mitigate, the concern? Moreover, supposing that the compound EPTS score is a better predictor of longevity than age alone, this does little to justify taking account of age in calculating EPTS. To the extent that EPTS is more accurate than age as a predictor of longevity, it is precisely because of the weight that EPTS places on

53. See *Concepts for Kidney Allocation*, ORGAN PROCUREMENT & TRANSPLANTATION NETWORK 5 (Feb. 16, 2011), <http://optn.transplant.hrsa.gov/SharedContentDocuments/KidneyConceptDocument.pdf>.

54. See *Report*, *supra* note 17, at 3.

55. *Id.*

56. See *Proposal*, *supra* note 4, at 12.

factors *other* than age. But it is the marginal contribution of age itself that should be scrutinized under the ADA.⁵⁷

A second, more critical explanation of the discrepant judgments therefore warrants consideration. Under either scheme, age is being used as a measure of life expectancy, and under either scheme, this will appear to be arbitrary at the margins. But when age is cast as a proxy for conditions such as heart disease, and incorporated alongside other paradigmatically medical criteria such as diabetes status, the inference from years lived to years left is attenuated and “medicalized” in a way that may invite greater deference. In other words, the indirect longevity-matching scheme can more easily be understood to be making the essentially medical judgments that fall within the “normal operation” of the OPTN, and which, indeed, might be seen as part and parcel of its statutory mandate to allocate organs in accordance with “established medical criteria.”⁵⁸

If this explanation is correct, it appears to represent an unfortunate triumph of form over substance. Under both proposals, age would function as a measure of life expectancy—and in both cases, the mechanism of this relationship is obviously that many health risks mount with age. It is not clear why professing to use age only to estimate those health risks, rather than to estimate longevity, should affect the legality of the plan. Moreover, in both cases, the consideration of age is permissible only if it is important to furthering the program’s objectives. The question whether longevity matching itself is necessary to achieving the program’s purposes is therefore unavoidable under either approach; it is not sufficient to say that age-based differentiation is permissible so long as age is merely “a proxy for medical variables.”⁵⁹

II. BEYOND THE AGE DISCRIMINATION ACT

This analysis confirms that the legality of the OPTN plan under the ADA poses difficult questions concerning both the fit between age and longevity and the relevance of longevity matching itself to the OPTN’s purposes. But while the answers to these questions are somewhat uncertain, the questions

57. This last argument is subject to a narrow caveat: the formula for calculating EPTS takes account of both age alone and an interaction variable for age and diabetes status. See *Proposal*, *supra* note 4, at 12 (specifying the EPTS formula). Some fraction of the increased accuracy of EPTS relative to age alone could therefore be due to the more nuanced way in which EPTS takes account of age, as opposed to exclusively the nonage factors it encompasses.

58. See *supra* notes 32-33 and accompanying text.

59. *Report*, *supra* note 17, at 3.

themselves are not. As we have seen, something is wrongfully discriminatory, according to the ADA, if it lacks the virtue of fit—that is, if the age-based differentiation at issue is insufficiently relevant or important to what the program is trying to accomplish.

The ADA is thus structured to root out irrational, prejudiced exclusions of classes of people on the basis of age. That reflects the thrust of the law’s purpose. As the House Committee Report explained:

Non-involvement of older persons is traceable time and again, not to their own desires, but to a determination by the leaders of many institutions in our society to discriminate against persons as workers and as volunteers solely because they have reached a given age. They refuse to consider the merits of each case. In so doing they reflect by their deeds a deep-seated prejudice against the elderly.⁶⁰

The law therefore targets arbitrary age classifications that reflect a misguided refusal to assess individual cases—while permitting age categories that actually make a significant contribution to furthering a program’s purposes.

This way of understanding the wrong of discrimination—as a form of wrongful arbitrariness—is deeply rooted in the law and in legal theory.⁶¹ It also has currency among physicians and bioethicists who employ the Institute of Medicine’s definition of discrimination as disparate treatment on the basis of “irrelevant traits.”⁶² Discrimination claims are not only about challenging arbitrariness, however, but also about insisting on the public recognition of people’s equal worth and dignity.

As scholars and jurists have often recognized, acts that classify along socially salient lines are troubling in part because they risk demeaning or denigrating the equal moral standing of those who are disfavored.⁶³ “Classifications based on race carry a danger of stigmatic harm,” the Supreme Court has explained, threatening the right “to be treated with equal dignity and

60. H.R. REP. NO. 94-67, at 15 (1975).

61. For critical discussion of the idea of discrimination as arbitrariness, see MATT CAVANAGH, *AGAINST EQUALITY OF OPPORTUNITY* 156 (2002); DEBORAH HELLMAN, *WHEN IS DISCRIMINATION WRONG?* 114-37 (2008); and Patrick S. Shin, *The Substantive Principle of Equal Treatment*, 15 *LEGAL THEORY* 149, 152-54 (2009).

62. See Ladin & Hanto, *supra* note 7, at 2320.

63. For recent scholarship elaborating this insight, see, for example, HELLMAN, *supra* note 61; and Shin, *supra* note 61, at 162.

respect.”⁶⁴ Similarly, as Charles Black argued in his influential defense of *Brown v. Board of Education*, the moral force of the Court’s holding turned on “the fact that the *social meaning* of segregation is the putting of the Negro in a position of walled-off inferiority.”⁶⁵ More broadly, as Charles Taylor writes, “our identity is partly shaped by recognition or its absence, . . . and so a person or group of people can suffer real damage, real distortion, if the people or society around them mirror back to them a confining or demeaning or contemptible picture of themselves.”⁶⁶

The danger that classification will take on a social meaning of contempt for a class of people, though perhaps implicit in all line drawing, is especially acute when the action involves deciding how to value people’s lives. Expressly disfavoring older transplant candidates thus raises serious concerns that are not reducible to the claim that the scheme is unduly arbitrary or lacking in means-ends rationality. Of course, the longevity-matching proposal does not actually rest on the judgment that some people are of lesser worth, or entitled to lesser respect, than others. It only supposes that some people’s lives are *more worth saving*, for the simple reason that there is more life there to be saved.⁶⁷ But this distinction – between a person’s worth and the worth of saving her life – is very thin indeed. It would not be unreasonable to worry that, in 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.

Viewed in this way, the concern that the new proposal discriminates against older people is of a piece with other recent controversies surrounding the valuation of life and the rationing of resources, which have often invited struggles over dignity and respect rather than simple rationality or fairness. For

64. *City of Richmond v. J.A. Croson Co.*, 488 U.S. 469, 493 (1989); cf. *Heckler v. Mathews*, 465 U.S. 728, 739 (1984) (suggesting that “discrimination itself” can cause serious injury “by stigmatizing members of the disfavored group as . . . less worthy participants in the political community”).

65. Charles L. Black, Jr., *The Lawfulness of the Segregation Decisions*, 69 *YALE L.J.* 421, 427 (1960) (emphasis added); cf. HELLMAN, *supra* note 61, at 54-55 (crediting Black’s article as the “inspiration” for Hellman’s own view, which assesses discriminatory acts in terms of the meanings they express).

66. Charles Taylor, *The Politics of Recognition*, in *MULTICULTURALISM: EXAMINING THE POLITICS OF RECOGNITION* 25 (Amy Gutmann ed., 1994); see also JOSEPH RAZ, *THE MORALITY OF FREEDOM* 254 (1986) (identifying antidiscrimination rights as a means to “foster a public culture which enables people to take pride in their identity” in various groups).

67. For a general defense of such medical rationing on the basis of quality-adjusted life-years, see PETER H. SCHUCK & RICHARD J. ZECKHAUSER, *TARGETING IN SOCIAL PROGRAMS: AVOIDING BAD BETS, REMOVING BAD APPLES* 50-59 (2006).

example, in two of its economic analyses in 2002, the EPA treated saving someone more than seventy years old as worth about two-fifths less than the standard statistical life.⁶⁸ Outraged seniors protested at an EPA meeting wearing price tags that read “Seniors on Sale, 37% Off,”⁶⁹ and critics pilloried the EPA’s move as “dropping the value on human beings as they age” and implying that some people are “cheap as dirt.”⁷⁰ In short, the suggestion that some people’s lives were less worth saving was understandably heard to say that the people themselves were worth less.

Approaching the valuation of life in terms of the obligation not to show disrespect for people’s equal worth thus renders worries about age discrimination in the new kidney regime both more understandable and more potent. As in the EPA case, unease about the OPTN’s new policy is better seen not simply as a reaction to an irrational stereotype of older people as nearer to death—a generalization that few would deny—but rather as taking offense at the idea that some people are worth more than others.

This symbolic dimension of the problem is distinct not only from the concerns of the ADA, but also from the questions of distributive justice or equity that have dominated discussion of longevity matching among bioethicists.⁷¹ The central dispute in that emerging literature concerns whether allocating kidneys on the basis of expected longevity is unfair to older candidates, or rather justified by the objective of securing a reasonable lifespan to all patients, itself a possible requirement of fairness.⁷² Whatever the resolution of that question of distributive justice, however, we should also

68. See Katharine Q. Seelye & John Tierney, *E.P.A. Drops Age-Based Cost Studies*, N.Y. TIMES, May 8, 2003, <http://www.nytimes.com/2003/05/08/us/epa-drops-age-based-cost-studies.html>.

69. John J. Fialka, *Balancing Act: Lives vs. Regulations: ‘Senior Death Discount’ Riles Critics but OMB Favors Analyses That Weigh Life Expectancy*, WALL ST. J., May 30, 2003, at A4.

70. Robert Trigaux, *An Ominous New Meaning for Senior Discount*, ST. PETERSBURG TIMES, May 19, 2003, http://www.sptimes.com/2003/05/19/news_pf/Columns/An_ominous_new_meanin.shtml.

71. See, e.g., Ladin & Hanto, *supra* note 7, at 2318 (approaching kidney allocation as a matter of “balancing equity and efficiency”); Ross & Thistlethwaite, *supra* note 7, at 5 (arguing that transplant candidates are entitled to an equal chance of obtaining a kidney, but not a kidney of equal longevity); see also Ross et al., *supra* note 7 (defending an alternative proposal on the ground that it better balances efficiency and equity).

72. For a short summary of this debate, see Ladin & Hanto, *supra* note 7, at 2318. On the broader question of distributive justice between generations, see NORMAN DANIELS, *AM I MY PARENTS’ KEEPER?: AN ESSAY ON JUSTICE BETWEEN THE YOUNG AND THE OLD* (1988); and Dennis McKerlie, *Justice Between the Young and the Old*, 30 PHIL. & PUB. AFF. 152 (2002).

interrogate the *meaning* of disfavoring older candidates and the attitudes that it may model and engender.

Indeed, the 1986 Task Force Report that informed the organization of the OPTN appears to have anticipated such concerns. The report noted that “assigning priority to younger candidates” could be justified by “medical utility,” since age serves “as a predictor of . . . a longer period of survival after transplantation.”⁷³ The task force urged “utmost caution” about the use of age, however, emphasizing the importance of employing “objective medical criteria” that are “well recognized and widely accepted” in order to ensure that “medical judgments are reflected rather than judgments of social worth.”⁷⁴

Such concerns are sensitive to the social context in which classifications take place. The new longevity-matching proposal must therefore be understood against a backdrop of entrenched stereotypes that portray older people as “nagging, irritable, decrepit, cranky, weak, feeble-minded, verbose, and cognitively deficient,” as well as “asexual, impotent, useless, and ugly.”⁷⁵ State-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 these demeaning attitudes toward older people. In so doing, the scheme could also undermine public confidence in the neutrality of the organ network—a vital resource in a regime that relies on voluntary participation.

Although this dimension of age-based differential treatment is neglected by the ADA, it may point toward another explanation for the government’s puzzling opposition to only *direct* age matching. I suggested above that distinguishing between direct and indirect age matching appears to be an odd formalism, exhibiting heightened deference to nominally “medical” judgments.⁷⁶ More charitably, however, it could reflect sensitivity to the social meaning of age-classifying policy choices, and a corresponding insistence that longevity matching be accomplished by mechanisms whose meanings are less corrosive of solidarity or mutual respect.⁷⁷

In other words, the government’s insistence that age be treated as a proxy for particular health conditions, used only as one part of computing a

73. ORGAN TRANSPLANTATION, *supra* note 37, at 90.

74. *Id.* at 90–91.

75. Robert McCann & Howard Giles, *Ageism in the Workplace: A Communication Perspective*, in AGEISM: STEREOTYPING AND PREJUDICE AGAINST OLDER PERSONS 163, 166 (Todd D. Nelson ed., 2002).

76. See *supra* notes 58–59 and accompanying text.

77. I am grateful to Dov Fox for suggesting this interpretation of the discrepancy.

compound longevity estimate, might be justified by concerns similar to those expressed in the Task Force Report—that allocation criteria should be limited to factors that are “widely accepted” as “objective medical criteria,” precisely in order to avoid exhibiting “judgments of social worth.”⁷⁸ Thus, as Paul Mishkin wrote of affirmative action programs that afford “pluses” but avoid quotas, “[e]ven when the net operative results may be the same, the use of euphemisms may serve valuable purposes” in shaping “public reactions” to a regime of differential treatment.⁷⁹

Even if this is the implicit aim of the government’s compromise, of course, it is an open question how far it succeeds. More fundamentally, it is significant that these concerns have no place within the formal legal conception of wrongful discrimination elaborated by the ADA. The expressive content of the proposed rule might be scrutinized if it were subject to meaningful review under the Equal Protection Clause, for, arguably at least, “[s]ymbolism and social meaning have always shaped the law of equal protection.”⁸⁰ But, as I noted at the outset, that possibility is effectively foreclosed by the Supreme Court’s conclusion that the aged do not constitute a “suspect class.”⁸¹ Some of the most fundamental questions about whether the new scheme wrongfully discriminates against older people are therefore left to the discretion of the agencies developing the plan—as well as to a public reckoning over its benefits and its felt significance, outside the courts.

78. ORGAN TRANSPLANTATION, *supra* note 37, at 91.

79. Paul J. Mishkin, *The Uses of Ambivalence: Reflections on the Supreme Court and the Constitutionality of Affirmative Action*, 131 U. PA. L. REV. 907, 927-28 (1983); see also Elizabeth S. Anderson & Richard H. Pildes, *Expressive Theories of Law: A General Restatement*, 148 U. PA. L. REV. 1503, 1540 (2000) (“Form is not just about form for formalism’s sake. Different means of pursuing affirmative action can express different understandings about the appropriate role of race in public life.”); cf. Elizabeth S. Anderson, *Integration, Affirmative Action, and Strict Scrutiny*, 77 N.Y.U. L. REV. 1195, 1236 (2002) (observing that, in racial redistricting cases, “[t]he Court prefers that, when states consider race, their actions are ambiguous enough to be explained in other ways”).

80. Richard Primus, *The Future of Disparate Impact*, 108 MICH. L. REV. 1341, 1347 (2010); see also Deborah Hellman, *The Expressive Dimension of Equal Protection*, 85 MINN. L. REV. 1, 2 (2000) (arguing that equal protection analysis should turn on “the meaning or expressive content of the law or policy at issue”).

81. See *Mass. Bd. of Ret. v. Murgia*, 427 U.S. 307, 313-14 (1976); 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 (2010) (summarizing and criticizing this doctrine).

CONCLUSION

There is an irony to this result. The ADA incorporated capacious exceptions to its prohibition on discrimination in the recognition that, whereas race-based distinctions in access to federally assisted programs are necessarily “arbitrary,” “age may often be a reasonable distinction for these purposes.”⁸² The regime therefore defers significantly to the ordinary political process—permitting age distinctions that are either authorized by law or instrumentally important to achieving the objectives of programs that have secured federal funding. The Supreme Court invoked a similar logic of deference in holding that the aged do not constitute a “suspect class,” explaining that they do not require the “extraordinary protection from the majoritarian political process” that strict scrutiny entails.⁸³

The irony is that, in codifying a narrow *legal* understanding of what constitutes wrongful age discrimination, the law inevitably exerts a pull on the democratic processes to which it purports to defer. The OPTN thus takes itself to have redressed the concern that its plan “may be perceived as age discrimination” by eschewing the particular form of differentiation that, according to “legal experts,” risked infringing the ADA—even though the task force that organized the network long ago raised serious concerns about the use of age classifications that had nothing to do with the ADA.⁸⁴ Popular discussion of the plan during the public comment period has likewise been shaped by the constitutional premise that age classifications, if instrumentally rational, are permissible. Thus, in a telling local news segment, an anchor lays out the new longevity-matching proposal, raises the concern that it mistreats older transplant candidates, and then turns to an attorney to explain to viewers whether “there’s any potential for age discrimination in this.”⁸⁵ The answer, she explains, is that there is not, because “age is not a suspect class.”⁸⁶

The interplay between legal and moral conceptions of discrimination in the unfolding debate over the OPTN kidney proposal thus exemplifies a phenomenon of broader significance. When a legal regime embraces and

82. H.R. REP. NO. 94-670, at 56 (1975) (Conf. Rep.).

83. *Murgia*, 427 U.S. at 313 (quoting *San Antonio Indep. Sch. Dist. v. Rodriguez*, 411 U.S. 1, 28 (1973)).

84. ORGAN TRANSPLANTATION, *supra* note 37, at 90; *Proposal*, *supra* note 4, at 7.

85. *Proposed Kidney Policy: Is It Age Discrimination?* (WFMY CBS NEWS 2 (Greensboro, N.C.) television broadcast Sept. 24, 2012), <http://www.digtriad.com/news/article/247080/1/Proposed-Kidney-Policy-Is-It-Age-Discrimination>.

86. *Id.*

institutionalizes part, but less than all, of a preexisting normative concept, a conceptual misalignment results. Such misalignments can effect a kind of normative displacement—inviting moral questions to be recast as legal ones, only to meet them with too-easy and potentially misleading answers. In this case, I have argued, the longevity-matching proposal is likely legal under the ADA, and immune from review under current equal protection law. But equally important is that these regimes create a legally cognizable wrong of discrimination that captures only a fraction of the underlying moral costs of discriminatory action. The proposed plan should be assessed not only in terms of its instrumental rationality, but also in light of the social meaning of treating older people's lives as less worth saving. Its justifiability therefore turns in part on questions that the operative legal frameworks may be ill suited to answer—or, for that matter, to ask.

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