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The Crazy Quilt of Laws: Bringing Uniformity to Surrogacy Laws in the United States

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The Crazy Quilt of Laws: Bringing Uniformity to Surrogacy Laws in the United States

Makenzie Russo
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“Our bodies were married in a glass dish, and our boy was carried by another woman for nine months. He is our most vivid dream realized- the embodiment of the most blindly powerful force in the universe, brought to life the only way he could be.

With a little help.”

- Alex Kuczynski, *Her Body, My Baby*

Introduction

Like many couples, R.W.S. and B.C.F. wanted a child of their own. But the couple—in this case two gay men from Minneapolis—had ruled out adoption, which left surrogacy their only viable option.

So the two men did what so many others in their position have done: They turned to the Internet. On the website of Surrogate Mothers Online, a volunteer-run support group for the surrogacy community, they came across a posting from a Minneapolis-area woman offering her services as a surrogate. Before long, the couple entered into a contract with the surrogate and paid her an undisclosed fee for her services. Through medical science, the woman soon became impregnated with a baby from R.W.S.’ sperm and her own egg. Nine months later the surrogate gave birth—first, to a healthy baby girl, then to litigation.

At first, everything went smoothly between the new fathers and their surrogate. After the baby girl was born, the surrogate visited the newborn at the men’s home, and the nonbiological father proceeded with his plans to adopt the little girl, which was to have included a voluntary termination of the surrogate’s parental rights.

Then, seemingly out of the blue, about a month after giving birth to the girl, the surrogate—identified in court records only as E.A.G.—showed up unannounced at the couple’s front door with her father, young son and another surrogate in tow. She proceeded to tell the two men she had changed her mind about giving up the baby and wanted the girl back.

...

This story, documented in the American Bar Association Journal, highlights not only how surrogacy has become a multimillion dollar industry, but also ways in which this third-party reproductive option comes with the caveat “buyer beware.”

Modern technology and innovative procedures have opened the possibility of parenthood to a variety of people who can't have children of their own—single people, people with medical issues or infertility problems, same-sex couples and other nontraditional families. The demand has spawned a proliferation of new businesses, including fertility clinics, surrogacy agencies, and online brokers specializing in matching Indian- or Ukrainian-based surrogates for prospective parents who have been confronted with surrogacy in the U.S. being either unaffordable or illegal in their home state.¹ Since the 1980s, surrogacy has swept the nation and helped thousands of individuals realize their dream of raising children that are, at least in part, genetically their own. However, the United States, unlike many other countries, has no national policies governing assisted reproductive technology, including surrogacy. Laws on the issue vary widely from one state to the next, creating a “crazy quilt of laws” for those who choose to pursue surrogacy.

Surrogacy first entered the collective public conscience almost 25 years ago when Mary Beth Whitehead reneged on her promise to give up all parental rights to Baby M, the daughter for whom she served as a surrogate for a New Jersey couple. The Baby M case grabbed the attention of the public and sparked a nationwide debate over the ethical, moral, and legal complexities surrounding surrogacy agreements. As addressed in Chapter 1, this controversy prompted some states to speak to the matter, either through prohibitive measures or enforcement of surrogacy contracts. However, explicit laws are few and far between as the majority of states remained silent and chose not to address the validity of surrogacy agreements on any level; leaving many such arrangements in legal limbo and raising a number of vexing social, legal and ethical issues for the courts to resolve.

Typically, family law is a matter reserved for the states, which explains why there is such

¹ Hansen, Mark. "As Surrogacy Becomes More Popular, Legal Problems Proliferate." *ABA Journal*. 120, no. 3 (March 2011): 55 <http://www.jstor.org.ezproxy.trincoll.edu/stable/pdf/25799046.pdf> (Accessed April 10, 2016).

a lack of consistency throughout the country. Over the years, organizations such as the American Bar Association and Uniform Law Commission have recognized the need to address the validity of surrogacy agreements and have offered proposals and model acts that would help to govern assisted reproductive technologies and surrogacy. However, these model acts were inadequate in bringing about complete reform and uniformity because they are not effective until adopted by a state legislature, as discussed in Chapter 2. Thus, to understand the legal landscape surrounding surrogacy, it is imperative to delve into policy implementation, or lack thereof, on a state-by-state basis. Doing so illuminates the fact that there is no national consensus on how to approach surrogacy and each individual state has created its own complex contingencies, with outcomes fluctuating even between jurisdictions.

The lack of consistency among states makes surrogacy a riskier endeavor than need be. Chapter 3 of this thesis seeks to investigate the consequences of failing to fully regulate surrogacy and the booming industry surrounding it. While the American Fertility Society and The American College of Obstetricians and Gynecologists recognized that infertility is a disease stemming from the abnormal function of the reproductive system², policymakers have been slow to treat it as such. Currently, only fifteen states offer some form of coverage for assisted reproductive technology (ART) treatments, and even fewer mandate coverage for in vitro fertilization (IVF). These discrepancies among health care policies force many intended parents to pay out-of-pocket, engage in riskier procedures to attempt to lower costs, or approach surrogacy in a “do-it-yourself” fashion, which increases the probability of legal action. States that fail to offer comprehensive guidance for surrogacy contracts, health care mandates and

² Hawkins, Jessica. "Separating Fact from Fiction: Mandated Insurance Coverage of Infertility Treatments." *Washington University Journal of Law & Policy* 23, no. 203 (January 2007): 203-227 http://openscholarship.wustl.edu/cgi/viewcontent.cgi?article=1337&context=law_journal_law_policy (Accessed April 20, 2016).

surrogacy clinic practices make it a daunting and expensive decision for those interested in this form of alternative family planning.

Finally, Chapter 4 will offer a policy solution to guide surrogacy agreements. This model act includes the most fundamental components that should be clearly addressed and outlined by any state policymaker that works to implement surrogacy legislation. Because sweeping federal legislation is unforeseeable, an effort from the grassroots and advocacy groups to push such legislation upon state policymakers would help to achieve consistent surrogacy laws throughout the United States.

Currently, surrogacy can be a minefield and the industry is largely unregulated. But as medical science continues to push the envelope forward, making the process of having a baby via methods other than that intended by nature more accessible, the legal issues are multiplying. This thesis seeks to dig deeper than ever before into the legal landscape surrounding surrogacy. By investigating just how each individual state handles surrogacy disputes it is my hope to help others understand just how dire the situation can be and that it is time to press for uniform legislation throughout the country.

Chapter 1.
Medical Advancements, Surrogacy and the
Need for Clear Legal Guidance

For one reason or another, some women have trouble or are wholly unable to carry a pregnancy. Surrogacy allows couples faced with infertility³ to raise a baby that is, at least in part, genetically their own. In the last 30 years there have been momentous advancements in the science and technology that inform alternative family planning. However, the laws throughout the United States have failed to keep pace with the revolution in assisted reproductive technology (ART), making the process a potentially perilous one for the unwary or the unwise. The lack of uniform laws regarding surrogacy agreements is often referred to as the “crazy quilt of laws.”⁴ The patchwork and disjointed nature of these laws puts the parties involved in surrogacy agreements in a position of uncertainty and unnecessarily increases the transaction costs of such arrangements.⁵ Despite the legal uncertainties, thousands of children are born each year pursuant to gestational agreements.⁶

Traditional and gestational surrogacies have significantly different ethical and legal consequences. Many of the concerns raised in traditional surrogacy, in particular those concerning a woman contracting to give up parental rights for her biological child, do not exist in gestational surrogacy.⁷ Ultimately, the parties entering into the surrogate relationship have a right

³ Infertility is defined as “a disease of the reproductive system that impairs the body’s ability to perform the basic function of reproduction.” Am. Soc’y for Reprod. Med., *Quick Facts About Infertility*, ReproductiveFacts.Org

⁴ Hill, Lawrence. "The Case For Enforcement of the Surrogacy Contract." *Politics and the Life Sciences* 8, No. 2 (February 1990): 147-160, <http://www.jstor.org.ezproxy.trincoll.edu/stable/pdf/4235682.pdf> (Accessed April 10, 2016).

⁵ Dashiell, Craig. "From Louise Brown to Baby M and Beyond: Proposed Framework for Understanding Surrogacy." *Rutgers Law Review* 3, No. 65 (Spring 2013): 852-890 <http://www.lexisnexis.com.ezproxy.trincoll.edu/hottopics/lnacademic/?verb=sf&sf=AC07STJrnlsSrch> (Accessed April 19, 2016).

⁶ Unif. Parentage Act§ 801-809 (amended 2002). http://www.uniformlaws.org/shared/docs/parentage/upa_final_2002.pdf (Accessed April 26, 2016).

⁷ Arshagouni, Paul G. "Be Fruitful and Multiply, by Other Means, If Necessary: The Time Has Come to Recognize and Enforce Gestational Surrogacy Agreements." *DePaul Law Review* 61, No. 3 (2012): 799-

to know that their rights and obligations under the arrangement are fixed and not subject to change.

What is surrogacy?

Traditional Versus Gestational Surrogacy

Surrogacy is the “use of a woman’s gestational capability to assist in the development of a child” that another person or couple intends to parent.⁸ As part of the arrangement, the woman carrying the child agrees to relinquish any parental claims that she may have regarding the resulting child or children.⁹ Surrogacy is divided into two categories: traditional or gestational. In traditional surrogacy, the surrogate carrier bears a child “formed from her own egg”¹⁰. The sperm used is usually from the intended father, but it can also be from a donor. This form is usually less expensive and less medically complicated than gestational surrogacy, but the traditional surrogate may be more likely to bond with the child she is carrying because of the genetic relation.¹¹ In addition, because this process requires the use of the surrogate’s eggs, the biological connection makes it relatively easy for courts to determine that the birth mother is also the legal mother. Such reasoning led to decisions such as the *Baby M.* case, as discussed later on in this chapter.¹²

848 <http://via.library.depaul.edu/cgi/viewcontent.cgi?article=1106&context=law-review> (Accessed April 19, 2016).

⁸ Arshagouni, 805.

⁹ Arshagouni, 820.

¹⁰ Miller, A. Paige. "The Silence Surrounding Surrogacy: A Call for Reform in Alabama." *Alabama Law Review* 65, No. 5 (September 2014): 1376-1391
https://www.law.ua.edu/pubs/lrarticles/Volume%2065%20Issue%205/Issue%205/Miller_1375-1391.pdf

¹¹ Larkey, Amy. "Redefining Motherhood: Determining Legal Maternity in Gestational Surrogacy Arrangements." *Drake Law Review* (2003): 605-632
<http://www.ncbi.nlm.nih.gov/pubmed/15214337>

¹² Spivak, Carla. "The Law of Surrogate Motherhood in the United States." *American Journal of Comparative Law* 58, (2010): 97-114. Web.

A gestational surrogate has an embryo placed into her uterus, but the surrogate's egg is not used to create the embryo.¹³ This process eliminates any biological relationship between the surrogate mother and the child.¹⁴ Gestational surrogacy, also known as full surrogacy, tends to be coupled with additional costs because the intended parents must acquire genetic material or transfer their own genetic material to the surrogate through expensive medical procedures. Gestational surrogacy is increasingly more popular than traditional surrogacy because it allows an infertile couple the chance to have a child who is genetically related to both the male and the female parent.¹⁵ In addition, while several states have banned commercial surrogacy, or paying a surrogate an additional fee beyond her medical and living expenses, it is not uncommon.

Altruistic Versus Commercial Surrogacy

As I have noted, the two forms of surrogacy traditional and gestational. Beyond this, the intended parents also must decide whether to engage in either "voluntary" or "commercial" surrogacy.¹⁶ Voluntary surrogacy entails using a surrogate previously known to the intended parents.¹⁷ This person is usually a friend or relative.¹⁸ The benefits of choosing a surrogate

<http://www.jstor.org.ezproxy.trincoll.edu/stable/pdf/20744535.pdf> (Accessed October 27, 2015).

¹³ Strasser, Mark. "Traditional Surrogacy Contracts, Partial Enforcement, and the Challenge for Family Law." *Journal of Health Care & Law Policy* 18, No.1 (2015): 85-113

<http://www.lexisnexis.com.ezproxy.trincoll.edu/hottopics/lnacademic/?verb=sf&sfi=AC07STJrnlsSrch> (Accessed April 16, 2016).

¹⁴ Miller, 1381.

¹⁵ Hisano, Erin Y. "Gestational Surrogacy Maternity Disputes: Refocusing on the Child." *Lewis & Clark Law Review* 15, No. 2 (Summer 2011): 519-551

<http://www.lexisnexis.com.ezproxy.trincoll.edu/hottopics/lnacademic/?verb=sf&sfi=AC07STJrnlsSrch> (Accessed April 19, 2016).

¹⁶ Eisenberg, David F. "Evolving with the Times: A Push to Legalize Surrogate Parenting Contracts in the State of New York." *Pace Law Review* 33, No. 1 (Winter 2013): 302-26.

<http://www.lexisnexis.com.ezproxy.trincoll.edu/hottopics/lnacademic/?verb=sf&sfi=AC07STJrnlsSrch> (Accessed April 19, 2016).

¹⁷ Eisenberg, 310.

¹⁸ Eisenberg, 310.

known to the intended parents is that it dramatically reduces the cost of the process¹⁹, and significantly decreases the likelihood of conflict after the birth. However, the downside of voluntary surrogacy is that many intended parents would prefer to avoid potential family conflicts if something should go wrong with the pregnancy or birth.²⁰

In contrast to voluntary surrogacy, intended parents can also choose to pursue commercial surrogacy.²¹ In commercial surrogacy, the intended parents seek the assistance of a “brokering agency,” whose primary responsibility is to match the intended parents with a suitable surrogate.²² If a match is made, legal contracts are drafted between the parties.²³ When a brokering agency is used, the intended parents have no prior familiarity with the surrogate. For many intended parents, this estranged relationship is preferable, as they have no desire to include the surrogate in their family once the child is born. As a drawback, however, commercial surrogacy carries significant financial expenses.²⁴ These expenses will be further discussed in Chapter 3.

While it is beyond the scope of this paper to discuss the ethical issues regarding compensating surrogates, it is important that the existing conversation be exposed. Many scholars reject the claim that compensating surrogates would lead to the exploitation of poor, minority women. In fact, many point to research that shows that the vast majority of surrogates participate solely for altruistic reasons and that compensation is just an added benefit. In her book *Pathways to Parenthood: The Ultimate Guide to Surrogacy*, author Stacy Ziegler shares

¹⁹ Ziegler, Stacy. *Pathways to Parenthood: The Ultimate Guide to Surrogacy*. (Florida: BrownWalker Press, 2005), 26.

²⁰ Eisenberg, 310.

²¹ Eisenberg, 310.

²² Eisenberg, 310.

²³ Eisenberg, 311.

²⁴ Eisenberg, 310.

her experience of being a gestational carrier and explains that most of the surrogates that she has had the pleasure of knowing are college educated, middle-class stay-at-home mothers and “not the uneducated, vulnerable, poor women the media has at times made them out to be.” With that said, regardless of the method chosen by the intended parents, there is no guidance for either one. This will play an important role as we look into the multiple factors that state legislators take into consideration when determining the legality of surrogacy arrangements.

A Brief History on the Development of Surrogacy

Despite its longstanding presence as an alternative to conventional child-bearing, surrogacy remains one of the most controversial practices in the field of assisted reproduction. Reproductive technologies date back to the eighteenth century. However, the spark for this revolutionary form of alternative family planning came from in vitro fertilization (IVF), the technological breakthrough that allowed babies to be conceived outside the womb.²⁵ In IVF, ovarian stimulation is followed by the collection of eggs ready for fertilization.²⁶ Concise Medical Dictionary explains in vitro fertilization as “the fertilization of an ovum (‘egg’) outside the body, the resulting zygote being incubated to the blastocyst stage and then being implanted in the uterus.” In other words, a child is conceived by joining eggs and sperm outside of the body and returning the embryo to a womb to resume normal development. This procedure overcomes many previously untreatable causes of infertility.²⁷

²⁵ Spar, Debora. "For Love and Money: The Political Economy of Commercial Surrogacy." *Review of International Political Economy* 12, No. 2 (May 2005): 287-309
http://www.jstor.org/stable/25124020?seq=1#page_scan_tab_contents (Accessed April 16, 2016).

²⁶ Garrison, Marsha. "Law Making for Baby Making: An Interpretive Approach to the Determination of Legal Parentage." *Harvard Law Review* 113, No. 4 (February 2000): 835-923.
http://www.jstor.org/stable/1342435?seq=1#page_scan_tab_contents (Accessed April 16, 2016).

²⁷ Wade, Nicholas. "Pioneer of In Vitro Fertilization Wins Nobel Prize." *The New York Times*, October 4, 2010. <http://www.nytimes.com/2010/10/05/health/research/05nobel.html?pagewanted=all&mtref=www.google.com&gwh=5562B049FD0B8EB8DA5DEE0091E55396&gwt=pay>

Both forms of surrogacy, traditional and gestational, use the technology of IVF, which became available in 1978 after the birth of Louise Brown. Like 40 percent of infertile women, Mrs. Brown suffered from a blockage in her fallopian tubes. She could produce eggs and carry a child, but she could not produce that child in her own womb. For the first time, doctors were able to take an egg from Mrs. Brown's ovaries, fertilize it with Mr. Brown's sperm, and then re-implant the eight-week cell embryo back into Mrs. Brown's uterus.²⁸ The principal advantage of IVF from a surrogacy standpoint is that it has the potential to split the genetic mother from the surrogate mother so as to impregnate the surrogate with another woman's eggs and enable her to give birth to a genetically unrelated child.

Since the birth of the first test-tube baby, Louise Brown, in July of 1978, some five million babies worldwide have been conceived via IVF.²⁹ The birth of baby Louise brought about a resurgence of surrogacy as a viable option for women to conceive without engaging in intercourse.³⁰ Before then, one woman served as both the genetic mother and gestational mother of the child. Thus, this scientific breakthrough that separates the various stages of reproduction, namely genetics and gestation, complicates the task of defining legal parenthood.³¹

The Rising Demand for Surrogacy

While the use of assisted reproductive technology (ART) has increased significantly since the birth of the first "test-tube" baby in 1978, the number of children born through

²⁸ Miller, 1380.

²⁹ Spar, 293.

³⁰ Davis, Erica. "The Rise of Gestational Surrogacy and the Pressing Need for International Regulation." *Minnesota Journal of International Law* 21, No. (Winter 2012): 120-144
<http://www.lexisnexis.com.ezproxy.trincoll.edu/hottopics/lnacademic/?verb=sf&sfi=AC07STJrnlSrch>
(Accessed April 19, 2016).

³¹ Lascarides, Denise E. "A Plea for the Enforceability of Gestational Surrogacy Contracts." *Hofstra Law Review* 25 (Summer 1997): 120-144
<http://www.lexisnexis.com.ezproxy.trincoll.edu/hottopics/lnacademic/?verb=sf&sfi=AC07STJrnlSrch>
(Accessed April 19, 2016).

surrogate arrangements has also risen dramatically (Alabama, 2014). A 2010 report by the nonprofit Council for Responsible Genetics said that data from the Centers for Disease Control and Prevention and the Society for Assisted Reproductive Technology, a professional organization, show that the number of infants born to surrogates almost doubled from 2004 to 2008, to nearly 1,400 babies from 738.³² With this marked increase in the use of surrogate mothers, the general public's knowledge of surrogacy's existence, acceptance of the practice, and awareness of surrogacy's accompanying issues have also increased significantly.³³ News coverage of surrogacy cases, namely *In re Baby M* and *Johnson v. Calvert*, swept the nation in the late 1980s and truly drew attention to how these questions were being answered completely differently on a state-by-state basis, creating a "crazy quilt of laws."

As women continue to postpone motherhood, many face difficulties conceiving children or fear the elevated risks that accompany the advancing age of the mother. Thus, the rise in infertility, in conjunction with advances in reproductive medicine, has increased the demand for surrogates.³⁴ Using the Key Statistics data from the National Survey of Family Growth from 2006-2010, the Centers for Disease Control (CDC) reported that the number of women ages 15-44 in the United States with impaired fecundity, the impaired ability to get pregnant or carry a baby to term, is 6.7 million or roughly 10.9%.³⁵ Further, they report that the number of married women ages 15-44 that are infertile, unable to get pregnant after at least 12 consecutive months

³² Lydersen, Kari. "Make Room for Daddies: Surrogate Demand Grows." *Chicago Business Insider*, February 2, 2013. <http://www.chicagobusiness.com/article/20130202/ISSUE03/302029981/make-room-for-daddies-surrogate-demand-grows>

³³ Arshagouni, 805.

³⁴ London, Catherine. "Advancing A Surrogate-Focused Model of Gestational Surrogacy Contracts." *Cardozo Journal of Law & Gender* 18 (2012): 391- 422
<http://www.lexisnexis.com.ezproxy.trincoll.edu/hottopics/lnacademic/?verb=sf&sfi=AC07STJrnlsSrch>
(Accessed April 19, 2016).

³⁵ Centers for Disease Controls, "Key Statistic from the National Survey of Family Growth" (data for 2006-2010).

of unprotected sex with their husband, is 1.5 million or roughly 6%.³⁶ Lastly, the number of women ages 15-44 who have ever used infertility services is roughly 7.4 million.³⁷ These numbers indicate that there are many Americans who might potentially opt for the use of a surrogate to build a family. Indeed, a 2014 *New York Times* article projected that more than 2,000 babies would be born through gestational surrogacy in the United States that year, almost three times as many as a decade ago.³⁸ Experts expect these numbers to continue to rise because of advances in reproductive technology, increasing numbers of same sex marriages and growing social acceptance of surrogacy.³⁹

Early Judicial Responses

The Supreme Court has yet to address surrogacy, and Congress has not created any federal legislation governing the process.⁴⁰ Therefore, when disputes between parties develop, courts lack statutory guidance in settling the conflicts. Two seminal cases in state courts show conflicting interpretations of surrogacy agreements. Although the cases vary factually, *In re Baby M* and *Johnson v. Calvert* illustrate the way in which two courts faced with determining the validity of a surrogacy agreement and answered it differently.⁴¹

³⁶ London, 396.

³⁷ London, 397.

³⁸ Lewin, Tamar. "Surrogates and Couples Face a Maze of Laws, State by State." *The New York Times*. September 17, 2014, <http://www.nytimes.com/2014/09/18/us/surrogates-and-couples-face-a-maze-of-laws-state-by-state.html>.

³⁹ Roser, Mary Ann. "Texas Sees Spike in Surrogate Pregnancies." *Washington Times*. July 6, 2014 <http://www.washingtontimes.com/news/2014/jul/6/texas-sees-spike-in-surrogate-pregnancies/?page=all>

⁴⁰ Miller, 1379.

⁴¹ Arshagouni, 800.

In re Baby M (1988)

In 1988, the New Jersey Supreme Court focused the nation's attention on surrogacy in *In re Baby M*. In the first major surrogacy case in United States history, the court held a traditional surrogacy contract unenforceable and against public policy.⁴² The case involved a married couple, Mr. and Mrs. Stern, and a surrogate, Mary Beth Whitehead. The Sterns wanted to have a child, but Mrs. Stern had been told by doctors that she might have multiple sclerosis and that becoming pregnant would take a debilitating physical toll on her body. The couple considered an adoption but was warned that, as a result of their differing religions and older age, they could face significant and discouraging delays. Desperate, the Sterns responded to an advertisement by the Infertility Center of New York City.

Mrs. Whitehead desired to become a surrogate mother to help couples like the Sterns. In addition, she wanted the \$10,000 surrogacy fee. Thus, the Whiteheads and the Sterns entered into a contractual agreement. The contract provided that Mrs. Whitehead would become pregnant through artificial insemination using Mr. Stern's sperm, "carry the child to term, bear it, deliver it to the Sterns, and thereafter do whatever was necessary to terminate her maternal rights so that Mrs. Stern could thereafter adopt the child." After the birth, Mrs. Whitehead found that giving the baby over to the Sterns was difficult but she relinquished her to the Sterns. Soon after, Mrs. Whitehead became deeply disturbed and "stricken with unbearable sadness," desperate for the child she had birthed and requested the baby girl back for a week. Relying on Mrs. Whitehead's promise to return the child and not wanting to risk her suicide, the Sterns complied. Mrs.

⁴² Arshagouni, 803.

Whitehead did not keep her word and the Sterns did not receive the child back until four months later, when she was taken from the home of Mrs. Whitehead's parents.⁴³

The Sterns sued, seeking to enforce the surrogacy agreement and asking for permanent custody of the child. The trial court found the surrogacy contract enforceable and awarded permanent custody to Mr. Stern. The New Jersey Supreme Court held the surrogacy contract to be invalid because it conflicted with both the laws and the public policy of the state.⁴⁴ The promise to surrender the child, made before birth or even conception, the court stated, directly contradicted New Jersey adoption law. Centrally, the court noted that the contract abrogated settled law to the effect that the child's best interest should determine custody, and that the rights of each natural parent of a child are equal to those of the other.⁴⁵

The New Jersey Supreme Court, however, invalidated the contract on the grounds that it violated New Jersey adoption statutes. The court determined that the \$10,000 fee awarded to Mrs. Whitehead was for the adoption of the child, not for Mrs. Whitehead's services. Because New Jersey laws prohibit the payment of money in connection with a child's adoption, the court considered the surrogacy agreement as an attempt to skirt the law.⁴⁶ "This is the sale of a child, or at the very least, the sale of a mother's right to her child, the only mitigating factor being that one of the purchasers is the father," the high court said.⁴⁷ Therefore, applying principles of family law, the court concluded that placing the child in the custody of Mr. Stern would be in the best interests of the child. Three years after the invalid surrogacy contract was created, the Sterns

⁴³ Arshagouni, 804.

⁴⁴ Miller, 1381.

⁴⁵ Miller, 1379.

⁴⁶ Miller, 1381.

⁴⁷ Hartocollis, Anemona. "And Surrogacy Makes 3: In New York, a Push for Compensated Surrogacy." *The New York Times*. February 19, 2014, <http://www.nytimes.com/2014/02/20/fashion/In-New-York-Some-Couples-Push-for-Legalization-of-Compensated-Surrogacy.html>.

finally received permanent custody of their child, while Mrs. Whitehead received only visitation rights.

Johnson v. Calvert (1993)

Conversely, in 1993, a California court held in *Johnson v. Calvert* that a gestational surrogacy agreement was not, on its face, against public policy. In this case, the Calverts turned to surrogacy because they could not have children after Crispina Calvert's uterus was removed. Since her ovaries could still produce eggs, they decided to sign a contract with Johnson, which provided that an embryo would be implanted into her womb. Johnson agreed to carry the child to term and, upon delivery, relinquish all parental rights in favor of the Calverts. In return, the Calverts would pay all medical and other related child bearing expenses, as well as pay Johnson \$10,000 for her services as a surrogate.⁴⁸ Prior to the birth of the child, the relations between the parties deteriorated and the Calverts filed suit, seeking a declaration that they were the legal parents of the unborn child. After the child's birth, Johnson was granted temporary visitation rights, even though blood tests excluded her as the genetic mother. The trial court ruled that the Plaintiffs, the Calverts, were the child's genetic, biological, and natural father and mother and terminated the Defendant's, Johnson's, right to visitation. The court of appeal affirmed this ruling and Johnson appealed.

In its decision, the California Supreme Court focused largely on the intent of the parents instead of following the analysis undertaken in *In re Baby M*, which used the child's best interest.⁴⁹ In this case, the California Supreme Court rejected any analogy to, or implication of,

⁴⁸ Gordon, Eric E. "The Aftermath of Johnson v. Calvert: Surrogacy Law Reflects a More Liberal View of Reproductive Technology." *St. Thomas Law Review* 6 (1993) 191-211
<http://www.lexisnexus.com.ezproxy.trincoll.edu/hottopics/lnacademic/?verb=sf&sfi=AC07STJrnlsSrch>
(Accessed April 19, 2016).

⁴⁹ Quinlan, Adam. "Recognizing Gestational Surrogacy Contracts: "Baby-Steps" Toward Modern Parentage Law in Maine After Nolan v. Labree." *Maine Law Review* 65, No. 2 (2013): 808-821

the adoption statutes, stating the “gestational surrogacy differs in crucial respects from adoption and so is not subject to the adoption statutes.”⁵⁰ In addition, the court described Johnson, the gestational carrier, as a “genetic hereditary stranger” to the child and deemed the Calverts to be the “genetic, biological, and natural” parents of the child based on medical evidence.⁵¹ The court further determined that any compensation paid to the gestational surrogate was “meant to compensate her for her services in gestating the fetus and undergoing labor, rather than for giving up ‘parental’ rights to the child.”⁵² Thus, the court decided to recognize the gestational surrogacy contract as a personal services contract and not a contract over parentage.

In re Baby M and *Calvert* represent the judicial “tip-toeing and inconsistency in analyzing surrogacy agreements, and consequently, the cry to legislatures to clarify surrogate relationships.”⁵³ These two cases, while factually distinguishable, illustrate that without explicit legislative direction, courts will be forced to handle these sensitive and difficult issues to the best of their abilities.⁵⁴ The courts took very different approaches when determining whether or not to enforce surrogacy agreements, with the key distinction being that Baby M was born to a traditional surrogate, while the child born in *Johnson v. Calvert* was born to a gestational surrogate. However, in both cases, the courts appear to recognize that contracts carry a presumption of validity.⁵⁵ These two cases famously demonstrate the inconsistencies and

<http://www.lexisnexis.com.ezproxy.trincoll.edu/hottopics/lnacademic/?verb=sf&sfi=AC07STJrnlSrch>
(Accessed April 19, 2016).

⁵⁰ *Johnson v. Calvert*, Cal. Sup. Ct., 5 Cal4th 84, 851 P.2d 776 (1993)

⁵¹ Goodwin, Anne. "Determination of Legal Parentage in Egg Donation, Embryo Transplantation, and Gestational Surrogacy Arrangements." *Family Law Quarterly* 26, No. 3 (Fall 1992): 275-91
<http://www.jstor.org.ezproxy.trincoll.edu/stable/pdf/25739911.pdf> (Accessed April 19, 2016).

⁵² Arshagouni, 804.

⁵³ Quinlan, 811.

⁵⁴ Quinlan, 811.

⁵⁵ Dashiell, 873.

unpredictability of surrogacy agreement litigation outcomes. It is problematic to leave such cases to the courts when there is so little precedent upon which to base decisions. Since many potential parents are likely to opt for gestational surrogacy, clear specific laws are needed to outline the obligations of all of the parties involved in such an agreement.

Common Approaches to Determining Legal Parentage in Gestational Surrogacy Agreements

The parenting possibilities created by IVF present a host of legal issues. The aforementioned cases are examples of judicial attempts to answer unprecedented questions about kinship, parenthood, and surrogacy. But, as has been demonstrated above, courts are limited to deciding the specific issues presented to them in the cases. There is considerable debate about how best to determine the parentage of child born via assisted reproductive technologies.⁵⁶ Under common law, a woman who carries and gives birth to a child is presumed to be the mother.⁵⁷ Traditional understandings of parenthood involve biology and marriage but we are shifting into an age of science where such traditional understandings exacerbate existing dilemmas arising from assisted reproductive technologies (ART).⁵⁸

Modern day science has made it so that genetics and gestation can be separated in practice and the result is a confusing array of “parents.” For example, would-be parents A and B might obtain sperm from Man C and eggs from Woman D, then have a doctor implant the resulting pre-embryos to be carried to term by Woman E who is married to Man F.⁵⁹ Defining parenthood is increasingly important in cases involving gestational carriers because as many as

⁵⁶ Purvis, Dara E. "Intended Parents and the Problem of Perspective." *Yale Journal of Law and Feminism* 24 (2012): 211- 253
<http://www.lexisnexis.com.ezproxy.trincoll.edu/hottopics/lnacademic/?verb=sf&sfi=AC07STJrnlsSrch>
(Accessed April 19, 2016).

⁵⁷ Miller, 1382.

⁵⁸ Quinlan, 813.

⁵⁹ Hisano, 549.

six people might believe that they have parental rights once the child is born. For obvious reasons, it is important to ensure that each person is in full understanding of his or her rights and responsibilities throughout the process from start to finish. The California Court of Appeals has emphasized the importance of this problem in its 1998 decision in *Buzzanca v. Buzzanca*. In this case, a California couple, Luanne and John Buzzanca, commissioned a baby with a donor egg and a surrogate but divorced before the child was born and John did not want to pay child support. At first, the court decided that the child had no legal parents, and John was not responsible. However, this decision was overturned because, as the California appellate court decision put it, the baby “never would have been born had not Luanne and John both agreed to have a fertilized egg implanted in a surrogate.”⁶⁰ Further, this court opinion stated:

Again we call upon the Legislature to sort out the parental rights and responsibilities of those involved in artificial reproduction. No matter what one thinks of artificial insemination, traditional and gestational surrogacy (in all of its permutations) and- as now appears in the not-too-distant future, cloning and even gene splicing- courts are still going to be faced with the problem of determining lawful parentage. A child cannot be ignored. Even if all the means of artificial reproduction were outlawed with draconian criminal penalties visited on the doctors and parties involved, courts would still be called upon to decide who the lawful parents are and who – other than the taxpayers – is obligated to provide maintenance and support for the child. These cases will not go away. Again we must call on the Legislature to sort out the parental rights and responsibilities of those involved in artificial reproduction. Courts can continue to make decisions on an ad hoc basis without necessarily imposing some grand scheme. Or, the Legislature can act to impose a broader order which, even though it might not be perfect on a case-by-case basis, would bring some predictability to those who seek to make use of artificial reproductive techniques.⁶¹

⁶⁰ Grose, Jessica. "The Sherri Shepherd Surrogacy Case Is a Mess. Prepare for More Like It." *Slate*. April 28, 2015, http://www.slate.com/blogs/xx_factor/2015/04/28/sherri_shepherd_surrogacy_case_there_s_little_consent_on_the_ethical_dimensions.html (Accessed April 22, 2016).

⁶¹ *Buzzanca v. Buzzanca*, 72 Cal. Rptr. 2d 280 (Cal. Ct. App. 1998)

Genetic-Based Parenthood

The judicial method that focuses on genetics to determine parental rights in gestational surrogacy de-emphasizes pregnancy and childbirth in its analysis and reinforces the importance of biology in determining parentage.⁶² The decision in favor of genetic parents goes a long way in protecting infertile couples who hire gestational surrogates. The Ohio Court of Appeals is among a number of courts that have enforced surrogacy contracts under the theory that the parents are the ones with a genetic tie to the child. In *J.F. v. D.B.* (2006), the Ohio Court of Appeals ruled that a surrogacy contract did not violate public policy because the surrogate had no parental rights to forego: under Ohio law, “the individuals who provide the genes of that child are the natural parents.”⁶³ Similarly, in *Clark v. Besito* (1994), an Ohio court ruled that “the law requires that those who provided the child with its genetics... must be designated as the legal and natural parents.” In addition, the genetic link to the intended parents also influenced the court’s reasoning in *Johnson v. Calvert* (1993). Criticism of the genetic contribution test arises from the inconsistency of its results. So, for example if the commissioning couple uses a donor ovum for implantation in the surrogate, may the egg donor make a claim for parenthood?⁶⁴ Moreover, the genetic test is inconsistent with most states’ laws denying a legal claim to paternity to sperm donors.⁶⁵ Thus, because the genetic motherhood standard determines parentage rights based on who is genetically related to the child in a surrogacy arrangement, it is possible that where children are produced from the gametes of anonymous donors, the intended parents would have

⁶² Miller, 1377.

⁶³ *J.F. v. D.B.*, 165 Ohio App. 3d 791 (Ohio Ct. App. 2006)

⁶⁴ Larkey, 610.

⁶⁵ Larkey, 610.

no claim of parentage rights to those children other than through adoption because they did not contribute genetic material.⁶⁶ The following approach attempts to resolve these deficiencies.

Intent-Based Parenthood

Intent theories of parenthood suggest that the law should grant parental rights and responsibilities to those who caused a child to come into being with the intent of parenting that child once it was born.⁶⁷ As mentioned, the Supreme Court of California resolved the dispute in *Johnson v. Calvert* (1993) by looking into the intent of the parties in signing the contract. Conceding that under the 1973 Uniform Parentage Act, both gestation and genetic ties can give rise to a presumption of motherhood, the Court determined that “when the two means do not coincide in one woman, she who intended to procreate the child- that is, she who intended to bring about the birth of a child that she intended to raise as her own- is the natural mother under California law.”⁶⁸ Reasoning that the child would not have been born but for the intention of the Calverts, the Court found that intent to be the primary determinant of parentage, and also observed that finding parentage in the people who had chosen to bring the child into being was also in the best interests of the child.⁶⁹ Other jurisdictions also hold that intent manifested in a surrogacy agreement offers a third way, besides procreation and adoption, that parenthood can best be established.⁷⁰ For example, Arkansas law provides that a child born to surrogate mother

⁶⁶ Bennett, SaraAnn C. ""There's No Wrong Way to Make a Family." Surrogacy Law and Pennsylvania's Need for Legislative Intervention." *Penn State Law Review* 118 (Fall 2013): 407-436 <http://www.lexisnexis.com.ezproxy.trincoll.edu/hottopics/lnacademic/?verb=sf&sfi=AC07STJrnlSrch> (Accessed April 19, 2016).

⁶⁷ Purvis, 220.

⁶⁸ Miller, 1385.

⁶⁹ Larkey, 615.

⁷⁰ Larkey, 615.

is presumed to be the child of the biological father and the intended mother as long as the father is married.⁷¹

Gestational Motherhood

State statutes that declare surrogacy contracts void in effect employ the doctrine of motherhood by gestation, refusing to grant a commissioning mother parental rights over the objection of the gestational mother.⁷² This theory proposes that the law should always recognize the gestational mother as the child's mother regardless of the source of egg and sperm. This approach is rooted in the common law presumption that the woman who gives birth is the mother, and also emphasizes the traditional definition of mother and the "gestational mother's contribution to the fetus growing insider her."⁷³ The flaw many commentators note in this theory is that it interferes with private ordering and the right to enter voluntary contracts, as well as invading the constitutionally protected area of privacy to make decisions about reproduction and child rearing.⁷⁴ Those who oppose straying from the gestational motherhood approach argue that the elimination of the gestational mother's paternal rights reduces the woman's body to a container that carries the genetic parents' baby and trivializes the pregnancy as a service for the "real" mother.⁷⁵ This approach faces critiques pertaining to the rights of the contracting parents who would potentially lose their genetic child if the gestational mother had the power to revoke her decision to terminate her parental rights.

⁷¹ Ark. Code Ann. §9-10-201 {(2002)}

⁷² Larkey, 618.

⁷³ Kindregan, Charles P., Jr. "Considering Mom: Maternity and The Model Act Governing Assisted Reproductive Technology." *Journal of Gender, Social Policy & Law* 17, No .3 (Summer 2008): 602-625 <https://www.wcl.american.edu/journal/genderlaw/17/kindregan.pdf> (Accessed April 19, 2016).

⁷⁴ Kindregan, 205.

⁷⁵ Kindregan, 205

Pre-Birth Orders

Defining parentage and awarding parental rights to individuals during this process carries a heavy weight in cases regarding assisted reproductive technologies. Legalized procedures are used to formalize the intent of the parties to a surrogacy agreement to obtain a pre-birth parentage order in which the intended parents are declared the legal parents before the child is born.⁷⁶ There are numerous benefits to such orders. First and foremost, the intended parents are determined to be the legal parents of the child before the child's birth, thereby giving them immediate and sole access to and control over the child and its postnatal care and medical treatment upon birth.⁷⁷ This also allows the names of the intended parents to go on the original birth records at the hospital and governing department of health, avoiding the process of amending the birth certificate.⁷⁸ The determination of parentage before birth also allows the hospital to discharge the child directly to the intended parents rather than to the surrogate. Finally, from a purely emotional perspective, a pre-birth parentage order permits the intended parents to participate in the delivery and hospital experience as much like the natural delivery of their own child as possible.

The availability, validity, and long-term effect of such orders differ in respective jurisdictions. Depending on the state and jurisdiction that the child is born in, if the intended parent or parents do not obtain a pre-birth order they will either have to do a stepparent adoption

⁷⁶ Byrn, Mary P., and Steven H. Snyder. "The Use of Rebirth Parentage Orders in Surrogacy Proceedings." *Family Law Quarterly* 39, No.3 (Fall 2005): 633-662
http://www.jstor.org.ezproxy.trincoll.edu/stable/pdf/25740514.pdf?_=1461102305219

⁷⁷ Byrn, 635.

⁷⁸ Byrn, 637.

or complete adoption. After the adoption is final, the state will reissue the birth certificate with the named of the parents and the original will be sealed.⁷⁹

Conclusion

Human reproduction is a very private and sensitive topic with many religious, social, and political undertones, and it does not naturally lend itself to easy solutions. When assigning parental status to someone other than a biological progenitor, courts and legislatures have relied on several policy goals.⁸⁰ The most important of these aims has been ensuring that children have at least one, preferably two, legal parents who are responsible for their care and support.⁸¹ This policy goal is paramount because it is understood to serve the interests of both children and the public. Nevertheless, it is clear that even in states with statutes governing surrogacy usually fail to offer clear, or even murky, answers as to the rights and obligations of these various parties. Thus, legislation is required because states court decisions do not, and cannot, provide sufficient legal guidance for the parties involved in surrogacy arrangements. Instead, the jurisdictional chaos has created the “crazy quilt of laws” that makes the process of surrogacy exceptionally complex and daunting. The time has come for uniform legislation to be passed in all fifty states of the United States of America.

⁷⁹ Zielger, 25.

⁸⁰ Kindregan, 620.

⁸¹ Kindregan, 620.

Chapter 2.
The Crazy Quilt of Laws: Approaches to Resolving Confusion

Currently, there is nothing resembling a national consensus on how to implement surrogacy and no federal law, leaving the states free to do as they wish. The 1988 *Baby M* decision generated a nationwide reaction and because surrogacy was virtually unregulated by Congress or the states prior to the New Jersey Supreme Court's holding, there was a widespread response among state legislatures and judiciaries. However, the results were incredibly inconsistent throughout the country and are constantly changing. This chapter seeks to explain the disjointed nature of how surrogacy is actually practiced in the United States.

Regulation of Surrogacy

Federal Legislation

Currently, there is no uniform federal law explicitly governing surrogacy agreements. Generally, the topic is addressed by state legislation, leaving the country's existing law something like a "patchwork quilt."⁸² As one commentator noted: "there are more laws in the United States governing the breeding of dogs, cats, fish, exotic animals, and wild game species than exist with respect to the use of surrogate and reproductive technologies to make people."⁸³ This lack of guidance, coupled with the inconsistency of the laws that are in place, has caused many to argue that the only way to bring order to the surrogacy process is through uniform federal legislation.⁸⁴ However, in order to pass federal legislation, the law must overcome federalism issues since family law generally falls under the states' power. Nonetheless, proponents of federal legislation argue three possible means by which Congress could claim power to pass such legislation. First, Congress could regulate surrogacy "if surrogacy is

⁸² Arshagouni, 844.

⁸³ Caplan, Arthur. "The Baby Market", *NY TIMES ROOM FOR DEBATE BLOG*, December 29, 2009, <http://roomfordebate.blogs.nytimes.com/2009/12/29/the-baby-market/>

⁸⁴ Miller, 1388.

considered a constitutionally protected right.”⁸⁵ Second, Congress could regulate surrogacy under the Commerce Clause powers if surrogacy is found to affect interstate business through either the payments to fertility centers or through the impact on health.⁸⁶ Finally, the federal government’s broad treaty power has the potential to “provide a basis for regulation” of surrogacy. The Senate has the power “to give ‘advice and consent’ to a treaty, allowing Congress to approve” enacting legislation on a subject that is traditionally considered to fall under the states’ powers.⁸⁷ Ultimately, none of these arguments have proven to be strong enough to make federal legislation a legitimate option and there is not a strong constituency pushing Congress to act.

In 1989, in the wake of *Baby M*, two members of the House of Representatives attempted to pass federal legislation that would prohibit or restrict surrogacy agreements. Thomas Luke, the Democratic Representative for Ohio’s first congressional district, sponsored the first bill, known as the Surrogacy Arrangements Acts of 1989. This act sought to impose criminal penalties upon anyone who “knowingly makes, engages in, or brokers a surrogacy agreement.”⁸⁸ Ultimately, the bill accumulated only three co-sponsors and failed to advance out of the House Committee on Energy and Commerce.⁸⁹ The second bill was introduced by Robert Dornan, and was called the Anti-Surrogate-Mother Act of 1989. This bill sought to criminalize all activities relating to surrogacy, whether commercial or non-commercial.⁹⁰ However, the bill found no co-sponsors

⁸⁵ Miller, 1383.

⁸⁶ Miller, 1384.

⁸⁷ Miller, 1384.

⁸⁸ H.R. 275, 101st Cong. S 2(a) (1989).

⁸⁹ Miller, 1385.

⁹⁰ H. R. 576, 101st Cong. (1989).

and stalled in the House Committee on the Judiciary.⁹¹ Any arguments in favor of regulating surrogacy have failed because the majority of individuals, regardless of whether they approve or disapprove of surrogacy in practice, see this as a family matter that belongs in the private sphere and that it is to be protected from intrusion by public forces.⁹² No further attempts at uniform federal legislation have been made, leaving courts, prospective parents and surrogates with only the “patchwork quilt” of state legislation as guidance.⁹³

The Development of Model Acts Over Time

While the United States Congress has failed to pass any law regulating surrogacy, a few model acts exist that address the subject. The Uniform Parentage Acts, the Uniform Status of Children of Assisted Conception Act and the ABA Model Act governing Assisted Reproductive Technologies all address the validity of gestational surrogacy agreements.⁹⁴

1973 Uniform Parentage Act (UPA)

The Uniform Law Commission is a body that provides states with legislation that brings clarity and stability to critical areas of statutory law and promotes uniform acts in areas of state law where uniformity is desirable and practical.⁹⁵ However, it is important to note that the Uniform Law Commission can only propose legislation and no uniform law is effective until a state legislature adopts it. The National Conference of Commissioners on Uniform State Laws’ Parentage Act Summary explains that around the time that this act was created, a child whose

⁹¹ Miller, 1384.

⁹² Markens, Susan, *Surrogate Motherhood and the Politics of Reproduction*. (Berkeley: U of California, 2007).

⁹³ Miller, 1385.

⁹⁴ Miller, 1385.

⁹⁵ Brett, Taylor E., "The Modern Day Stork: Validating The Enforceability of Gestational Surrogacy Contracts in Louisiana." *Loyola Law Review* 60 (December 2014): 687-45.
<http://www.lexisnexis.com.ezproxy.trincoll.edu/hottopics/lnacademic/?verb=sf&sfi=AC07STJrnlsSrch>
(Accessed April 19, 2016).

mother was not married was an illegitimate child under the common law.⁹⁶ Further, the father of an illegitimate child was burdened neither with rights nor obligations of parenthood. The United States Supreme Court eliminated illegitimacy as a legal barrier in a number of cases in the 1960s and 1970s.⁹⁷ As a result, the Uniform Law Commissioners created the 1973 Uniform Parentage Act (UPA),⁹⁸ which focused on the law regarding determination of parentage, paternity actions, and child support.⁹⁹ Section 2 of the UPA confirmed and completed the revolution with very simple language: “The parent and child relationship extends equally to every child and every parent, regardless of the marital status of the parent.”¹⁰⁰ The UPA was followed by a number of other proposed uniform acts since it did not cover enough ground to effectively guide and inform surrogacy arrangements.

Uniform Status of Children of Assisted Conception Act (USCACA)

In 1988, the Uniform Law Commission promulgated the Uniform Status of Children of Assisted Conception Act. The USCACA was written in response to new technologies of assisted conception, like in vitro fertilization and artificial insemination. The USCACA was not intended to be a regulatory, binding act but to provide guidance on how states could protect the “security and well-being” of children born through ART.¹⁰¹ In other words, states were free to adopt the USCACA in its entirety, to use the Act as a basis for enacting their own laws, or to ignore it

⁹⁶ Uniform Law Commission. *Parentage Act Summary*. The National Conference of Commissioners on Uniform State Laws. (Chicago, Illinois. 2016), 4.
<http://www.uniformlaws.org/ActSummary.aspx?title=Parentage%20Act> (Accessed April 19, 2016).

⁹⁷ Brett, 601.

⁹⁸ Unif. Parentage Act§ 801-809 (amended 2002).
http://www.uniformlaws.org/shared/docs/parentage/upa_final_2002.pdf (Accessed April 26, 2016).

⁹⁹ Miller, 1384.

¹⁰⁰ Uniform Law Commission Summary, 1.

¹⁰¹ Brett, 603.

completely.¹⁰² Notably, the USCACA contained two provisions applicable to surrogacy contracts: one authorized these agreements as subject to court approval, and the other rendered all surrogacy contracts void and unenforceable.¹⁰³ Currently, only two states have implemented the surrogacy provisions and have selected opposite options. Virginia chose to regulate these agreements, while North Dakota opted to declare them void up until recently.¹⁰⁴ Still, many states decided not to adopt the USCACA and instead chose to internally address the parental right to children both through ART and the enforceability of surrogacy contracts.

2000 and 2002 Uniform Parentage Acts

In 2000, the Uniform Law Commission revised the Uniform Parentage Act and added a proposal by the National Conference of Commissioners on Uniform State Law on the acceptance of surrogacy agreements.¹⁰⁵ The Act was again amended in 2002 as a response to inconsistencies between states and their requirements for surrogacy contracts. For the purpose of my research, the most pertinent article of the new UPA is Article 8, which addresses gestational surrogacy agreements and incorporated parts of the USCACA on the issue. However, this article was, too, made optional to enacting states because of the recognition that gestational agreements are valid in some states and not in others. Moving forward, the 2002 UPA was designed to carefully control gestational agreements by asserting that a court must validate such agreements before they are enforceable, and all parties to the agreement, including the gestational mother's spouse,

¹⁰² Brett, 603.

¹⁰³ Brett, 603.

¹⁰⁴ Office of Policy Analysis. *Legal Issues Concerning Assisted Reproduction*. By Botts, Jennifer K., Lindsay Eastwood, and Lauren Nestor. Annapolis, Maryland. The Department of Legislative Services, Dec. 2012.

¹⁰⁵ Luckey, Cara. "Commercial Surrogacy: Is Regulation Necessary to Manage the Industry?" *Wisconsin Journal of Law, Gender & Society* 26, No. 2 (2012): 213-240
<http://www.lexisnexis.com.ezproxy.trincoll.edu/hottopics/lnacademic/?verb=sf&sfi=AC07STJrnlsSrch>
(Accessed April 19, 2016).

if married, must consent to its terms. Additionally, it stipulated that the hearing that the court conducts to validate a gestational agreement is analogous to a proceeding for an adoption of a child.¹⁰⁶ Before a court can approve the agreement, a child welfare agency must conduct “a home study of the intended parents” to ensure fitness and readiness for parenthood¹⁰⁷ and also must verify the birth mother’s qualifications to carry the child.¹⁰⁸ The birth mother may be compensated, and has the power to terminate the agreement.¹⁰⁹ And the Act also provides that the intended parents may petition the court for an order designating them the legal parents of the child after is or she is born.¹¹⁰ While the UPA has been adopted in part by approximately thirteen states,¹¹¹ few have elected to include Article 8. While not without criticism, UPA Article 8 is generally considered a good-faith attempt to address the practice of surrogacy and could be a reasonable model for states to adopt.¹¹² Having such provisions available to the states even in optional form is important simply because gestational agreements are being used all the time, and the legal parenthood of children should not be in doubt when such agreements are used.¹¹³

ABA Model Act Governing Assisted Reproductive Technologies

In 2008, the American Bar Association (ABA) created the Model Act Governing Assisted Reproductive Technology as a response to the “confusion and contradictions” in the application of existing statutes and common law resulting from the legal issues regarding

¹⁰⁶ Miller, 1385.

¹⁰⁷ *Legal Issues Concerning Assisted Reproduction*, 4.

¹⁰⁸ Uniform Law Commission, <http://www.uniformlaws.org/ActSummary.aspx?title=Parentage%20Act>

¹⁰⁹ Uniform Law Commission, <http://www.uniformlaws.org/ActSummary.aspx?title=Parentage%20Act>

¹¹⁰ *Legal Issues Concerning Assisted Reproduction*, 4.

¹¹¹ Arshagouni, 814.

¹¹² Miller, 1382.

¹¹³ Uniform Law Commission, <http://www.uniformlaws.org/ActSummary.aspx?title=Parentage%20Act>

ART.¹¹⁴ However, these laws are not binding and are intended only to guide states as they formulate their own laws. The model act seeks to give participants and the resulting offspring of assisted reproduction clear legal rights, obligations, and protections by establishing legal standards for the use, storage, and other disposition of gametes and embryos. The ABA Model Act lays out two approaches to surrogacy agreements: Alternative A and Alternative B.¹¹⁵ Alternative A tracks the UPA, with many of the same requirements for enforceable gestational surrogacy agreements, such as residency requirements, judicial pre-approval, and a home study of the intended parents.¹¹⁶ The main difference between the two alternatives is that Alternative B allows for self-executing contracts without requiring prior court approval, which many consider more practical than either Alternative A or the UPA.¹¹⁷ Alternative B imposes certain eligibility requirements for the surrogate as well.¹¹⁸ For example, she must be at least twenty-one years of age; have given birth to at least one child; have completed a medical evaluation and mental health evaluation; be represented by independent legal counsel; and have medical insurance.¹¹⁹ Furthermore, Alternative B requires that the intended parents have a medical need for having a child through surrogacy, and that at least one of the parents must provide gametes for the embryo.¹²⁰ To date, no state has adopted the model act.¹²¹ But, as I will discuss in Chapter 4, I believe that Alternative B of this act provides an exceptionally comprehensive and workable

¹¹⁴ Model Act Governing Assisted Reprod. Tech. (Proposed Official Draft 2008)

¹¹⁵ Arshagouni, 817.

¹¹⁶ *Legal Issues Concerning Assisted Reproduction*, 7.

¹¹⁷ *Legal Issues Concerning Assisted Reproduction*, 8.

¹¹⁸ *Legal Issues Concerning Assisted Reproduction*, 8.

¹¹⁹ *Legal Issues Concerning Assisted Reproduction*, 7.

¹²⁰ *Legal Issues Concerning Assisted Reproduction*, 7.

¹²¹ *Legal Issues Concerning Assisted Reproduction*, 7.

outline for gestational agreements and should be incorporated into state laws to guide the practice of surrogacy.

State Legislation: Differences Pertaining to Enforcement of Contracts and Regulation

Because there is no binding U.S. Supreme Court decision or congressional regulation, states remain free to regulate surrogacy agreements to their liking. Unlike other regimes such as adoption, visitation, and custody that are becoming more settled in the United States, surrogacy remains one area of family law that many states either disagree about or remain silent upon altogether.¹²² State legislatures' reactions to surrogacy agreements have varied widely, ranging from full acceptance and enforcement of all gestational surrogacy agreements to a complete rejection of any surrogacy arrangements enforced through criminal penalties.¹²³ The majority of states, however, have said virtually nothing directly pertaining to surrogacy agreements.¹²⁴ When it comes to laws that acknowledge and regulate surrogacy agreements, states can be separated into four main categories: permissive, silent, existing case law, and prohibitive.

States Permitting Surrogacy

Currently, seventeen states have laws permitting surrogacy, but they vary greatly in both breadth and restrictions.¹²⁵ Even so, this is significant because it shows that these states have chosen to acknowledge the validity and legality of surrogacy agreements through status regulation. This approach "allows the state to channel surrogacy into particularly favored forms and to encourage voluntary compliance with its regulations by facilitating legal recognition of

¹²² Caster, Austin. "Don't Split the Baby: How the U.S. Could Avoid Uncertainty and Unnecessary Litigation and Promote Equality by Emulating the British Surrogacy Law Regime." *Connecticut Public Interest Law Journal* 10 (Spring 2011): 477-521
<http://www.lexisnexis.com.ezproxy.trincoll.edu/hottopics/lnacademic/?verb=sf&sfi=AC07STJrnlsSrch>
(Accessed April 19, 2016).

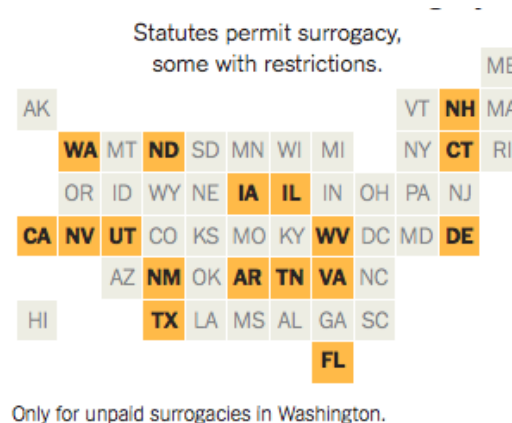
¹²³ Arshagouni, 805.

¹²⁴ Arshagouni, 805.

¹²⁵ Lewin.

those surrogacy arrangements that comply with the statutory requirements.”¹²⁶ As directed by the New Hampshire code, these laws aim to effectively “standardize the minimum components of gestational carrier agreements, and recognize that written gestational carrier agreements are valid and enforceable legal contracts.” In the event of a dispute, these states choose to recognize and enforce surrogacy agreements so long as they meet the requirements set forth. These states, as you can see in Figure 1, do not follow any particular pattern in terms of ideological tendencies (conservative states versus liberal states) or geography. When looking at the Figure below, please note that a state colored in orange indicates that said state is permissive towards surrogacy agreements.

Figure 1: Permissive States



Creative Family Connections. Where States Stand on Surrogacy, in Tamar Lewin, “Surrogates and Couples Face a Maze of Laws, State by State,” *New York Times*. Sept. 14, 2014. Web.

There are various ways in which the state legislatures have chosen to restrict the surrogacy alternatives permitted.¹²⁷ The major state-by-state distinctions can often be attributed to varying opinions about: (1) whether the surrogacy agreement is traditional or gestational, (2) whether the surrogate is compensated beyond pregnancy-related expenses, and (3) the marital

¹²⁶ Rao, Radhika. *Surrogate Motherhood: International Perspectives: Surrogacy Law in the United States: The Outcome of Ambivalence.* (Oxford: Hart Publishing, 2003), 23.

¹²⁷ Bennett, 415.

status and sexual orientation of the intended parents.¹²⁸ Other requirements include that at least one intended parent provide the genetic material for the surrogacy¹²⁹ and/or proof that the commissioning mother cannot physically gestate a pregnancy to term. Furthermore, some states allow the intended parents to obtain a pre-birth order whereas others require the parents to be treated as adoptive parents, even if the child is genetically their own. This all goes to show that although status regulation statutes exist in these states that regulate surrogacy, little uniformity is found between these laws.¹³⁰ Figure 2 serves as an outline of the deviation among the seventeen states pertaining to, what I believe to be, the most important requirements for the intended parents. Methodologically, I read each individual state code to systematically search for the requirements, regulations and most crucial contingencies set forth in each state.

¹²⁸ Brett, 610.

¹²⁹ Brett, 611.

¹³⁰ Brett, 611.

Figure 2: Deviations Among Permissive States

	Pre-Birth	Married	Compensation	Donors	Required Infertility
NH	Yes	Yes	Yes	*	Yes
CT	Yes	No	Unclear	Yes	No
DE	Yes	No	Yes	Yes	Unclear
WV	Yes	Unclear	Yes	Unclear	Unclear
VA	No	Yes	No	*	Yes
FL	No	Yes	No	Unclear	Yes
IL	No*	No	Yes	*	Yes
TN	Yes	Yes	Unclear	Yes	Unclear
IA	Yes* ¹³¹	Unclear	Yes ¹³²	Yes	Unclear
AR	No	Unclear	Unclear	Unclear	Unclear
ND	Yes	No	No	No	Unclear
NM	Yes ¹³³	Unclear	No	Yes	Unclear
TX	Yes ¹³⁴	Yes	Unclear	Yes	Yes
UT	Yes	Yes	Yes	*	Yes
WA	No	Unclear	No	Unclear	Unclear
NV	Yes	Yes	Yes	Yes	Yes
CA	Yes	No	Yes	Yes	No

Key:

Pre-birth order: Yes=possible, No= not possible

Married: Yes= they must be, No= not required

Compensation: Yes= allowed beyond pregnancy-related expenses, No= limited to pregnancy-related expenses

Donor: Yes= allowed, No= must be intended parents' gametes, *=At least one parent must be genetically related

Proof: Yes= Need proof, No= Don't

Unclear: a finding that there was no mention of it

¹³¹ Yes, but it is only a partial order. Under the Iowa Code, the woman bearing the child is presumed to be the legal mother. Therefore, only the Intended Father (if a heterosexual couple) or the biological father (if a same-sex couple) can obtain a pre-birth order, requiring a 2-step process. The non-biological parent must then undergo a post-birth process, either in Iowa or elsewhere, to terminate the Gestational Carrier's rights and establish the second parent's rights.

¹³² The Iowa Code implicitly permits Gestational Surrogacy. It specifically exempts surrogacy agreements from Iowa Code §710.11, which prohibits the purchase or sale of an individual.

¹³³ Until recently, the initial birth certificate named the Gestational Carrier as the mother. With the cooperation of Vital Records, courts have started to name both Intended Parents on the initial birth certificate directly. (Creative Family Connections, 2016)

Immediately one can see that there is no particular rhyme or reason behind the way that these laws are passed or practiced. Thus, there is an obvious lack of uniformity among these permissive states. Even more importantly, this chart is able to clearly demonstrate that although these states have taken steps towards regulating surrogacy agreements, there is still an astounding lack of clarity surrounding essential elements of the process. Each box that holds the word “unclear” is a finding that the state has failed to mention or specify exactly what the proper protocol is when it comes to a particular factor. For example, it is important to consider that even in states where compensation is acknowledged and permitted, there is potential confusion as to the degree of compensation allowed. Some states will define compensation as “payment of any valuable consideration for services in addition to payment for reasonable medical and ancillary costs,”¹³⁵ whereas others, such as New Hampshire, will uphold the definition as “payment of any reasonable, valuable consideration to the gestational carrier” and not clarify whether that includes beyond pregnancy related expenses.

Additionally, the requirements do not end with the intended parents. Above mentioned states have additional laws that outline the requirements and qualifications of surrogates before they can enter into an agreement. Not surprisingly, these too vary among the states that regulate surrogacy agreements. Important considerations generally include the age of the surrogate, mental health, physical health, and whether or not she has carried a child before. Applications of these laws differ state-by-state and can be seen through a comparison between Florida and Illinois, two states that explicitly permit surrogacy. Florida’s gestational surrogacy contract law requires that a gestational surrogate does not use her own eggs and must be at least 18 years

¹³⁵ Delaware Code 13, § 8-801

old.¹³⁶ On the other hand, Illinois' law is much more detailed and comprehensive because it includes requirements such as that gestational surrogates to be at least 21 years old, have already given birth to at least one child, and to complete a medical and mental health evaluation in addition to undergoing a consultation with independent legal counsel.¹³⁷ These kinds of discrepancies help to demonstrate how there is a great need for comprehensive reform in order to provide clarity about the rights and obligations of all individuals who wish to enter into such an agreement to build a family in any given state.

States That Are Silent on the Issue

In twenty-one states, there is neither a law nor a published case regarding surrogacy, according to Diane Hinson, a Washington, D.C., lawyer who specializes in assisted reproduction.¹³⁸ Marcy Darnovsky, executive director of the Center for Genetics and Society postulated that "lawmakers are wary of touching assisted reproduction because of the incendiary politics that surround the issue of abortion, which touches on conception and embryos."¹³⁹ Further, Arthur Caplan, director of the division of Medical Ethics and New York University's School of Medicine commented that, "it is unregulated because it touches on two, 'third rail' issues. It touches on abortion and also the creation of embryos, which politicians run away from because too many people still disagree about the right to use reproductive technologies, particularly who should pay for them and how much."¹⁴⁰ It is important to understand that even if a state does not recognize surrogacy contracts, it does not also mean that someone cannot have

¹³⁶ § 742.15, Fla. Stat. ({2015})

¹³⁷ 750 ILCS 47/1 – 47/75 ({2014})

¹³⁸ Lewin.

¹³⁹ Ollove, Michael. "States Not Eager to Regulate Fertility Industry." *The Pew Charitable Trusts*, March, 18, 2015. <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/3/18/states-not-eager-to-regulate-fertility-industry>

¹⁴⁰ Ollove.

a surrogate in that state. In fact, in these states where no statute or case law expressly prohibits gestational surrogacy, it is assumed to be permitted and is practiced. However, the parties involved must be aware that the contract can be unenforceable.¹⁴¹ The inaction approach embodies the American ambivalence towards surrogacy: it is an attempt to permit surrogacy while simultaneously discouraging it by creating a regime in which those who enter into surrogacy contracts do so at their own peril, without any of the protections provided by state enforcement of other types of contracts.¹⁴² By taking this stance of inaction, “the state seeks to withdraw its support by refusing to enforce surrogacy contracts and by declining to prescribe specific rules governing the allocation of parental rights and responsibilities in this context.”¹⁴³

In the absence of specific statutory guidance, when parties to an assisted reproduction agreement disagree, courts are forced to determine the legal parentage of the children on a case-by-case basis.¹⁴⁴ As such, it is entirely unclear how enforceable such contracts would be in these states.¹⁴⁵ The resulting lack of uniformity and unpredictability creates a state of legal limbo for parties to any such agreements in the future. Figure 3 below shows the twenty-one states that take the silence approach to the issue of surrogacy.

¹⁴¹ Zeigler, 25.

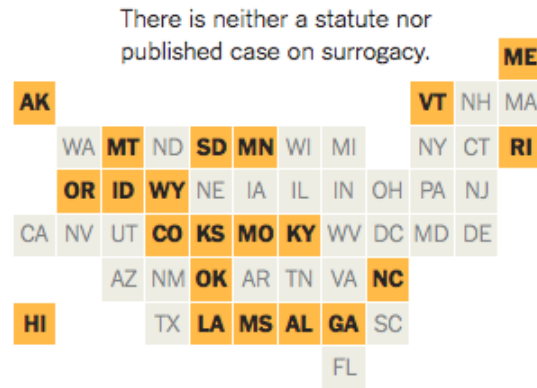
¹⁴² Rao, 23.

¹⁴³ Rao, 23.

¹⁴⁴ Botts, Eastwood, Nestor, 7.

¹⁴⁵ Arshagouni, 821.

Figure 3: Silent States



Source: Creative Family Connections LLC

Creative Family Connections. Where States Stand on Surrogacy, in Tamar Lewin, “Surrogates and Couples Face a Maze of Laws, State by State,” *New York Times*. Sept. 14, 2014. Web

States Where Surrogacy Agreements Are Void

In five states, surrogacy contracts are void and unenforceable. Arizona and Indiana invalidate all surrogacy agreements by statute.¹⁴⁶ In addition to declaring surrogacy agreements void, some jurisdictions also impose civil or criminal penalties. The District of Columbia imposes a civil penalty up to \$10,000 and a criminal penalty of up to one year imprisonment on anyone who facilitates a surrogacy contract.¹⁴⁷ Additionally, New York Code §8-122 declares unequivocally that “surrogate parenting contracts are hereby declared contrary to public policy of this states, and are void and unenforceable.” In effect, New York imposes a penalty of up to \$500 on anyone entering into a surrogacy agreement and a civil penalty of up to \$10,000 for facilitating a surrogacy agreement in exchange for compensation.¹⁴⁸ Further, anyone in New York who assists in arranging a surrogacy contract after already being subject to a civil penalty is

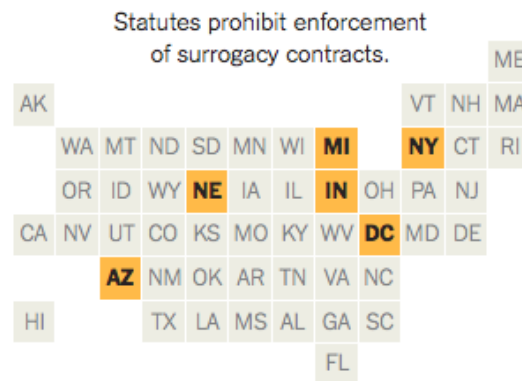
¹⁴⁶ Ariz. Rev. Stat. Ann. § 25-218 ({2007}), Ind. Code § 31-20-1-1 to 20-1-3.

¹⁴⁷ D.C. Code §16-402(b) ({2001}).

¹⁴⁸ N.Y. Dom. Rel. Law § 123(2)(a)-(b) ({2013}).

guilty of a felony.¹⁴⁹ Michigan has the toughest penalties for entering into or facilitating a surrogacy contract. It imposes a fine of up to \$10,000 and up to one year imprisonment for entering into a surrogacy contracts and a fine of up to \$50,000 and up to 5 years imprisonment for anyone compensated for facilitating a surrogacy contract.¹⁵⁰ Below, in Figure 4, the map portrays which five states are the most prohibitive.

Figure 4: Prohibitive States



Creative Family Connections. Where States Stand on Surrogacy, in Tamar Lewin, “Surrogates and Couples Face a Maze of Laws, State by State,” *New York Times*. Sept. 14, 2014. Web

These laws seem to be ever changing and such staunch opposition could be attributed to the fact that surrogacy remains a political third rail, drawing resistance from anti-abortion groups, opponents of same-sex marriage, the Roman Catholic Church, some feminists, and those who see surrogacy as an experiment that could have unforeseen long-range effects.¹⁵¹ Jennifer Lahl, president of the Center for Bioethics and Culture in California is one of the strongest opponents of surrogacy and has publicly stated that she sees the practice as rife with risk. “Informed consent is not really possible in a relatively new field,” she said. “This is part of the American entrepreneurial approach where we design things, put them out there, they can be

¹⁴⁹ N.Y. Dom. Rel. Law § 123(2)(a)-(b) ({2013}).

¹⁵⁰ Mich. Comp. Laws Ann. §722.859.

¹⁵¹ Lewin.

dangerous, and then have to ratchet them back to add safety limits. I see assisted reproductive technology, which is relatively new, as a space where we're starting to see the harms."¹⁵² Additionally, there are numerous ethical arguments that also might explain why some legislators have decided to impose harsh penalties to dissuade people from participating in a surrogacy agreement. A full discussion of the ethical issues is beyond the scope of this research, however, it is important to understand these opposing perspectives since not all states are moving in a progressive direction. For example, recently in Kansas there was proposed legislation that would have imposed a criminal penalty on those entering into a surrogacy contract. The proposal's hearing was ultimately packed with surrogacy supporters, but those who testified against surrogacy brought forth the claims of exploitation, argued that there can be no such thing as informed consent in these agreements and that America was creating a lower, "breeder" class.¹⁵³

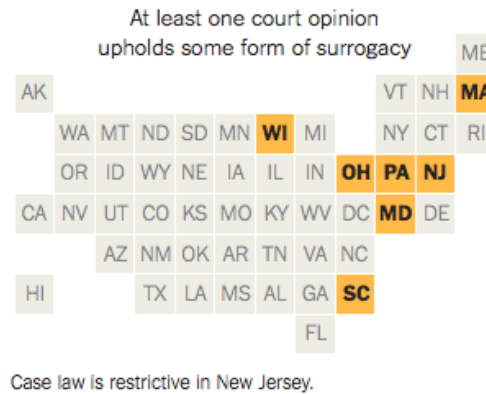
Slight Mention in Case Law

In states where the legislature passed no law, state courts were presented with cases in which they had to decide whether surrogacy was legal and enforceable or was not. Seven states have at least one court opinion upholding some form of surrogacy, as seen in Figure 5 below. In such states where courts are left to decide questions about surrogacy, two very common disputes arise from intended parents' requests to be issued a pre-birth order and, on occasion, even over custody of the child. Outcomes can even vary by state jurisdiction, adding to the cost, stress and unpredictability of these arrangements. Many scholars argue that leaving such delicate situations for the courts to decide is a terrible way to handle the situation, especially because so little precedent exists for them to follow. The result is the never-ending patchwork of state laws.

¹⁵² Lewin.

¹⁵³ Lewin.

Figure 5: States With Existing Case Law



Creative Family Connections. Where States Stand on Surrogacy, in Tamar Lewin, “Surrogates and Couples Face a Maze of Laws, State by State,” *New York Times*. Sept. 14, 2014. Web.

The most notorious example is the aforementioned New Jersey case *In re Baby M*. In this case, the New Jersey Supreme Court ruled in favor of a traditional surrogate, declaring that her maternal rights could not be terminated against her will despite the arguments put forth by the intended parents. In recent cases, New Jersey Courts have not been swayed that Baby M should be distinguishable from gestational surrogacy agreements. In *A.G.R. v. D.R.H. (2009)*, a gay male couple residing in New Jersey entered into a gestational surrogacy contract with D.R.’s sister, A.G.R.¹⁵⁴ After giving birth to twins, with no genetic relation to herself, A.G.R. filed suit to retain parental rights and to void the contract she had entered into with D.R. and S.H. The couple moved for a summary judgment, claiming that because A.G.R. had no genetic link to the children that the case was distinguishable from Baby M. The Defendants relied on cases from other states, including *Johnson v. Calvert* but the Court reaffirmed its position that the public policy considerations of Baby M were correct and stated that Baby M applies to all surrogacy

¹⁵⁴ Conklin, Caitlin. "Simply Inconsistent: Surrogacy Laws in the United States and the Pressing Need for Regulation." *Women's Right Law Reporter* 35 (Fall 2013): 67-94
<http://www.lexisnexus.com.ezproxy.trincoll.edu/hottopics/lnacademic/?verb=sf&sfi=AC07STJrnlsSrch>
 (Accessed April 19, 2016).

agreements, not just traditional ones.¹⁵⁵ The Court went on to write that public policy in California and New Jersey are not the same and, therefore, the case could not apply. Ultimately, the Court held that A.G.R. would retain her parental rights and that the contract was void.

Another example of how state court is an inadequate forum to resolve issues concerning surrogacy without legislative guidance is the Massachusetts case *Culliton v. Beth Israel Deaconess Medical Center*. In this case, the commissioning parents entered into a contract with the surrogate mother than involved compensation to the surrogate in return for physical and legal custody of the resulting child.¹⁵⁶ The parents asked a Family and Probate Court judge to issue an order of pre-birth parentage, but he denied the request.¹⁵⁷ The judge based his decision on his interpretation of adoption and paternity statutes, which disallow a declaration of adoption parentage before the birth of the child.¹⁵⁸ Later on, the Massachusetts Supreme Court declined to use adoption statutes as they could not adequately apply to surrogacy contracts. In fact, the Court noted in its *Culliton* decision how important it was for these inadequacies to be addressed by stating the “legislature is the most suitable forum to deal with the questions involved in this case, and other questions as yet unlitigated, by providing a comprehensive set of laws that deal with the medical, legal, and ethical aspects of these practices.”¹⁵⁹ The Court noted that new protocols need to be considered with gestational surrogacy arrangements but ultimately upheld the contract and gave the commissioning parents legal custody of the children.¹⁶⁰

¹⁵⁵ Conklin, 75.

¹⁵⁶ *Culliton v. Beth Israel Deaconess Med. Ctr.*, 756 Mass.2d 1133, 1135 (2001)

¹⁵⁷ Luckey, 234.

¹⁵⁸ Luckey, 235.

¹⁵⁹ *Culliton*, 756 Mass.2d at 74.

¹⁶⁰ Luckey, 235.

In these cases from both New Jersey and Massachusetts courts, the court was forced to look at statutes already enacted and try to apply them to a gestational surrogacy contract. The legal consequences in states such as New Jersey and Massachusetts include that the intended parents and surrogates do not have defined legal rights and responsibilities under the law. This has led to a tremendous amount of forum shopping as couples look for states that have a higher degree of predictability and favorability. Without statutory guidance for the courts to use, along with the possibility that contracts will be voided in any given jurisdiction, there is an increased potential for exploitation and coercion of all parties to surrogacy agreements.¹⁶¹ In general, where state legislatures have adopted surrogacy regulations the governing rules are clearer and much more detailed than in jurisdictions where courts, unguided by legislation, have had to formulate surrogacy law by deciding the few cases presented to them.¹⁶²

Conclusion

All in all, although the science and economy of ART is growing, the laws regulating the practice of surrogacy are almost nonexistent, to the detriment of not only the surrogates and the parents, but also, most importantly, the children created through the process. Additionally, the utter lack of consistency artificially limits the supply of surrogacy agencies, medical specialists, and gestational surrogates, thereby further increasing costs.¹⁶³ Attempts have been made to improve the system but none go far enough to ensure that each individual party to the agreement will be fully protected and aware of the potential outcomes. A more uniform state-by-state

¹⁶¹ Luckey, 235.

¹⁶² Field, Martha. "Compensated Surrogacy in the Age of Windsor." *Washington Law Review* 89 (December 2014): 1155- 1184
<http://www.lexisnexis.com.ezproxy.trincoll.edu/hottopics/lnacademic/?verb=sf&sfi=AC07STJrnlsSrch>
(Accessed April 19, 2016).

¹⁶³ Arshagouni, 808.

approach would eliminate the confusion, ambiguity, and uncertainty that currently exist in the provision of gestational surrogacy services.¹⁶⁴

¹⁶⁴ Arshagouni, 845.

Chapter 3.
The Consequences of Failing to Provide Legal Guidance

Today science is able to create life for those who desire a family, but are restricted by uncontrollable forces of nature. I reiterate that given the growing prevalence of surrogacy as a serious option for infertile couples, the lack of legislative action is alarming. This chapter seeks to investigate the consequences of failing to fully regulate surrogacy and the booming industry surrounding it. The lack of governmental guidance over such a delicate process has numerous negative consequences for the system itself and those involved. Looking into these highly relevant issues will inform my discussion about the best possible solutions.

Consequences of Failing to Provide Comprehensive Surrogacy Laws

The Crazy Quilt

As previously discussed, state legislators have failed to keep pace with the revolution in assisted reproductive technology (ART), creating an inconsistent legal landscape. With the current “crazy quilt of laws” intended parents and surrogates find themselves wrestling with a surrogacy system that is extremely daunting to navigate. Each individual state has a different way of handling surrogacy and many of them have nothing to say at all. While most states leave it to the courts to rule on the enforceability of surrogacy contracts, courts are ill-equipped to appropriately set policy on such a complicated issue.¹⁶⁵ The lack of consistency makes surrogacy a riskier endeavor than it need be. Even in states with more liberal views, intended parents remain unsure about many aspects of their agreements. Secondly, the lack of regulation forces intended parents and surrogates to forum shop until they find an arrangement that can be made in a state with favorable laws.

¹⁶⁵ Council for Responsible Genetics, *Surrogacy in America*, by Magdalina Gugucheva, (Cambridge, MA, 2010), 1-40.
<http://www.councilforresponsiblegenetics.org/pageDocuments/KA EVEJ0A1M.pdf> (Accessed April 16, 2016).

Price

Not only is the legal landscape of surrogacy inconsistent, but another fundamental flaw with the current system is that the cost of surrogacy in the United States is often too expensive for most infertile couples. In fact, the high cost of assisted reproductive services is arguably the most conspicuous feature of this process. From the very beginning, the costs associated with ART treatment in general are often over \$10,000.¹⁶⁶ Further, according to RESOLVE a cycle of IVF costs approximately \$8,158 plus \$3,000 to \$5,000 for medications.¹⁶⁷ And it is important to note that it frequently takes multiple cycles to achieve pregnancy, with success rates decreasing with each try. Now, for those who cannot overcome their medical issues using ART, and are wholly unable to become pregnant or carry a pregnancy to term but would like to consider surrogacy, the costs can quickly become much higher. It is estimated that a surrogacy arrangement for one child costs around \$100,000 to \$150,000 in the United States.¹⁶⁸ Additionally, there has been no uniform pricing or price resolutions proposed to curb the commodification of these procedures.¹⁶⁹ Because of the prohibitive costs and inconsistent laws it is not uncommon for couples to turn towards less developed countries emerging as international surrogacy centers.

¹⁶⁶ Spar, Debora, and Anna M. Harrington. "Building a Better Baby Business." *Minnesota Journal of Science and Technology* 10, No. 1 (2009): 53-65. (Accessed April 19, 2016)
http://conservancy.umn.edu/bitstream/handle/11299/155696/1/ahc_asset_366020.pdf

¹⁶⁷ Spar, 46.

¹⁶⁸ Richards, Brianne. "'Can I Take the Normal One?' Unregulated Commercial Surrogacy and Child Abandonment." *Hofstra Law Review* 44 (2015): 201- 235
http://www.hofstralawreview.org/wp-content/uploads/2015/12/DD.1.Richards.final2_.pdf

¹⁶⁹ Pietrzak, Anetta. "The Price of Sperm: An Economic Analysis of the Current Regulations Surrounding the Gamete Donation Industry." *Journal of Law & Family Studies* 14 (2012): 121-35
<http://epubs.utah.edu/index.php/jlfs/article/viewFile/636/457> (Accessed April 1, 2016).

Discrepancies in Health Care Policies

Lack of guidance pertaining to surrogacy extends beyond enforcement of surrogacy contracts and into health care policies as well. Health insurance guarantees that an individual will not have to bear the entire burden of his/her health care expenses. But in the case of infertility, the majority of patients assume the responsibility of covering the costs of treatment according to RESOLVE, a national infertility association. In 1992, the American Fertility Society and The American College of Obstetricians and Gynecologists recognized that infertility is a disease stemming from the abnormal function of the reproductive system.¹⁷⁰ Despite this recognition, there has been a general lack of willingness to include infertility treatment in health insurance policies. And, while some states have elected to enact legislation that requires health insurance companies to cover at least a portion of infertility treatments, Congress has not acted to mandate funding of treatment under health insurance policies.¹⁷¹ Thus all regulation remains to be passed on a state-by-state basis.

Thus, for the purposes of this research, health care is an important concern for the legislature to address because couples and gestational mothers are turning to insurance companies to absorb the expenses that go along with surrogacy.¹⁷² The aforementioned ABA Model Act included the requirement that adequate provisions be made for “all reasonable health-care expenses associated with the gestational agreement until the birth of the child.”¹⁷³ But no state has adopted this model.

¹⁷⁰ Hawkins, 207

¹⁷¹ Preisler, Andrea. "Assisted Reproductive Technology: The Dangers of an Unregulated Market and the Need for Reform." *DePaul Journal of Health Care Law* 15, No. 2 (January 2014): 213-36
<http://via.library.depaul.edu/cgi/viewcontent.cgi?article=1016&context=jhcl> (Accessed April 19, 2016).

¹⁷² Luckey, 221.

¹⁷³ ABA Model Act Governing Assisted Reproductive Technology §703(2)(d) (February 2008),
<http://www.abanet.org/family/committees/artmodelact.pdf>

Additionally, the Family Act is a bill that sought to create a tax credit for the out-of-pocket costs associated with in vitro fertilization and fertility preservation. This act was introduced in the U.S. Senate by Senator Kirsten Gillibrand (D-NY) and in the U.S. House of Representatives by Congressman John Lewis (D-GA) in May, 2013 and acknowledges that many couples that face infertility often have to choose between their desire to establish a family and their future financial well-being. The bill was first introduced in 2011 during the 112th Congress but did not pass. It was re-introduced in the 113th Congress but it failed once again and has not been again re-introduced in the House or Senate at this time. The Family Act would help thousands of people access medical treatment for infertility that otherwise would be unavailable to them due to lack of coverage. Major advocacy groups such as RESOLVE continuously support the bill and take strides to help it get passed and made into law.

Currently, only a few states have addressed the necessity of health plans to include infertility treatments.¹⁷⁴ In fact, according to the National Conference of State Legislatures, fifteen states have passed laws that require insurers to either cover or offer coverage for infertility diagnosis and treatment.¹⁷⁵ The following is a summary of statutes from the states that have addressed infertility treatments in their insurance conditions that has been compiled by the National Conference of State Legislatures using information gathered by the American Society for Reproductive Medicine (ASRM) and the Centers for Disease Control and Prevention:¹⁷⁶

Arkansas: Requires accident and health insurance companies to cover in vitro fertilization.¹⁷⁷

¹⁷⁴ Luckey, 222.

¹⁷⁵ Information compiled by the National Conference of State Legislatures and gathered by the American Society for Reproductive Medicine (ASRM) and the Centers for Disease Control and Prevention

¹⁷⁶ National Conference of State Legislature, *State Laws Related to Insurance Coverage for Infertility Treatment*, Washington D.C., NCSL, 2014 <http://www.ncsl.org/default.aspx?tabid=14391>

¹⁷⁷ Ark. Code Ann. §23-85-137, 23-86-118 ({1987, 2011})

California: Requires health care coverage for infertility, but not in vitro fertilization. Infertility may refer to the inability to carry a pregnancy to term for a year or more. Infertility treatment refers to diagnosis and tests, medication, surgery and gamete intrafallopian transfer.¹⁷⁸

Connecticut: Requires health insurance to provide coverage for medically necessary expenses in the diagnosis and treatment of infertility- including in vitro fertilization procedures.¹⁷⁹

Hawaii: Requires all accident and insurance policies that provide pregnancy-related benefits to also include a one-time only benefit for outpatient expenses arising from in vitro fertilization procedures. In order to qualify for in vitro fertilization procedures, the couple must have a history of infertility for at least five years or if the infertility is due to a medical condition.¹⁸⁰

Illinois: If the policy provides pregnancy-related benefits, it must provide coverage for the diagnosis and treatment of infertility. This includes several types of ART.¹⁸¹

Louisiana: Prohibits the exclusion of coverage for the diagnosis and treatment of a medical condition otherwise covered by the policy, contract, or plan, solely because the condition results in infertility. The law does not require insurers to cover fertility drugs, in vitro fertilization or other assisted reproductive techniques, reversal of a tubal ligation, a vasectomy, or any other method of sterilization.¹⁸²

Maryland: Prohibits certain health insurers that provide pregnancy-related benefits from excluding benefits for all outpatient expenses arising from in vitro fertilization procedures performed. An insurer may limit coverage to three in vitro fertilization attempts per live birth, not to exceed a maximum lifetime benefit of \$100,000. The law clarifies that an insurer or employer may exclude the coverage if it conflicts with the religious beliefs and practices of a religious organization, on request of the religious organization. Regulations that became effective in 1994 exempt businesses with 50 or fewer employees from having to provide the IVF coverage.¹⁸³

Massachusetts: Require general insurance policies and other health organizations that provide pregnancy-related benefits to also provide coverage for the diagnosis and treatment of infertility, including in vitro fertilization.¹⁸⁴

¹⁷⁸ Cal. Ins. Code § 10119.6 ({2011}).

¹⁷⁹ Conn. Gen. Stat § 38a-509, -536 ({1989, 2005})

¹⁸⁰ Haw. Rev. Stat. §§ 431:10A-116.5, 432.1-604 ({1989, 2003})

¹⁸¹ 215 ILC 5/356m ({2016})

¹⁸² La. Stat. Ann. § 22:1036 ({2001})

¹⁸³ Md. Ins. Code Ann. § 15-810 ({2000})

¹⁸⁴ Mass. Ann. Laws ch. 175, § 47H (Lexis Nexis {2008}); ch. 176A, § 8K; ch. 176B, §4J, ch. 176G, § 4; 211 Mass. Code Regs 37.00 ({2010})

Montana: Requires health maintenance organizations to provide health services on a prepaid basis; including infertility services.¹⁸⁵

New Jersey: Requires health insurers to provide coverage for medically necessary expenses incurred in diagnosis and treatment of infertility, including medications, surgery, in vitro fertilization, artificial insemination, and several types of ART.¹⁸⁶

New York: Prohibits individual and group health insurance policies from excluding coverage for certain medical expenses that are otherwise covered by the policy solely because the medical condition results in infertility. The laws were amended in 2002 to require certain insurers to cover infertility treatment for women between the ages of 21 and 44 years. The laws exclude coverage for in vitro fertilization, gamete intrafallopian tube transfers and zygote intrafallopian tube transfers.¹⁸⁷

Ohio: Requires health maintenance organizations (HMOs) to provide basic health care services, which include infertility services, when medically necessary.¹⁸⁸

Rhode Island: Requires any contract or policy of health insurance and health maintenance organizations to provide coverage for medically necessary expenses for the diagnosis and treatment of infertility, including coverage for IVF procedures.¹⁸⁹

Texas: Requires that all health insurers offer and make available coverage for services and benefits for expenses incurred or prepaid for outpatient expenses that may arise from in vitro fertilization procedures. In order to qualify for in vitro fertilization services, the couple must have a history of infertility for at least five years or have specified medical conditions resulting in infertility. The law includes exemptions for religious employers.¹⁹⁰

West Virginia: Requires health insurers to cover basic health care services, including infertility services.¹⁹¹

The information above demonstrates how medical insurance coverage for infertility treatments is sparse and inconsistent at the State level. While these fifteen states require some form of

¹⁸⁵ Mont. Code Ann. §33-31-102 ({2011})

¹⁸⁶ N.J. Stat. Ann. §17:48-6x; N.J. Stat. Ann. §17:48-6x17:48A-7w; N.J. Stat. Ann. §17:48-6x 17:48E-35.22; N.J. Stat. Ann. §17:48-6x 17B:27-46.1x. ({2001})

¹⁸⁷ N.Y. Ins. Law § 3216 (13); § 3221(6); §4303(a)(1)(E). ({1990, 2002, 2011})

¹⁸⁸ Ohio Rev. Code Ann. § 1751.01 ({1991})

¹⁸⁹ R.I. Gen. Laws § 27-18-30, § 27-19-23, § 27-20-20 and § 27-41-33 ({1989, 2007})

¹⁹⁰ Tex. Insurance Code Ann. § 1366.001 et seq. (1987, 2003)

¹⁹¹ W. Va. Code § 33-25A-2 ({1997})

coverage of ART, only ten of them mandate coverage of IVF, which is the most fundamental medical component of the surrogacy process. In fact, the language of the California, New York, and Louisiana statutes explicitly allows IVF to be excluded from coverage. Further, Louisiana law “Prohibits the exclusion of coverage for the diagnosis and treatment of a correctable medical condition, solely because the condition results in infertility,” but it “does not require insurer to cover fertility drugs, IVF or other assisted reproductive techniques.”¹⁹² Limited insurance coverage contributes to the tendency for fertility care to operate more as a business than other areas of medicine, with market forces instead of regulatory oversight shaping the parameters of practice.¹⁹³

As mentioned, surrogacy can become extremely expensive. This is problematic because data has shown that states without insurance coverage have the highest number of embryos transferred per IVF cycle and the highest number of high-order multiple births (triplets or more).¹⁹⁴ The underlying assumption is that the patients’ financial burden may lead to a transfer of more embryos in order to increase the chances of success in just one cycle. If patients have no insurance coverage to help with the costs, they may only be able to afford one or two treatment cycles. If, on the other hand, IVF is covered by an insurance mandate like those existing in a handful of states, physicians and patients can make decisions that are most medically

¹⁹² La. Stat. Ann. § 215.23 ({2001})

¹⁹³ Lyerly, Anne. "Marking the Fine Line: Ethics and the Regulation of Innovative Technologies in Human Reproduction." *Minnesota Journal of Science and Technology* 11, No. 2 (2010), 685-711 (Accessed April 20, 2016).

<http://scholarship.law.umn.edu/cgi/viewcontent.cgi?article=1173&context=mjlst>

¹⁹⁴ American Society for Reproductive Medicine, *Oversight for Assisted Reproductive Technologies*, Washington D.C., American Society for Reproductive Medicine, 2010, 8
[http://www.reproductivefacts.org/uploadedFiles/Content/About_Us/Media_and_Public_Affairs/OversiteOfART%20\(2\).pdf](http://www.reproductivefacts.org/uploadedFiles/Content/About_Us/Media_and_Public_Affairs/OversiteOfART%20(2).pdf)

appropriate.¹⁹⁵ Additionally, as will be discussed later in this chapter, insurance coverage could also promote and strengthen existing oversight and quality controls by requiring adherence to ASRM guidelines or performance of ART procedures only at clinics to SART standards.¹⁹⁶

Inequity

In turn, another unintended consequence of not having comprehensive programs, uniform pricing, or inclusive health care options is vast inequity. Time and time again scholars mention inequity when considering the current framework of surrogacy and how it is practiced in actuality. Inevitably, with such high costs and without the support of insurance companies, one could see how surrogacy is painted as being only for those who have the resources to pay for it. Only a fortunate few can afford to spend \$50,000, much less \$100,000, in order to have a chance at a baby.¹⁹⁷ Many couples are excluded from the “baby business” from the outset, and many more find themselves burdened by the huge expenses they accumulate on the way to either parenthood or exhaustion. Today some non-profit groups like the InterNational Council for Infertility Information Dissemination (INCIID) are tackling the issue of inequity by providing IVF scholarships for those in need.¹⁹⁸ Others like RESOLVE are fighting for more expansive insurance coverage. However, the current landscape of ART in the United States remains largely the province of the rich, or at least the well-to-do.¹⁹⁹

¹⁹⁵ Harlow, Jain T., “Uniform Insurance Coverage and Outcomes of In Vitro Fertilization” *New England Journal of Medicine* (2002): 661-66

¹⁹⁶ *Oversight of Assisted Reproductive Technology*, 11

¹⁹⁷ Spar, 45.

¹⁹⁸ Spar, 50.

¹⁹⁹ Spar, 50.

Pursuing Surrogacy Despite the Obstacles

United States

Another fault in failing to fully regulate the process is that people are continuing to explore surrogacy as a viable option for family building regardless of the status of the laws. Even in states where surrogacy is prohibited and criminalized people continue to enter into surrogacy agreements in pursuit of having a biological child. States that have passed legislation that prohibits and punishes parties involved in surrogacy agreements have simply deprived intended parents and surrogates from having defined rights under the law and created jurisdictional forum shopping, where infertile couples and surrogates go to other states that have more favorable laws.²⁰⁰ Offering some kind of a “well oiled” system would help to control and regulate the process because one would have to go to an American medical facility to have access. Given the current complex structure of the surrogacy industry, we know of cases where there is a complete lack of oversight because the arrangement took place outside of any legal boundaries within the United States. The legal prohibitions and uncertainties found in many states, combined with costs up to \$150,000 per child, result in many infertile couples looking internationally, particularly to India, to find surrogacy services. Rudy Rupak, co-founder and president of PlanetHospital, just one medical tourism agency in the U.S., said he expected to send at least 100 couples to India in 2008 for surrogacy, up from 25 in 2007, the first year he offered the service.²⁰¹

²⁰⁰ Patton, Brock A. "Buying a Newborn: Globalization and the Lack of Federal Regulation of Commercial Surrogacy Contracts." *UMKC Law Review* (Winter 2010): 507- 533
<http://www.lexisnexis.com.ezproxy.trincoll.edu/hottopics/lnacademic/?verb=sf&sfi=AC07STJrnlsSrch>

²⁰¹ Gentleman, Amelia, “Foreign Couples Turn to India for Surrogate Mothers.” *New York Times*, March 4, 2008.
<http://www.nytimes.com/2008/03/04/world/asia/04iht-mother.1.10690283.html>

International Solutions: Outsourcing Gestational Surrogacy

Not having comprehensive regulation of this medical issue increases the probability that people will resort to methods that fall below the radar. In an attempt to avoid the legal prohibitions and uncertainties found in many states, as well as to seek a less costly option, many intended parents travel overseas to find surrogacy services. “Fertility tourism” has become a multi-billion dollar industry in countries such as India, Ukraine and Thailand.²⁰² Dr. Sudhir Ajia, co-founder of a surrogacy clinic in India, said that about ninety-five percent of his clients are international, and thirty to forty percent are American.²⁰³ It quickly became a popular option for individuals who don’t have sufficient health insurance but have the ability to travel. India emerged as a major center for low-cost surrogacy because of its skilled doctors, medical infrastructure, and vast population of women willing to be surrogates.²⁰⁴ The fee paid by the intended parents for this service costs between \$18,000 and \$30,000, which is roughly a third of the typical price in the United States.²⁰⁵ The surrogates earn around \$5,000 to \$8,000 for their service, which is a substantial amount of money in their country, and allows them to buy homes for their families or educate their children.²⁰⁶

However, less than one year ago, in October of 2015, the Indian Council of Medical Research, a government-appointed body, instructed the country’s fertility clinics to stop providing surrogacy services for clients from abroad. The move is a part of a government effort to impose tighter limits on a growing unregulated industry that critics argue exploits poor, local

²⁰² Richards, 210.

²⁰³ Richards, 209.

²⁰⁴ Richards, 210.

²⁰⁵ Richards, 210.

²⁰⁶ Richards, 210.

women.²⁰⁷ On the other hand, those who oppose this decision argue that banning surrogacy for feigners would do more harm than good. “Our apprehension and fear is that the whole business will go underground,” said Manasi Mishra, who heads the research division at the New Delhi based Center for Social Research.²⁰⁸ Even more so, Thailand also was a popular low-cost alternative to the United States as the industry originally benefited from regulations in India, which prohibited same-sex couples from hiring surrogate mothers. But, like India, Thailand has recently imposed a similar ban on surrogacy services for foreigners after a string of scandals shed light on the flaws of the largely unregulated industry.²⁰⁹

The multiple bans on international surrogacy services underscores how international surrogacy can be problematic and fraught with risk. While only time can tell how the market will react to the ban on foreign clients in India and Thailand, it can be predicted that people will flock to countries where the demands of surrogacy can be met such as Ukraine or Mexico where no such regulations exist. Surrogacy services are by no means inherently exploitative. However, the risk of exploitation is very real. While these ethical dilemmas are beyond the scope of this particular research, the possibility of exploitation must be briefly addressed. The factors that could potentially lead to exploitation are more prevalent in countries where poverty is more widespread and women possess less political, economic, and social control over their own

²⁰⁷ Sugden, Joanna, “Foreign Couples in Limbo After India Restricts Surrogacy Services.” *Wall Street Journal*, November 16, 2015

<http://www.wsj.com/articles/foreign-couples-in-limbo-after-india-restricts-surrogacy-services-1447698601> (Accessed April 1, 2016).

²⁰⁸ Najar, Nida, “India Wants to Ban Birth Surrogacy for Foreigners.” *New York Times*, October 18, 2015, <http://www.nytimes.com/2015/10/29/world/asia/india-wants-to-ban-birth-surrogacy-for-foreigners.html>

²⁰⁹ Fuller, Thomas, “Thailand’s Business in Paid Surrogacy May be Foundering in a Moral Quagmire.” *New York Times*, August 26, 2014,

http://www.nytimes.com/2014/08/27/world/asia/in-thailands-surrogacy-industry-profit-and-a-moral-quagmire.html?_r=0

lives.²¹⁰ We have the capacity to ensure that gestational surrogacy services are safe and that legal questions as to the status and relationships among the parties are clear from the outset.²¹¹ However, the complex and prohibitive nature of gestational surrogacy in the United States today only serves to encourage intended parents to travel to countries where gestational surrogacy has fewer legal and social protections.

The Self-Regulating American Surrogacy Industry

When one combines the supply side, which is being driven by the developments in assisted reproductive technology, with the demand side, which has arguably existed since time immemorial, the result is a market.²¹² The dominant market forces in ART include the fertility clinics, the physicians, the pharmaceutical companies, the suppliers, the representative organizations, the embryo laboratories, the gamete middlemen and brokers, and the infertile consumers.²¹³ It is estimated that today's ART industry reaps annual revenues of nearly seven billion dollars, and that figure continues to grow as the use of reproductive technology skyrockets.²¹⁴ These market forces and technological advances all operate in a robust marketplace with minimum state and federal regulatory control.²¹⁵ Therefore, regulatory agencies, such as the CDC and Department of Health & Human Services (DHHS), "are free to develop close and collaborative relationships with the market stakeholders."²¹⁶ Research has

²¹⁰ Arshagouni, 821.

²¹¹ Arshagouni, 821.

²¹² Spar, 46.

²¹³ Preisler, 223.

²¹⁴ Preisler, 223.

²¹⁵ Preisler, 223.

²¹⁶ Reddix-Small, Brenda, "Assessing the Market for Human Reproductive Tissue Alienability: Why Can We Sell Our Eggs But Not Our Livers?" *Vanderbilt Journal of Entertainment and Technology* 643, No. 10 (Spring 2008): 645- 689

<http://www.lexisnexis.com.ezproxy.trincoll.edu/hottopics/lnacademic/?verb=sf&sfi=AC07STJrnlSrch>

made it evident that the lack of uniformity among the states also extends to the policies regarding regulation of the practices of surrogacy clinics themselves. Professional organizations provide the most substantial guidelines for clinics, but these are either non-pervasive or not legally binding²¹⁷ and arguments that this industry is effectively self-regulated fall flat in the face of evidence that suggests otherwise.

Regulation of Procedures for Surrogacy Clinics, or Lack Thereof

In the United States, particularly within those states which expressly permit commercial surrogacy, surrogacy clinics are almost entirely self-regulating businesses.²¹⁸ Providers utilizing exclusively private money to operate are largely free to develop their own rules and procedures governing reproductive technology.²¹⁹ The American Society for Reproductive Medicine (ASRM), a leading advocate for increased ART regulation, does issue lengthy guidelines to its membership, which consists of fertility clinics and sperm banks. However, critics point out, it does not sanction those who are in violation of guidelines.²²⁰ As a result, these guidelines and standards clearly fall short of providing adequate oversight for the protection of participants in innovative procedures. Further, following the guidelines is purely voluntary, and adherence to them is not required for professional certification, which itself is not expressly required and does not hinder participation in the market.²²¹

²¹⁷ "Guiding Regulatory Reform in Reproduction and Genetics." *Harvard Law Review* 120, No. 574 (2006): 575-596 http://www.jstor.org/stable/pdf/40042611.pdf?_=1461210701173 (accessed March 1, 2016).

²¹⁸ Beeson, Diane and Marcy Darnovsky. "Global Surrogacy Practices." *Center for Genetics and Society*. January 16th, 2015. <http://www.geneticsandsociety.org/article.php?id=8305> (Accessed February 8, 2016).

²¹⁹ Preisler, 220.

²²⁰ Ollove.

²²¹ Preisler, 221.

Further, the ASRM and the Society for Assisted Reproductive Technology (SART) created the Reproductive Laboratory Accreditation Program.²²² As an accredited clinic, providers are required to comply with SART and ASRM guidelines. However, this accreditation is ultimately meaningless since neither the ASRM nor SART has the ability to enforce any requirements where even initial participation is voluntary.²²³ While many of the 400-500 clinics offering assisted reproductive technologies in the United States are members of professional organizations such as SART and ASRM and follow clinical and ethical guidelines produced by these organizations, the majority does not.²²⁴ A Centers for Disease Control and Prevention study found that only 20% of ART programs follow such guidelines.²²⁵ Furthermore, I will reiterate that the associations do not have authority to sanction those ART providers in violation of the guidelines, nor do they have an independent auditing mechanism to detect such violations.²²⁶ Thus, these clinics are essentially self-policing and lack any kind of authoritative oversight. Furthermore, a 2009 article published in *Fertility and Sterility* specifically surveyed embryo transfer practices in the United States and found that 94 percent of the clinics surveyed reported routinely following ASRM embryo transfer guidelines, but 55 percent of these same clinics admitted that they would deviate from the guidelines based upon the patient's request.²²⁷ And

²²² Preisler, 221.

²²³ Preisler, 221.

²²⁴ Riggan, Kristen. "Regulation (or Lack Thereof) of Assisted Reproductive Technologies in the U.S. and Abroad." *The Center for Bioethics and Human Dignity*. March 4, 2011.

<https://cbhd.org/content/regulation-or-lack-thereof-assisted-reproductive-technologies-us-and-abroad>

²²⁵ Centers for Disease Control and Prevention, American Society for Reproductive Medicine, Society for Assisted Reproductive Technology, *2006 Assisted Reproductive Technology Success Rates: National Summary and Fertility Clinic Reports* (Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2008).

²²⁶ Preisler, 221.

²²⁷ Rao, Radhika. "How (Not) to Regulate ARTs: Lessons from Octomom." *Albany Law Journal*. (March 2011): 313- 321.

<http://www.albanylawjournal.org/Documents/Articles/21.2.313-Rao.pdf>

another 75 percent said they would deviate for patients with previously failed IVF cycles.²²⁸ This evidence suggests that self-regulation will not work because physicians fail to follow their own guidelines. The financial incentives to deviate from the guidelines are enormous as clinics implant more embryos in order to inflate their success rates.

Further proof of this is exemplified by the notorious California case of Nadya Suleman, also known as “Octomom.” In this case, Dr. Michael Kamrava implanted *twelve* embryos at the request of his patient, Ms. Suleman.²²⁹ Ultimately, nationwide public outcry about the news of the birth of octoplets lead to an investigation of Dr. Kamrava followed by dismissal from the ASRM and the eventual loss of his California medical license. However, not all cases of gross negligence spark a nationwide controversy over medical ethics and warrant a thorough investigation. Studies show that this kind of conduct is not an isolated departure from the guidelines, but is actually a relatively common occurrence.²³⁰ In fact, it is alleged that many physicians often engage in multiple transfers in the hopes of increasing their success rates and attracting more clients.

Of all of the disadvantages of the lack of regulation on the industry, none are as severe as the lack of restrictions on the number of children who can be produced by any single IVF cycle.²³¹ ART produces approximately 40% of the triplet pregnancies in the United States. While some countries have introduced regulations with limitations on the number of embryos transferred, the United States has not. Professional societies have actively advocated for

²²⁸ Rao, 315.

²²⁹ Rao, 316.

²³⁰ Rao, 316.

²³¹ Ollove, Michael. “Lightly Regulated In Vitro Fertilization Yields Thousands of Babies Annually.” *The Washington Post*, April 13, 2015.
https://www.washingtonpost.com/national/health-science/lightly-regulated-in-vitro-fertilization-yields-thousands-of-babies-annually/2015/04/13/f1f3fa36-d8a2-11e4-8103-fa84725dbf9d_story.html

limitations on the number of embryos transferred based on evaluation of the evidence regarding number of embryos transferred, multiple pregnancy rates, and individual patient clinical circumstances.²³² However, oversight requires funding and mechanisms for enforcement. The current development and oversight of ART in the United States reflects a great diversity of institutions, organizations, and perspectives on a federal, state, professional and private level. However, no single body is able to functionally represent the interests and fully protect the well being of the individuals pursuing ART. Thus, we are left with a system that does not and cannot promise to bring legal action against clinicians engaging in clinical or ethically dubious practice.

Conclusion

While infertility and pregnancy are deeply personal issues that deserve adequate privacy protection, the risk of harm and exploitation demands greater study of this market. Assisted reproductive technology has advanced and flourished in the unregulated market in which it operates. Statistics showing the rapid growth in gestational surrogacy cycles, which are especially concentrated in some states, indicate that surrogacy has become a booming industry and bolster the conclusion that we need regulatory oversight. A 2010 report from the Council for Responsible Genetics explains that the market for surrogate workers has received little attention from health scientists and policymakers. The United States' unwillingness to regulate surrogacy is not without consequence. The current framework of the practice makes surrogacy a journey of uncertainty and also makes it exceptionally expensive. Thus it is crucial that more data be obtained about the size of the market, the individuals involved and the risks they face. In turn, researchers should properly assess the current framework and be able to raise awareness of the issue among constituents and policymakers, and also supply policymakers with adequate

²³² Adamson, David. "Regulation of Assisted reproductive Technologies in the United States." *Family Law Quarterly*, 39, No. 3 (Fall 2005):727-744
http://www.jstor.org/stable/pdf/25740518.pdf?_id=1459973033091

information when implementing proper regulatory safeguards for surrogates, intended parents and the resulting children.

Chapter 4

Policy Recommendation

Uniform State Laws To Guide Surrogacy Agreements: The Fundamentals

Allowing individual states to dictate their respective policies towards surrogacy contracts is both ineffective and problematic. The absence of legal standards makes it extremely difficult for lawyers to advise clients about ART and for judges to resolve disputes that arise out of the use of ART technology, especially in cases involving surrogacy. The California appellate court compellingly articulated the need for clear legal guidance in the written decision of *Buzzanca v. Buzzanca* (1998) when they stated,

“We join the chorus of judicial voices pleading for legislative attention to the increasing number of complex legal issues spawned by recent advances in the field of assisted reproduction. Whatever merit there may be to a fact-driven case-by-case resolution of each new issue, some over- all legislative guidelines would allow the participants to make informed choices and the courts to strive for uniformity in their decisions.”²³³

Guidelines and laws affecting the right to family and privacy are challenging and controversial; however, in this context they are undoubtedly necessary.²³⁴ The United States needs to improve its own regulations by adopting a uniform regulation for every state to follow, which would consequently eliminate the incongruences that exist with the current regulation of surrogacy agreements.²³⁵

Any legislation regarding surrogacy should permit and encourage parties, with the assistance of counsel, to reach a well-defined and clear agreement that satisfies the objectives and needs of each party to the contract. It is the purpose of this chapter to provide a viable legislative suggestion so that surrogacy patients, participants, parents, providers and the resulting children and their siblings can some day have clear legal rights, obligations and protections. As

²³³ *Buzzanca v. Buzzanca*, 61 Cal.App.4th 1410, 1428-29, 72 Cal. Rptr. 280 (Cal.App. 1998).

²³⁴ Preisler, 233.

²³⁵ Luckey, 237.

discussed in Chapter 3, the ABA Model Act provides a flexible framework that aimed to serve as a mechanism to resolve contemporary controversies, to adapt to the need for resolution of controversies that are envisioned but that may have not yet occurred, and to guide the expansion of ways by which families are formed.²³⁶ Article 7 of the original ABA Model Act Governing Assisted Reproductive Technologies, the portion that addresses gestational surrogacy agreements, was proposed as an optional protocol for the states to consider and only enact if they so choose. The ABA Model Act incorporated two separate alternatives; Alternative A is considered the “judicial authorization model” and Alternative B is known as the “administrative model.” Alternative B offers a more streamlined, user-friendly administrative model to establish parentage in surrogacy arrangements.²³⁷

Thus, a slightly modified version of Alternative B of the ABA Model Act, one that caters to the elements that I have stressed throughout my research, inspires the following legislation proposal. The ABA Model Act has comprehensive guidelines for how gestational surrogacy contracts can be managed and enforced. In particular, it does a great job of ensuring that all parties are able to give informed consent by providing eligibility requirements, mandating mental health consultations and requiring independent legal counsel. Additionally, the implementation of this Act would establish clarity in the event of disputes over parentage, procedure, compensation and noncompliance. However, there are a few areas that could be strengthened, particularly in terms of eligibility requirements of the intended parents. I have italicized these in the following Model Act. Additionally, a combination of the Family Act and several state

²³⁶ American Bar Association Model Act Governing Assisted Reproductive Technologies, (Feb. 2008). <http://apps.americanbar.org/family/committees/artmodelact.pdf> (Accessed April 26, 2016).

²³⁷ Kindregan, Charles P., and Steven H. Snyder. “Clarifying the Law of ART: The New American Bar Association Model Act Governing Assisted Reproductive Technology”. *Family Law Quarterly* 42 (2) (2008): 203–29. <http://www.jstor.org.ezproxy.trincoll.edu/stable/25740654>.

insurance mandates has informed my suggestions on infertility health care reform. The Model Act Governing Surrogacy contains the fundamental components of any future state surrogacy legislation that should be incorporated as legally binding law across the country.

Being that sweeping federal legislation on this topic is entirely unforeseeable, I believe that the best way to move forward on the issue is for advocacy groups to unite and urge state policymakers to pass legislation. Ultimately, all fifty states should hold uniform laws to ensure that participants of surrogacy and other forms of ART are fully aware of their rights and obligations and can use the process properly and successfully. While all aspects concerning the hiring of a gestational carrier are critical, this chapter investigates specifically: determining parentage, eligibility requirements, legal representation, breaches of contract, compensation, health insurance and surrogacy clinic regulations.

Achieving Uniformity: A Model Act

Model Act Governing Surrogacy

ARTICLE 01. GESTATIONAL AGREEMENTS

SECTION 01. RIGHTS OF PARENTAGE

1. Except as provided in this Act, the woman who gives birth to a child is presumed to be the mother of that child for purposes of State law.
2. In the case of a gestational carrier arrangement satisfying the requirements set forth in paragraph 3 of this Section:
 - (a) The intended parents shall be the parents of the child for purposes of State law immediately upon the birth of the child;
 - (b) Parental rights shall vest in the intended parent or parents immediately upon the birth of the child;
 - (c) Sole custody of the child shall rest with the intended parent or parents immediately upon the birth of the child; and

(d) Neither the gestational carrier nor her legal spouse, if any, shall be the parent of the child for purposes of State law immediately upon the birth of the child.

3. The parties to a gestational carrier arrangement shall assume the rights and obligations of paragraph 2 of this Section if:

(a) The gestational carrier satisfies the eligibility requirements set forth in paragraph 1 of Section 02;

(b) The intended parent or parents satisfy the eligibility requirements set forth in paragraph 2 of Section 02; and

(c) The gestational carrier arrangement occurs pursuant to a gestational agreement meeting the requirements set forth in Section 03.

SECTION 02. ELIGIBILITY

1. A gestational carrier shall be deemed to have satisfied the requirements of this Act if she has met the following requirements at the time the gestational agreement is executed:

(a) She is at least 21 years of age;

(b) She has given birth to at least one child;

(c) She has completed a medical evaluation relating to the anticipated pregnancy;

(d) She has completed a mental health evaluation relating to the anticipated gestational carrier arrangement;

(e) She has undergone legal consultation with independent legal counsel regarding the terms of the gestational agreement and the potential legal consequences of the gestational carrier arrangement; and

(f) She has, or obtains prior to the embryo transfer, a health insurance policy that covers major medical treatments and hospitalization and the health insurance policy has a term that extends throughout the duration of the expected pregnancy and for 8 weeks after the birth of the child; provided, however, that the policy may be procured by the intended parents on behalf of the gestational carrier pursuant to the gestational agreement.

2. The intended parent or parents shall be deemed to have satisfied the requirements of this Act if he, she, or they have met the following requirements at the time the gestational agreement is executed:

(a) He, she, or they contribute at least one of the gametes that will ultimately result in an embryo that the gestational carrier will attempt to carry to term;

(b) He, she, or they have a medical need for the gestational carrier arrangement as evidenced by a qualified physician's affidavit attached to the gestational agreement;

(c) He, she, or they have completed a mental health evaluation relating to the anticipated gestational carrier arrangement;

(d) He, she, or they have undergone a complete background check, and have a clean criminal record;

(e) He, she, or they have undergone legal consultation with independent legal counsel regarding the terms of the gestational agreement and the potential legal consequences of the gestational carrier arrangement; and

(f) He, she, or they maintain the financial means necessary to provide for the child.

SECTION 03. REQUIREMENTS FOR A GESTATIONAL AGREEMENT.

1. A gestational agreement is enforceable only if:

(a) It meets the contractual requirements set forth in paragraph 2 of this Section; and

(b) It contains at a minimum each of the terms set forth in paragraph 3 of this Section.

2. A gestational agreement shall meet the following requirements:

(a) It shall be in writing;

(b) It shall be executed prior to the commencement of any medical procedures in furtherance of the gestational carrier arrangement (other than medical or mental health evaluations necessary to determine eligibility of the parties pursuant to Section 02 of this Act) :

(i) By a gestational carrier meeting the eligibility requirements of paragraph 1 of Section 02 of this Act and, if married, the gestational carrier's legal spouse; and

(ii) By the intended parent or parents meeting the eligibility requirements of paragraph 2 of Section 02 of this Act. In the event an intended parent is married, both wife and her legal spouse must execute the gestational agreement;

(c) Each of the gestational carrier and the intended parent or parents shall have been represented by separate, independent counsel in all matters concerning the gestational carrier arrangement and the gestational agreement;

(d) Each of the gestational carrier and the intended parent or parents shall have signed a written acknowledgment that he or she received information about the legal, financial,

and contractual rights, expectations, penalties, and obligations of the gestational agreement;

(e) If the gestational agreement provides for the payment of compensation to the gestational carrier, the compensation shall have been placed in escrow with an independent escrow agent prior to the gestational carrier's commencement of any medical procedure (other than medical or mental health evaluations necessary to determine the gestational carrier's eligibility pursuant to paragraph 1 of Section 702 of this Act); and

(f) It shall be witnessed by two (2) disinterested competent adults.

3. A gestational agreement shall provide for:

(a) The express written agreement of the gestational carrier to:

(i) Undergo embryo or gamete transfer and attempt to carry and give birth to the child; and

(ii) Surrender custody of all resulting children to the intended parent or parents immediately upon the birth;

(b) If the gestational carrier is married, the express agreement of her legal spouse to:

(i) Undertake the obligations imposed on the gestational carrier pursuant to the terms of the gestational agreement; and

(ii) Surrender custody of all resulting children to the intended parent or parents immediately upon the birth;

(c) The right of the gestational carrier to utilize the services of a physician of her choosing, after consultation with the intended parents, to provide her care during the pregnancy; and

(d) The express written agreement of the intended parent or parents to:

(i) Accept custody of all resulting children immediately upon birth regardless of number, gender, or mental or physical condition; and

(ii) Assume sole responsibility for the support of the child immediately upon his or her birth.

SECTION 04. NONCOMPLIANCE

Noncompliance occurs when the gestational carrier, her spouse, or the intended parent or parents breach a provision of the gestational agreement or any party to or agreement for a surrogacy arrangement fails to meet any of the requirements of this Act.

SECTION 05. EFFECT OF NONCOMPLIANCE

1. In the event of Noncompliance as defined in Section 04, a court of competent jurisdiction shall determine the respective rights and obligations of the parties to any surrogacy arrangement based solely on evidence of the parties' original intent.

2. There shall be no specific performance remedy available for a breach by the gestational carrier of a gestational agreement term that requires her to be impregnated.

ARTICLE 02. PAYMENT TO DONORS AND GESTATIONAL CARRIERS

SECTION 201. REIMBURSEMENT

1. A donor may receive reimbursement for economic losses resulting from the retrieval or storage of gametes or embryos and incurred after the donor has entered into a valid agreement in a record to be a donor.

2. Economic losses occurring before the donor has entered into valid agreement in a record to be a donor may not be reimbursed, except as provided for in paragraph 3 hereof.

3. Premiums paid for insurance against economic losses directly resulting from the retrieval or storage of gametes or embryos for donation may be reimbursed, even if such premiums have been paid before the donor has entered into a valid agreement in a record, so long as such agreement becomes valid and effective before the gametes or embryos are used in assisted reproduction in accordance with the agreement.

SECTION 202. COMPENSATION

1. The consideration paid to a donor or prospective gestational carrier for her services must be reasonable and negotiated in good faith between the parties.

2. Compensation may not be conditioned upon the purported quality or genome-related traits of the gametes or embryos.

3. Compensation may not be conditioned on actual genotypic or phenotypic characteristics of the donor or of the child.

ARTICLE 03. HEALTH INSURANCE

SECTION 301. INFERTILITY DEFINED

1. For the purposes of health insurance coverage, infertility means:

(a) Resulting from a disease or condition that causes abnormal function of the reproductive system, the inability to:

(i) Conceive after attempts at conception by unprotected sexual intercourse have been made for at least one year; or

(ii) Sustain a pregnancy to live birth; or

(b) The presence of another condition recognized by accepted medical standards as a cause of the inability to achieve or sustain a pregnancy to live birth; or

(c) The desire to achieve pregnancy by means other than sexual intercourse. Insurance coverage provided for (a) and (b) above may not be denied on the basis of this subparagraph.

SECTION 302. ELIGIBILITY/ PATIENT REQUIREMENTS

1. The patient and her spouse must have at least a 2-year history of unexplained infertility OR the infertility must be associated with at least one of the following: MRKH; endometriosis; DES exposure; blocked or surgically removed fallopian tubes that are not the result of voluntary sterilization; abnormal male factors contributing to the infertility.

SECTION 302. COVERAGE

1. Any insurance policy that covers more than 50 people and offers pregnancy-related benefits must also cover the costs related to infertility diagnosis and fertility treatments.²³⁸

2. This includes coverage of out of pocket costs associated with in vitro fertilization (IVF) including medical procedures, prescription medications, professional charges, the transfer of an embryo and other necessary costs.²³⁹

2. Cover out of pocket costs of fertility preservation procedures if the man or woman is diagnosed with cancer and the cancer treatment or disease itself may result in infertility.

3. An entity subject to this section may limit coverage of the benefits required under this section to three in vitro fertilization attempts per live birth, and need not exceed a maximum lifetime benefit of \$100,000.²⁴⁰

²³⁸ *New Jersey Family Building Act, Hearing Before the Senate Health Committee, New Jersey Senate, 209th Legislature, No. 1076, a Bill to Require Health Insurers to Provide Coverage for Medically Necessary Expenses Incurred in Diagnosis and Treatment of Infertility, January 24, 2000, (2001)* <http://www.njleg.state.nj.us/bills/BillView.asp> (Accessed April 25, 2016).

²³⁹ The Family Act, S 881/HR 1851

²⁴⁰ Md. Code. Ann., Ins. § 15-810 ({2000}).

4. The fertility treatments are performed at fertility clinics or medical centers that conform to the guidelines put in place by the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists.²⁴¹

ARTICLE 04. CLINIC REGULATIONS

- (a) The Reproductive Laboratory Accreditation Program created by ASRM and SART must accredit clinics where surrogacy procedures are administered;
- (b) All clinics must diligently follow the guidelines set for by ASRM for ART services, especially the set limitation on the number of embryos allowed to be transferred per IVF cycle;
- (c) Any violation of guidelines will jeopardize the clinic's membership and warrant an investigation and possible sanctions;
- (d) Annual data reports regarding success rates, medical issues and embryo transfers should be submitted to the Center for Disease Control and Prevention (CDC) for further examination.

Reasoning

Legal Clarification of Parentage

The Model Act does a sufficient job of providing a detailed description of the rights of parentage in a gestational surrogacy agreement. As discussed in Chapter 1, the parenting possibilities created by IVF and surrogacy present a host of legal issues. Traditional understandings of parenthood involve biology and marriage but we are shifting into an age of science where such traditional understandings exacerbate existing dilemmas arising from assisted reproductive technologies. Clearly defining that the “intended parents shall be the parents of the child for purposes of State law immediately upon the birth of the child,” helps to avoid conflict and confusion when considering who has a legal claim to the resulting child. Additionally, it eliminates the need for a pre-birth order and judicial involvement. As also previously discussed, this would give the intended parents immediate control over the child's postnatal care and also

²⁴¹ New Jersey Family Building Act, 2001.

http://www.njleg.state.nj.us/2000/bills/pl01/236_.htm (Accessed April 22, 2016).

allow for the names of the intended parents to go on the initial birth records. Furthermore, by determining that the intended parents are, for all intents and purposes, the child's lawful parents, all parties can move forward in full understanding that neither the gestational carrier nor her spouse shall be the parent of the child. Formally adopting an intent based approach to defining parentage allows for the individual, or couple, identified as an intended parents in a surrogacy contract to be treated in law as a natural parent under all circumstances. Establishing this principle into law would eradicate any confusion between the roles of the parties throughout the surrogacy process, from start to finish.

Eligibility Requirements

It is essential to establish various strict requirements that help to carefully monitor who is eligible to legally partake in a surrogacy agreement. In terms of the gestational carrier, it is reasonable to ensure that she meets the conditions of being over twenty-one years of age and that she has already carried at least one pregnancy to term. These preconditions also contribute to guarantee that the surrogate would know what to expect during her future pregnancy, would understand the gravity of the situation and would be able to truly make a fully informed decision. Preconditions involving the contribution of gametes, proof of infertility, mental health evaluation and legal consultations are all critical in guaranteeing a proper and smooth execution of a surrogacy agreement. However, my additions to the eligibility requirements of the intended parents have a more central focus on the well being of the resulting child. Before bringing a baby into the world I believe that there should be a degree of inquiry into the intended parent's finances, backgrounds, and household conditions to ensure that the child will be raised in a safe and nurturing environment.

Guiding Surrogacy Agreements Using Contract Law

The complexity of a gestational surrogacy agreement requires both oversight and enforceability. This thesis has thoroughly demonstrated that state-by-state judicial analysis of gestational surrogacy agreements has generated inconsistent precedent throughout the country.²⁴² Facilitating legal recognition of surrogacy arrangements that comply with clear and specific statutory guidelines would encourage compliance and allow for the process to be truly safe and viable. When exploring workable policy options, Alternative B of the ABA Model Act Governing Assisted Reproductive Technologies is the most feasible model because of its self-executing nature. With the increasing rate of surrogacy agreements and the continued rise of infertility, the judicial pre-approval required by Alternative A is unnecessarily cumbersome.²⁴³ Also, the additional requirements Alternative B imposes on the surrogate ensure that willing, educated, and experienced mothers are able to knowledgeably enter into surrogacy contracts. These requirements decrease the likelihood of litigation after the baby is born by taking steps to ensure that the surrogate mother understands the emotions and risks involved, has the capacity to uphold her end of the agreements, is independently represented, and has insurance coverage.²⁴⁴ It is logical to infer that since this method would be less burdensome on the parties involved, that they would be more inclined to truly follow the guidelines. Also, handling this process through contract law guarantees that once an agreement is binding and neither party can deny its terms.

Further, the Model Act provides a comprehensive outline of the proper procedure to follow and also explicitly states that any agreement that is made improperly is unenforceable. To

²⁴² Mary Lyndon Shanley, "Surrogacy Mothering" and Women's Freedom: A Critique of Contracts for Human Reproduction, 18 J. Women in Culture & Society 618, No. 620 (Spring 1993): 618- 639. http://www.jstor.org/stable/pdf/3174860.pdf?_id=1461694312599 (Accessed April 26, 2016).

²⁴³ Miller, 1386.

²⁴⁴ Miller, 1386.

begin, an enforceable contract requires a voluntary commitment by all contracting parties.²⁴⁵ Therefore, the implementation of this Act would guarantee that parties have sufficient information and resources available to mutually assent to the contractual terms prior to signing. This is further ensured through the provision requiring that the commissioning couple finance a surrogate's independent legal representation. In turn, this would enable her to obtain legal counsel of her choosing, a measure that is central to the validity and fairness of the contract.²⁴⁶ This will decrease the chances for misconduct or impropriety between the surrogate and the intended parents. The ability to provide procedural clarity and ensure the enforceability of surrogacy arrangements is exactly what this process desperately needs.

Breach of Contract

Like any other legally binding document, there must be a provision in place that explains the consequences of failing to abide by the terms of the settlement. Noncompliance is defined in the Model Act as “when the gestational carrier, her spouse, or the intended parent or parents breach a provision of the gestational agreement or any party to or agreement for a surrogacy arrangement fails to meet any of the requirements of this Act.” This section serves as an acknowledgment that the surrogacy arrangement is legally binding and that there are to be repercussions should any given party fail to adhere to his or her end of the agreement. This not only serves to give the intended parents a sense of ease that there cannot be a dispute upon the birth of the child, but it also acts as a safeguard for the surrogate who is guaranteed to be properly reimbursed and compensated for her services. Thus, both parties can proceed with the knowledge that the terms of the agreement are not subject to change. Clearly defining the rules,

²⁴⁵ London, 400.

²⁴⁶ London, 406.

guidelines, and repercussions provide a sense of direction to all parties involved. Finally, there would be no sense of unpredictability for this highly delicate process.

Compensation

Commercial surrogacy contracts provide that the commissioning couple will be responsible for costs the surrogate mother incurs during the course of the pregnancy, such as living expenses, travel expenses, and lost wages.²⁴⁷ It is fully understood that compensation paid to the surrogate is meant to compensate her for her services in gestating the fetus and undergoing labor, not for giving up the parental rights to the child. It also addresses potential concerns about social engineering, forbidding contracts to tie payment to the characteristics of the donor or the child.²⁴⁸ Given the nine months of around-the-clock service and physical toll that childbirth takes on a woman's body, it only makes sense that a surrogate be paid reasonable compensation. Additionally, surrogates, like child care providers, are providing a service some parents need and should be compensated.

Despite ongoing debates over allowing compensation to be a part of the surrogacy process, it should be understood that some surrogates may be partially motivated by money. The worry about impoverished women becoming a "breeder-class" has been elaborated on by Steven Snyder, a Minnesota lawyer who serves as chair of the American Bar Association's Assisted Reproductive Technologies Committee, who said that women in poverty generally couldn't enter a paid surrogacy agreement without jeopardizing their welfare benefits.²⁴⁹ In this country, most

²⁴⁷ York, Stephen G., *A Contractual Analysis of Surrogate Motherhood and a Proposed Solution*, 24 Loy. L. A. Rev. 25, (January 1990): 395- 420
<http://digitalcommons.lmu.edu/cgi/viewcontent.cgi?article=1657&context=llr> (Accessed April 21, 2016).

²⁴⁸ Hartocollis.

²⁴⁹ Barton, Gina. "Paid Surrogacy Triggers Debate About Legal, Moral Issues," *Reproductive Possibilities*. August 8, 2012. <http://www.reproductivepossibilities.com/paid-surrogacy-legal-moral-issues.cfm>

surrogates have careers or are stay-at-home moms who want to supplement their husbands' salaries, he said.²⁵⁰ Currently, eight out of the seventeen states that permit surrogacy also explicitly allow for the surrogate to be compensated. It is crucial that the conditions of such compensation be clearly defined and outlined by statutory law to ensure that all parties are able to have their needs met by the terms of the contract.

Health Insurance

The World Health Organization, the American Society for Reproductive Medicine (ASRM), and the American College of Obstetricians and Gynecologists (ACOG) recognize infertility as a disease. However, public policymakers, employers and insurers have been slow to treat it as such. For many, the cost of treatment for infertility is prohibitive. Couples should not have to spend their life savings, second mortgage their home, or incur thousands of dollars of debt to treat this disease and to fulfill a fundamental aspect of life the desire to bear children and raise a family.²⁵¹ The option to pursue medical treatment for infertility must be available to all those who need treatment, not solely those with the resources to pay for the treatment out of pocket. Currently, only 15 states have some level of mandatory insurance coverage for infertility treatments, and only 10 that require coverage for IVF. Offering treatment for those in need would solve a number of problems that arise within the current framework for surrogacy. First, it would make surrogacy a viable option for more people and decrease the prevalence of international forum shopping. Additionally, strictly offering coverage for treatments that are carried out in accredited facilities ensures that all procedures are properly administered and documented, allowing for further research on the subject and ensuring that procedures are all

²⁵⁰ Barton.

²⁵¹ "Insurance Coverage of Infertility Treatments." *RESOLVE*, 2016.
<http://www.resolve.org/about/insurance-coverage-of-infertility-treatments.html>

carried out safely, while following the suggested guidelines. Lastly, helping those in need with the cost of fertility treatments will help to decrease the numbers of multiple embryo transfers, which place the surrogate and resulting child at higher risk for medical issues. As mentioned, it is common that patients who cannot afford multiple IVF treatments request that their physician implant multiple embryos, hoping to increase the chances for a pregnancy. Providing health insurance coverage for infertility diagnosis and treatment would help thousands of individuals struggling with this disease to get the care that they need.

Surrogacy Clinic Regulations

Medical advancements concerning assisted reproductive technologies have helped turn the science of making babies into a \$3 billion-a-year industry, according to Harvard Business School professor Debora Spar in her 2006 book, *The Baby Business: How Money, Science and Politics Drive the Commerce of Conception*.²⁵² The demand has spawned a proliferation of new businesses, including fertility clinics, surrogacy agencies, and online brokers- all operating in an industry that is almost entirely self-regulating. Due to the fact that the guidelines provided by the ASRM are seemingly unenforceable, critics have argued that ASRM's main function is to advance the business interest of its members, unfettered by government regulation.²⁵³ While this allegation may be too extreme, it is reasonable to contend that a process as delicate as gestational surrogacy warrants some form of higher regulation. As mentioned in Chapter 3, the lack of governance over surrogacy clinic practices has resulted in physicians engaging in risky practices, whether it is at the request of a patient or to simply increase their own success rates. Thus, the requirements set forth in The Model Act would safeguard against risky practices and procedures

²⁵² Spar, Deborah. *The Baby Business: How Money, Science and Politics Drive the Commerce of Conception*. Massachusetts: Harvard Business Review Press, 2006.

²⁵³ Ollove.

by requiring physicians to diligently follow ASRM guidelines, and sanctioning those who violate them. Good public policy requires medical professionals to follow a specific set of guidelines, and take action if they fail to, in order to ensure the safety of the surrogate and the resulting children.

Conclusion

Surrogacy has been able to enrich the lives of so many by enabling those who truly yearn for parenthood, but are unable to conceive naturally, to raise a child that is genetically their own. The spark for this revolutionary form of alternative family planning came from in vitro fertilization (IVF), the technological breakthrough that allowed babies to be conceived outside the womb. However, the ability to separate gestation and genetics also brought to light a host of ethical and legal issues. Using IVF to bring about a pregnancy has made it possible for up to six individuals to be involved in creating a life, thereby creating a confusing array of “parents.” Courts throughout the country have taken different approaches when determining the validity of surrogacy agreements or which party to award parental rights to in the face of a disagreement. Also, policymakers struggle to deal with the topic of surrogacy, as it remains a political third rail. But the time has come for legislatures to implement clear legal guidelines for surrogacy arrangements to keep the process safe and manageable for those choosing to pursue this method of alternative family planning.

It is clear that the law of surrogate motherhood in the United States today is in a state of flux and confusion. There is nothing resembling a national consensus on how to govern surrogacy and no federal law, leaving the states free to do as they wish. This has resulted in a convoluted hodgepodge of laws throughout the country, making surrogacy a daunting and risky option. Allowing the states to react as they wish has generated inconsistent outcomes and has simply been an inadequate approach to handling such a delicate process. While some organizations have recognized the need for uniformity throughout the country, few state legislatures have chosen to act on the issue and adopt uniform model acts into law. Having virtually no laws regulating the practice of surrogacy too often becomes detrimental not only for

the surrogates and the parents, but also, most importantly, the children created through the process.

Additionally, the utter lack of consistency extends beyond surrogacy contracts themselves and into other realms such as inevitable forum shopping, health care and surrogacy clinic regulation. Although the American Fertility Society and The American College of Obstetricians and Gynecologists have classified infertility as a disease, health care providers have been slow to treat it as such. Only fifteen states mandate coverage for infertility treatments, and out of those fifteen only ten states require that IVF be covered too. Hiring a surrogate in the United States can cost upwards of \$100,000 and many intended parents are forced to pay out-of-pocket for treatments and services. As would be expected, this increases the potential for individuals to seek out options that they can afford, whether it be making unwise medical decisions, picking a surrogate straight off of the internet or choosing to go to a third-world country where surrogacy is a fraction of the price. These acts of desperation are a product of a surrogacy system in the United States that does not aim to be simple or truly accessible to all. Instead, scholars argue, access to surrogacy on American soil is for the rich or well-to-do.

Lastly, it is crucial to address the fact that the surrogacy industry remains largely self-regulating. Cases have come to light where medical professionals deviate from the guidelines pertaining to embryo transfers either at the request of a patient who hopes to save money or even to raise their own success rates. It has been exposed that there is no real way to sanction the offenders and that there is no monitoring body to limit the amount of times that these deviations occur. While the industry actors argue that the self-regulating scheme is effective, data has proved otherwise. Thus, I put forward that only accredited clinics should be allowed to provide surrogacy related treatments. These clinics should not only be required to follow ASRM

guidelines, but they should submit annual reports that would allow organizations to monitor the system and conduct comprehensive studies to fully understand the big picture of surrogacy.

In an attempt to be realistic, I believe that the best way to establish uniformity for surrogacy laws in the United States would be for advocacy groups to formulate a reasonable, yet comprehensive law and take the issue to individual state legislators. Currently, there is no strong base or constituency promoting this cause, which makes it easy for policymakers to continue to ignore the subject. But in the mean time, legal issues continue to multiply. The Model Act Governing Surrogacy touches on all of the main legal points pertaining to surrogacy that would ensure that all parties are fully aware of their position throughout the process and that their rights can be protected. These points range from requirements for intended parents and surrogates, to independent legal counsel, to compensation, to health care, to surrogacy clinic regulation. All of these considerations would bring clarity and greater certainty to what is currently an intimidating and unstable system. Surrogacy does not have to be a unpredictable minefield. With the right counsel and communication there is great potential for surrogacy to bring happiness to thousands of people who are eager to be parents and would likely raise upstanding citizens.

APPENDIX

American Bar Association Model Act Governing Assisted Reproductive Technology (February 2008)

ARTICLE 7. GESTATIONAL AGREEMENT

[Legislative Note: It is not the intent of this act to conflict with or supersede provisions of the Uniform Parentage Act or applicable intestacy provisions of the Uniform Probate Code. Accordingly, any state or territory considering adoption of this model act should carefully review its statutes to determine if those uniform acts have been adopted in that jurisdiction and, if so, refer to those existing provisions rather than enacting either alternative of this Article 7. Since the gestational agreement provisions of the Uniform Parentage Act are bracketed and, therefore, optional, an alternative procedure to determine parentage in a gestational surrogacy arrangement is offered that does not require a judicial proceeding if, and only if, the parties comply with all of the other procedural protections of the statutory alternative. The judicial preauthorization model is offered as Alternative A, and the administrative model is offered as Alternative B.]

[ALTERNATIVE A:

SECTION 701. GESTATIONAL AGREEMENT AUTHORIZED

1. A prospective gestational carrier, her legal spouse if she is married, a donor or the donors, and the intended parent(s) may enter into a agreement in a record providing that:
 - (a) The prospective gestational carrier agrees to pregnancy by means of assisted reproduction;
 - (b) The prospective gestational carrier, her legal spouse if she is married, and the donors relinquish all rights and duties as the parents of a child conceived through assisted reproduction; and
 - (c) The intended parents become the parents of the child.
2. The intended parents must be parties to the gestational agreement.
3. A gestational agreement is enforceable only if validated as provided in Section 703.
4. A gestational agreement does not apply to the birth of a child conceived by means of sexual intercourse.
5. A gestational agreement may provide for payment of consideration under Article 8 of this Act.
6. A gestational agreement may not limit the right of the gestational carrier to make decisions to safeguard her health or that of the embryo(s) or fetus.

SECTION 702. REQUIREMENTS OF PETITION

1. The intended parents and the prospective gestational carrier may commence a proceeding in the [appropriate court] to validate a gestational agreement.
2. A proceeding to validate a gestational agreement may not be maintained unless:
 - (a) The carrier or the intended parents have been residents of this State for at least 90 days;
 - (b) The prospective gestational carrier's legal spouse, if she is married, is joined in the proceeding; and
 - (c) A copy of the gestational agreement is attached to the petition.

SECTION 703. HEARING TO VALIDATE GESTATIONAL AGREEMENT

1. If the requirements of paragraph 2 are satisfied, a court may issue an order validating the gestational agreement and declaring that the intended parents will be the parents of a child born during the term of the agreement.
2. The court may issue an order under paragraph 1 only on finding that:
 - (a) The residence requirements of Section 702 have been satisfied and the parties have submitted to the jurisdiction of the court under the jurisdictional standards of this Act;
 - (b) Unless waived by the court, the relevant child-welfare agency has made a home study of the intended parents and the intended parents meet the standards of suitability applicable to adoptive parents;
 - (c) All parties have voluntarily entered into the agreement and understand its terms;
 - (d) Adequate provision has been made for all reasonable health-care expense associated with the gestational agreement until the birth of the child, including responsibility for those expenses if the agreement is terminated; and
 - (e) The consideration, if any, paid to the prospective gestational carrier is reasonable.

SECTION 704. INSPECTION OF RECORDS

The proceedings, records, and identities of the individual parties to a gestational agreement under this article are subject to inspection under the standards of confidentiality applicable to adoptions as provided under other law of this State.

SECTION 705. EXCLUSIVE, CONTINUING JURISDICTION

Subject to the jurisdictional standards of Section 201 of the Uniform Child Custody Jurisdiction and Enforcement Act, the court conducting a proceeding under this article has exclusive, continuing jurisdiction of all matters arising out of the gestational

agreement until a child born to the gestational carrier during the period governed by the agreement attains the age of 180 days.

SECTION 706. TERMINATION OF GESTATIONAL AGREEMENT

1. After issuance of an order under this article, but before the prospective gestational carrier becomes pregnant by means of assisted reproduction, the prospective gestational carrier, her legal spouse, or either of the intended parents may terminate the gestational agreement by giving notice of termination in a record to all other parties.
2. The court for good cause shown may terminate the gestational agreement.
3. An individual who terminates a gestational agreement shall file notice of the termination with the court. On receipt of the notice, the court shall vacate the order issued under this article. An individual who does not notify the court of the termination of the agreement is subject to appropriate sanctions.
4. Neither a prospective gestational carrier nor her legal spouse, if any, is liable to the intended parents for terminating a gestational agreement pursuant to this Section.

SECTION 707. PARENTAGE UNDER VALIDATED GESTATIONAL AGREEMENT

1. Upon birth of a child to a gestational carrier, the intended parents shall file notice with the court that a child has been born to the gestational carrier within 300 days after assisted reproduction. Thereupon, the court shall issue an order:
 - (a) Confirming that the intended parents are the parents of the child;
 - (b) If necessary, ordering that the child be surrendered to the intended parents; and
 - (c) Directing the agency maintaining birth records to issue a birth certificate naming the intended parents as parents of the child.
2. If the parentage of a child born to a gestational carrier is alleged not to be the result of assisted reproduction, the court shall order genetic testing to determine the parentage of the child.
3. If the intended parents fail to file notice required under paragraph 1, the gestational carrier or the appropriate State agency may file notice with the court that a child has been born to the gestational carrier within 300 days after assisted reproduction. Upon proof of a court order issued pursuant to Section 703 validating the gestational agreement, the court shall order the intended parents are the parents of the child and are financially responsible for the child.

SECTION 708. GESTATIONAL AGREEMENT: EFFECT OF SUBSEQUENT MARRIAGE

1. After the issuance of an order under this article, subsequent marriage of the gestational carrier does not affect the validity of a gestational agreement, her legal spouse's consent to the agreement is not required, and her legal spouse is not a presumed father of the resulting child.

SECTION 709. EFFECT OF NONVALIDATED GESTATIONAL AGREEMENT

1. A gestational agreement, whether in a record or not, that is not judicially validated is not enforceable.

2. If a birth results under a gestational agreement that is not judicially validated as provided in this Section 703, the parent-child relationship is determined as provided under other law.

3. Individuals who are parties to a nonvalidated gestational agreement as intended parents may be held liable for support of the resulting child under other law.

END ALTERNATIVE A]

[ALTERNATIVE B:

SECTION 701. RIGHTS OF PARENTAGE

1. Except as provided in this Act, the woman who gives birth to a child is presumed to be the mother of that child for purposes of State law.

2. In the case of a gestational carrier arrangement satisfying the requirements set forth in paragraph 4 of this Section:

(a) The intended parents shall be the parents of the child for purposes of State law immediately upon the birth of the child;

(c) The child shall be considered the child of the intended parent or parents for purposes of State law immediately upon the birth of the child;

(d) Parental rights shall vest in the intended parent or parents immediately upon the birth of the child;

(e) Sole custody of the child shall rest with the intended parent or parents immediately upon the birth of the child; and

(f) Neither the gestational carrier nor her legal spouse, if any, shall be the parent of the child for purposes of State law immediately upon the birth of the child.

3. In the case of a gestational carrier arrangement meeting the requirements set forth in subsection 4 of this Section, in the event of a laboratory error in which the resulting child is not

genetically related to either of the intended parents, the intended parents will be the parents of the child for purposes of State law unless otherwise determined by a court of competent jurisdiction in an action which can only be brought by one or more of the genetic parents within sixty (60) days of the date of the child's birth.

4. The parties to a gestational carrier arrangement shall assume the rights and obligations of paragraphs 2 and 3 of this Section if:

(a) The gestational carrier satisfies the eligibility requirements set forth in paragraph 1 of Section 702;

(b) The intended parent or parents satisfy the eligibility requirements set forth in paragraph 2 of Section 702; and

(c) The gestational carrier arrangement occurs pursuant to a gestational agreement meeting the requirements set forth in Section 703.

SECTION 702. ELIGIBILITY

1. A gestational carrier shall be deemed to have satisfied the requirements of this Act if she has met the following requirements at the time the gestational agreement is executed:

(a) She is at least 21 years of age;

(b) She has given birth to at least one child;

(c) She has completed a medical evaluation relating to the anticipated pregnancy;

(d) She has completed a mental health evaluation relating to the anticipated gestational carrier arrangement;

(e) She has undergone legal consultation with independent legal counsel regarding the terms of the gestational agreement and the potential legal consequences of the gestational carrier arrangement; and

(f) She has, or obtains prior to the embryo transfer, a health insurance policy that covers major medical treatments and hospitalization and the health insurance policy has a term that extends throughout the duration of the expected pregnancy and for 8 weeks after the birth of the child; provided, however, that the policy may be procured by the intended parents on behalf of the gestational carrier pursuant to the gestational agreement.

2. The intended parent or parents shall be deemed to have satisfied the requirements of this Act if he, she, or they have met the following requirements at the time the gestational agreement is executed:

(a) He, she, or they contribute at least one of the gametes that will ultimately result in an embryo that the gestational carrier will attempt to carry to term;

(b) He, she, or they have a medical need for the gestational carrier arrangement as evidenced by a qualified physician's affidavit attached to the gestational agreement;

(c) He, she, or they have completed a mental health evaluation relating to the anticipated gestational carrier arrangement; and

(d) He, she, or they have undergone legal consultation with independent legal counsel regarding the terms of the gestational agreement and the potential legal consequences of the gestational carrier arrangement.

SECTION 703. REQUIREMENTS FOR A GESTATIONAL AGREEMENT.

1. A gestational agreement is enforceable only if:

(a) It meets the contractual requirements set forth in paragraph 2 of this Section; and

(b) It contains at a minimum each of the terms set forth in paragraph 3 of this Section.

2. A gestational agreement shall meet the following requirements: (a) It shall be in writing;

(b) It shall be executed prior to the commencement of any medical procedures in furtherance of the gestational carrier arrangement (other than medical or mental health evaluations necessary to determine eligibility of the parties pursuant to Section 702 of this Act) :

(i) By a gestational carrier meeting the eligibility requirements of paragraph 1 of Section 702 of this Act and, if married, the gestational carrier's legal spouse; and

(ii) By the intended parent or parents meeting the eligibility requirements of paragraph 2 of Section 702 of this Act. In the event an intended parent is married, both wife and her legal spouse must execute the gestational agreement;

(c) Each of the gestational carrier and the intended parent or parents shall have been represented by separate, independent counsel in all matters concerning the gestational carrier arrangement and the gestational agreement;

(d) Each of the gestational carrier and the intended parent or parents shall have signed a written acknowledgment that he or she received information about the

3.

legal, financial, and contractual rights, expectations, penalties, and obligations of the gestational agreement;

(e) If the gestational agreement provides for the payment of compensation to the gestational carrier, the compensation shall have been placed in escrow with an independent escrow agent prior to the gestational carrier's commencement of any medical procedure (other than medical or mental health evaluations necessary to determine the gestational carrier's eligibility pursuant to paragraph 1 of Section 702 of this Act); and

(f) It shall be witnessed by two (2) disinterested competent adults. A gestational agreement shall provide for:

(a) The express written agreement of the gestational carrier to:

(i) Undergo embryo or gamete transfer and attempt to carry and give birth to the child; and

(ii) Surrender custody of all resulting children to the intended parent or parents immediately upon the birth;

(b) If the gestational carrier is married, the express agreement of her legal spouse to:

(i) Undertake the obligations imposed on the gestational carrier pursuant to the terms of the gestational agreement; and

(ii) Surrender custody of all resulting children to the intended parent or parents immediately upon the birth;

(c) The right of the gestational carrier to utilize the services of a physician of her choosing, after consultation with the intended parents, to provide her care during the pregnancy; and

(d) The express written agreement of the intended parent or parents to:

(i) Accept custody of all resulting children immediately upon birth regardless of number, gender, or mental or physical condition; and

(ii) Assume sole responsibility for the support of the child immediately upon his or her birth.

4.
following provisions:

A gestational agreement is enforceable even though it contains one or more of the

(a) The gestational carrier's agreement to undergo all medical exams, treatments, and fetal monitoring procedures that the physician recommends for the success of the pregnancy;

(b) The gestational carrier's agreement to abstain from any activities that the intended parent or parents or the physician reasonably believes to be harmful to the pregnancy and future health of the child, including, without limitation, smoking, drinking alcohol, using non-prescribed drugs,

using prescription drugs not authorized by a physician aware of the gestational carrier's pregnancy, exposure to radiation, or any other activities proscribed by a health care provider;

(c) The agreement of the intended parent or parents to pay the gestational carrier reasonable compensation; and

(d) The agreement of the intended parent or parents to pay for or reimburse the gestational carrier for reasonable expenses (including, without limitation, medical, legal, or other professional expenses) related to the gestational carrier arrangement and the gestational agreement.

SECTION 704. DUTY TO SUPPORT

1. Any individual who is considered to be the parent of the child pursuant to Section 701 of this Act shall be obligated to support the child.

2. The breach of the gestational agreement by the intended parent or parents shall not relieve such intended parent or parents of the support obligations imposed by this Act.

3. A gamete donor may be liable for child support only if he or she fails to enter into a legal agreement in which the donor relinquishes rights to any gametes, resulting embryos, or children and the intended parent or parents fail to enter into an agreement in which the intended parent or parents agree to assume all rights and responsibilities for any resulting child.

SECTION 705. ESTABLISHMENT OF THE PARENT-CHILD RELATIONSHIP

1. For purposes of the State's relevant parentage act, the parent-child relationship that arises immediately upon the birth of the child pursuant to Section 701 is established, if, prior to or within 24 hours of the birth of a child born through a gestational carrier arrangement, the attorneys representing both the gestational carrier and the intended parent or parents certify that the parties entered into the gestational agreement intended to satisfy the requirements of Section 703 of this Act with respect to the child.

2. The attorneys' certifications required by paragraph 1 of this Section shall be filed on forms prescribed by the relevant State regulatory agency and in a manner consistent with the requirements of the State's relevant parentage act, if any.

3. The attorney certifications required by paragraph 1 of this Section shall be effective for all purposes hereunder if completed prior to or within twenty-four (24) hours after the child's birth.

4. Upon compliance with the certification provision of this Section, all hospital representatives and/or employees and the State's relevant regulatory agency shall complete all birth records and the original birth certificate of the child to reflect the intended parent or parents, and only the intended parent or parents, as the child's parent(s) thereon.

SECTION 706. EFFECT OF GESTATIONAL CARRIER'S SUBSEQUENT MARRIAGE

Subsequent marriage of the gestational carrier after her execution of a gestational agreement does not affect the validity of the gestational agreement, her legal spouse's consent to the gestational agreement is not required, and her legal spouse is not a presumed parent of the resulting child.

SECTION 707. IMMUNITIES

Except as provided in this Act, no person shall be civilly or criminally liable for non-negligent actions taken pursuant to the requirements of this Act. This provision shall not prevent liability or actions between or among the parties, including actions brought by or on behalf of the child, based on negligent, reckless, willful, or intentional acts that result in damages to any party.

SECTION 708. NONCOMPLIANCE

Noncompliance occurs when the gestational carrier, her spouse, or the intended parent or parents breach a provision of the gestational agreement or any party to or agreement for a surrogacy arrangement fails to meet any of the requirements of this Act.

SECTION 709. EFFECT OF NONCOMPLIANCE

1. In the event of Noncompliance as defined in Section 707, a court of competent jurisdiction shall determine the respective rights and obligations of the parties to any surrogacy arrangement based solely on evidence of the parties' original intent.
2. There shall be no specific performance remedy available for a breach by the gestational carrier of a gestational agreement term that requires her to be impregnated.

SECTION 710. DAMAGES

1. Except as expressly provided in the gestational agreement, the intended parent or parents shall be entitled to all remedies available at law or equity.
2. Except as expressly provided in the gestational agreement, the gestational carrier shall be entitled to all remedies available at law or equity.

SECTION 711. RULEMAKING

The relevant State regulatory agency may adopt rules pertaining to the required medical and mental health evaluations for a gestational agreement. Until the relevant State regulatory agency adopts such rules, medical and mental health evaluations and procedures shall be conducted in accordance with the recommended guidelines published by the ASRM, SART, and the American College of Obstetricians and Gynecologists (ACOG). The rules may adopt these guidelines or others by reference.

SECTION 712. IRREVOCABILITY

No action to invalidate a gestational carrier arrangement meeting the requirements of paragraph 4 of Section 701 of this Act or to challenge the rights of parentage established pursuant to Section 701 of this Act and the relevant State parentage act provisions shall be commenced after 12 months from the date of birth of the child.

END ALTERNATIVE B]

ARTICLE 8. PAYMENT TO DONORS AND GESTATIONAL CARRIERS

SECTION 801. REIMBURSEMENT

1. A donor may receive reimbursement for economic losses resulting from the retrieval or storage of gametes or embryos and incurred after the donor has entered into a valid agreement in a record to be a donor.
2. Economic losses occurring before the donor has entered into valid agreement in a record to be a donor may not be reimbursed, except as provided for in paragraph 3 hereof.
3. Premiums paid for insurance against economic losses directly resulting from the retrieval or storage of gametes or embryos for donation may be reimbursed, even if such premiums have been paid before the donor has entered into a valid agreement in a record, so long as such agreement becomes valid and effective before the gametes or embryos are used in assisted reproduction in accordance with the agreement.

SECTION 802. COMPENSATION

1. The consideration, if any, paid to a donor or prospective gestational carrier must be reasonable and negotiated in good faith between the parties.
2. Compensation may not be conditioned upon the purported quality or genome-related traits of the gametes or embryos.
3. Compensation may not be conditioned on actual genotypic or phenotypic characteristics of the donor or of the child.

Family Act, S 881/HR 1851 (May 2013)

A BILL to amend the Internal Revenue Code of 1986 to provide an income tax credit for the costs of certain infertility treatments, and for other purposes.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, **SECTION 1. SHORT TITLE.***

This Act may be cited as the “Family Act of 2013”.

SEC. 2. FINDINGS.

Congress finds the following:

- (1) The American Society of Reproductive Medicine recognizes infertility as a disease, and the Centers for Disease Control and Prevention have described infertility as an emerging public health priority in the United States. Globally, the World Health Organization also formally recognizes infertility as a disease.
- (2) According to the Centers for Disease Control and Prevention, approximately 3,000,000 Americans suffer from infertility.
- (3) A portion of those 3,000,000 people are cancer survivors who were diagnosed as infants, children, or young adults. Their treatments included chemotherapy, radiation, and surgery which have led to irreparable damage to their reproductive systems.
- (4) Military families notably are also impacted by infertility as a result of lower extremity war injuries arising from the perils of modern warfare. For active duty individuals, frequent changes in permanent duty station, combat deployments, and training rotations complicate access to fertility treatments. In addition, active duty individuals or veterans have no coverage for in vitro fertilization (IVF) through their military health insurance and must pay out of pocket for those expenses, even within military treatment facilities.
- (5) For many, the cost of treatment for the disease of infertility is prohibitive. According to the American Society for Reproductive Medicine, the cost per cycle of IVF is approximately \$12,500, and on average couples require at least 2 cycles. Many couples have to choose between their desire to establish a family and their future financial well-being.
- (6) Medical insurance coverage for infertility treatments is sparse and inconsistent at the State level. Only 8 States have passed laws to require comprehensive infertility coverage, and under those State laws employer-sponsored plans are exempt; therefore, coverage for treatments such as IVF is limited. According to Mercer’s 2005 National Survey Employer-Sponsored Health Plans, IVF was voluntarily covered by 19 percent of large employer sponsored health plans and only 11 percent of small employer-sponsored health

plans. Even in States with coverage mandates, out-of-pocket expenses for these treatments are significant.

(7) According to the latest National Survey of Family Growth, African-American and Hispanic women are more likely to be infertile than Caucasian women, yet studies indicate that they are less likely to use infertility services.

SEC. 3. CREDIT FOR CERTAIN INFERTILITY TREATMENTS.

IN GENERAL.—Subpart A of part IV of sub-chapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting before section 24 the following new section:

SEC. 23A. CREDIT FOR CERTAIN INFERTILITY TREATMENTS.

(a) ALLOWANCE OF CREDIT.—In the case of an eligible individual, there shall be allowed as a credit against the tax imposed by this chapter for the taxable year an amount equal to 50 percent of the qualified infertility treatment expenses paid or incurred during the taxable year.

(b) LIMITATIONS.—

(1) DOLLAR LIMITATION.—The amount of the credit under subsection (a) for any taxable year shall not exceed the excess (if any) of—

(A) the dollar amount in effect under section 23(b)(1) for the taxable year, over

(B) the aggregate amount of the credits allowed under subsection (a) for all preceding taxable years.

(2) INCOME LIMITATION.—

(A) IN GENERAL.—The amount otherwise allowable as a credit under subsection (a) for any taxable year (determined after the application of paragraph (1) and without regard to this paragraph and subsection (c)) shall be reduced (but not below zero) by an amount which bears the same ratio to the amount so allowable as—

(i) the amount (if any) by which the taxpayer's adjusted gross income exceeds the dollar amount in effect under clause (i) of section 23(b)(2)(A); bears to \$40,000.

(B) DETERMINATION OF ADJUSTED GROSS INCOME.—For purposes of subparagraph (A), adjusted gross income shall be determined without regard to sections 911, 931, and 933.

(3) DENIAL OF DOUBLE BENEFIT.—

(A) IN GENERAL.—No credit shall be allowed under subsection (a) for any expense for which a deduction or credit is taken under any other provision of this chapter.

(B) GRANTS.—No credit shall be allowed under subsection (a) for any expense to the extent that reimbursement or other funds in compensation for such expense are received under any Federal, State, or local program.

(C) INSURANCE REIMBURSEMENT.—No credit shall be allowed under subsection (a) for any expense to the extent that payment for such expense is made, or reimbursement for such expense is received, under any insurance policy.

(4) LIMITATION BASED ON AMOUNT OF TAX.—In the case of a taxable year to which section 26(a)(2) does not apply, the credit allowed under subsection (a) for any taxable year shall not exceed the excess of—

(A) the sum of the regular tax liability (as defined in section 26(b)) plus the tax imposed by section 55; over

(B) the sum of the credits allowable under this subpart (other than this section) and section 27 for the taxable year.

(c) CARRYFORWARDS OF UNUSED CREDIT.—

(1) RULE FOR YEARS IN WHICH ALL PERSONAL CREDITS ALLOWED AGAINST REGULAR AND ALTERNATIVE MINIMUM TAX.—In the case of a taxable year to which section 26(a)(2) applies, if the credit allowable under subsection (a) exceeds the limitation imposed by section 26(a)(2) for such taxable year reduced by the sum of the credits allowable under this subpart (other than this section), such excess shall be carried to the succeeding taxable year.

(2) RULE FOR OTHER YEARS.—In the case of taxable year to which section 26(a)(2) does not apply, if the credit allowable under subsection (a) exceeds the limitation imposed by subsection (b)(4) for such taxable year, such excess shall be carried to the succeeding taxable year and added to the credit allowable under subsection (a) for such succeeding taxable year.

(3) LIMITATION.—No credit may be carried forward under this subsection to any taxable year after the 5th taxable year after the taxable year in which the credit arose. For purposes of the preceding sentence, credits shall be treated as used on a first-in first-out basis.

(d) QUALIFIED INFERTILITY TREATMENT EXPENSES

(1) IN GENERAL.—The term ‘qualified infertility treatment expenses’ means amounts paid or incurred for the treatment of infertility via in vitro fertilization if such treatment is—

(A) provided by a licensed physician, licensed surgeon, or other licensed medical practitioner and added to the credit allowable under subsection (a) for such succeeding taxable year.

(B) administered with respect to a diagnosis of infertility by a physician licensed in the United States.

(2) TREATMENTS IN ADVANCE OF INFERTILITY ARISING FROM MEDICAL TREATMENTS.—In the case of expenses incurred in advance of a diagnosis of infertility for fertility preservation procedures which are conducted prior to medical procedures that, as determined by a physician licensed in the United States, may cause involuntary infertility or sterilization, such expenses shall be treated as qualified infertility treatment expenses—

(A) notwithstanding paragraph (1)(B), and

(B) without regard to whether a diagnosis of infertility subsequently results. Expenses for fertility preservation procedures in advance of a procedure designed to result in infertility or sterilization shall not be treated as qualified infertility treatment expenses.

(3) INFERTILITY.—The term ‘infertility’ means the inability to conceive or to carry a pregnancy to live birth, including iatrogenic infertility resulting from medical treatments such as chemotherapy, radiation or surgery. Such term does not include infertility or sterilization resulting from a procedure designed for such purpose.

(e) ELIGIBLE INDIVIDUAL.—For purposes of this section, the term ‘eligible individual’ means an individual—

(1) who has been diagnosed with infertility by a physician licensed in the United States, or

(2) with respect to whom a physician licensed in the United States has made the determination described in subsection (d)(2).

(f) FILING REQUIREMENTS.—Married taxpayers must file joint returns. Rules similar to the rules of paragraphs (2), (3), and (4) of section 21(e) shall apply for purposes of this section.”

(g) CONFORMING AMENDMENTS.—

(1) The table of sections for subpart A of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting before the item relating to section 24 the following new item: “Sec. 23A. Credit for certain infertility treatments.”.

(2) Section 23(c)(1) of such Code is amended by striking “25D” and inserting “23A, 25D,”

(3) Section 25(e)(1)(C) of such Code is amended by inserting “23A,” before “25D,”.

(4) Section 1400C(d) of such Code is amended by striking “section 25D” and inserting “sections 23A and 25D”.

(h) **EFFECTIVE DATE.**—The amendments made by this section shall apply to taxable years beginning after December 31, 2013.

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