



Future Choices

Assisted Reproductive Technologies and the Law

Jessica Arons
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Introduction and Summary

In our modern world, sex is no longer the exclusive method for humans to reproduce. A new group of medical options, known as “assisted reproductive technologies,” are challenging our understanding of parenthood and biological relationships.

Louise Brown, the world’s first “test tube baby,” was born in 1978. Since then, the field of assisted reproduction has taken off, bringing increasingly new and innovative ways to create children—as well as increasingly more complex family relationships and ethically fraught medical practices.

The relationship between technology and the law in this context is symbiotic. If we think of the new technologies as plants, growing toward the sky and leading us into new medical, scientific, and ethical realms, then the legal terrain is the soil, dictating which practices can develop and thrive and which must wither away. Every decision to regulate or not creates unique incentives and disincentives for the fertility industry and those it serves.

For now, the fertility industry remains largely unregulated in the United States. Where regulation of these technologies has occurred, however, it has had real-life consequences for thousands of people and ripple effects on multiple areas of the law, from adoption to abortion, from health insurance to inheritance.¹

While some states have passed laws that indirectly affect the practices of fertility clinics, legislatures and courts have focused more on the ramifications of these procedures. Who are the legal parents of a child who was created by the efforts of five people—two genetic donors, one gestational mother, and two “intended” parents who set it all in motion? In a custody dispute over a frozen embryo, what principles of law should apply—property, contract, family, constitutional, or some combination thereof?

Assisted reproductive technologies bring to the fore important questions about who we are as individuals and families and whom society deems entitled to reproduce and parent. And these questions are not going to go away. While some might like to stop the clock so they can hash out the ground rules, others keep right on playing.

The latest case in point: In January 2007, a team of doctors announced plans to undertake the first uterine transplant in the United States.² Nearly every day, a story comes out about new technologies and their impact on the families who have used them.

Assisted reproductive technologies bring to the fore important questions about who we are as individuals and families and whom society deems entitled to reproduce and parent.

Those who seek to use these technologies include those who are infertile for both medical and social or situational reasons. Medical infertility affects about 10 percent of the reproductive age population—approximately 7.3 million people—and strikes people of all socioeconomic backgrounds.³ Infertility affects men and women equally: men and women each account for 35 percent of infertility cases, 20 percent of cases result from combined problems in the woman and the man, and in 10 percent of cases the cause of infertility cannot be identified.⁴ Although age can be a factor in infertility, sexually transmitted infections, exposure to certain chemical agents, tobacco and alcohol use, and excessive weight gain or loss are all risk factors for infertility as well.⁵

In addition to those who experience physiological obstacles to conceiving or maintaining a pregnancy, those who are physically capable of reproducing but do not have a partner of the opposite sex with whom to reproduce are increasingly taking advantage of assisted reproductive services. They include lesbian, gay, and transgender couples as well as single individuals of any sexual orientation or gender identity.⁶

Where people line up along the political spectrum in their opinions about assisted reproductive technologies is not always where one might expect. A conservative who previously believed life begins at conception may decide that it does not begin until implantation once he and his wife elect to undergo in vitro fertilization. A progressive who ardently defends the right to have an abortion for any reason may not believe there is a right to screen and discard embryos that have unwanted characteristics.

The disputes described throughout this paper reveal the painful and emotionally

fraught controversies that can arise when assisted reproductive arrangements do not go as planned. But as a political issue, assisted reproductive technologies provide our society with the opportunity to have thoughtful, respectful debates about a whole host of critical questions, from how we define family to when we think human life begins—deeply felt beliefs that in other contexts have proven to be quite volatile and polarizing.

Given the novelty of assisted reproductive technologies and the absence of entrenched positions on what services should be permitted or prohibited and under what circumstances, there is reason to hope that the discussion in this context can be civil and productive, perhaps even changing the way we think about our more settled positions and helping us better understand others' perspectives on more familiar political topics.

The questions about assisted reproduction come at a time when various groups within the progressive movement are making a concerted effort to work together on issues of common concern and speak with a more unified voice on the pressing topics of the day. All members of the progressive movement have a stake in what types of assisted reproductive technologies are available, to whom they are available, and how they are used—especially the reproductive rights, health, and justice community; the LGBT (lesbian, gay, bisexual, transgender) community; the disability rights community; the environmental community; and the economic, racial, and social justice communities. It is critical that the groups who focus on these issues begin to address assisted reproduction in their work.

Ultimately, Americans of all viewpoints will be challenged by the questions raised

by assisted reproductive technologies. To that end, the Center for American Progress has prepared this report so that people can become familiar with some of these technologies, understand how the law has developed in this area thus far, and ask how we want to proceed in the future.

We see this work as a natural sequel to our paper, “More than a Choice: A Progressive Vision for Reproductive Health and Rights.” In that paper, we discussed a very comprehensive agenda, which included cautionary tales and aspirational goals regarding assisted reproduction. We hope that “Future Choices” will lay the groundwork for the progressive movement to make hard but essential decisions about how to move forward in this complicated field.

Given that progressivism embodies an openness to change, a healthy respect for facts and nuanced arguments, and a drive for pragmatic solutions, the progressive movement can lead the way in forging just policies regarding these new ways of creating families. As we seek to answer the numerous questions raised by the few laws governing assisted reproduction, it may be useful to keep in mind the following progressive values:

- ♦ The right to privacy
- ♦ Procreative liberty
- ♦ Social justice

- ♦ The health and well-being of women and children
- ♦ Equality of the sexes
- ♦ Equal opportunity for parenting by people of all backgrounds
- ♦ Equitable access to health care
- ♦ Respect for moral and autonomous personal decisions
- ♦ Cautious optimism with regard to scientific progress
- ♦ Regard for biological and genetic diversity
- ♦ Evidence-based policymaking

The policy decisions we must make are difficult and may reveal tensions among our sometimes competing interests, but the process of developing our positions ultimately should help us clarify our values and priorities, make the progressive movement stronger overall, and, most importantly, improve people’s lives.

In this paper, we first provide a basic overview of assisted reproduction. Then, we address three primary areas in which legislators and courts have already spoken to some degree—health insurance coverage, embryo disposition, and parentage determinations—and examine the policy implications that their decisions create.

Where people line up along the political spectrum in their opinions about assisted reproductive technologies is not always where one might expect.

Assisted Reproductive Technologies: A Glossary

Oocyte or Ovum—a human egg

Gametes—human egg and sperm

Zygote—a one-celled fertilized egg

Embryo—a multi-celled fertilized egg, up to 8 weeks of development

Fetus—a prenatal developing human from the 8th week of gestation until birth

Egg or Oocyte Donor⁷—a woman who allows her eggs to be used to create a child whom she does not intend to parent (or to be used in scientific research), whether or not in exchange for compensation

In Vitro Fertilization (IVF)—the creation of an embryo by combining sperm and egg in a laboratory dish

Traditional Surrogate—a woman who agrees to be impregnated through artificial insemination and give birth to a child who will be raised by others, whether or not in exchange for compensation

Gestational Surrogate—a woman who agrees to be impregnated with another woman's fertilized egg and give birth to a child who will be raised by others, whether or not in exchange for compensation

Gestational Mother—a woman who carries and gives birth to a child to whom she is not genetically related but whom she intends to parent

Gestational Carrier—a woman who carries and gives birth to a child to whom she is not genetically related; this can be either a gestational surrogate or a gestational mother

Intended Parents (also Contracting or Commissioning Parents)—people who use assisted reproduction to create a child whom they intend to parent, whether or not they have a genetic or biological relationship to that child

Collaborative Reproduction—reproduction involving more than two biogenetic parents

A Brief Overview of Assisted Reproduction

Assisted Reproductive Technologies, or ART in medical parlance, are defined as any fertility procedures in which both eggs and sperm are manipulated outside the body in a laboratory.⁸ Perhaps the most well-known type of ART today is In Vitro Fertilization. IVF involves the mixing of an egg and sperm in a laboratory dish. Once an embryo has developed from the fertilized egg, it can be implanted in a woman's uterus to be gestated and born.

Variations on IVF include injecting sperm directly into an egg, combining sperm and egg in the lab but transferring them to the woman's body before fertilization, or transferring an embryo to the fallopian tubes instead of the uterus.⁹ Once an embryo has been created, Preimplantation Genetic Diagnosis and Preimplantation Genetic Screening can be used to screen embryos for genetic characteristics or chromosomal defects, respectively. Embryos with desired traits are then implanted; those with unwanted traits discarded.¹⁰

Technically, fertility drugs that stimulate egg production in ovaries and Intrauterine Insemination—or IUI, also known as Artificial Insemination—in which sperm is injected into the uterus, do not qualify as ART because the processes occur inside a woman's body and each process by itself only involves the manipulation of eggs or sperm, not both.¹¹ Nevertheless, we include them in our discussion because they are still fertility treatments, and very popular ones at that, and are implicated by the laws and cases described below.¹²

Before delving into the legal discussion below, it is helpful to understand the following concepts:

Genetic Parents

The eggs used in ART processes can be that of a woman who intends to gestate and raise the child; that of a woman who wishes to be the genetic mother of the child produced but who cannot carry a pregnancy and must use a relative, friend, or stranger as a gestational surrogate; that of a woman whose lesbian partner will carry the pregnancy; or that of a woman who has donated or sold her eggs and does not intend to have a relationship with the child produced. Likewise, a man who provides sperm for an ART process may or may not intend to parent that child.

The Price of Eggs: Compensation or Commodification?

In order to harvest eggs for procedures like in vitro fertilization, a woman must be injected with a series of three types of hormones—first, to suppress her normal ovarian function; second, to stimulate multiple egg production; and third, to trigger ovulation. An ART provider then retrieves the matured eggs by inserting a needle into the ovary and suctioning out the eggs.

The known but infrequent short-term health risks include overstimulation of the ovaries, with a range of adverse outcomes ranging from mild to severe, and hormonal side effects. The long-term health risks, if any, are still unknown due to a lack of follow-up studies. Given the relatively invasive nature of the process, the time commitment required, and the possible health consequences, much debate has centered on whether women who provide eggs for others' use should be paid for their services.

The American Society for Reproductive Medicine has recommended that egg donors receive no more than \$5,000 per cycle. It reached this number by multiplying the average number of hours

an egg donor spends in a medical setting by the average payment to sperm donors.¹³

Some have criticized this formula as too low for not taking into account the invasiveness of the procedure and the greater potential for adverse health effects. Others have argued the standard is too high because any large payment may coerce a woman into providing eggs when she otherwise would not. Critics of high prices also worry that the qualities that elicit more money reflect lingering eugenic notions of "good" and "bad" genes.

A recent survey showed that most payments to egg donors from clinics do fall within the \$5,000 guideline set by ASRM, but the survey did not include egg donor agencies which are known to advertise higher prices.¹⁴ At least one clinic in the survey brokered a fee as high as \$15,000,¹⁵ and others have been reported to advertise as much as \$100,000 for "top-notch" eggs.¹⁶ Currently, there is no limit in the United States on the number of times a woman can donate eggs, and the risks, if any, of multiple retrievals are unknown because there have been an insufficient number of studies.

Surrogacy

A surrogate is used when a woman who wishes to be a mother cannot carry a pregnancy or when a man, whether straight or gay, wishes to have a genetically related child and does not have a female partner who can bear the child. If a surrogate uses her own eggs, she is referred to as a "traditional surrogate." If she uses another woman's eggs (either from the intended mother or from a third-party donor), she is called a "gestational surrogate." Much debate has centered on whether surrogates should be paid for their services, whether surrogacy contracts should be enforced, and how to resolve custody disputes when one or more parties to a surrogacy agreement change their minds.

Frozen Embryos, Frozen Gametes, and the Posthumous Creation of Children

When more embryos are created than needed to successfully impregnate a woman, the excess embryos typically are frozen and stored in a fertility clinic until they can be used for future pregnancy attempts, donated to others seeking to have a child, donated for clinical or scientific research, or thawed and discarded. Sometimes the disposition of such embryos has been arranged for by contract; sometimes not. Regardless of whether a contract exists, disputes can arise over what will happen to the embryos and how they can be used.

In addition to embryos, gametes—egg and sperm—can be collected and frozen

for later use. While sperm freezing is considered safe, egg freezing technology is improving but still has a remarkably low success rate of 2 to 4 percent,¹⁷ and its effect on offspring is not yet known. When a person dies, his or her partner or parents may use frozen gametes or try

to collect them from the body to create a child. Such practices have raised questions about whether a child created under such circumstances can be considered an heir to the deceased—especially if there was no clear consent from the deceased for a child to be created posthumously.

Multiple Risks of Multiple Pregnancies

Because IVF and its variants can be expensive and invasive, clinics and patients often try to maximize the benefits of each cycle by retrieving as many eggs as possible, creating as many embryos as possible, and sometimes implanting as many embryos as possible. This practice has led to a steep increase in multiple pregnancies and births—more than half of IVF children born in the United States are part of a set.¹⁸

The conventional wisdom has been that the more embryos that can be implanted in a woman, the greater the chances are that she will become pregnant. That assumption, however, is being reexamined now that the evidence suggests that the transfer of multiple embryos may in fact lead to a *decreased* pregnancy rate for some groups of women and as the practice has become an object lesson in unintended consequences. For even if the practice does lead to a higher pregnancy and birth rate, the tradeoff may be several children with impaired health.

Although pregnancy always carries some amount of risk, it is well-documented that the more fetuses a woman carries, the greater the risks to her health and to any resulting offspring.¹⁹ Even a twin pregnancy has a higher risk of adverse outcomes than a singleton. Any multiple pregnancy brings risks to the mother including hemorrhaging, blood clots, high blood pressure, extreme vomiting, gestational diabetes, anemia, infection, extended bed rest, and even death. For babies, the risks involve premature birth and low birth weight, both of which can result in a number of impairments, as well as severe birth defects or death.²⁰

Beyond the potentially negative medical outcomes, parents of multiples also may have less time to pay attention to and bond with each child and may experience increased stress and fatigue, not to mention more financial pressures than with singleton births.²¹ Therefore, when a woman conceives a multiple pregnancy, her physician may recommend that she undergo a procedure called “selective reduction,” which involves terminating one or

more of the fetuses so that those remaining can continue to term and have a better chance of being healthy.

The practice of transferring multiple embryos has raised ethical questions about whether it is acceptable to do so with the knowledge that aborting some of the fetuses may later be medically indicated. Also of concern is whether it is ethical for patients to refuse selective reduction when they are aware of the attendant risks of carrying multiple fetuses to term.

The good news is that transferring only one embryo may be equally effective in establishing a successful pregnancy for women under 35 when a new technique for culturing embryos is used.²² Alternative technologies alone, however, will not be sufficient to address the various incentives, such as wanting to have an instant family or wanting to keep costs low, that cause clients of assisted reproduction to opt for the transfer of multiple embryos.

In the meantime, medical associations and some governments have weighed in on the debate. For instance, in 2006 the American Society of Reproductive Medicine issued guidelines that no more than two embryos should be implanted for women under 35, no more than three for women who are 35 to 37, no more than four for women who are 38 to 40, and no more than five for women over 40.²³ Clinics, however, are not required to follow the guidelines.

Some countries have imposed limits. In the United Kingdom, for example, the Human Fertilisation and Embryology Authority has set a limit of two embryos for women under 40 and three embryos for women over 40, but it is examining whether it should change its rules to make one embryo the norm.²⁴ In Italy, by contrast, a maximum of three embryos may be created at a given time and, barring exceptional circumstances, all embryos created *must* be implanted simultaneously²⁵—a likely response to the Catholic Church’s teachings that embryos should not be intentionally destroyed due to its belief that human life begins at fertilization.

Insurance Coverage of Infertility Treatments

The one thing the majority of these procedures have in common is that they are quite expensive. The average cost of an IVF cycle in the United States is \$12,400.²⁶ Using a surrogate may cost around \$60,000; eggs can go for anywhere from \$2,500 to \$50,000 or even \$100,000; and screening embryos for genetic traits adds approximately \$3,500 to the price of assisted reproduction.²⁷ For most people then, having health insurance coverage of some or all infertility treatments may make the difference between accessing those services or not.

This section will cover two areas of the law: state statutes that require health plans to cover or offer infertility services and court cases that determine whether federal antidiscrimination laws are violated by employer health plans that do not cover infertility treatments. (See text box on page 9 on the intersection of state and federal laws in this arena.)

Embedded in the statutory requirements are judgments on who qualifies as “deserving” of coverage, which reasons for excluding coverage are deemed legitimate, and what types of treatments are considered valid. In the court cases, judges have tried to answer whether infertility is a disability, whether lack of coverage for infertility treatments that only women can use constitutes sex discrimination, and whether discrimination against the infertile is pregnancy discrimination.²⁸

State Health Insurance Mandates and Exclusions

Fourteen states currently require some types of health insurance plans²⁹ to include coverage of certain infertility services³⁰ or to make such coverage available.³¹ In contrast, Louisiana and Nevada explicitly exempt health plans from having to cover certain infertility services in statutes that require coverage for other reproductive health care.³² (See Table 1 on page 10.)

Of the 14 states requiring coverage or the opportunity for coverage, five have their mandates apply only for patients who are married,³³ and four of those require the wife’s eggs to be fertilized with the husband’s sperm³⁴—in other words, they cannot use donated gametes if they want their treatments to be covered by insurance. Even if the laws do not expressly limit coverage to married couples, nearly all 14 states routinely refer to coverage for “medically necessary expenses” or define infertility to be the inability to conceive after a specified period of unprotected sexual intercourse, thereby implicitly excluding from coverage single people and lesbian, gay, and transgender couples.

Federalism 101 and Assisted Reproduction

Our Constitution provides for a balance of power among the federal and state governments. In some areas, only Congress can legislate; other areas are subject only to state regulation; and in still others, both can govern so long as the state laws do not conflict with the federal ones. For instance, the states generally have the power to regulate the practice of medicine, the insurance industry, family law, contract law, and property law—all areas implicated by assisted reproduction.

That power is limited, however, by areas that overlap with the federal government's power, as well as where the Constitution imposes its own limits. With regard to ART specifically, constitutional rights such as the right to procreate or the right not to procreate may restrict a state's ability to regulate assisted reproduction. And federal employment law prohibits discrimination based on certain characteristics, which can affect the health benefits an employer must offer its employees. Thus, in this paper, we will be discussing both federal and state law as appropriate.

Four states allow health plans to impose age requirements on coverage for infertility services. Connecticut³⁵ allows coverage to be excluded when a person turns 40; New Jersey³⁶ requires coverage for patients age 45 or younger; New York's³⁷ coverage applies from age 21 to 44; and Rhode Island³⁸ sets age limits of 25 to 40, but only for female patients.

Some states allow insurance plans to impose monetary limits on the infertility services provided, but other states have crafted benefit maximums on the type, amount, or frequency of services. For instance, Connecticut does not require coverage beyond four cycles of ovulation induction, three cycles of IUI, and two cycles of techniques that involve the transfer of gametes or embryos. Connecticut also has the only cap in the country on the number of embryo implantations allowed: two per each cycle of treatment.³⁹

Hawaii requires only one cycle of IVF to be covered.⁴⁰ Illinois limits the number of egg retrievals to four for a first birth and two for a second birth.⁴¹ It appears that no egg retrievals are covered after a patient has had two live births. Maryland gives couples three chances to achieve a live birth with IVF and has a lifetime

monetary cap on benefits, but there is no lifetime cap on the number of IVF cycles allowed assuming a child is born at least once every three attempts and the monetary cap has not been reached.⁴² Finally, New Jersey imposes a lifetime cap on cycles involving egg retrieval at four.⁴³

Of course, none of the above states prohibits treatments that go beyond their specified limits; they simply do not require insurers to provide coverage for treatments in excess of the caps in the statutes.⁴⁴

Seven states permit some type of exemption for religious institutions whose beliefs conflict with certain methods of treatment for infertility.⁴⁵ Some of the exemptions apply to issuers of health insurance plans, some to employers to whom the plans are issued, and some to both. Massachusetts exempts an employer only if it is a diocese.⁴⁶ Connecticut also allows individuals to request a policy or rider that excludes such services due to their religious or moral beliefs.⁴⁷ Two states require notice to be issued to each insured or prospective insured that such services have been excluded pursuant to a religious exemption.⁴⁸

While some states have acted to ensure that people with health insurance can

TABLE 1: STATE MANDATES FOR INFERTILITY INSURANCE

STATE	COVERAGE MANDATE		BENEFIT RESTRICTIONS					RELIGIOUS EXEMPTION	
	Mandate to Cover	Mandate to Offer	Age	Marriage	Own Gametes	Benefit Caps	Government Program Exclusions	Employer	Other
Arkansas	•			•	•				
California		•						•	• ^a
Connecticut	•		< 40 yrs			• ^b		•	• ^c
Hawaii	•			•	•	• ^d			
Illinois	•					• ^e		•	• ^f
Maryland	•			•	•	• ^g		•	
Massachusetts	•							• ^h	
Minnesota							•		
Montana	•						•		
New Jersey	•		< 46 yrs ⁱ			• ^j	•	• ^k	
New York	•		21–44 yrs						
Ohio	•						•		
Oklahoma							•		
Pennsylvania							•		
Rhode Island	•		25–40 yrs ^l	•		• ^m	•		
Texas		•		•	•			• ⁿ	• ^o
West Virginia	•								

CA a Health plan exemption.

CT b Cap of 2 embryo implantations per cycle.

c Individual exemption available; notice of exclusion required.

HI d Maximum Benefit: One cycle of IVF.

IL e Maximum Benefit: 4 egg retrievals for the first birth; 2 egg retrievals for the second birth.

f Any entity that issues a plan or policy is exempted.

MD g Maximum Benefit: 3 IVF cycles per live birth with a lifetime cap of \$100,000.

MA h Law exempts diocese employers only.

NJ i A woman is considered “infertile” if she is under 35 and unable to conceive for 2 years or if she is older than 35 and unable to conceive after 1 year.

j Egg retrieval is capped at 4 cycles per lifetime.

k Religious employers do not have to cover specific types of procedures; a notice of exclusion is required.

RI l Age limit applies to women only.

TX m Maximum Benefit: \$100,000 lifetime cap.

n Exempts self-insured employers only.

o Law includes exemptions for insurers and HMOs.

obtain infertility services, others have limited access for people who receive public medical assistance.⁴⁹ For instance, Minnesota and Oklahoma explicitly exclude fertility drugs from their public medical assistance programs.⁵⁰ And Montana, New Jersey, Ohio, Pennsylvania, and Rhode Island do not provide infertility treatments to recipients of Medicaid, the State Children’s Health Insurance Program, or other state medical assistance programs.⁵¹

As can be seen from the statutes already in place, several policy positions have been expressed through the regulation of the health insurance industry’s coverage of assisted reproduction. For instance, the states that limit coverage to married couples simultaneously exclude unmarried couples and single people, reflecting a bias against their fitness as parents. The limitation to medical infertility likewise excludes the situationally infertile.

The states that require couples to use their own sperm and eggs discourage the use of donor gametes. The imposition of age limits may be based on medical concerns or concerns about the ability of older parents to raise their children to adulthood, but it may also be based on preconceived notions of what is an appropriate age to become a parent. The exclusion of public benefits for infertility services not only reveals possible concerns about the financial cost of parenthood, but also may reflect a historical prejudice in our country against low-income parents.⁵²

From a progressive perspective, the religious exemptions in some of these laws seem especially problematic. Religious exemptions in the context of reproductive health care are nothing new. Numerous states allow individuals and facilities to refuse to provide abortion care, counseling, or referrals on religious grounds, and federal funding requires hospitals to allow employees to opt out of providing such care. Some states also allow pharmacists and/or pharmacies to refuse to fill prescriptions for birth control or emergency contraception if it interferes with their religious beliefs.

Although the practice of any religion should be accorded great respect, when a religiously affiliated entity engages in a pervasively secular service such as the provision of insurance or employing staff for predominately nonreligious activities, secular standards of conduct should apply. In short, those who would otherwise be eligible for insurance coverage should be able to obtain such coverage.

Beyond the questions raised by the above limitations is the threshold question of whether health insurance coverage for infertility treatments should be a priority

for policymakers in the first place. Not to minimize the suffering of people who face infertility, but with 47 million people in the United States lacking health insurance for basic health care, it may be hard to justify investing substantial resources in what is a relatively new and still somewhat experimental medical field.

Moreover, our resources may be better spent investigating and addressing the upstream causes of infertility, such as untreated sexually transmitted infections and exposure to environmental toxins. That said, where legislators have acted to expand access to infertility services, it is incumbent upon progressives to ensure that restrictions are based on rational and legitimate reasons rather than abject bias.

Employer-Based Health Insurance and Federal Antidiscrimination Laws:

The Americans with Disabilities Act, Title VII of the Civil Rights Act, and the Pregnancy Discrimination Act

Rochelle Saks received health benefits from her employer, Franklin Covey Co. The health plan covered several types of infertility products and procedures, including fertility drugs and most surgical infertility treatments. The plan did not, however, cover surgical impregnation procedures such as IUI and IVF, all of which happen to be performed only on women. Do such exclusions amount to sex discrimination, pregnancy discrimination, and/or disability discrimination? As we shall see in the cases detailed below, lawsuits on these grounds have uniformly failed for Saks and others in her position.

Where legislators have acted to expand access to infertility services, it is incumbent upon progressives to ensure that restrictions are based on rational and legitimate reasons rather than abject bias.

The Americans with Disabilities Act

Congress passed the Americans with Disabilities Act in order to protect people with disabilities from discrimination in the terms, conditions, or privileges of their employment, which includes the provision of fringe benefits such as health insurance.⁵³ In order to qualify as a person with a disability under the ADA, one must establish that he or she has a physical or mental impairment that substantially limits a major life activity.⁵⁴

Initially, the courts were split when considering whether infertility qualified as a disability under the ADA.⁵⁵ In *Bragdon v. Abbott*,⁵⁶ however, the Supreme Court ruled that reproduction was a major life activity and that a person with HIV qualified for protection under the ADA because HIV substantially impaired that major life activity.

Since that ruling, courts have readily found that infertility also is a physical impairment that substantially affects the major life activity of reproduction, and a person struggling with infertility falls within the class of people the ADA was designed to protect.⁵⁷

Nevertheless, courts have been reluctant to find a violation of the ADA simply because an employer's health plan excludes some or all infertility treatments. The primary reason for this outcome is that the health plans at issue have offered the same set of benefits to both infertile and fertile employees.⁵⁸ Therefore the benefits received are not conditioned upon a person's fertility.

Second, the courts have consistently read the ADA not to require insurance companies to offer a specific set of ben-

efits: "Had Congress intended to control which coverages had to be offered by employers, it would surely have spoken more plainly."⁵⁹ The fact that the selection of benefits offered may adversely affect people with specific disabilities is of no consequence, so long as the restriction was not intended to burden that class of people.

Title VII and the Pregnancy Discrimination Act

Only two federal appellate courts have considered whether health plans that exclude infertility treatments violate Title VII of the Civil Rights Act of 1964 or the Pregnancy Discrimination Act. Both ruled against the plaintiffs.⁶⁰

Title VII prohibits discrimination in employment based on a number of factors, including discrimination "because of sex."⁶¹ The Pregnancy Discrimination Act amends Title VII's definition of that phrase to include discrimination "on the basis of pregnancy, childbirth, or related medical conditions."⁶²

In *Krauel v. IMMC*, the plaintiff argued that because there is a causal connection between infertility and pregnancy, infertility was a medical condition "related to" pregnancy. Therefore, a health plan's failure to provide infertility treatments violated the PDA. The court disagreed, explaining that pregnancy and childbirth "occur after conception [and] are strikingly different from infertility, which prevents conception." The court also found that unlike pregnancy or potential pregnancy, infertility is a condition that applies to both men and women. Thus a policy that denies benefits for the treatment of infertility is gender neutral.⁶³

Similarly, in *Saks v. Franklin Covey Co.*, the Second Circuit found no violation of the PDA because fertility or reproductive capacity, as distinct from childbearing capacity, is common to both men and women. Because the PDA was intended to clarify the scope of sex discrimination under Title VII, the court concluded that a condition must be unique to women in order for it to fall within the PDA.⁶⁴

Because the Franklin Covey plan only excluded fertility procedures that were performed on women, Rochelle Saks also argued that the exclusion violated Title VII's prohibition on sex discrimination. The court acknowledged that in some circumstances, complete coverage of male surgeries but not female surgeries might constitute a violation. But even though surgical impregnation procedures could only be performed on women, they could be used to overcome either male or female infertility. Therefore, the exclusions of those procedures disadvantaged men and women equally.⁶⁵

Some have suggested that case law regarding contraceptive equity may provide some guidance in this field.⁶⁶ In *Erickson v. Bartell Drug Co.*,⁶⁷ the Western District of Washington found that because only women use prescription contraceptives, a health plan's failure to cover prescription contraceptives constituted sex and pregnancy discrimination. Yet the only appellate court to rule on the matter, the Eighth Circuit, recently came to the opposite conclusion.⁶⁸

Even if the courts were to reach consensus on the contraceptive question, the *Saks* court found a distinction between the two circumstances. It viewed the contraceptive exclusion as burdening only women, but saw the surgical impregnation exclusion as disadvantaging both women and men.

From a review of the decisions, it is clear that the courts are not likely to interpret these statutes as requiring the inclusion of infertility treatments in employer health benefit plans. If the result is to change, Congress must amend existing law.⁶⁹

The PDA itself was a congressional response to a Supreme Court decision that found no sex discrimination when an employee disability benefits plan provided compensation during all periods of disability except pregnancy. Congress disagreed with the Court and passed the PDA in order to correct the mistake.⁷⁰

Once again, though, progressives must first determine whether there is value in changing the antidiscrimination laws to ensure coverage of infertility treatments under employee health benefit plans. Specifically:

- Does the lack of coverage of such care discriminate against infertile people?
- When plans exclude procedures that are performed only on women but can be used to correct infertility in both women and men, do they discriminate on the basis of sex?
- Should infertility be considered sufficiently related to pregnancy to fall under the PDA's protection?
- Are society's interests best served by advocating for expanded coverage of infertility treatments or for some other type of health care?

These questions do not have easy answers, but it is important that we ask them and attempt to resolve them.

Disposition of Frozen Embryos

After two years of fertility treatments and the night before Augusta Roman was to undergo implantation of embryos created through IVF, her husband Randy informed her that he had had a change of heart and did not want to go through with the procedure. The couple underwent counseling and then divorce. The only contested issue was their remaining three embryos.

Augusta won in the trial court, but Randy won in the appellate court. While the case was awaiting appeal with the Texas Supreme Court, both parties vowed to appeal all the way to the United States Supreme Court, which had the papers buzzing about the “legal implications for *Roe v. Wade*.”⁷¹ The argument advanced by Augusta’s lawyers in the briefs to the Texas Supreme Court was that a woman should have the same right to control the disposition of embryos outside her womb as she has of naturally conceived embryos. Randy countered that such a position would reduce men to mere sperm donors.⁷²

Ultimately, the Texas Supreme Court refused to consider the appeal and the case ended there.⁷³ But the issue over which the Romans fought is bound to come up again. It is estimated that approximately half a million frozen embryos are currently being stored by fertility clinics in the United States.⁷⁴ Patients who have not used all the embryos they have created have several options from which to choose in deciding what to do with the embryos. They can:

- ☑ Use the embryos themselves for procreative purposes at a later date
- ☑ Donate the embryos to others who would like to have children (sometimes referred to as embryo “adoption”)
- ☑ Donate the embryos for medical or scientific research (primarily embryonic stem cell research)
- ☑ Have the embryos thawed and discarded
- ☑ Keep the embryos frozen indefinitely

Whether overwhelmed by the complexity of the decision or simply because they are never pressed to make a decision, some couples opt for a sixth unofficial option: abandonment. In response to the latter, some fertility clinic contracts now require that if a couple fails to pay storage fees or remain in touch with the clinic, the embryos will

become the property of the clinic after a specified period of time and can be destroyed or used for research. But there is little statutory or case law to provide clinics and patients with guidance.

Statutory Law

Only a handful of states have enacted statutes that are related in any way to the disposition of frozen embryos. The majority of these laws simply require that couples undergoing fertility treatments be provided with “information sufficient to enable them to make an informed and voluntary choice regarding the disposition of any unused” embryos or other genetic material; that they be presented with the option of storing, discarding, or donating the embryos; and that donation for research purposes be accompanied by written consent.⁷⁵ Under these statutes, none of the options except donation for research requires written consent, and patients do not have to select a disposition in order to commence treatment.⁷⁶

Florida alone requires that a physician and couple enter into a written agreement providing for the disposition of gametes and embryos “in the event of a divorce, the death of a spouse, or any other unforeseen circumstance.”⁷⁷ The statute, however, also provides that absent a written agreement, decision-making authority regarding the embryos shall reside jointly with the couple—which may not be of much use should the couple encounter a dispute about control of the embryos. Even if there is a written agreement pursuant to the statute, it is possible a court would re-evaluate the contract in light of changed circumstances if a dispute arises about the terms of the contract itself.

Only two states—New Hampshire and Louisiana—make any pronouncements about what may or may not be done with embryos, but the two statutes are about as different as can be.⁷⁸ New Hampshire merely mandates that an embryo that has not been implanted may not remain unfrozen for more than 14 days beyond fertilization. It also places a ban on transferring an embryo to a uterus if the embryo has been donated for research purposes.⁷⁹

Louisiana’s regulatory scheme regarding human embryos is unique both in its scope and in its implications.⁸⁰ To begin with, it defines a human embryo as a fertilized ovum that will develop into an “unborn child” and classifies it as a “juridical person”—meaning one with legal rights to sue or be sued—prior to implantation and at any other time “rights attach to an unborn child.” The law allows IVF patients to “express their identity” or to forfeit their rights as parents, be treated as gamete donors, and put their embryos up for “adoptive implantation.”

Under Louisiana law, a viable embryo may not be intentionally destroyed and the physicians and medical facilities that perform IVF are charged with safeguarding the fertilized ova in their care. The judicial standard to be applied to any disputes that arise is the “best interest of the in vitro fertilized ovum,” which is the same standard used when determining the custody of children.

The unmistakable import of this law is to undermine abortion rights by treating embryos as if they were born children.⁸¹ Although the statutory scheme has not been invoked to challenge abortion rights directly, it invests non-sentient, microscopic organisms with rights—including,

There is little statutory or case law to provide clinics and patients with guidance.

apparently, the right to be gestated and born—and legal standing in court.

Beyond abortion law, this regulatory framework raises a number of other significant constitutional issues. It transforms fertility patients into gamete donors, it potentially violates their right not to procreate, and it denies them their right to determine the disposition and use of their own genetic material.⁸²

Case Law

Left without statutory guidance, courts have struggled to determine whose interests shall prevail when disputes arise between couples as to the disposition of their unused embryos.

Of the six highest state courts to address this issue thus far, Tennessee's was the first. In *Davis v. Davis*,⁸³ the Tennessee Supreme Court decided that it must first reach the threshold question of how to categorize the human embryo. Rejecting suggestions that embryos are either persons or property, the court found that they inhabit “an interim category that entitles them to special respect because of their potential for human life.”⁸⁴

The court declared that any agreement regarding the disposition of frozen embryos should be presumed valid and enforceable.⁸⁵ Because there was no contract in the *Davis* case, however, the court engaged in a balancing test, where it weighed the interests of the parties against each other.

The court determined that the essential question was whether the parties would become parents, thereby implicating their constitutional right to privacy and the

related right to procreate or to avoid procreation. Despite the increased stress and discomfort that women undergo in the IVF process, the court found that women and men must be seen as “entirely equivalent gamete providers.”⁸⁶

Furthermore, unlike with the question of abortion, the case did not involve interference with a woman's bodily integrity; therefore her interests would not automatically trump the man's.⁸⁷ The court also found that the state's interest in the potential life embodied by the embryos was “at best slight” and not sufficient to justify any infringement upon individuals to make their own decisions about whether to allow the IVF process to continue.⁸⁸

Under the particular facts of the case, the couple divorced and the husband wanted to prevent the embryos from being implanted. The wife initially wanted to use the embryos herself, but by the time the case reached the state supreme court, she had changed her position to wanting to donate the embryos to a childless couple. The court determined that unwanted parenthood for the husband was a greater burden than the wife's knowledge that the IVF process would be rendered futile and the embryos she helped create would never become children.

The court noted, however, that it would have been a closer case had the wife wanted to use the embryos herself. In that event, the court said, an additional factor to consider would be whether she could achieve parenthood by other reasonable means, including adoption.

Since *Davis*, five other courts of last resort have addressed the issue. Generally, they first have inquired whether a couple signed a consent form with the fertility

clinic that indicated what their intent was when they created the embryos. Some courts, however, have been reluctant to enforce such agreements given that what a couple decided when they started treatment may differ vastly from how they feel after several years and significantly changed circumstances, such as the divorce that brought them into court.

In *Kass v. Kass*,⁸⁹ New York's highest court held that agreements between couples regarding their unused frozen embryos should be enforced unless those agreements violate public policy⁹⁰ or unless the couple's circumstances have significantly changed. "Advance directives," the court said, "both minimize misunderstandings and maximize procreative liberty by reserving to the progenitors the authority to make what is in the first instance a quintessentially personal, private decision."⁹¹

New Jersey and Iowa's supreme courts also agreed that such contracts should be honored, but subject to a large caveat—the right of either party to change his or her mind prior to use or destruction of the embryos.⁹² This model, known as the "mutual consent" model, requires that both parties must contemporaneously agree in order for any action to be taken.

According to the New Jersey court, when a couple disagrees as to the disposition of the embryos, the interests of both parties must be evaluated (effectively a balancing test).⁹³ In Iowa, when the parties disagree, the status quo must be maintained until they can reach resolution or until the fertility clinic is no longer contractually obligated to maintain the embryos, with the expenses for maintaining the embryos to be paid by the person opposing destruction of the embryos.⁹⁴

Although the courts have adopted a variety of tests to resolve such issues, thus far they have consistently ruled in favor of the spouse who opposes use of the embryos for procreative purposes. Massachusetts, New Jersey, and Iowa all based their reasoning in part on the fact that advance agreements to procreate or form other family relationships violate their states' public policy and are unenforceable.⁹⁵ Tennessee, in contrast, was reluctant to announce any bright-line rule and strained to point out that its holding should not be read to provide an automatic veto to a party seeking to avoid parenthood.⁹⁶

The only other state supreme court to have considered this issue, the Supreme Court of Washington, limited its ruling to the contractual rights of the parties. In *Litowitz v. Litowitz*,⁹⁷ the couple had used the husband's sperm and a donor's eggs to create the embryos. Although only the husband had a biological connection to the embryos, the court found that both husband and wife had equal contractual rights. However, because the contract provided that the clinic could destroy the embryos after five years and more than five years had passed, the court assumed the embryos were destroyed and declined to rule on which party would control the embryos if they did still exist.

In *Roman v. Roman*, described above, the Texas Court of Appeals also followed a contractual approach. It observed that there was "an emerging majority view that written embryo agreements between embryo donors and fertility clinics to which all parties have consented are valid and enforceable so long as the parties have the opportunity to withdraw their consent to the terms of the agreement."⁹⁸ The court also gleaned from the handful of Texas statutes that do address assisted

reproduction that the public policy of the state would support this approach.⁹⁹

Randy and Augusta had signed a consent form in which they explicitly elected to have their embryos destroyed in the event that they divorced. Augusta claimed that she thought the provision only applied to embryos that remained after at least one attempt at implantation, but the court found that the agreement was clear and unambiguous: “Although Augusta’s choice may not have been fully considered, the evidence shows that she was aware of and understood the significance of her decision.”¹⁰⁰

What all of these courts have emphasized is that such disputes should be governed by statute and that these decisions should be confined as much as possible to the particular set of facts encountered in each case.

On the one hand, it makes sense to require any person who contributes genetic material to an embryo with the intent to become a parent to designate, in advance, what should happen to that embryo if it is not used for its initial purpose. The process alone should help couples think through future scenarios and commit themselves to a particular course that may reduce the likelihood that a dispute will arise. To that end, further regulation may be helpful.

On the other hand, it is in the clinics’ best interests to have patients fill out consent forms and it is likely that they now routinely collect information about what is to be done with unused embryos, obviating the need for legislative mandates. Moreover, as many of the cases above indicate, even where there are initial agreements, some disputes will inevitably

arise and the courts must nevertheless adjudicate whether the agreements will be enforced.

If allowing one progenitor to use an embryo against another progenitor’s objection amounts to forced procreation for the objector, should patients even be given the option to choose to have their embryos used by one partner or by others for procreative purposes? Perhaps such an option should come with a caveat that its selection requires mutual consent at the time of actual use so that patients are on notice that enforcement of this option is conditional. That solution, however, would seem to dictate that provisions to discard the embryos or use them for research should always be enforced; otherwise we are back in the position of allowing one progenitor to use embryos against another progenitor’s will.

It may also be beneficial to have guidance on what happens when donor gametes are used to create embryos. Should sperm or egg donors have a say in what happens to an embryo to which they contributed if it is not used by the intended parents? In practice, it appears that a donor’s right to withdraw consent to the use of gametes expires when the gametes are collected or, at the latest, when the gametes are used to create embryos.

But if an embryo is not used for its intended purpose, should donors have the opportunity to indicate what they would like to happen to the embryos or to place limits on what may happen? Or should the embryos be treated as the property of the intended parents, with them having exclusive control over disposition? And should an intended parent who used a donor have as much say as an intended parent who contributed sperm or eggs?

We should ensure that such guidance reflects progressive values and does not violate or undermine constitutional protections.

These questions have the potential to challenge and test our most core values, among them:

- When the right to procreate clashes with the right not to procreate, which one should prevail?
- Does our answer change when we are talking about an established pregnancy in a woman versus an embryo in a lab?

- What do we mean by consent, and how long does it last?

As with child custody disputes, fights over embryos can be incredibly fact sensitive and courts will no doubt have to resolve these disputes from time to time. But despite the nature of these suits, they can still benefit from legislative guidance. We should ensure that such guidance reflects progressive values and does not violate or undermine constitutional protections.

Parentage Determinations

“For most of human history... ‘being a father was a matter of conjecture, and being a mother was a matter of fact.’ Now nothing can be known for sure.”¹⁰¹

The new reproductive technologies are so emotional and contentious precisely because they challenge our basic understanding of what it means to be a parent. Throughout history, each child has had two, and only two, biological parents. As a result, U.S. family law is built around the concept that a child will have, at most, two legal parents. Until recently, those parents were either biological or adoptive (see text box below). And it is a zero sum game—in order to adopt a child, birth parents must first relinquish their rights or have them terminated.

Now, due to the wonders of “collaborative reproduction” (the phrase used when intended parents recruit others to help them bring a child into existence), a child can have up to three biological parents—the man who provides the sperm, the woman who provides the egg, and the woman who carries the pregnancy and gives birth. Up to three more people also may be viewed under the law (and in their own eyes) as a parent of a child—the “intended” or “contracting” parent(s) who sought to create a child through assisted reproduction, and the husband of a gestational surrogate who has elected to keep the child or children to whom she gave birth.

Which of these adults, and how many of them, should qualify as the legal parents? In Pennsylvania, the answer may now be three. In April 2007, an appellate state court panel ruled that two lesbian co-parents and their sperm donor friend all are the legal parents of and financially responsible for the children they had created.¹⁰²

So far, no other appellate court in the United States has assigned more than two legal parents to a child. In fact in a well-known surrogacy case in which the genetic/intended father, the genetic/intended mother, and the gestational surrogate all had claims as legal parents, the California Supreme Court expressly declined to expand the number of legal parents beyond two.¹⁰³

But additional courts are likely to face this question in the coming years. And the possible parentage combinations they could encounter seem almost endless. A child could have three women vying to be its mother—the egg provider, the gestational carrier, and an intended mother—or no mother at all. Recently, a Maryland man and the surrogate he hired to carry twins created with his sperm and a donor’s eggs won a court case to have no mother listed on the birth certificate.¹⁰⁴

One day, technology may allow for two genetic mothers: a technique known as ooplasmic transfer involves injecting ooplasm (the material outside the cell's nucleus) from one woman's egg into another woman's egg. It was used in a handful of cases where it was thought that a woman's infertility was caused by her ooplasm. Because DNA exists in both the nucleus and the ooplasm, a child born from this process would have two genetic mothers. The Food and Drug Administration, however, currently has a moratorium on clinical trials using this procedure.¹⁰⁵

All states have parentage acts that provide statutory guidelines for determining the paternity of a child when it is uncertain, but those laws are not sufficient to address the complicated circumstances that result from the use of new reproductive technologies. Slowly but surely, the states are beginning to recognize the need for legislation that explicitly governs the determination of paternity and maternity when a child has been created with assisted reproduction.

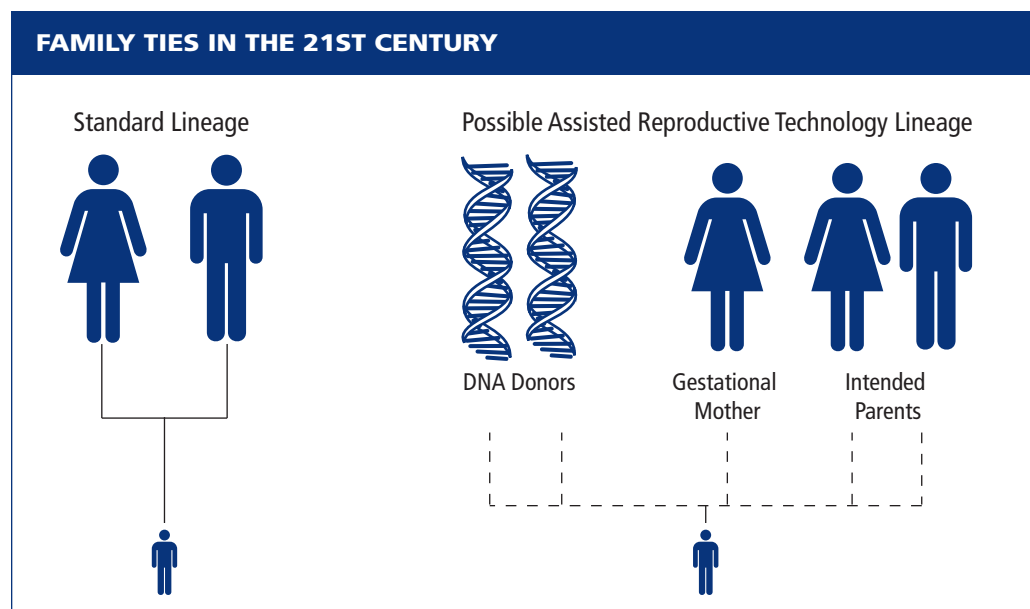
Nevertheless, the states that have moved in this direction have provided a patchwork response. The latest version of a model law known as the Uniform Parentage Act was approved by the National Conference of Commissioners of Uniform State Laws in 2002 and includes several provisions that address assisted reproduction and gestational agreements. But only seven states had enacted it by 2006, and none passed it verbatim.¹⁰⁶

Other states have crafted their own solutions. The topics they cover and the limitations they impose vary immensely. It will be quite a while before there is any true uniformity or consensus regarding the legal presumptions that control how parentage disputes should be determined.

A child could have three women vying to be its mother or no mother at all.

Assisted Reproduction Generally

The first statutes to address assisted reproduction were those related to artificial insemination. The majority of states now



have laws providing that a man who consents to artificial insemination of his wife will be considered the father of any resulting child and the sperm donor will not be the father. Normally, these laws require both the husband and wife to consent to the insemination in writing and for the insemination to be done under the supervision of a physician. These statutes, however, often provide that where a husband has failed to give written consent, he can still be found to be the father if he and his wife held the child out as their own during the first years of the child's life.¹⁰⁷

Some of these statutes have been broadened to cover consent to any type of assisted reproduction and/or to include unmarried people. Most of these statutes, however, are silent as to families headed by unmarried heterosexual, gay, lesbian, or trans couples, as well as single parents. For them, whether their rights as parents will be recognized is still uncertain and largely unknown.

Occasionally, where states have not updated their laws to account for new types of families, courts will apply the more conventional laws by analogy. In *Elisa B. vs. Emily B.*, for instance, the California Supreme Court applied its state Uniform Parentage Act to find that a lesbian who consented to the insemination of her partner, welcomed the twins produced into their home, and held them out as the couple's children was a legal mother of the children. Therefore, intent and consent were sufficient to establish legal parenthood absent any biological relationship to the child.¹⁰⁸

In *K.M. v. E.G.*,¹⁰⁹ the companion case to *Elisa B.*, the court again reasoned by analogy to find that genetic consanguinity can be a basis for finding maternity

just as it is for finding paternity. That case involved a woman who had donated ova to her lesbian partner, who then carried the pregnancy and gave birth. The court found that both women could establish maternity under the law because one had provided genetic material and the other had given birth. The court further found that nothing precluded a child from having two parents who both happened to be women, as long as there was no third person making a claim for parenthood.

Egg and Embryo Donation

Charles and Cindy,¹¹⁰ an unmarried couple in Tennessee, decided to start a family together in their 40s. Using a donor's eggs and Charles's sperm, Cindy became pregnant and gave birth to triplets. They moved into a larger home together and began rearing their children. After some time, however, their relationship began to deteriorate. Charles became less involved with the children and began to withhold financial support.

When Cindy filed a petition to establish parentage and obtain custody and child support, Charles argued that she did not qualify as the children's mother under state law because she had no genetic connection to them. Having no statute directly on point to resolve Charles and Cindy's dispute, the Tennessee Supreme Court applied a multi-factor test that considered genetics, intent, gestation, and the fact that there was no dispute with a genetic mother to find that Cindy was indeed the legal mother. The court ended with a plea for legislative action to govern future cases.¹¹¹

Only six states, however, have statutes that explicitly address the parental rights involved with egg or embryo donation.

They each create a presumption that the birth mother is the legal mother. They also specify when a husband's consent is or is not required for donating or using eggs or embryos.

In Colorado, a wife who uses egg donation will be treated as the natural mother if she and her husband consent in writing to assisted reproduction under a physician's supervision. But a spouse's written consent is not required when a married woman donates her eggs or a married man donates his sperm to someone outside the marriage.¹¹²

Texas, Utah, and Washington also do not require a married woman to obtain her husband's consent to donate her eggs.¹¹³

In Washington, a woman who gives birth to a child will be treated as the natural mother unless she and an egg donor have entered into a written agreement that the egg donor will be considered the natural mother (in which case the "donor" has not really donated her eggs).¹¹⁴ When there are disputes, both egg donors and gestational carriers have the opportunity to assert maternity by filing an affidavit and a physician's certificate within 10 days of a child's birth.¹¹⁵

Ohio provides that a woman who gives birth pursuant to an embryo donation will be treated as a natural mother. If she is married and her husband consented to the procedure, then he will be treated as the natural father.¹¹⁶

Adoption and ART

According to Debora Spar, author of *The Baby Business*, adoption started in this country as an informal practice in which families would assume responsibility for orphaned relatives or take in abandoned children and put them to work. The practice of legally adopting a child and conferring rights and privileges on that child began in the mid-19th century and spread from related children to unrelated ones by the beginning of the 20th century. Around the same time, aid societies began to send children from overpopulated urban areas to more rural states and normalized the concept of long-distance adoption.

As the stigma of adoption lessened in the wake of legalized birth control and abortion, open adoptions became more prevalent. Advocates of open adoption argue that children have a right to know about their genetic identity and family history, and birth mothers have a right to know what happened to the children they relinquished. With additional societal changes, adoptive parents have changed as well. Although some states and agencies still impose marriage restrictions on adoptive couples, single people and lesbian, gay, bisexual, or transgender couples are increasingly becoming adoptive parents. And interracial adoption, though still controversial, is becoming more and more common.

As adoption became more regulated, public and private agencies sprung up that acted as intermediaries between parents, children, and the state. Today, public agencies primarily handle the adoption of children from foster care, while private agencies manage the adoption of domestic newborns and children from other parts of the world. All three types of adoption involve home studies and evaluations of the adoptive parents, as well as additional administrative hoops for international adoptions.

State, federal, and international laws regulating adoption are intended to protect the best interests of each child, prohibit the selling of children, and prevent the exploitation of birth mothers and adoptive parents. But their effectiveness has been called into question from time to time. Depending on the source of a child, an adoption can cost anywhere from zero to \$35,000, but fees occasionally go as high as \$100,000.¹¹⁷

The analogy to surrogacy and egg and sperm donation is not hard to make. Many of the same questions can be asked. Who is fit to be a parent? At what point does a fee become baby selling? Does a child have a right to know his or her origins? It will be interesting to see how the answers in one sector of the "baby market" influence the answers in another sector.

Now that new mores and technologies allow for new family structures, new laws are needed that directly address these new circumstances.

Oklahoma addresses both egg and embryo donation, but only when used by married couples. A child conceived with a donor egg is considered a legitimate child of the married couple who used the egg. The egg donor has no rights to the child.

With embryo donation, the physician performing the transfer must have the written consent of the married couple donating the embryo and the married couple receiving the embryo. Any resulting child will be treated as a naturally conceived legitimate child of the recipient couple. The statute explicitly states that embryo donation is not considered child trafficking when the embryo is donated by the biological parents, the embryo is not offered for sale or sold, and the provisions of the statute are followed.¹¹⁸

The vast majority of parentage laws that exist were enacted in order to address the issue of illegitimacy, not assisted reproduction. When passed, they reflected the mores of the times. Now that new mores and technologies allow for new family structures, new laws are needed that directly address these new circumstances. Although many of the cases that arise will be fact sensitive, so were the illegitimacy cases that preceded them; statutory guidelines would nevertheless be helpful in establishing the frameworks in which these cases can be decided.

Surrogacy

Although the market for surrogacy is still relatively small—in 2000, there were only 1,210 attempts at gestational surrogacy¹¹⁹—when problems arise, they are monumental for those involved and their societal implications can be profound.

Perhaps the most famous surrogacy case is that of “Baby M.” In 1985, William Stern and Mary Beth Whitehead entered into a contract in which, for \$10,000, Ms. Whitehead agreed to be inseminated with Mr. Stern’s sperm, become pregnant, carry the pregnancy to term, deliver the child to Mr. Stern and his wife, and terminate her maternal rights. The payment was not to be made until the child was surrendered and Ms. Whitehead’s rights were terminated.

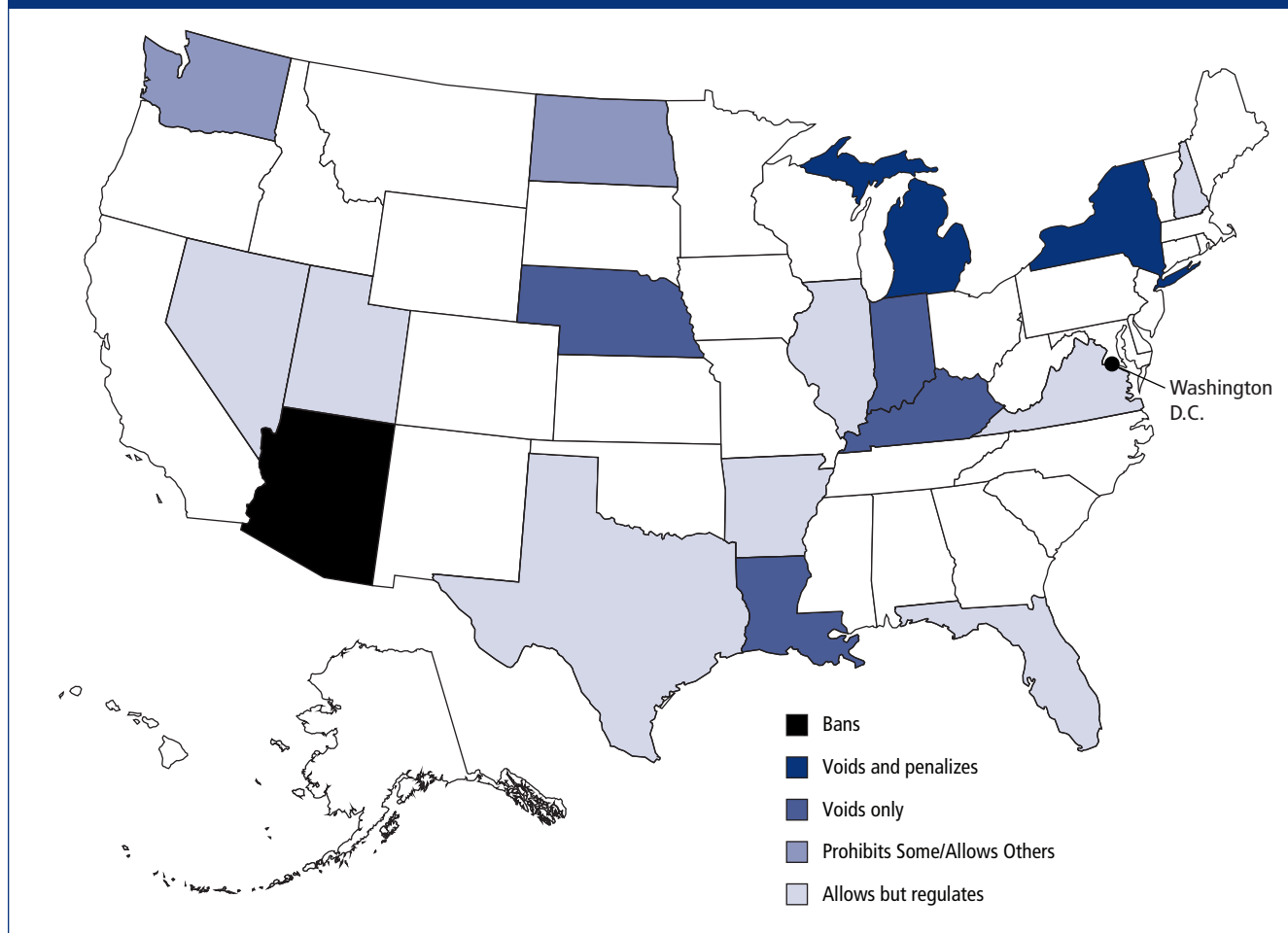
Initially, Ms. Whitehead complied with the contract and turned the child over to the Sterns. The next day, however, she returned and begged to have the child for one more week. The Sterns agreed, but after numerous unsuccessful attempts to retrieve the child over a four-month period, they obtained a court order to get the child back. Instead of turning over the child, Ms. Whitehead and her family fled to Florida. Eventually, the child was found and returned to the Sterns.

The case garnered considerable media attention and prompted several states to enact laws governing surrogacy. A review of the relevant statutes and case law reveals that the reactions to the practice of surrogacy are, literally and figuratively, all over the map.

Statutes

The approaches states have taken range from banning surrogacy agreements and penalizing the participants, to refusing to enforce surrogacy agreements, to allowing but enforcing them only if certain procedures have been followed. (For a detailed description of the state laws regarding surrogacy, see appendix on page 35.)

SURROGACY LAWS BY STATE



Arizona and the District of Columbia ban them. Washington bans contracts for compensation beyond certain expenses. Michigan and New York void surrogacy contracts and impose penalties. Indiana, Kentucky, Louisiana, Nebraska, and North Dakota void some or all types of surrogacy contracts.¹²⁰

Ten states allow certain types of surrogacy contracts but regulate them in some fashion.¹²¹ An additional five states take no position but specify that other laws do not apply to surrogacy arrangements.

Disincentives for surrogacy contracts span from outright bans, with or without

accompanying punishments, to declaring that such contracts are void and unenforceable. The difference turns on whether the state takes a passive or active role in deterring such agreements.

States that declare the contracts void will simply refuse to enforce the agreements. If people enter such contracts and problems arise, they will have to sort out the disagreements on their own.

In contrast, the states that ban surrogacy contracts do not allow such contracts to be made and sometimes will penalize anyone involved in making the contract. Some states combine these approaches

TABLE 2: STATE SURROGACY LAWS

STATE	SURROGACY REGULATIONS						
	<i>Court approval</i>	<i>Screening</i>	<i>Residency requirement</i>	<i>Limits compensation</i>	<i>Provisions if no valid contract</i>	<i>Protects unmarried people</i>	<i>Intended mother can't bear child</i>
Arkansas						•	
Florida	T	•		•			G
Illinois		•			•	•	
Nevada				•			
New Hampshire	•	•	•	•	•		•
North Dakota							
Texas	•	•	•		•		•
Utah	•	•	•	•	•		•
Virginia	•	•		•	•		•
Washington				•	•		

G=Gestational

T=Traditional

by voiding the contracts and assigning penalties. Generally, where there are punishments, brokers are punished more severely than participants.

The states that allow surrogacy vary greatly in terms of whether a surrogate may receive compensation beyond necessary expenses, whether she has a period of time after the birth to change her mind about surrendering the child, whether a court must approve the agreement, and the number of requirements the parties must satisfy ranging from medical and psychological evaluations to home studies.

The vast majority of statutes require the intended parents to be married, but a few do not. If the surrogate is married, the statutes invariably require her husband to consent and be a party to the agreement. The states also vary as to whether at least one of the intended parents must be genetically related to the child and whether the surrogate may use her own eggs.

Finally, while not approving of surrogacy affirmatively, some states have made it clear that their prohibitions on selling children do not apply to surrogacy arrangements or fees related to such agreements.¹²² Similarly, Tennessee does not expressly authorize surrogacy, but its adoption law does provide that an official surrender and adoption of a child born pursuant to a “surrogate birth” are not necessary in order to terminate the parental rights of the birth mother or establish the parental rights of the intended parents.¹²³

Case Law

The majority of states still lack any statutory guidance on surrogacy agreements. When asked to resolve surrogacy disputes, the courts have looked to statutes related to adoption, custody, paternity determinations, termination of parental rights, and “baby selling”; the federal and state constitutions; and public policy considerations.

<i>At least one intended parent must contribute gametes</i>	<i>No surrogate eggs</i>	<i>Surrogate makes health decisions</i>	<i>Intended parents must accept child</i>	<i>Intended parents become parents at birth</i>	<i>Time period for surrogate to change mind or challenge contract</i>
G		G	•	G	T
•	•			•	•
Both	•				
•					•
Both	•				
	•	•			
•	•	•			
•		•	•		•

In *Baby M.*, described above, the Supreme Court of New Jersey ruled that “payment of money to a ‘surrogate’ mother [was] illegal, perhaps criminal, and potentially degrading to women.”¹²⁴ The court found that paid surrogacy arrangements violated the state’s statutes prohibiting the use of money in connection with adoptions, requiring proof of parental unfitness or abandonment before termination of parental rights, and making surrender of custody and consent to adoption revocable in private placement adoptions.

The court also found that the contract violated the state’s public policy, namely that a child’s custody should be determined by an analysis of the child’s best interests; that natural parents have equal rights with regard to their child; that consent to adoption be informed, voluntary, and meaningful; and that the sale of a child is pernicious. It also noted that class disparities are a common characteristic of paid surrogacy, which also gave cause for concern.

The court acknowledged that constitutional issues were implicated for both parties—for Mr. Stern, the right to procreate; for Ms. Whitehead, the right to companionship of one’s child. The court, however, determined that Mr. Stern did exercise his right to procreate and voiding the surrogacy contract did not interfere with the exercise of that right.

The court also found that there was no basis to terminate Ms. Whitehead’s parental rights. Therefore she too would not suffer a constitutional deprivation. Ultimately, the court declared that both were the child’s natural parents, but the child’s best interest warranted granting custody to the Sterns and visitation rights to Ms. Whitehead.¹²⁵

In stark contrast to New Jersey, the California Supreme Court has been very open to the use of assisted reproduction and has paved the way in adapting state law to technological advancements and allowing their use to flourish. With its

landmark decision of *Johnson v. Calvert*,¹²⁶ the court set forth what has come to be called the “intent” test when addressing surrogacy disputes.

In that case, Anna Johnson agreed to carry and deliver the genetic child of Mark and Crispina Calvert. Unfortunately, relations soured during the pregnancy, and by the time the child was born the parties were already in court asserting their competing rights as parents. The court determined that although the California Uniform Parentage Act did not specifically address surrogacy, it applied to any case in which parentage was in dispute. The court found that under the Act, both women had established grounds for maternity—Anna by giving birth, and Crispina by providing genetic material—yet California law recognized only one natural mother for every child.¹²⁷

The court concluded that when the roles of genetic consanguinity and giving birth do not coincide in one woman, the one who intended from the outset to procreate and raise the child is the natural mother under California law. This holding effectively precludes a gestational surrogate from ever changing her mind about a surrogacy agreement.

The court also found that the surrogacy contract at issue was not inconsistent with public policy because, according to the court, gestational surrogacy differed in crucial respects from adoption and was not subject to the adoption statutes; it did not constitute involuntary servitude; it did not treat children as commodities; and it did not exploit or dehumanize women, including women of lower economic status. With regard to the last point, the court thought the argument that a woman could not knowingly and intelligently

enter into such an agreement smacked of paternalism. Moreover, it thought the legislature, not the courts, was the proper forum for resolving such questions.

Finally, the court determined that, because Johnson was not the legal, natural mother, she had no constitutionally protected liberty interest based on her status as a “birth mother” and therefore no right to the companionship of the child. A woman who agrees to be a gestational surrogate “is not exercising her own right to make procreative choices; she is agreeing to provide a necessary and profoundly important service” to a couple who are exercising their right to “procreate a child genetically related to them by the only available means.”¹²⁸

The California Court of Appeals applied this holding in *In re Marriage of Buzzanca*,¹²⁹ where the child was at risk of having too few parents rather than too many. In that case, a gestational surrogate carried a child created with gametes from anonymous donors for a married couple who were the intended parents. When the couple divorced, the husband attempted to claim no responsibility for the child because he had no biological relationship to the child. Flatly rejecting that position, the court held that both the husband and wife would be deemed the legal parents because they had initiated and consented to the assisted reproduction that brought about the birth of that child.

The California Court of Appeals has determined, though, that the intent test is only to be used when the birth mother and the genetic mother are different women. When a surrogate uses her own eggs, then she will be considered the natural, legal mother regardless of the intent of the parties. Because genetics and

birth coincide in the same woman, there is no need to use intent to break the “tie” between two mothers, as there was in the *Johnson* case. Without a formal consent to adoption, the intended mother has no right to the child.¹³⁰

In contrast, Ohio has rejected outright the *Johnson* intent test in favor of a test that relies primarily on genetics. In *Belsito v. Clark*, the court found that the intent test was unworkable for a number of reasons, including the difficulty of proving intent. It found genetics to be a much more reliable and established method for determining parentage. Therefore, the presumption in Ohio is that the genetic mother will be the legal mother.

The court noted, however, that genetics should not be the exclusive test for determining parentage and that birth can be used as a secondary test. Under the birth test, the birth mother could still be found to be the legal parent if the genetic parents consented.¹³¹ Of course, if that is the case, it is unlikely the parties would end up in court unless there is a problem with the birth certificate.

Legal scholar Dorothy Roberts of Northwestern University has argued that, even in *Johnson*, a major factor in these cases involves establishing the primacy of genetics over gestation, and she contends that a racial subtext often drives such decisions. For instance, in *Johnson*, Anna was African-American, Crispina was Filipina, and Mark was white. The press, however, focused much more attention on Anna’s race than on Crispina’s and portrayed the child as white.

Roberts fears that gestational surrogacy doubly disadvantages economically vulnerable women of color who cannot

afford a court battle and who are unlikely to gain custody of a white child.¹³² Debora Spar, author of *The Baby Business*, confirms that by 2000, one-third of gestational surrogacy arrangements at the largest U.S. program involved surrogates and couples of different races.¹³³

One set of academics has noted that surrogacy agencies intentionally select surrogates who are primarily white, Christian, and married with children in order to give the impression that the practice does not exploit low-income women, yet the majority of surrogates fall within the lower-middle socioeconomic class. Most earn just above the poverty line, and 40 percent are otherwise unemployed, receiving financial assistance, or both.¹³⁴

In calling for a uniform, federal law governing surrogacy agreements, these commentators argue that such a standard would prevent forum shopping for states with more favorable surrogacy laws, which reduces the bargaining power of individual surrogates, draws prospective parents from all over the country with the promise of easy risk-free transactions, and allows agencies to get around the most restrictive state laws.¹³⁵ This suggestion raises several questions, among them:

- How do we best ensure that the practice of commercial surrogacy does not exploit its participants?
- How do we balance the interests of the gestational mother against the genetic parents when they conflict?
- Do we let the states continue to experiment with a range of possible solutions, or does such a patchwork approach only lead to regulatory chaos that enables commercially savvy actors

Whatever decisions we make should be guided by our desire to balance our apprehension about exploitation with our respect for individual autonomy, our sympathy for biological and intended parents with our concern for the well-being of the children produced.

to take advantage of surrogates and intended parents?

Another option would be to encourage states to enact some version of Section 8 of the Uniform Parentage Act, which addresses surrogacy agreements.¹³⁶ Although states have the power to regulate adoption and custody, many adhere to model uniform laws on those topics. Should surrogacy follow the same route, or is it somehow different enough to warrant federal action?

How we handle surrogacy will depend on how we answer the following questions:

- Is commercial surrogacy a repugnant practice that must be banned and punished?
- Do we simply want to discourage surrogacy by refusing to enforce contracts?
- Is surrogacy a valid and honorable form of employment that women should be free to undertake so long as they fully understand the medical and legal risks involved?
- Do intended parents have a right to procreate with the assistance of a surrogate?

If we do choose to allow but regulate surrogacy, we must then decide:

- Should we treat surrogacy more like natural conception, with minimal state interference, or like adoption, with a high level of government intervention?
- Should surrogates have time to decide whether to keep the children they bore?
- What compensation, if any, should be allowed?

- What should be the remedies, if any, when a contract is breached?
- When disputes arise, how should courts determine parentage—by genetics, by birth, by intent, or by some other test?
- Should the same rules apply to both traditional and gestational surrogates?

Again, these questions are not easy to answer, but they must be asked. Whatever decisions we make should be guided by our desire to balance our apprehension about exploitation with our respect for individual autonomy, our sympathy for biological and intended parents with our concern for the well-being of the children produced.

Posthumous Creation of a Child

Until the advent of reproductive technologies, it was possible for a child to be born after the death of a genetic parent in only one situation—when a father died while the child was still in utero. In a twist that seems purely science fiction, children can now not just be born but conceived after the death of one or both of their parents, sometimes years later. Frozen gametes and embryos are the main vehicle for this trend, but sperm (and one day eggs) also could be collected from a recently deceased body in extreme circumstances.¹³⁷

In addition to whatever emotional fallout may occur, this new practice has created ripples in inheritance law and posed new questions for government programs that manage Social Security and other benefits. A notorious case in

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the 1980s raised the issue briefly: Elsa and Mario Rios, a wealthy couple who lived in Los Angeles, had undergone IVF treatment in Australia and had two frozen embryos stored there when they died in a plane crash without a will and without any instructions as to their unused embryos.¹³⁸

Suddenly people were faced with questions such as who gets to decide the embryos' fate and would they be entitled to inherit the money? It spurred clinics to begin asking their patients for written indications of their wishes, but 20 years later most states in the United States still have not amended their laws to address this type of situation.

This issue will become more and more pressing as families begin to learn of this reproductive option. Increasingly, soldiers who are already involved in IVF programs are storing their sperm before heading off to war, concerned that they may receive wounds in combat that affect their fertility or worried they may not come home at all. Already, one Virginia clinic has banked sperm for 500 servicemen and the Pentagon is in the process of developing a benefits policy for "post-mortem conception."¹³⁹ Below is a review of the relevant statutes and case law.

Statutes

Only a handful of states have addressed whether a child created by assisted reproduction after the death of a genetic parent shall be entitled to inherit or receive government benefits from that parent. Normally they require the decedent to have demonstrated some intent to be a parent of a child that may be created after his or her death.

For instance, in Florida a child conceived from the gametes of a person who dies before placement of gametes or embryos in a woman's body is not eligible for a claim against the decedent's estate unless the decedent provided for such a child in his or her will.¹⁴⁰

In Virginia, if a genetic parent dies before the implantation of an embryo, there are two ways he or she will be found to be a legal parent of a resulting child: if implantation occurred before notice of death could reasonably be communicated to the physician, or if that person consented in writing to being a parent prior to implantation.¹⁴¹ It should be noted that Virginia's statute does not expressly require contemplation of posthumous implantation; it appears that general consent to assisted reproduction is sufficient.

The remaining seven states¹⁴² that address the issue follow a provision that was originally included in the Uniform Status of Children of Assisted Conception Act and now appears as section 707 of the Uniform Parentage Act.¹⁴³ According to that section, the deceased must have specifically consented in a record to becoming a parent through assisted reproduction that might occur after his or her death in order to be considered the legal parent of any resulting child.

Case Law

When the federal government has disputed a claim to Social Security benefits by children created after a parent's death, the courts have looked to state law to determine whether they are eligible to receive the benefits. Therefore, it is particularly important for states to act in this arena or for federal government benefits

programs to adopt regulations that create predictability for families considering this reproductive option.

In *Gillett-Netting v. Barnhart*,¹⁴⁴ the federal government denied Social Security benefits to children conceived by IVF after their father's death because they were not his dependents at the time of his death. The Ninth Circuit, however, found that they were considered legitimate children under Arizona law. Thus, they could be deemed his dependents and did not have to demonstrate actual dependency.

Similarly, in *Stephen ex rel. Stephen v. Barnhart*,¹⁴⁵ a child was conceived after his father's death and again was denied Social Security benefits because he was not a dependent child at the time of the parent's death. The District Court applied the Florida law that says a child conceived after a parent's death is not eligible for a claim against the estate unless provided for in the will. Because the child in this case was not included in his father's will, he had no claim to the Social Security benefits. The court distinguished the case from *Gillett-Netting* because Florida had a statute that specifically deals with posthumous fertilization while Arizona did not.

If a wife uses her deceased husband's sperm and inherits from him directly, then perhaps regulation is not needed to protect her interests and the child's. But other questions still remain, among them:

- Should the practice of posthumous conception and/or implantation be allowed at all, and if so should counseling first be required?
- Must the deceased have consented specifically to posthumous conception and/or implantation in order for the child to have legal rights and entitlements?
- Should there be a time limit on the use of a deceased person's gametes or embryos created from their gametes?
- Who gets to use the gametes or embryos derived from a deceased person—a spouse or partner, a girlfriend or boyfriend, a parent?

This is an area where advance knowledge of a consistent set of laws would be especially helpful to the families who use assisted reproduction.

Conclusion

Although assisted reproductive technologies are allowing us to create family relationships that have never existed previously in history, the questions raised here are simply new variations on old themes:

- What family structures are most beneficial for children?
- What are legitimate limits on the right to be a parent?
- How far can the state intervene in regulating the family?
- How can we achieve recognition and protection for new and evolving family structures?

Naturally, the weighty questions discussed in this paper cannot be answered overnight, but it should be clear that progressives, and indeed all Americans, must become more aware of the development of policies regarding assisted reproduction and more engaged in the policymaking process. As these technologies continue to advance, as the market continues to expand, and as the legal precedents continue to grow, it would be foolish and shortsighted to ignore these issues or remain silent.

While the fertility industry affects only a small percentage of people at the moment, the demand for ART is constantly growing and its use is becoming more normalized. Closing our eyes to the problems described above is not an option. Neither is simply letting the “brave new world” come or trying to stop scientific and technological progress. Some amount of regulation and oversight will be necessary, and the current patchwork approach is unsustainable.

The questions surrounding ART challenge progressives to define our values and put them into practice in a concrete way. These technologies implicate numerous rights that we hold dear, including the right to use more traditional reproductive technologies like abortion and contraception, the right to create families with the people we love, and the right to make informed decisions about the most intimate aspects of our lives. At the same time, the ramifications of ART underscore how even our most personal choices can affect public health and shape the communities in which we live.

Although ART has the potential to cut across interest-group politics with its relevance for numerous areas of progressive concern, its interconnection with reproductive health, rights, and justice is especially strong. As we discussed in our paper, *More than a Choice*,

The ramifications of ART underscore how even our most personal choices can affect public health and shape the communities in which we live.

reproductive rights involve the ability to become a parent and to parent with dignity, to determine whether or when to have children, to have a healthy pregnancy, and to have healthy and safe families and relationships. Clearly, assisted reproduction is directly related to the first category, but it influences the other categories as well. We must keep these goals in mind as we develop our positions on the use of these new technologies.

Academics have debated many of the benefits and risks of ART for some time. Now, it is up to activists to convene the relevant stakeholders for respectful conversation that will help us determine the best ways to proceed. We also must act

to educate policy makers and the public so that we can have a more informed discourse that will enable us to make the tough but necessary choices to navigate this complex and rapidly changing terrain.

While it may be tempting to stay nestled in the realm of philosophy and theory, we must find ways to move forward. As demonstrated in this paper, others have already begun to act in this forum and regulate according to their beliefs—sometimes decidedly conservative beliefs. If we are to ensure a balanced and just approach to the use of these technologies, progressives must enter the fray as soon as possible. The future has arrived.

Appendix: Surrogacy Laws

Bans

Arizona

ARIZ. REV. STAT. ANN. § 25-218 (2007)

Arizona prohibits all surrogacy contracts, whether paid or unpaid, declares the surrogate as the legal mother and entitled to custody, and establishes a rebuttable presumption that the surrogate's husband, if she is married, is the father.¹⁴⁶

District of Columbia

D.C. CODE §§ 16-401 to -402 (2007)

D.C. prohibits all kinds of surrogacy contracts, declares them unenforceable, and punishes violators with up to a \$10,000 fine and/or one year in prison.

Washington

WASH. REV. CODE §§ 26.26.011-.903 (2007)

Contracts that pay compensation beyond reasonable expenses and contracts with unemancipated minors or women with a mental illness or disability are prohibited.¹⁴⁷ Violation of these prohibitions is a gross misdemeanor. Contracts for compensation also are void and unenforceable as contrary to public policy. Compensation is defined as any payment beyond actual medical costs, other expenses related to pregnancy, and legal fees related to drafting of the contract. (Contracts without compensation are allowed. *See infra.*)

Voids and Penalizes

Michigan

MICH. COMP. LAWS §§ 722.851-.863 (2007)

Michigan declares surrogacy contracts to be void and unenforceable as contrary to public policy, and punishes violations. A party to a surrogacy contract is liable for a misdemeanor punishable by a fine up to \$10,000 and/or one year in jail. Someone who induces or arranges such an agreement is guilty of a felony carrying up to a \$50,000

fine and/or 5 years in jail. The same punishment applies to anyone involved in an arrangement with a surrogate who is an unemancipated minor, mentally ill, or suffers from a developmental or mental disability. As a further disincentive, if a custody dispute arises, the person who has physical custody (likely the birth mother) may retain it until a court orders otherwise.¹⁴⁸

New York

N.Y. LAW DOM. REL. §§ 121-124 (2007)

New York declares surrogacy contracts contrary to public policy, void, and unenforceable. Parties to a contract are subject to a civil penalty of up to \$500. People who assist in arranging the contract are liable for up to a civil penalty of \$10,000 and forfeiture of the fee received in brokering the contract; a second violation constitutes a felony. A birth mother's participation in the contract, however, may not be held against her in a custody dispute with the genetic parents or grandparents.

Voids

Indiana

IND. CODE §§ 31-9-2-126 to -127, 31-20-1-1 to -1-3 (2007)

Indiana declares surrogacy agreements void and against public policy. But if a parentage determination must be made, courts should not base their best interest analysis solely on the fact that a person entered into a surrogacy agreement.

Kentucky

KY. REV. STAT. ANN. § 199.590 (2006)

Kentucky declares traditional surrogacy agreements void; it does not address gestational surrogacy. The state also prohibits compensation for facilitating a surrogacy contract.

Louisiana

LA. REV. STAT. ANN. § 9:2713 (2007)

Louisiana declares traditional surrogacy agreements null, void, and unenforceable as contrary to public policy; it does not address gestational surrogacy.

Nebraska

NEB. REV. STAT. § 25-21,200 (2007)

Nebraska declares surrogacy contracts void and unenforceable. The law assigns rights and obligations regarding the child to the biological father.

North Dakota

N.D. CENT. CODE §§ 14-18-01 to -08, 14-19-01, 14-20-01 to -66 (2007)

North Dakota voids traditional surrogacy contracts. If the surrogate is genetically related to the child, then she is declared the mother and her husband, if she is married, is deemed the father. (North Dakota recognizes gestational surrogacy agreements. *See infra.*)

Allows but Regulates

Arkansas

ARK. CODE. ANN. §§ 9-10-201 to -202 (2007)

Arkansas protects unmarried couples and single people as well as married people who use artificial insemination or surrogacy. If a woman is a surrogate, then the child's parents will be 1) the biological father and his wife, if he is married, 2) the biological father alone, if he is unmarried, or 3) the intended mother, if anonymous sperm was used.

Florida

FLA. STAT. §§ 63.212-.213, 742.15-.16 (2007)

Florida regulates traditional and gestational surrogacy separately. Traditional surrogacy is referred to as a “preplanned adoption agreement” with a “voluntary mother.” The most important distinction between them is that under preplanned adoptions, the birth mother has 48 hours after the birth of the child to change her mind, the adoption must be approved by a court, and the intended parents do not have to be biologically related to the child. In contrast, under a gestational surrogacy contract, the surrogate must agree to relinquish her rights to the child upon birth, the intended mother must show that she cannot safely maintain a pregnancy or deliver a child, and at least one of the intended parents must be genetically related to the child. Both sets of laws require the surrogate mother to submit to medical evaluation; make the surrogate the default parent if an intended parent who is expected to be a biological parent turns out not to be related to the child; limit the types of payment allowed; require the surrogate to be at least 18; and require the intended parents to agree to accept any resulting child, regardless of any impairment the child may have. Recruitment fees for traditional surrogates are prohibited.

Illinois

750 ILL. COMP. STAT. 45/6, 750 ILL. COMP. STAT. 47/10 to 47/75, 410 ILL. COMP. STAT. 535/12 (2007)

Illinois protects unmarried couples and single people as well as married couples under a gestational surrogacy contract. The surrogate may not supply her own eggs and at least one of the intended parents must be genetically related to the child. Under a valid agreement, the intended parents become the legal parents immediately upon birth and the parent-child relationship can even be established before birth (the only state to allow this). A person can bring a challenge to the agreement or the rights assigned under it within twelve months of the child's birth. The surrogate and intended parents must undergo evaluations and independent legal consultation. If the statutory requirements are not met, a court shall determine parentage based on evidence of the parties' intent.

Nevada

NEV. REV. STAT. § 126.045 (2007)

Nevada allows married couples to enter into a contract with a surrogate for "assisted conception." Based on the definition of that phrase, the statute applies to gestational surrogacy when both intended parents have supplied gametes. Payment is restricted to living and medical expenses related to the birth.

New Hampshire¹⁴⁹

N.H. REV. STAT. ANN. §§ 168-B:1 to -B:32 (2007)

New Hampshire has a very extensive statutory scheme that regulates surrogacy arrangements. The intended parents must be married and at least one of them must supply gametes. The surrogate has 72 hours after birth in which to decide whether to keep the child. The arrangement must be judicially preauthorized, evaluations and counseling of the parties must be conducted prior to impregnation of the surrogate, home studies of all parties must be conducted, all parties must be 21 or older, the intended mother must be physically unable to bear a child, the eggs must come from the surrogate or the intended mother (no donor eggs), the surrogate must have had at least one prior delivery, genetic counseling is required if the surrogate is 35 or older, and there is a residency requirement of 6 months for either the gestational mother or the intended parents. Fees are limited to medical expenses, lost wages, insurance, legal costs, and home studies. Fees for arranging a surrogacy contract are prohibited. There are also provisions addressing what happens if the contract is breached or terminated.

North Dakota

N.D. CENT. CODE §§ 14-18-01 to -08, 14-19-01, 14-20-01 to -66 (2007)

North Dakota recognizes gestational surrogacy agreements. Intended parents are the legal parents of a child when a gestational carrier is implanted with an embryo created with gametes from both of the intended parents. (North Dakota voids traditional surrogacy arrangements. *See supra.*)

Texas

TEX. FAM. CODE ANN. §§ 160.751-.763 (2007)

Texas's law is modeled after Part 8 of the Uniform Parentage Act of 2002. A gestational agreement must be validated in court. The gestational mother may not use her own eggs. She must have had at least one prior pregnancy and delivery. She maintains control over all health-related decisions during the pregnancy. The intended mother must show that she is unable to carry a pregnancy or give birth. The intended parents must be married and must undergo a home study. There is a residence requirement of at least 90 days for either the gestational mother or the intended parents. An agreement that has not been validated is not enforceable, and parentage will be determined under the other parts of Texas's Uniform Parentage Act.

Utah

UTAH CODE ANN. §§ 78-45g-801 to -809 (2007)

Utah's law is modeled after Part 8 of the Uniform Parentage Act of 2002. A gestational surrogacy agreement must be validated in court. The gestational surrogate must have had at least one prior pregnancy and delivery. She maintains control over all health-related decisions during the pregnancy. She may not use her own eggs. The intended mother must show that she is unable to carry a pregnancy or give birth. At least one intended parent must provide gametes. If the gestational surrogate is married, her husband's sperm may not be used. The intended parents must be married and must undergo a home study. All parties must be at least 21 and must participate in counseling. There is a residence requirement of at least 90 days for either the gestational mother or the intended parents. The gestational surrogate may not be receiving Medicaid or other state assistance at the time she enters the agreement. Payment to the gestational surrogate is allowed but must be "reasonable." An agreement that has not been validated is not enforceable, and parentage will be determined under the other parts of Utah's Uniform Parentage Act.

Virginia

VA. CODE ANN. §§ 20-156 to -165 (2007); *see also* VA. CODE ANN. §§ 32.1-257, 64.1-5.1, 64.1-8.1 (2007)

Virginia requires pre-authorization of a surrogacy contract by a court. If the contract is approved, then the intended parents will be the legal parents. If the contract is voided, the surrogate mother and her husband, if any, will be named the legal parents and the intended parents will only be able to acquire parental rights through adoption. If the contract was never approved, then the surrogate can file a consent form relinquishing rights to the child. But if she does not, the parental rights will vary based on whether either of the intended parents have a genetic relationship to the child. Depending on the circumstances, they may need to adopt in order to obtain parental rights. Notwithstanding all of the above, if the surrogate is the genetic mother, she may terminate the contract within the first six months of pregnancy.

Virginia's requirements for court approval include: a home study; a finding that all parties meet the standards of fitness applicable to adoptive parents; the surrogate must be married and have delivered at least one prior live birth; the parties must have undergone medical evaluations and counseling; the intended mother must be infertile or unable to bear a child; and at least one intended parent must be genetically related to the child. The intended parents must accept the child regardless of its health or appearance. The surrogate retains sole responsibility for the clinical management of the pregnancy. During the approval proceedings, the court must appoint counsel for the surrogate and a guardian ad litem to represent the interests of any resulting children. The court's approval of assisted conception under the contract is effective for twelve months. Compensation beyond reasonable medical and ancillary costs is not allowed. Recruitment fees are punishable as a misdemeanor and the parties may collect damages from the broker. The law also provides for an allocation of costs when an unvalidated contract is terminated under various circumstances.

Washington

WASH. REV. CODE §§ 26.26.011-.903 (2007)

Surrogate contracts are generally allowed but contracts for compensation are prohibited (*see supra*). If a dispute arises over a child born to a surrogate mother, the party with physical custody may retain custody until a court orders otherwise. Intended parents can establish their parentage under a valid surrogacy contract. If a child is born under an invalid contract, parentage shall be determined under the other parts of Washington's Uniform Parentage Act.

Endnotes

- 1 Naturally, the commercial structure of the fertility industry also has real-life ramifications, but that topic is beyond the scope of this paper. For a thorough review of the market aspects of assisted reproduction, see Debora L. Spar, *The Baby Business: How Money, Science, and Politics Drive the Commerce of Conception* (Boston: Harvard Business School Press, 2006).
- 2 Rob Stein, "First U.S. Uterus Transplant Planned; Some Experts Say Risk Isn't Justified," *The Washington Post*, January 15, 2007, p. A01.
- 3 "Hidden No More: What Everyone Should Know About Infertility," available at http://www.resolve.org/site/PageServer?pagename=lrn_wii_home (last accessed November 2007); "Fast Facts About Infertility," available at http://www.resolve.org/site/PageServer?pagename=fmed_mcff_ffj (last accessed November 2007).
- 4 "Infertility Myths and Facts," available at http://www.resolve.org/site/PageServer?pagename=lrn_ffaf_moi (last accessed November 2007).
- 5 "Frequently Asked Questions About Infertility," available at www.resolve.org/site/PageServer?pagename=lrn_wii_faq (last accessed November 2007).
- 6 See Liza Mundy, *Everything Conceivable: How Assisted Reproduction Is Changing Men, Women, and the World* (New York: Knopf, 2007), ch. 5-7.
- 7 Some have noted that people who provide eggs or sperm for a fee are "vendors," not "donors." However we will use the term "donor" in this paper because of its current widespread use.
- 8 "Multiple Pregnancy and Birth: Considering Fertility Treatments," available at http://www.asrm.org/Patients/multiple_pregnancy_and_birth.pdf (last accessed November 2007).
- 9 The variation used will depend on the type of fertility problem that is in need of correction.
- 10 Originally, PGD and PGS were used primarily to screen for early-onset life-threatening or severely impairing diseases. However, PGD and PGS also have been used for late-onset diseases, for diseases that are not severely debilitating, or for non-therapeutic characteristics such as sex. The current and potential uses of this technology have raised criticism from some activists in the disability rights, civil rights, women's rights, and LGBT rights movements.

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- 11 "Multiple Pregnancy and Birth: Considering Fertility Treatments," available at http://www.asrm.org/Patients/multiple_pregnancy_and_birth.pdf (last accessed November 2007).
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- 13 Anne Harding, "Survey belies tales of donor egg market gone awry," Reuters News Service, May 31, 2007, available at <http://uk.reuters.com/article/healthNews/idUKFLE16477220070531> (last accessed November 2007).
- 14 Peggy Orenstein, "Your Gamete, Myself," *New York Times Magazine*, July 15, 2007, available at <http://www.nytimes.com/2007/07/15/magazine/15egg-t.html?ex=1187409600&en=41cd9fb9fb0178d5&ei=5070> (last accessed November 2007).
- 15 Ibid.
- 16 Spar, *The Baby Business*, at xi, 46.
- 17 "ASRM Issues Guidelines For Egg Freezing To Preserve Fertility For Some Young Women," available at www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=2&DR_ID=48371 (last accessed November 2007).
- 18 Mundy, *Everything Conceivable*, p. 214. Multiple pregnancies also can result from the use of hormonal drugs, such as Clomid, that stimulate egg production.
- 19 March of Dimes, "Multiple Pregnancy and Birth: Considering Fertility Treatments" (2006), available at http://www.asrm.org/Patients/multiple_pregnancy_and_birth.pdf (last accessed November 2007); Shari Roan, "Multiple births, multiple risks; The recent news of sextuplet births isn't being celebrated by fertility experts," *Los Angeles Times*, June 25, 2007, p. F01.
- 20 Mundy, *Everything Conceivable*, p. 215-19; American Society of Reproductive Medicine, "Patient's Fact Sheet: Complications of Multiple Gestations" (2001), available at <http://www.asrm.org/Patients/FactSheets/complications-multi.pdf> (last accessed November 2007).

- 21 American Society of Reproductive Medicine, "Patient's Fact Sheet: Challenge of Parenting Multiples" (2003), available at <http://www.asrm.org/Patients/FactSheets/challenges.pdf> (last accessed November 2007).
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- 23 The Practice Committee of the Society for Assisted Reproductive Technology and the Practice Committee of the American Society for Reproductive Medicine, "Guidelines on number of embryos transferred" (2006), available at <http://www.asrm.org/Media/Practice/NoEmbryosTransferred.pdf> (last accessed November 2007).
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- 26 "Frequently Asked Questions About Fertility," available at www.asrm.org/Patients/faqs.html#Q6 (last accessed November 2007).
- 27 Spar, *The Baby Business*, p. x-xii, 46.
- 28 Restrictions on services imposed by insurance companies also carry policy implications, but those are beyond the scope of this paper.
- 29 For instance, some laws apply only to HMOs or exempt only HMOs. Each law specifies which types of health plans must cover or offer to cover infertility services. Likewise, most of the laws regulating coverage of infertility services specify which services must be included and sometimes mention which services may be excluded.
- 30 States that require insurers to include coverage of particular infertility treatments in their health plans include Arkansas, Connecticut, Hawaii, Illinois, Maryland, Massachusetts, Montana, New Jersey, New York, Ohio, Rhode Island, and West Virginia. See ARK. CODE ANN. §§ 23-86-118, 23-85-137 (2007); CONN. GEN. STAT. §§ 38a-509, 38a-536 (2007); HAW. REV. STAT. §§ 431:10A-116.5, 432:1-604 (2007); 215 ILL. COMP. STAT. 5/356m, 125/5-3 (2007); MD. CODE ANN., INS. § 15-810 (2007); MD. CODE ANN., HEALTH-GEN. § 19-701 (2007); MASS. GEN. LAWS ch. 175, § 47H; ch. 176A, § 8K; ch. 176B, § 4J; ch. 176G, § 4 (2007); MONT. CODE ANN. §§ 33-31-102, 33-22-1521 (2005); N.J. STAT. ANN. §§ 17:48-6x, 17:48A-7w, 17:48E-35.22, 17B:27-46.1x, 26:2J-4.23 (2007); N.Y. INS. LAW §§ 3221(k)(6), 4303(s) (2007); OHIO REV. CODE ANN. § 1751.01 (2007); R.I. GEN. LAWS §§ 27-18-30, 27-19-23, 27-20-20, 27-41-33 (2007); W. VA. CODE § 33-25A-2 (2007); see also "States mandating infertility insurance coverage," available at www.inciid.org/article.php?cat=statemandates&id=275 (last accessed November 2007).
- 31 California and Texas only require health plans to offer coverage of infertility services for those who want it included in their health plan. See CAL. HEALTH & SAFETY CODE § 1374.55 (2007); TEX. INS. CODE ANN. §§ 1366.001-.007 (2007); see also "States mandating infertility insurance coverage," available at www.inciid.org/article.php?cat=statemandates&id=275 (last accessed November 2007).
- 32 LA. REV. STAT. ANN. § 22:215.23 (2007); NEV. REV. STAT. ANN. §§ 689A.0415, 689B.0376, 695B.1916, 695C.1694, 695C.1715 (2007).
- 33 Arkansas, Hawaii, Maryland, Rhode Island, and Texas have marriage requirements. See ARK. CODE ANN. §§ 23-86-118, 23-85-137 (2007); 054 00 Ark. Reg. 001 (2007); HAW. REV. STAT. §§ 431:10A-116.5, 432:1-604 (2007); MD. CODE ANN., INS. § 15-810 (2007); MD. CODE ANN., HEALTH-GEN. § 19-701 (2007); R.I. GEN. LAWS §§ 27-18-30, 27-19-23, 27-20-20, 27-41-33 (2007); TEX. INS. CODE ANN. §§ 1366.001-.007 (2007); 28 TEX. ADMIN. CODE § 11.512 (2007).
- 34 Arkansas, Hawaii, Maryland, and Texas require couples to use their own gametes. See ARK. CODE ANN. §§ 23-86-118, 23-85-137 (2007); 054 00 Ark. Reg. 001 (2007); HAW. REV. STAT. §§ 431:10A-116.5, 432:1-604 (2007); MD. CODE ANN., INS. § 15-810 (2007); MD. CODE ANN., HEALTH-GEN. § 19-701 (2007); TEX. INS. CODE ANN. §§ 1366.001-.007 (2007); 28 TEX. ADMIN. CODE § 11.512 (2007).
- 35 CONN. GEN. STAT. §§ 38a-509, & 38a-536 (2007).
- 36 N.J. STAT. ANN. §§ 17:48-6x, 17:48A-7w, 17:48E-35.22, 17B:27-46.1x, 26:2J-4.23 (2007).
- 37 N.Y. INS. LAW §§ 3221(k)(6), 4303(s) (2007).
- 38 R.I. GEN. LAWS §§ 27-18-30, 27-19-23, 27-20-20, 27-41-33 (2007).
- 39 CONN. GEN. STAT. §§ 38a-509, 38a-536 (2007).
- 40 HAW. REV. STAT. §§ 431:10A-116.5, 432:1-604 (2007).
- 41 215 ILL. COMP. STAT. 5/356m, 125/5-3 (2007).
- 42 MD. CODE ANN., INS. § 15-810 (2007); MD. CODE ANN., HEALTH-GEN. § 19-701 (2007).
- 43 N.J. STAT. ANN. §§ 17:48-6x, 17:48A-7w, 17:48E-35.22, 17B:27-46.1x, & 26:2J-4.23 (2007).
- 44 Instead of setting caps, Massachusetts requires parity for infertility services: it does not allow health plans to set benefit maximums that are more restrictive than those set for services unrelated to infertility. MASS. GEN. LAWS ch. 175, § 47H; ch. 176A, § 8K; ch. 176B, § 4J; ch. 176G, § 4 (2007); 211 MASS. CODE REGS. §§ 37.00-37.12 (2007).
- 45 The Catholic Church, for instance, prohibits any assisted reproduction procedures that involve obtaining sperm through masturbation, adding a third party into the act of conception, or substituting a laboratory procedure for intercourse, effectively prohibiting most types of assisted reproduction. "Reproductive Technology (Evaluation & Treatment of Infertility) Guidelines for Catholic Couples," available at www.usccb.org/prolife/issues/nfp/treatment.htm (last accessed November 2007). The states with religious exemptions are California, Connecticut, Illinois, Maryland, Massachusetts, New Jersey, and Texas. See CAL. HEALTH & SAFETY CODE § 1374.55 (2007); CONN. GEN. STAT. §§ 38a-509, 38a-536 (2007); 215 ILL. COMP. STAT. 5/356m, 125/5-3 (2007); MD. CODE ANN., INS. § 15-810 (2007); MD. CODE ANN., HEALTH-GEN. § 19-701 (2007); MASS. GEN. LAWS ch. 175, § 47H; ch. 176A, § 8K; ch. 176B, § 4J; ch. 176G, § 4 (2007); N.J. STAT. ANN. §§ 17:48-6x, 17:48A-7w, 17:48E-35.22, 17B:27-46.1x, 26:2J-4.23 (2007); TEX. INS. CODE ANN. §§ 1366.001-.007 (2007).

- 46 MASS. GEN. LAWS ch. 175, § 47H; ch. 176A, § 8K; ch. 176B, § 4J; ch. 176G, § 4 (2007).
- 47 CONN. GEN. STAT. §§ 38a-509, 38a-536 (2007).
- 48 CONN. GEN. STAT. §§ 38a-509, 38a-536 (2007); N.J. STAT. ANN. §§ 17:48-6x, 17:48A-7w, 17:48E-35.22, 17B:27-46.1x, 26:2J-4.23 (2007).
- 49 To our knowledge, no state provides coverage of infertility treatments to recipients of public benefits. We simply mention here those states that have expressly codified the exclusions in their statutes or regulations. Several states also explicitly exclude coverage of fertility drugs or other infertility services within their state plans for medical assistance.
- 50 MINN. STAT. § 256B.0625, Subd. 13(a) (2006); 56 OKLA. STAT. § 204 (2007).
- 51 MONT. ADMIN. R. 37.79.309, 37.85.207 (2007); N.J. STAT. ANN. §§ 17:48-6x, 17:48A-7w, 17:48E-35.22, 17B:27-46.1x, 26:2J-4.23 (2007); OHIO ADMIN. CODE §§ 5101:3-2-03, 5101:3-4-07, 5101:3-4-28 (2007); PA. STAT. ANN. tit. 62, § 443.6 (2006); R.I. GEN. LAWS § 23-13-21 (2007).
- 52 In contrast, for instance, the IRS allows individuals to include some infertility treatment costs in deductible health care costs, which benefits those who can afford out-of-pocket payments for services in the first place. See, e.g., Sandra Block, "Individual Insurance Buyers Should Check IRS Deductions," *USA Today*, Oct. 14, 2003, available at http://www.usatoday.com/money/perfi/columnist/block/2003-10-14-ym_x.htm (last accessed November 2007).
- 53 *Saks v. Franklin Covey Co.*, 117 F. Supp. 2d 318, 323 (S.D.N.Y. 2000).
- 54 See *Krael v. Iowa Methodist Med. Ctr.*, 95 F.3d 674, 677 (8th Cir. 1996).
- 55 *Ibid.*
- 56 *Bragdon v. Abbott*, 524 U.S. 624 (1998).
- 57 *LaPorta v. Wal-Mart Stores, Inc.*, 163 F. Supp. 2d 758, 765 (W.D. Mich. 2001); *Saks*, 117 F. Supp. 2d at 324.
- 58 *Krael*, 95 F.3d at 678; *Saks*, 117 F. Supp. 2d at 326.
- 59 *Alexander v. Am. Airlines*, 2002 U.S. Dist. LEXIS 7089, *6 (N.D. Tex.); cf. *Niemeier v. Tri-State Fire Protection Dist.*, 2000 U.S. Dist. LEXIS 12621, *19 (N.D. Ill.) (noting that the PDA does not require an employer to cover every expense associated with pregnancy; it just must treat pregnancy and related conditions in a neutral way).
- 60 Some courts have found potential PDA or Title VII violations, however, when an employee has experienced an adverse employment action (like termination) for taking leave in order to undergo surgical impregnation. *Erickson v. Bd. of Governors*, 911 F. Supp. 316 (N.D. Ill. 1995), *rev'd on other grounds*, 207 F.3d 945 (7th Cir. 2000); *Pacourek v. Inland Steel Co.*, 858 F. Supp. 1393 (N.D. Ill. 1994).
- 61 42 U.S.C. §§ 2000e to 2000e-17 (2000).
- 62 42 U.S.C. § 2000e(k) (2000).
- 63 *Krael*, 95 F.3d at 679-80.
- 64 *Saks v. Franklin Covey Co.*, 316 F.3d 337, 345 (2d Cir. 2003).
- 65 The court did note that an argument could be made that the exclusion disadvantaged unmarried female employees as compared to unmarried male employees, but *Saks* did not make that argument.
- 66 See Justin Trent, *Health Care Law Chapter: Assisted Reproductive Technologies*, 7 GEO. J. GENDER & L. 1143, at *10 (2006).
- 67 *Erickson v. Bartell Drug Co.*, 141 F. Supp. 2d 1266 (W.D. Wash. 2001).
- 68 *Standridge v. Union Pac. R.R. Co.*, 479 F.3d 936 (8th Cir. 2007).
- 69 Relief may also be available at the state level. Connecticut, for instance, includes fertility in its definition of discrimination on the basis of sex in its human rights statute. CONN. GEN. STAT. § 46a-51 (2007).
- 70 *Saks*, 316 F.3d at 343-44 (discussing Congress's reaction to *Gen. Elec. v. Gilbert*, 429 U.S. 125 (1976)).
- 71 Kevin Stack, "Her Embryos or His?" *Los Angeles Times*, May 30, 2007, p. A1.
- 72 *Ibid.*
- 73 "Court Won't Hear Battle over Embryos," *The New York Times*, Aug. 26, 2007, available at http://www.nytimes.com/2007/08/26/us/26embryos.html?_r=2&oref=slogin&oref=slogin (last accessed November 2007).
- 74 Mundy, *Everything Conceivable*, p. 7.
- 75 See CAL. HEALTH & SAFETY CODE § 125315 (2007); CONN. GEN. STAT. § 19a-32d (2007); MD. CODE ANN. art. 83A, § 5-2B-10 (2007); N.J. STAT. ANN. § 26:2Z-2 (2007); see also MASS. GEN. LAWS ch. 111L, § 4 (2007) (similar to other statutes but no requirement of written consent for research donation).
- 76 Massachusetts does require that an informed consent form be executed by the patient prior to treatment, but only with regard to the nature of the treatment, not to the disposition of unused embryos. See also CAL. PENAL CODE § 367g (2007).
- 77 FLA. STAT. § 742.17 (2007).
- 78 In addition, New Mexico states that IVF will not be governed as clinical research provided that the procedure includes "provisions to ensure that each living fertilized ovum, zygote or embryo is implanted in a human female recipient." But it does not appear to mandate affirmatively that every embryo created be implanted in a woman. N.M. STAT. ANN. § 24-9A-1 (2007).
- 79 N.H. REV. STAT. ANN. § 168-B:15 (2007).
- 80 See LA. REV. STAT. ANN. §§ 9:121-9:133 (2007).

- 81 One could read the law to say that fetuses, and therefore embryos, have no rights. But there would be little purpose in enacting such a law.
- 82 For further analysis of the Louisiana human embryo statutes, see Jessica Arons, "Sex, Lies, and Embryos," *Science Progress*, October 16, 2007, available at www.scienceprogress.org/2007/10/sex-lies-and-embryos/ (last accessed November 2007).
- 83 Davis v. Davis, 842 S.W.2d 588 (Tenn. 1992).
- 84 Ibid. at 597.
- 85 Ibid.
- 86 Ibid. at 601.
- 87 Ibid.
- 88 Ibid. at 602.
- 89 Kass v. Kass, 696 N.E.2d 174 (N.Y. 1998).
- 90 In addition to looking to the text in statutes to decide cases, courts often look to the policies that underlie or are expressed by the statutes. Some contracts are said to be against public policy if they are seen as injurious to the public good, and courts will refuse to enforce them for that reason. See, e.g., Black's Law Dictionary 1041 (5th ed. 1979).
- 91 Kass, 696 N.E.2d at 180.
- 92 J.B. v. M.B., 783 A.2d 707 (N.J. 2001); In re Witten, 672 N.W.2d 768 (Iowa 2003).
- 93 J.B., 783 A.2d at 719.
- 94 In re Witten, 672 N.W.2d at 783.
- 95 A.Z. v. B.Z., 725 N.E.2d 1051, 1057-58 (Mass. 2000); J.B., 783 A.2d at 717-18; In re Witten, 672 N.W.2d at 781.
- 96 Davis, 842 S.W.2d at 604.
- 97 Litowitz v. Litowitz, 48 P.3d 261 (Wash. 2002).
- 98 Roman v. Roman, 193 S.W.3d 40, 48 (Tex. App. 2006).
- 99 Ibid. at 49-50.
- 100 Ibid. at 53.
- 101 Mundy, *Everything Conceivable*, p. 101 (quoting an adoption lawyer).
- 102 Elizabeth Marquardt, "When 3 Is Really a Crowd," *The New York Times*, July 16, 2007, available at <http://www.nytimes.com/2007/07/16/opinion/16marquardt.html> (last accessed November 2007).
- 103 Johnson v. Calvert, 851 P.2d 776 (Cal. 1993); see also Belsito v. Clark, 644 N.E.2d 760 (Ohio Misc. 1994). Of course, these decisions are each made based upon a particular set of facts, and it is impossible to predict the extent to which prior agreements, understandings, and actions influenced each judicial outcome.
- 104 Andrea F. Siegel, "Ruling Alters Idea of Mother," *Baltimore Sun*, May 17, 2007.
- 105 Galpern, *supra* note 12, "Assisted Reproductive Technologies," available at <http://geneticsandsociety.org/downloads/ART.pdf>.
- 106 "The Uniform Parentage Act of 2002," available at <http://family-law.lawyers.com/paternity/The-Uniform-Parentage-Act-of-2002.html> (last accessed November 2007).
- 107 See Maria Kokiasmenos & Lori Mihalich, *Health Care Law Chapter: Assisted Reproductive Technology*, 5 GEO. J. GENDER & L. 619, at *3-4.
- 108 Elisa B. v. Emily B., 117 P.3d 660 (Cal. 2005); see also In re Parentage of Robinson, 890 A.2d 1036 (N.J. Super. 2005); Chambers v. Chambers, 2002 Del. Fam. Ct. LEXIS 39. But see In re Parentage of L.B., 122 P.3d 161 (Wash. 2005) (lesbian non-biological co-parent did not have standing to establish parentage under Washington Uniform Parentage Act, but she did have standing under the state's common law).
- 109 K.M. v. E.G., 117 P.3d 673 (Cal. 2005).
- 110 In order to protect the privacy of the parties and their children, the court did not divulge the couple's last names.
- 111 In re C.K.G., 173 S.W.3d 714 (Tenn. 2005).
- 112 COLO. REV. STAT. § 19-4-106 (2006).
- 113 TEX. FAM. CODE ANN. § 160.704 (2007); UTAH CODE ANN. § 78-45g-704 (2007); WASH. REV. CODE § 26.26.715 (2007).
- 114 WASH. REV. CODE § 26.26.735 (2007).
- 115 WASH. REV. CODE § 26.26.101 (2007).
- 116 OHIO REV. CODE ANN. § 3111.97 (2007).
- 117 See Spar, *The Baby Business*, Ch. 6.
- 118 10 OKLA. STAT. §§ 554-556 (2007).
- 119 Spar, *The Baby Business*, p. 82.
- 120 In addition, although Maryland has not passed a law that addresses surrogacy, an Attorney General's opinion states that paid surrogacy contracts are generally illegal and unenforceable under the state law. However, the payment of a surrogacy fee will not be a bar to an adoption proceeding and may be considered with regard to the voluntariness of the birth mother's consent and other factors relevant to the adoption. 85 Op. Md. Att'y Gen. 348 (Dec. 19, 2000) (interpreting Md. CODE ANN., FAM. LAW § 5-362, which bars payment for children).

- 121 North Dakota and Washington fall into more than one category because they allow some types of contracts but void or ban others.
- 122 See, e.g., ALA. CODE § 26-10A-34 (2007); IOWA CODE § 710.11 (2006); OR. REV. STAT. § 163.537 (2005); W. VA. CODE § 48-22-803 (2007).
- 123 TENN. CODE ANN. § 36-1-102(48) (2007).
- 124 In the Matter of Baby M., 537 A.2d 1227, 1234 (N.J. 1988).
- 125 See also R.R. v. M.H., 689 N.E.2d 790 (Mass. 1998) (finding traditional surrogacy agreement unenforceable where compensation was paid beyond pregnancy-related expenses and mother was given no reasonable period after birth in which to revoke consent to father's custody).
- 126 Johnson v. Calvert, 851 P.2d 776 (Cal. 1993).
- 127 As noted previously, the court later clarified this position in K.M. v. E.G., 117 P.3d 673 (Cal. 2005).
- 128 Johnson, 851 P.2d at 787.
- 129 In re Marriage of Buzzanca, 72 Cal. Rptr. 2d 280 (Cal. Ct. App. 1998).
- 130 In re Marriage of Moschetta, 30 Cal. Rptr. 2d 893 (Cal. Ct. App. 1994).
- 131 Belsito v. Clark, 644 N.E.2d 760 (Ohio Ct. Comm. Pleas 1994); see also J.F. v. D.B., 848 N.E.2d 873 (Ohio App. 2006).
- 132 Dorothy Roberts, "Race and the New Reproduction," in *Killing the Black Body: Race, Reproduction and the Meaning of Liberty* (New York: Pantheon Press, 1997), available at <http://geneticsandsociety.org/article.php?id=1993> (last accessed November 2007).
- 133 Spar, *The Baby Business*, p. 82.
- 134 Katherine Drabiak, et al., "Ethics, Law, and Commercial Surrogacy: A Call for Uniformity" J.L. MED. & ETHICS, 300, 304, 306-308 (Summer 2007).
- 135 Ibid.
- 136 Due to the controversial nature of gestational agreements, the drafters made adoption of Part 8 of the 2002 Uniform Parentage Act optional for the states. See UNIF. PARENTAGE ACT Art. 8 cmt. at 68-69 (amended 2002), available at <http://www.law.upenn.edu/bll/archives/ulc/upa/final2002.pdf> (last accessed November 2007). Thus far, it appears that only Texas and Utah have enacted a version of it.
- 137 Arthur Caplan, "Should Kids Be Conceived after a Parent Dies?" *MSNBC.com*, June 27, 2007, available at <http://www.msnbc.msn.com/id/17937817/> (last accessed November 2007).
- 138 Claudia Wallis, "Quickening Debate over Life on Ice," *Time*, July 2, 1984, available at <http://www.time.com/time/magazine/article/0,9171,926680,00.html?iid=chix-sphere> (last accessed November 2007).
- 139 Linda Kramer, "He Looks Just Like His Dad," *People*, September 10, 2007, p. 111-12.
- 140 FLA. STAT. § 742.17 (2007).
- 141 VA. CODE ANN. § 20-158 (2007); see also VA. CODE ANN. §§ 64.1-5.1, 64.1-8.1 (2007).
- 142 COLO. REV. STAT. § 19-4-106 (2006); 13 DEL. C. § 8-707 (2007); N.D. CENT. CODE § 14-20-65 (2007); TEX. FAM. CODE § 160.707 (2007); UTAH CODE ANN. § 78-45g-707 (2007); WASH. REV. CODE § 26.26.730 (2007); WYO. STAT. ANN. § 14-2-907 (2007).
- 143 UNIF. PARENTAGE ACT § 707, at 67 (amended 2002), available at <http://www.law.upenn.edu/bll/archives/ulc/upa/final2002.pdf> (last accessed November 2007).
- 144 Gillett-Netting v. Barnhart, 371 F.3d 593 (9th Cir. 2004).
- 145 Stephen ex rel. Stephen v. Barnhart, 386 F. Supp. 2d 1257 (M.D. Fla. 2005).
- 146 The Arizona Court of Appeals found that the presumption provision violated the Equal Protection Clause of the federal and state constitutions because it did not afford a genetic mother the opportunity to rebut a presumption of maternity. That case involved a dispute between the intended parents who had divorced. The court made no ruling as to the validity of the statute if a gestational surrogate wanted to keep the child. Soos v. Superior Court, 897 P.2d 1356 (Ariz. 1994).
- 147 Every state would void a contract with a person who is not competent to enter into a contract, but Washington goes a step further by penalizing those who induced the incompetent person to enter the contract. Michigan does so as well.
- 148 The Michigan Court of Appeals has interpreted the statute to mean that any surrogate parentage contract that requires both the impregnation of a surrogate and the relinquishment of her parental rights is void and unenforceable, and those that provide compensation are unlawful and prohibited. However, the Act does not prohibit contracts which compensate for conception or gestation services alone, meaning a commercial contract potentially could be upheld if payment is not conditioned on the surrender of the child. Jane Doe v. Atty. Gen., 487 N.W.2d 484 (Mich. Ct. App. 1992).
- 149 New Hampshire and Virginia's surrogacy laws are modeled after the 2000 version of the Uniform Parentage Act. Amy M. Larkey, Note, *Redefining Motherhood: Determining Legal Maternity in Gestational Surrogacy Arrangements*, 51 DRAKE L. REV. 605, 630 (2003).

About the Author

Jessica Arons is the Director of the Women's Health and Rights Program at the Center for American Progress and a member of the Center's Faith and Progressive Policy Initiative. Prior to joining the Center, she worked at the ACLU's Reproductive Freedom Project, the labor and employment firm of James & Hoffman, the Virginia Supreme Court, and the White House. Jessica is an honors graduate of Brown University and William and Mary School of Law. She has been seen on MSNBC, Fox News, and ABC News and heard on Clear Channel radio. Her publications include "More Than a Choice: A Progressive Vision for Reproductive Health & Rights."

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