ASSISTED REPRODUCTIVE TECHNOLOGY

EGG DONATION AND SURROGACY ARRANGEMENTS IN LAW AND PRACTICE

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The medical component of Assisted Reproductive Technology (ART) in the United States is highly regulated by various governmental legislative acts and regulatory bodies on the federal and state levels, as well as by independent professional societies and consumer organizations. This oversight maintains standards of care, insures accuracy of statistical reporting, promotes education, and addresses issues ranging from common ART procedures to stem cell research and cloning. However, the fragmentary nature of this regulation combined with the swiftness of medical advances, among other factors,[1] have prevented any codified, practical "assisted reproduction law" to develop in pace with the science. This is especially evident in the practice of third party reproduction arrangements, which have implications beyond health and science.

Legal regulation of egg donation and surrogacy, which raises the politically charged issues of human rights and bioethics, has likewise not kept pace with consumer demand. The adoption model, with its designations of "birth mother," "biological mother," etc., has proved unsatisfactory as the sole legal structure of such arrangements. Currently there exists a patchwork of case and statutory law that varies from state to state. Each jurisdiction may or may not have laws or judicial precedent pertaining to the enforceability of a surrogacy contract, the compensation of gestational carriers, presumptions of maternity and paternity, and other issues. The compensation issue is especially important, since paying women to be carriers allows intended parents to hire carriers of their choosing. Compounding the complexity, many third party arrangements involve residents from different states, each with its own restrictions. This article provides a practical introduction to this field: definitions of terms, summaries of some important acts, case law and statutes, and descriptions of the legal documents required to carry out these arrangements.

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1. *See* David Adamson, *Regulation of Assisted Reproductive Technologies in the United States*, 39 Family Law Quarterly 722 (2005).

The Scope of IVF in the US and Definitions of Terms

In Vitro Fertilization (IVF)

The original "test tube" baby, Louise Joy Brown, was born in England in 1978. Now a mother herself, the controversy over Brown's conception has faded away as IVF has become widespread. IVF is a process in which oocytes (human eggs retrieved after an administered "cycle" of hormones to medically induce ovulation) and sperm are combined in a culture dish in the laboratory. Fertilization and very early embryo development occur outside the body (*in vitro* or "in glass"), rather than in the fallopian tube. The embryos are observed and then transferred into the uterus or cryopreserved (frozen) for later use.

Since its 1981 introduction in the United States, through the year 2002, almost 300,000 babies have been born in this country as a result of reported ART procedures (IVF accounts for ninety-nine percent of these ART births). In 2002, approximately one in every one hundred babies born in the United States was conceived using ART (the live birth rate of an IVF cycle in 2002 was twenty-eight percent).[2] According to the Center for Disease Control's (CDC) most recent reports,[3] a total of 89,533 fresh embryo cycles using non-donor eggs occurred in 2004 and 92,389 occurred in 2005. The live birth rate decreases with the age of the intended mother. In 2005, the live birth rate for women under thirty-five was 43.1%; for women forty-one to forty-two it was 17.6%.

Egg Donation

Successful human egg donation began in 1983.[4] By the early 1990s, an active market for donor eggs emerged.[5] Donor eggs are most commonly needed because of premature ovarian failure, diminished ovarian reserve (typically caused by advanced maternal age), or poor egg quality. According to the CDC,[6] in 2004 there were 9,283 fresh embryo transfers resulting from donor eggs and 4,439 frozen embryo transfers from donor eggs. In 2005, there were 9,649 fresh embryo transfers and 4,997 frozen embryo transfers. In that year, the fresh transfers yielded a 52.3 % live birth rate and the frozen yielded a 30.9% rate.

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2. *Frequently Asked Questions About Infertility*, American Society for Reproductive Medicine, http://www.asrm.org.

3. Assisted Reproductive Technology (ART) Report: 2005 Preliminary Accessible National Summary, Centers for Disease Control and Prevention, http://apps.nccd.cdc.gov/ART2005/nation05acc.asp.

4. Owen K. Davis, M.D., *The Medical Aspects of Egg Donation*, Resolve: The National Association for Infertility, http://www.resolve.org.

5. Debora L. Spar, The Baby Business: How Money, Science, and Politics Drive the Commerce of Conception 41-42 (Harvard Business School Press 2006).

6. 2004 Assisted Reproductive Technology (ART) Report: Accessible National Summary, Centers for Disease Control and Prevention, http://apps.nccd.cdc.gov/ART2004/nation04acc.asp.

Anonymous donor eggs are typically retrieved from healthy, rigorously screened women ages twenty-one to thirty-two, solicited through advertising placed by IVF clinics or private agencies. Egg donation is an invasive procedure comprising examination, testing, hormone stimulation through injected drugs, and the final retrieval, during which the oocytes are aspirated though a needle. The compensation ranges from about $3,000 to $10,000 (payment is for pain and suffering, not for eggs). There are no legal restrictions on how much may be offered, or how many times a woman can donate. The American Society of Reproductive Medicine (ASRM) and its adjunct, the Society for Assisted Reproductive Technology (SART) have published guidelines regarding financial incentives,[7] repetitive oocyte donation[8] and other ethical aspects by which members pledge to abide. Almost uniformly, the major, mainstream IVF clinics are SART members and therefore "SART compliant." The industry's self-regulation, provoked by the negative publicity surrounding the extravagant (and therefore coercive) fees offered to potential donors with exceptional physical or intellectual attributes, is intended to discourage any possible governmental legislation that would encumber the free practice US doctors now enjoy.[9] As Debora L. Spar explains in *The Baby Business*,[10] the conflict between the desperate need for infertile couples to exploit these medical advances and the squeamishness regarding the consumerist intrusion on human reproduction is a highly charged political issue. Industry self-regulation and the free market, rather than legislators, have thus far determined these ethical limitations.

The Egg Donation Contract

IVF clinics present donors with an informed consent form that describes in detail the egg donation process and the possible side effects of the drugs and procedures, and which generally guarantees anonymity. In absence of any specific legal guidelines pertaining to egg donation, sperm donation programs, which are more established, are used as precedent to waive any and all claim or responsibility to the eggs and any resulting embryos or offspring. Other Food and Drug Administration (FDA) regulations regarding the proper use of the embryos and the maintenance of records are also included in the consent form. This form is signed by the donor and doctor only.

Some IVF programs have their own donor programs, but many do not. If working with the latter, prospective recipients may employ a private, independent donor agency, which charges fees for its services. Responsible private donor agencies insist that donor and recipient(s) (recipient mother and, if applicable, father) have their relationship

7. 74 FERTILITY AND STERILITY (2000), and most recently 88 FERTILITY AND STERILITY 305, 305-09 (2007).

8. 82 FERTILITY AND STERILITY, Suppl. 1 (2004).

9. For regulations of ART in other countries, *see* Adamson, *supra* Note 1, at 739-42.

10. SPAR, *supra* Note 4, at 30.

governed by an egg donor agreement, which is usually drafted by the counsel for the recipient(s) and reviewed by donor and her independent lawyer. Unlike the informed consent form provided by the IVF facility, the egg donor contract is a complex document with a great many negotiable terms regarding schedule, protocols, fees, and anonymity. While acknowledging that egg donation falls under an "unsettled area of law," the document describes in significant detail the warrants, intents, rights and responsibilities of all parties, including donor's compensation.

Traditional Surrogacy and Gestational Surrogacy; Uniformity of Law

Surrogacy is another form of third party reproduction in which a woman contractually agrees to create and/or maintain a pregnancy for another person or couple, typically for monetary compensation. A traditional surrogate, using her own ova, is inseminated with the intended father's or donor's sperm, and the resulting child is related to her genetically. The more legally and medically accepted *gestational* surrogacy employs IVF technology to create embryo(s) formed by the intended mother's egg and intended father's sperm, or some other combination using donor egg and sperm. An agreed-upon number of embryo(s) are transferred into the uterus of the carrier.[11] In gestational surrogacy, the *carrier*, a term preferable to surrogate by many, has no genetic relationship to the resulting child.

There are no federal laws regarding either type of surrogacy. The National Conference of Commissioners on Uniform State Laws (Conference) has issued a series of Uniform Parentage Acts (UPA), first in 1973 and then amended versions in 2000 and 2002. The original 1973 UPA, adopted by about eighteen states, aimed to set rules for presumption of parentage for all children, irrespective of parental marital status. Maternity is presumed to any woman who gives birth, and paternity is presumed to her husband. This includes children resulting from artificial (donor) insemination, as described in Section 5.[12] Termination of parental rights occurs through adoption by birth parent consent, obtained only *after* the birth *and* a prescribed waiting period (which may vary from state to state). Monetary compensation to birth mothers (also varying by jurisdiction) is restricted and highly scrutinized.

Since 1973 the Conference has issued three subsequent acts, each addressing IVF and surrogacy. The Uniform Status of Children of Assisted Conception Act (USCACA),[13] in 1988, offered two opposing provisions for surrogacy arrangements: Alternative A permits regulated surrogacy for married heterosexual couples; Alternative B renders all such agreements void and unenforceable. However, only two states have

11. For SART guidelines regarding the restriction of number of embryos transferred to curtail multiple births, *see* 82 FERTILITY AND STERILITY 773, 773-4 (2004).

12. UNIF. PARENTAGE ACT § 5(a), 9B U.L.A. 407 (1973).

13. UNIF. STATUS OF CHILDREN OF ASSISTED CONCEPTION ACT (1988).

adopted this act: Virginia, Alternative A[14] and North Dakota, Alternative B[15]. The USCACA remains upheld in these states even though the Conference supplanted it with revised versions of the UPA in 2000 and 2002. Article 8 of the 2000 UPA addresses gestational surrogacy agreements, permitting them to married heterosexual couples if subjected to a judicial hearing and granted a court ordered validation. The 2002 UPA rescinds the marriage stipulation, but requires the intended couple to be male and female. Only Delaware, Texas, Utah, Washington, and Wyoming have adopted the amended UPA, and of these only Texas and Utah have accepted its surrogacy provisions.[16]

Thus, with the exception of a handful of states, these uniform acts have had little influence on the enforceability of surrogacy agreements in most of the country, and the adoption model remains the major point of reference. When addressing surrogacies through case law or statute, some states have been able to distinguish the traditional presumptions, procedures, and regulations regarding maternity and paternity from the adoption paradigm. Although some choose to adhere to the adoption model, others confront the new technology directly and create whole new approaches. Some fall elsewhere on the spectrum. Others still have no statutes at all, and any existing case law is non-committal or oblique, and little can be inferred regarding the enforceability of a surrogacy contract.[17] The following are some examples of significant case law and statutes from states around the country.

The Baby M[18] *Case and New Jersey Surrogacy Case Law*

In 1988, when surrogacies were mostly the traditional type, there were thirty commercial surrogacy agencies in the US, and the demand was relatively low.[19] In that same year, the sensational *Baby M* (Melissa Stern) case placed a glaring spotlight on surrogacy. This was a *traditional* surrogacy, in which Mary Beth Whitehead used her own egg and was inseminated with the intended father's sperm. The 1985 contract was signed by three parties: the surrogate, her husband, and the intended father. Mary Beth Whitehead agreed to be inseminated with William Stern's sperm, to relinquish her right to make a decision about an abor-

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14. VA, CODE ANN. §§ 20-156 to 20-165 (1991).

15. N.D. CENT. CODE § 14-18-05 (2002).

16. 13 DEL. CODE ANN. §§ 8-101 to 8-904 (1999); TEX. FAM. CODE ANN. §§ 160.001-160.763 (2001); UTAH CODE ANN Ch. 45g (2005); WASH. REV. CODE ANN. §§ 26.26.011-26.26.913 (2005); WYO. STAT. ANN. §§ 14-2-401 to 14-2-907 (2005).

17. *See, e.g.* Mid-South Insurance Co. v. Doe, *274 F.Supp.2d 757 (D.S.C. 2003);* OHIO REV. CODE § 3111.89 (2002); Decker v. Decker, *2001 Ohio App. LEXIS 4389 (Ohio Ct. App., 3d Dist. 2001);* Turchyn v. Cornelius, *1999 Ohio App. LEXIS 4129 (Ohio Ct. App., 7th Dist. 1999);* Belsito v. Clark, *644 N.E.2d 760 (Ct. Com. Pl., Summit County 1994);* Seymour v. Stotski, *611 N.E.2d 454 (Ohio Ct. App., 10th Dist. 1992);* Huddleston v. Infertility Center of America, *700 A.2d 453 (Pa. Super. Ct. 1997).*

18. 109 N.J. 396 (1988).

19. SPAR, *supra* Note 4, at 78.

tion to Stern, and to surrender her parental rights to Stern. Richard Whitehead, Mary Beth's husband, agreed to his wife's insemination with William Stern's sperm, to "surrender immediate custody of the child" and "terminate his parental rights." Upon surrender of a live infant, Stern agreed to pay $10,000 to Whitehead as "compensation for services and expenses" which should "in no way be construed as a fee for termination of parental rights or a payment in exchange for consent to surrender the child for adoption." A legal battle ensued when Whitehead, after giving birth, took the baby home and refused the money.

A 1987 trial granted full custody to the Sterns. On February 2, 1988, the Supreme Court of New Jersey overturned this ruling and invalidated the original contract. Custody was awarded to William Stern and visitation rights were granted to Whitehead. This decision made compensated surrogacy arrangements unenforceable in New Jersey; however, intended parents can enter uncompensated, uncontested gestational surrogacy arrangements, and become legal parents after a post partum waiting period.[20]

California Surrogacy Case Law: Johnson v. Calvert[21]

California leads the country in supporting surrogacy arrangements, and more US agencies are based there than in any other state. Established California case law privileges the *intent* of the conception and birth of children resulting from surrogacy arrangements, irrespective of genetic relation. These conditions always favor the intended parents. Furthermore, case law explicitly distinguishes surrogacy arrangements from adoptions, opening opportunities for free market compensation.

In *Johnson v. Calvert,* Mark and Crispina Calvert entered a contract with Anna Johnson to carry their genetic child (created with Mark's sperm and Crispina's egg). Johnson was to be compensated $10,000 after the birth. While still pregnant, Johnson demanded the money and threatened to keep the baby for herself. Both parties filed lawsuits, and the court found in favor of the Calverts. Appellate courts and the California Supreme court upheld this decision. Since both Johnson and Calvert had, according to California Family Code, legitimate claims to maternity (Johnson gave birth to the child; Calvert's egg created the embryo), the court determined that the party responsible for conceiving and intending

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20. *A.H.W. v. G.H.B.*, 772 A.2d 948 (N.J. Super. 2000). Other states that explicitly prohibit traditional surrogacy or compensated surrogacy of any kind are Indiana; *see* IND. CODE ANN. § 31-20-1-1 (2002); Louisiana; *see* LA. REV. STAT. ANN. § 9:2713 (2002); Michigan; see MICH. COMP. LAWS § 722.851-861 (2002); *Doe v. Kelley*, 487 N.W.2d 484 (Mich. Ct. App. 1992); Nebraska; *see* NEB. REV. STAT. § 25-21,200 (2002); New York; *see* N.Y. DOM. REL. LAW § 121(4) (McKinney 1999); North Carolina; *see* N.C. GEN. STAT. §§ 48-10-102, 48-10-103 (2002); Washington, *see* WASH. REV. CODE §§ 26.26.210-26.26.260 (2002); WASH. REV. CODE § 26.26.101 (2002); Opinion of the Attorney General; 1989 WL 428954 (Wash. A.G.).

21. 19 Cal. Rptr. 2d 494 (Cal. 1993).

to raise the child should be granted custody. This intention principle applies even if the child, created by donor egg and sperm, has no genetic relationship to the intended parents, as ruled in the paternal child support dispute *In re Marriage of Buzzanca*.[22]

The Johnson v. Calvert court also ruled that gestational surrogacy does not violate laws against payment for consent to adoption, since the contract is executed prior to conception. The court made the significant distinction that Anna was paid for her *services*, not for her baby.

Illinois Gestational Surrogacy Act and Massachusetts: Culliton v. Beth Israel Deaconess Medical Center[23]

Recent statutes and case law in Illinois and Massachusetts have addressed compensated surrogacy favorably, with limitations. The Illinois Gestational Surrogacy Act,[24] in effect since 2005, outlines detailed ground rules for legal gestational surrogacy. The carrier must be at least twenty-one years old, have given birth to at least one child, completed a physical and psychological medical evaluation, have health insurance that covers the duration of her pregnancy and eight weeks post partum, and have independent legal counsel regarding the terms of the contract. The intended parents must contribute at least one of the gametes resulting in the pre-embryo, undergo a mental health evaluation, and have independent legal counsel regarding the terms of the contract, and a doctor must certify a medical need for the surrogacy. The contract must be executed prior to the commencement of any medical procedures. If there is compensation for the carrier, it must be placed in escrow with an independent escrow agent. The carrier and her husband agree to surrender custody of the child immediately upon birth to the intended parents, who agree to accept sole custody.

In the Massachusetts case *Culliton v. Beth Israel Deaconess Medical Center*, the intended parents in a gestational surrogacy arrangement requested, before the birth, to assert their maternity and paternity by placing their names on the birth certificate. When the hospital refused, the Massachusetts Family Court dismissed the complaint, citing lack of authority. On appeal, the Supreme Judicial Court held that the Family Court had the authority because the intended parents were indeed the genetic parents, and their request was uncontested by any other party. The court concluded that traditional presumptions of paternity and maternity do not apply to the children of gestational surrogacy when both intended parents are genetically related.[25]

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22. 72 Cal. Rptr. 2d 280 (Ct. App. 4th 1998). *See also McDonald v. McDonald*, 608 N.Y.S.2d 477 (App. Div. 1994) (custody case regarding child created from a donor egg).

23. *756 N.E.2d 1133 (Mass. 2001).*

24. 750 ILL. COMP. STAT. §§ 47/1-47/75(2004).

25. *See Hodas v. Morin*, 814 N.E.2d 320 (Mass. 2004).

Gestational Surrogacy Contracts, Choice of Law, and the Pre-birth Parentage Order

In states where surrogacy agreements are not considered unenforceable, proper contracts signed by all parties before the child's conception, and when possible, pre-parentage birth orders, are the components of legal, successful surrogacy arrangements. Judicial pre-authorization of surrogacy agreements are required in some states.[26] Adoption and stepparent adoption remains necessary when pre-birth orders are not possible, for cases with same sex-parents, and some other circumstances.

A gestational surrogacy contract is an agreement between the intended parent(s) and the carrier and, if applicable, her husband. In jurisdictions without statutes, the "unsettled area of law" is acknowledged, and the current case law is cited. The contract discusses the rights and responsibilities of the parties as they relate to expected aspects of the medical procedures, insurance, and compensation. There are many issues for the intended parents, carrier, and their respective counsel to determine together, with the guidance of medical staff: the number of embryos to transfer, the number of additional embryo transfer cycles the carrier is willing to undergo if necessary, the possibility of selective reduction in case of multiples or medical abortion,[27] the nature of any contact between the carrier and intended parents during and after the pregnancy, the amount of compensation and its disbursement, expense reimbursement for child care, lost wages, maternity clothing, etc. In addition to legal counsel for both parties, it is recommended that a psychotherapist experienced in surrogacy guide them in resolving some of these sensitive issues, and continue to consult throughout the process.

Since intended parents and carriers often live in different states, choice of law must be resolved. In *Hodas v. Morin*,[28] the Massachusetts Supreme Judicial Court determined that Massachusetts both had jurisdiction and was a proper choice of law to grant a pre-birth parentage order to the intended parents, even though they were Connecticut residents. The carrier and her husband were New York residents, but contractually agreed to have the prenatal care and birth take place in a hospital in Massachusetts, where a pre-birth parentage order could be obtained. The contract was pursuant to Massachusetts law. The actual embryo transfer took place in Connecticut. The court ruled that Massachusetts had a "substantial relationship" to the transaction because of the intent for the birth to occur at a Massachusetts hospital (resulting in a Massachusetts birth certificate), and by the gestational carrier's prenatal care at a Massachusetts hospital in anticipation of delivery there. Furthermore, the granting

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26. *See, e.g.* N.H. REV. STAT. ANN. § 168-B:25(IV) (1990), as well as VA, TX, UT, as cited above.

27. The carrier makes a statement of intention but cannot be forced to adhere to its terms regarding her own body, such as with the issue of medical abortion (*Roe v. Wade*, 410 U.S. 113 (1973) controls); however, she may be held in breach of contract.

28. 442 Mass. 544, 814 N.E.2d 320 (2004)

of the order was not in conflict with public policy in Massachusetts. Connecticut law is silent on surrogacy. New York expressly forbids commercial surrogacy arrangements.[29]

A pre-birth parentage order obviates the need for adoption proceedings by assigning maternity and paternity to the intended parents before the birth. Once the pre-birth order is issued, intended parents appear on the original birth certificate, have the child discharged directly to them, and may have the child immediately covered by their health insurance. Pre-birth orders are mostly likely to be effective when both intended parents have a genetic relationship to the child(ren), and when the proceedings are uncontested. But even in some jurisdictions with statutes regulating surrogacy, proceedings to establish intended parents as legal parents can only begin after the birth.[30] When pre-birth orders are not possible, legal custody is customarily established through adoption.

Components of Successful Surrogacy Arrangements

Intended parents from any state in the US can avail themselves of surrogacy, and, when executed with care, the large majority of these arrangements are successful. Each gestational surrogacy agreement is a unique and elaborate puzzle made up of legal, medical, and psychological pieces. The most effective approach is an interdisciplinary one, comprising the participation of legal, medical, and psychological professionals. The temperaments and attitudes of the intended parents, carrier, and her partner or husband should be evaluated with great sensitivity. The laws and policies of the jurisdictions of all parties should be considered thoroughly by counsel, and all must be fully informed of their rights and obligations. Medical and social work professionals should screen all participants for their physical and psychological health before entering into any agreement, and should consult throughout the process.

A properly constructed gestational surrogacy arrangement is an expensive undertaking, with various legal, medical, insurance, carrier, and program expenses typically adding up to somewhere between $75,000 and $125,000. When corners are cut, whether in an effort to save cost or time, the risk of a disrupted engagement increases markedly.

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29. N.Y. Dom. Rel. Law § 121(4) (McKinney 1999).

30. N.H. Rev. Stat. Ann. § 168-B:26; Tex. Fam. Code Ann § 160.760; Utah Code Ann.§ 78-45g-807.