Council for Responsible Genetics

SURROGACY IN AMERICA

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INTRODUCTION

Since the birth of the first IVF baby, Louise Brown in 1978, the infertility and assisted reproductive technology (ART) industry in the United States has exploded. In vitro fertilization (IVF), just one of many medical services offered to infertile couples, has skyrocketed since the Centers for Disease Controls (CDC) began tracking the industry in 1998. The number of IVF births per year more than doubled in the following decade, exceeding 57,000 in 2007, according to the CDC. And IVF is just the tip of the iceberg among fertility services such as egg and sperm donation, hormonal therapy, artificial insemination, and even newer emerging technologies such as gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT). While ethical controversy surrounds many ART technologies, one particularly troubling method of reproduction has grown at an even greater rate than ART generally: the use of surrogate mothers.

These women, who "rent" their bodies and their wombs during the nine months it takes to carry someone else's child to term, are subjected to intensive testing and fertility medications. Beyond the risks associated with ART, surrogate workers often must bear the additional medical complications of multiple pregnancy.

Thus far, the market for surrogate workers has received little attention from health scientists and policymakers. The few statistics that are available, however, indicate that the practice is becoming increasingly prevalent in the United States – the number of babies born to gestational surrogates grew 89% percent in *just four years,* from 2004 to 2008. This rate far exceeds growth in the number of IVF babies generally.

The expansion of this market demands further study, oversight and regulation. Unfortunately, most of the necessary data is still unavailable. While we can deduce some information about what goes on behind the closed doors of surrogate matching agencies and fertility doctors' offices, too many essential facts about this industry remain unstudied. The scope of the market, the demographic characteristics of persons affected, the medical, legal and financial risks they undertake and the massive potential for exploitation all remain largely unexplored. At the same time, the risk of ethical, social, medical and psychological harm, to all parties involved – the women who agree to rent their bodies, the families that hire them, and the resulting children – is too great for us to remain in the dark. In this report we present a survey of the information that does exist. While scant, the data we do have points to a resounding need for further study, open debate, and tighter regulation of this marketplace.

QUESTIONS EXPLORED

1. **STATISTICS - What are the most recent statistics on surrogacy, both nationally and by state?**

   There are virtually no statistics on how many women and families are involved in the surrogacy market. The only numbers we do have exclusively describe gestational surrogacy IVF cycles, and give no indication of the prevalence of traditional surrogacy. Nor do statistics describing IVF cycles, rather than patients, paint an accurate picture of the demographic characteristics of surrogate workers. Nevertheless, the available reports from the CDC and the Society for Assisted Reproductive Technology (SART) clearly show that the number of infants born to gestational surrogates almost doubled from 2004 to 2008, from 738 babies born to nearly 1,400. These numbers, while only skimming the surface of the entire surrogacy market, will surely continue to rise. In the face of this growing industry, it is imperative that accurate data collection be initiated to understand the scope and implications of surrogacy in the United States..

2. **LAWS - What state surrogacy laws have changed since 2007? Is this in any way correlated to state statistics? Are there pending bills in any states that deal with surrogacy or will bear upon the surrogacy market?**

   Few states have changed their laws since 2007, despite CDC and SART statistics clearly indicating accelerated market growth. Furthermore, while there is a relationship between the regulation of surrogacy and its incidence, available statistics show high rates of noncompliance paired with low enforcement of existing law.

3. **HEALTH RISKS - What are the short and long-term health risks to women who become surrogates?**

   Few studies have looked at health risks to surrogates. However, the risks associated with fertility treatment and pregnancy, even outside the psychologically straining situation of a surrogacy agreement, are far from trivial. Furthermore, assisted reproduction pregnancies are even more risky due to the high rate of multiple births and the risk of infection. These risks must be further studied in order to adequately protect surrogate workers from medical harm.

4. **MILITARY SURROGACY - Is there any evidence that women in military families are more likely to serve as surrogate mothers?**

   Indirect, anecdotal evidence suggests that women in military families are disproportionately hired as surrogates. However, there is currently no attempt to explore the scope of the issue. Women with husbands fighting abroad deserve to be adequately protected from exploitation of their difficult situations. Further data collection and oversight of this market is necessary.

5. **FINANCIAL ASPECTS - What are the financial aspects of hiring a surrogate? What is the cost to intended parents? How much are surrogates paid? Who is profiting from this market?**

   Reports indicate that surrogates are paid between $12,000 and $25,000 per pregnancy, while costs to intended parents can range from $40,000 to $120,000. While seemingly large sums, these prices correspond to real pay as low as 50 cents per hour for surrogates, far below any state's minimum wage. Given anecdotal evidence that women serving as surrogates come from families of the lowest income brackets, these paltry figures further suggest that surrogacy agreements exploit vulnerable women.

6. **What are the limits of the available information on surrogacy, and why?**

   The information available on surrogacy is extremely limited. The stakeholders have no incentive to report their numbers given the ethical debate and regulatory action disclosure may incite. While infertility and pregnancy are deeply personal issues that deserve adequate privacy protection, the risk of harm and exploitation demands greater study of this market. Therefore, we recommend that ART clinics and surrogate matching agencies be required to disclose relevant statistics on the practice of both *traditional and gestational surrogacy.*

DEFINITIONS

Biological Mother/Genetic Mother

A woman who contributes her egg in order to produce the resulting child.

Biological Father/Genetic Father

A man who contributes his sperm in order to produce the resulting child.

Intended Parents

Individuals who intend to become the legal parents of the child produced as a result of a surrogacy agreement.

Gestational Mother

A woman who carries a developing fetus in her uterus until it is born.

Traditional Surrogacy

Traditional surrogacy refers to a contractual situation whereby a woman agrees to become impregnated, typically by artificial insemination (AI), using her own egg and the sperm of another man, usually the intended father of the baby. She agrees to carry the child to term and thereafter relinquish her parental rights to the child. Because the surrogate uses her own egg, she is considered the biological, genetic and gestational mother of the resulting child. Although usually impregnated through AI, it is possible that the surrogate is impregnated using IVF. While there is no data on how many women serve as traditional surrogates, AI is far less expensive than IVF, which is required for gestational surrogacy. While these ratios have not been documented, the lower cost suggests that many intended parents may choose traditional over gestational surrogacy.

Gestational Surrogacy

Gestational surrogacy refers to a contractual situation whereby a woman agrees to have an in vitro fertilized embryo implanted into her uterus, and then agrees to carry the resulting child to term. She further agrees to relinquish her parental rights upon birth of the child. To produce the implanted embryo, either the gametes (egg and sperm) of the intended parents or donor gametes may be used.

DISCUSSION

1. STATISTICS - What are the most recent statistics on surrogacy, both nation-wide and in individual states?

Currently, there are only two sources of very rough statistics on surrogacy, and these numbers report *on gestational surrogacy only.* There is no data whatsoever on the use of traditional surrogacy. While we do not know which method is more common, the tremendous cost of IVF as compared to AI suggests that many intended parents will likely choose traditional surrogacy despite the appeal of having a genetic link to their child. The current data also fails to

include any demographic characteristics describing surrogate workers, information that is highly relevant to questions of financial, medical, and racial exploitation. Nevertheless, the statistics we do have reveal an exploding market, one that nearly doubled from 2004 to 2008, producing a total of 5,238 babies over just four years. This growth rate shows no signs of slowing.

Both the CDC and SART collect data on success rates per individual IVF cycle from ART clinics nationally. The Centers for Disease Control require that individual assisted reproductive technology (ART) clinics report their success rates, which are made publically available in annual reports, the most recent of which is from 2007.[1] Unfortunately, the CDC collects information by IVF cycle, rather than individual patient, making it difficult to estimate the number of individuals who participate in ART. Nevertheless, each clinic is required to report whether it offers services to patients using a gestational surrogate and what percentage of IVF cycles were performed on surrogates. Therefore, while the CDC does not report gestational surrogacy statistics by state, it is possible to roughly estimate state statistics using individual clinic data. Importantly, the CDC collects no information on traditional surrogacy, as these surrogates are typically impregnated by AI rather than IVF. Although there has been inquiry into what proportion of families choose traditional versus gestational surrogacy, the vast disparity in cost between the two methods suggests traditional surrogacy is nearly as prevalent as, if not more prevalent than, gestational surrogacy. Therefore, the CDC statistics vastly underestimate the scope of the market.

The CDC also issues a report entitled the *Assisted Reproductive Technology Surveillance,*[2] which analyzes success rates and trends on ART generally. It contains a few very rough statistics on the success rates of gestational surrogacy IVF cycles based on maternal age, and no information on traditional surrogacy. These numbers are only reported on a national basis, and thus it is not possible to assess success rates in individual jurisdictions.

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[1] *2007Assisted Reproductive Technology Success Rates.* US Department of Health and Human Services, Centers for Disease Control (December 2009). http://www.cdc.gov/art/ART2007/PDF/COMPLETE_2007_ART.pdf. (Hereinafter "CDC Report.")

[2] Saswati Sunderam, et al. *Assisted Reproductive Technology Surveillance – United States, 2006*. Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion (June 12, 2009). http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5805a1.htm?s_cid=ss5805a1_e. (Hereinafter "CDC Surveillance.")

SART also collects information on the national number of IVF cycles performed on gestational surrogates.[3] These numbers are not broken down by state, and also focus exclusively on gestational, rather than traditional, surrogacy.

SART reports a significantly higher number of gestational surrogacy IVF cycles than the CDC does for 2007, likely due to the fact that small and new clinics are exempt from CDC reporting. However, not all IVF clinics are members of SART. *Therefore, it is likely that both data sets are under-inclusive.* The most significant limitation, however, comes from the unit of measure used by both CDC and SART data sets. Both report by IVF cycle, rather than by patients undergoing these cycles. The same women can undergo several unsuccessful cycles before finally becoming pregnant. She may also have a miscarriage and begin another IVF cycle in the same year. Therefore, the metric used by the only statistical studies of surrogacy render it impossible to estimate the number of women who serve as gestational surrogates on any given year, thus making it extremely difficult to deduce the scope and impact of this industry.

Reporting by IVF cycle also frustrates attempts to study important factors that may be critical in crafting appropriate regulations. When adverse medical events are tracked by cycle rather than patient it becomes impossible to study risk factors for surrogates, for example. It is possible that some women are particularly susceptible to complications during ART or pregnancy, and more data would better identity which populations are particularly vulnerable to these short and long-term health risks. Furthermore, reporting by cycle precludes any demographic analysis. This poses a major limitation on exploring questions of financial, racial or socio-economic exploitation. With existing statistics on surrogacy demonstrating a rapid rate of market growth, it becomes clear that much more information is needed to appropriately regulate the surrogacy industry.

A. CDC statistics

CDC's 2007 report indicates that there were 483 clinics performing IVF in that year, 430 of which submitted data for the report.[4] Of these, 352 clinics stated that they offered services to gestational surrogates and 204 clinics reported performing at least one cycle using a gestational

[3] While this informational is distributed internally, SART has not publicly published this data. The data for this report was received by the author from Eleanor Nicoll, Public Affairs Manager for the American Society for Reproductive Medicine, on June 9, 2010. (Hereinafter "SART Report.")

[4] *See* CDC Report, supra note 1 at 59.

surrogate.[5] Overall, the CDC statistics indicate that 1,293 IVF cycles involving gestational surrogates were performed in 2007.[6] The CDC further reported that 142,435 total IVF cycles were performed in 2007, resulting in 43,412 live birth deliveries that produced 57,569 infants born.[7] The number of infants is higher than the number of live births due to the fact that IVF frequently results in multiple birth pregnancies.[8] The CDC further issued statistics on the rates of success of gestational surrogacy pregnancies using fresh, non-donor eggs relative to non-surrogate pregnancies, based on the age of the genetic mother. In this analysis, the CDC reported that 1% of non-donor IVF cycles used gestational surrogates, totaling 733 cycles in 2007.[9] However, this number is below the total number of gestational surrogacy IVF cycles reported to the CDC in 2007, as frequently surrogacy arrangements also involve donor eggs.

The information reported by individual clinics was used to estimate how many IVF cycles were performed on gestational surrogates in each individual state in 2007, including the District of Columbia and Puerto Rico.[10, 11] CDC statistics were also used to estimate the number of live births resulting from gestational surrogacy by state, the percentage of national IVF cycles performed in each state, the percentage of national gestational surrogacy cycles performed in each state, and the proportion of IVF cycles within an individual state that were performed on gestational surrogates. These estimates are listed in Table 1.

[5] Author's calculations based on CDC Report, *id.* at 93–516.
[6] Author's calculations, *see* Table 1. Based on CDC Report, *id.* at 93–516.
[7] *Id.* at 15.
[8] *Id.* at 26. ("[T]he vast majority of multiple births in the United States are due to infertility treatments . . .")
[9] *Id.* at 59.
[10] Because the clinic fact sheets do not report a total number of cycles or births per clinic, but break these down in several categories depending on the age of the mother and whether frozen or donor embryos were used, these estimates involved a great deal of manual calculation. Therefore, there is a significant likelihood of human error.
[11] Methodology for calculating estimates: The number of cycles in each category was summed to obtain the total number performed in that clinic. The total number of live births was then obtained by summing the products of the live birth rate in each category and the number of cycles in each category. The estimated surrogacy cycles and live births resulting from surrogacy were estimated by calculating the product of the percentage of cycles using gestational carriers and the total number of cycles or the total number of live births. In calculating state totals, estimates for gestational surrogacy were rounded up to the whole number if the decimal was .5 or higher and if the clinic reported a whole-number percentage of cycles using gestational surrogates. Where the clinic reported <1%, the decimal was rounded down the next greatest whole number.

Table 1. Gestational Surrogacy Estimates, By State

State	State - Total Cycles	State - Total Births	State - Estimated Cycles from Surrogacy	State - Estimated Births from Surrogacy		% of Total National IVF Cycles	% of State Cycles Using Surrogates	% of National Cycles Using Surrogates
Alabama	959	320	9	3		0.70%	0.94%	0.70%
Alaska	87	21	1	0		0.06%	1.15%	0.08%
Arizona	2216	661	24	8		1.61%	1.08%	1.86%
Arkansas	309	100	0	0		0.22%	0.00%	0.00%
California	19218	5988	301	95		13.98%	1.57%	23.28%
Colorado	2240	998	29	14		1.63%	1.29%	2.24%
Connecticut	3611	1073	36	10		2.63%	1.00%	2.78%
Delaware	347	113	0	0		0.25%	0.00%	0.00%
D.C.	1362	375	9	2		0.99%	0.66%	0.70%
Florida	6358	1893	91	30		4.62%	1.43%	7.04%
Georgia	2608	949	16	5		1.90%	0.61%	1.24%
Hawaii	632	171	0	0		0.46%	0.00%	0.00%
Idaho	413	156	8	3		0.30%	1.94%	0.62%
Illinois	9646	2633	24	8		7.02%	0.25%	1.86%
Indiana	1894	556	15	5		1.38%	0.79%	1.16%
Iowa	790	340	4	1		0.57%	0.51%	0.31%
Kansas	888	317	14	5		0.65%	1.58%	1.08%
Kentucky	494	128	7	2		0.36%	1.42%	0.54%
Louisiana	856	262	7	2		0.62%	0.82%	0.54%
Maine	36	30	0	0		0.03%	0.00%	0.00%
Maryland	6021	1842	52	16		4.38%	0.86%	4.02%
Massachusetts	8447	2613	81	25		6.14%	0.96%	6.26%
Michigan	3202	1076	23	8		2.33%	0.72%	1.78%
Minnesota	2274	895	24	10		1.65%	1.06%	1.86%
Mississippi	306	89	3	1		0.22%	0.98%	0.23%
Missouri	1636	542	28	8		1.19%	1.71%	2.17%
Montana	0	0	0	0		0.00%	n/a	0.00%
Nebraska	600	214	6	2		0.44%	1.00%	0.46%
Nevada	1549	487	31	11		1.13%	2.00%	2.40%
New Hampshire	166	50	0	0		0.12%	0.00%	0.00%
New Jersey	8520	2708	105	92		6.20%	1.23%	8.12%
New Mexico	244	99	2	1		0.18%	0.82%	0.15%
New York	19065	5025	71	21		13.87%	0.37%	5.49%
North Carolina	2769	880	6	2		2.01%	0.22%	0.46%
North Dakota	127	35	5	2		0.09%	3.94%	0.39%
Ohio	3771	1149	30	9		2.74%	0.80%	2.32%
Oklahoma	679	275	0	0		0.49%	0.00%	0.00%
Oregon	1333	527	28	10		0.97%	2.10%	2.17%
Pennsylvania	3897	1105	32	9		2.83%	0.82%	2.47%
Puerto Rico	236	57	0	0		0.17%	0.00%	0.00%
Rhode Island	733	208	7	2		0.53%	0.95%	0.54%

South Carolina	849	359	10	4		0.62%	1.18%	0.77%
South Dakota	171	67	0	0		0.12%	0.00%	0.00%
Tennessee	1357	483	11	4		0.99%	0.81%	0.85%
Texas	7271	2776	67	25		5.29%	0.92%	5.18%
Utah	836	338	0	0		0.61%	0.00%	0.00%
Vermont	119	31	2	1		0.09%	1.68%	0.15%
Virginia	2817	859	42	14		2.05%	1.49%	3.25%
Washington	2623	1077	18	7		1.91%	0.69%	1.39%
West Virginia	113	36	0	0		0.08%	0.00%	0.00%
Wisconsin	787	236	14	4		0.57%	1.78%	1.08%
Wyoming	0	0	0	0		0.00%	n/a	0.00%
TOTAL	**137482**	**43222**	**1293**	**481**		**100.00%**	n/a	**100.00%**
AVERAGE	**2643.9**	**831.2**	**24.87**	**9.25**		**1.92%**	**0.92%**	**1.92%**

The most recent CDC *Surveillance* report is only available for 2006. This publication also states that 1% of all IVF cycles used a gestational surrogate[12]. The report further breaks down statistics on IVF cycles using a gestational carrier by intended mother's age. Importantly, IVF cycle success can greatly depend on the age of the genetic mother, regardless of the surrogate's age.[13] These statistics are summarized in Table 2.

Table 2. Relevant Statistics from CDC 2006 *Surveillance*

Treatment Group	**Mother's Age**				
	<35 n = 35,800 (%)	**35--37 n = 19,184 (%)**	**38--40 n = 15,267 (%)**	**41--42 n = 6,676 (%)**	**>42 n = 3,386 (%)**
Percentage of ART patients using fresh, non-donor eggs who used gestational carriers, by patient age group	0.9	1.2	1.1	1.3	1.1
Percentage of ART cycles using fresh, non-donor eggs, who used gestational surrogates, resulting in live births	44.6	37	26.6	15	6.6
Percentage of ART cycles using fresh, non-donor eggs, who did not use gestational surrogates, resulting in live births	47.5	40.4	29.5	17.9	7.9
Total percentage of ART cycles using fresh, non-donor eggs resulting in live births	44.7	37.1	26.7	15.1	6.6

B. SART statistics

The Society for Assisted Reproductive Technology also collects data from member clinics. SART reports that 2,502 IVF cycles were performed on gestational surrogates in 2008,

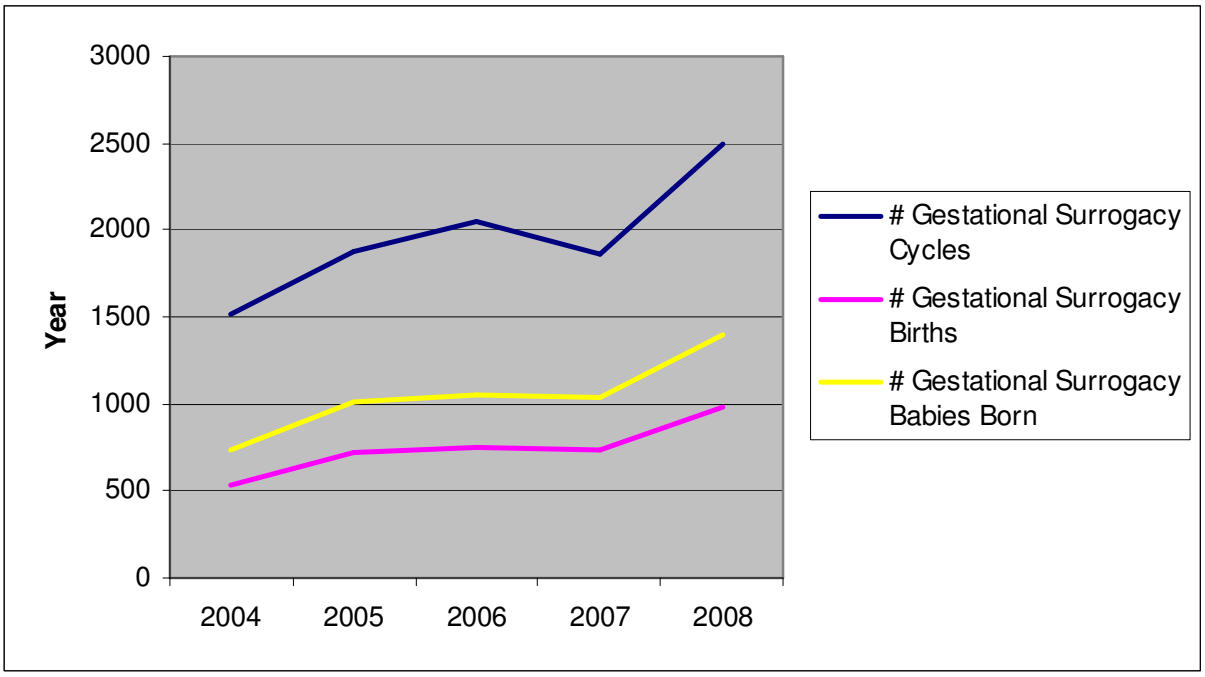
[12] *See* CDC Surveillance, *supra* note 2. *See also* CDC Surveillance, *infra* note 18 and accompanying text.
[13] *Id.* at Table 3, Table 4.

resulting 987 birth and 1,395 babies. Like the CDC report, SART numbers also indicate that the gestational surrogacy market is growing rapidly. See Chart 1. SART numbers are significantly higher than CDC numbers, however, likely due to the fact that many – at least 53 of the 483 ART clinics offering fertility treatments in the U.S. – do not report to CDC. Nevertheless, as many ART clinics are not SART members, it is highly probable that SART numbers also do not adequately capture the true rate of gestational surrogate use in the U.S.

Table 3. SART Statistics for Gestational Surrogacy, 2004–2008[14]

Year	Number of Gestational Surrogacy Cycles	Number of Gestational Births	Number of Gestational Surrogacy Babies Born[15]	Estimated Percent of Cycles Resulting in Pregnancy[14]	Average No. of Babies Born Per Gestational Surrogacy Birth
2004	1508	530	738	35.15%	1.39
2005	1872	714	1012	38.14%	1.42
2006	2043	756	1059	37.00%	1.40
2007	1866	737	1034	39.50%	1.40
2008	2502	987	1395	39.45%	1.41

Chart 1. SART – Trends in Gestational Surrogacy



[14] Because births in 2007 do not necessary correspond to IVF cycles performed in 2007 this is only a rough estimate. Many babies born in 2007 were conceived during IVF cycles in 2006.
[15] The number of babies born is greater than the number of births due to the high rate of multiple pregnancies.

2. <u>LAWS</u> – What state surrogacy laws have changed since 2007? Is this in any way correlated to state statistics? Are there pending bills in any states that deal with surrogacy or will bear upon the surrogacy market?

A. Changes in State Laws & Politics

Most states have unclear laws governing surrogacy agreements. Nevertheless, they can roughly be grouped into six categories, reflecting the degree of restriction they impose on surrogacy agreements.[16] Ranging most favorable to most restrictive, there are states that: (1) hold surrogacy agreements valid and enforceable, (2) have unclear statutes but favorable case law, (3) explicitly allow surrogacy agreements but regulate the market, (4) have unclear statutes and no case law, (5) hold surrogacy agreements void and unenforceable, and (6) prohibit and/or penalize individuals entering such agreements, sometimes under threat of heavy fines and jail time. Most states fall in the middle, and most do not have statutes that address the validity or legality of surrogacy contracts.

Despite the explosion of the surrogacy market, very few states have changed their laws in recent years. One exception is Ohio, where the State Supreme Court held in 2007 that a gestational surrogacy agreement prohibiting surrogates from asserting parental rights did not violate public policy.[17] Other states, namely Arizona and Arkansas, have passed laws on issues that bear on the surrogacy market, such as gay marriage, adoption, and gamete donation, but have declined to legislate on surrogacy itself. There are also bills pending in several jurisdictions, including California, Florida, Illinois, Kansas, Maryland, Massachusetts, Minnesota, Virginia and Washington, that propose to regulate surrogacy agreements. Finally, some state legislatures are currently reviewing bills that modify laws on relevant issues potentially affecting the surrogacy landscape. Still, these laws do not speak to the legality or enforceability of the surrogacy contracts themselves. States currently reviewing such legislation include Michigan, Oklahoma, and Tennessee. See Appendix A for more details on individual state laws.

Given the growing prevalence of surrogacy as a serious option for infertile couples, the lack of political action is alarming. While most states leave it to the courts to rule on the enforceability of surrogacy contracts, courts are ill-equipped to appropriately set policy on such a

[16] *See State Surrogacy Laws.* Human Rights Campaign (Sept. 2009). http://www.hrc.org/issues/2486.htm.
[17] *See* J.F. v. D.B., 879 N.E.2d 740 (Ohio 2007).

complicated issue. Whereas courts see surrogacy agreements as individual contracts assigning individual rights, there are systemic, industry-wide dangers that demand a more nuanced, informed and deliberative policymaking process. Statistics showing the rapid growth in gestational surrogacy cycles, which are especially concentrated in some states, indicate that surrogacy is becoming a booming industry and bolster the conclusion that we need regulatory oversight. More data on the size of the market, the individuals involved and the risks they face is absolutely necessary. Data is important not only in order to raise awareness of the issue among constituents and policymakers, but also in order to supply policymakers with adequate information when implementing proper regulatory safeguards for surrogates, intended parents and the resulting children.

B. What is the relationship between state gestational surrogacy statistics and existing state laws?

This report does not undertake any rigorous statistical examination of the relationship between state law and surrogacy statistics. However, a cursory analysis does yield interesting observations about the relationship between state policy and the predominance of surrogacy within the infertility and ART marketplace.

As previously mentioned, the legal frameworks of the various states range from holding surrogacy contracts valid and enforceable to imposing heavy civil and criminal penalties on parties entering such agreements, with the majority of states having ambiguous and unclear laws. One might predict that an increased likelihood of contractual enforcement by courts is associated with a higher rate of surrogacy. State statistics derived from CDC data largely support such an assumption. While roughly associated with the legality and enforceability of surrogacy agreements within the state, glaring exceptions suggest that existing laws either insufficiently regulate the surrogacy market or remain largely unenforced.

Because the CDC-derived statistics are not population-adjusted, the measure that best determines the influence of state policy on the decision to enter into a surrogacy agreement is the percentage of total state IVF cycles that were performed on gestational surrogates. See Table 4 for relative rates of gestational surrogacy compared to varying state policies on surrogacy contracts.

Table 4 demonstrates that states with laws upholding surrogacy contracts do witness higher rates of gestational surrogacy cycles relative to total IVF cycles. For example, in both Florida and Nevada, where surrogacy agreements are valid, enforceable and relatively unregulated, the percent of IVF cycles performed on gestational surrogates is significantly higher than the national average of 1%. Similarly, in states where courts favor enforcement of surrogacy contracts, most notably California and Wisconsin, the relative rates of gestational surrogacy are also higher than average. In North Carolina, on the other hand, where surrogacy agreements are prohibited by law, only .22% of IVF cycles involve surrogates, far below the national average of 1%.

Nevertheless, there are surprising exceptions and contradictions. For example, both Illinois and Virginia permit but heavily regulate surrogacy agreements. Despite similar laws, Illinois exhibits one of the lowest percentages of cycles using gestational surrogates, while Virginia touts one of the highest. Similarly, in Ohio, where courts favor enforcement of surrogacy agreements, only .80% of cycles in 2007 used surrogates, below the national average.

Where the laws are unclear, huge variations can be seen in the rate of surrogacy. Iowa, for example, exhibits one of the lowest relative rates of gestational surrogacy, while Oregon, also silent on the legality of surrogacy, reports one of the highest. While more data and analysis is necessary in order to explain these variations, the relative rate of surrogacy in a given state is likely influenced by a range of demographic variables, including median income, disparities in income, education, racial composition, access to healthcare, and cultural and political factors.

Importantly, even states that hold surrogacy agreements void and unenforceable have not managed to fully deter the practice. Clinics in New York, for example, perform over 5% of gestational surrogacy IVF procedures nationally. Even in states such as Michigan, where such agreements are prohibited under penalties of heavy fines and possible jail time, clinics still accept and perform IVF procedures on patients who used gestational surrogates.

Comparing the relative rates of surrogacy across states with varying laws shows just how inadequate current state regulatory frameworks are. In states where legislative deliberation has deemed that surrogacy is undesirable and should be prohibited, there appears to be no enforcement of this policy. In other words, ART clinics are blatantly breaking the law with little consequence. Where legislatures have ignored the issue, courts have influenced policy outcomes without adequate information on the size of the market, its demographic composition, the

medical and financial risks involved, and without the deliberative, democratic input essential in this ethically controversial area. Awareness-raising, data collection and deliberation are essential in order to formulate adequate oversight and in order to protect individuals implicated in this market.

Table 4. Relative Rates of Gestational Surrogacy Relative to State Law, 2007

State	% of National Cycles	% of State Cycles Using Surrogates	% of National Cycles Using Surrogates	Relevant State Law
Arkansas	0.22%	0.00%	0.00%	Valid & enforceable
Florida	4.62%	1.43%	7.04%	Valid & enforceable
New Hampshire	0.12%	0.00%	0.00%	Valid & enforceable
Nevada	1.13%	2.00%	2.40%	Valid & enforceable for married couples
New Jersey	6.20%	1.23%	8.12%	Valid & enforceable if uncompensated
Washington	1.91%	0.69%	1.39%	Valid & enforceable if uncompensated
California	13.98%	1.57%	23.28%	Courts favor enforcement
Connecticut	2.63%	1.00%	2.78%	Courts favor enforcement
Delaware	0.25%	0.00%	0.00%	Courts favor enforcement
Massachusetts	6.14%	0.96%	6.26%	Courts favor enforcement
Minnesota	1.65%	1.06%	1.86%	Courts favor enforcement
Ohio	2.74%	0.80%	2.32%	Courts favor enforcement
South Carolina	0.62%	1.18%	0.77%	Courts favor enforcement
Vermont	0.09%	1.68%	0.15%	Courts favor enforcement
Wisconsin	0.57%	1.78%	1.08%	Courts favor enforcement
Illinois	7.02%	0.25%	1.86%	Permitted but heavily regulated
Texas	5.29%	0.92%	5.18%	Permitted but heavily regulated
Utah	0.61%	0.00%	0.00%	Permitted but heavily regulated
Virginia	2.05%	1.49%	3.25%	Permitted but heavily regulated
Alabama	0.70%	0.94%	0.70%	Unclear
Alaska	0.06%	1.15%	0.08%	Unclear
Arizona	1.61%	1.08%	1.86%	Unclear
Colorodo	1.63%	1.29%	2.24%	Unclear
Georgia	1.90%	0.61%	1.24%	Unclear
Hawaii	0.46%	0.00%	0.00%	Unclear
Idaho	0.30%	1.94%	0.62%	Unclear
Iowa	0.57%	0.51%	0.31%	Unclear
Kansas	0.65%	1.58%	1.08%	Unclear
Kentucky	0.36%	1.42%	0.54%	Unclear
Maine	0.03%	0.00%	0.00%	Unclear
Maryland	4.38%	0.86%	4.02%	Unclear

Mississippi	0.22%	0.98%	0.23%	Unclear
Missouri	1.19%	1.71%	2.17%	Unclear
Montana	0.00%	n/a	0.00%	Unclear
Oregon	0.97%	2.10%	2.17%	Unclear
Pennsylvania	2.83%	0.82%	2.47%	Unclear
Rhode Island	0.53%	0.95%	0.54%	Unclear
South Dakota	0.12%	0.00%	0.00%	Unclear
Tennessee	0.99%	0.81%	0.85%	Unclear
West Virginia	0.08%	0.00%	0.00%	Unclear
Wyoming	0.00%	n/a	0.00%	Unclear
New York	13.87%	0.37%	5.49%	Unclear - void & unenforceable by statute but courts allow
Indiana	1.38%	0.79%	1.16%	Void & unenforceable
Louisana	0.62%	0.82%	0.54%	Void & unenforceable
Nebraska	0.44%	1.00%	0.46%	Void & unenforceable
North Dakota	0.09%	3.94%	0.39%	Void & unenforceable
Oklahoma	0.49%	0.00%	0.00%	Void & unenforceable
New Mexico	0.18%	0.82%	0.15%	Forbids
North Carolina	2.01%	0.22%	0.46%	Forbids
D.C.	0.99%	0.66%	0.70%	Prohibitted, up to $10,000 fine and jail time
Michigan	2.33%	0.72%	1.78%	Prohibitted, up to $50,000 fine and five years jail
Puerto Rico	0.17%	0.00%	0.00%	n/a
TOTAL	**100.00%**	n/a	**100.00%**	
AVERAGE	**1.92%**	**0.92%**	**1.92%**	

3. <u>HEALTH RISKS</u> – What are the short and long-term health risks to women who become surrogates?

Studies on the physical and mental health effects of becoming a surrogate mother are almost nonexistent. Nevertheless, we can deduce some of the potential dangers from the documented risks associated with AI, IVF, and pregnancy generally. The risk in any given surrogacy agreement depends on, among other factors:

- The health and age of the woman serving as a surrogate.
    - In any pregnancy, risk increases with age. While most agencies have age limits for surrogates, there is no oversight to ensure that only surrogates healthy enough to be pregnant are recruited.
- The type of surrogacy (gestational or traditional).

- IVF is generally more invasive, and therefore more risky, than AI. IVF also carries a higher risk of multiple pregnancy, which is riskier than single pregnancy.

- What hormones or drugs the surrogate is instructed to take.
  - All drugs have side effects. Many women undergoing AI also take fertility treatments, and it is possible that matching agencies and intended parents require this of surrogates as well, increasing the likelihood of an adverse reaction or multiple pregnancy. No data has been collected on what medications are in fact prescribed to surrogates and how frequently adverse reactions occur. Again, this information is necessary in order to ensure adequate protection of surrogate worker health.
- How many IVF or AI cycles a surrogate undergoes before reaching a successful pregnancy.
  - With each IVF or AI cycle, the surrogate is again exposed to the risks involved with the procedure. The surrogate must likely also continue fertility and hormone medication, increasing the risk of an adverse reaction.
- The number of embryos implanted.
  - The greater the number of embryos implanted during IVF, the higher the risk of a multiple pregnancy. While the CDC urges ART clinics to limit the number of embryos implanted during IVF in order to mitigate this risk, the U.S. has yet to cap the maximum number that may be implanted. The risks associated with multiple embryo implantation are greater when the individual bearing the risk is a hired surrogate, who often lacks the knowledge and bargaining power to demand fewer embryos be implanted in order to reduce her health risk. Intended parents, on the other hand, have financial incentives to increase the probability of pregnancy.
- The age of the woman providing the eggs.[18]
  - The CDC *Surveillance* report indicates that the age of the woman providing the egg in IVF greatly affects the probability of both a successful pregnancy

[18] *See* Surveillance, supra note 2 at Tables 3, 4, indicating that the success rates drop as maternal age increases, thereby also increasing the risk of complications during impregnation and pregnancy for the surrogate.

and a live birth. Therefore, the surrogate bears an elevated risk of miscarriage and pregnancy complications if the intended mother or egg donor is an older woman. Data on the demographics of intended parents who hire surrogates may demonstrate that the risk to surrogates is especially great because of intended mother age, again indicating possible areas for appropriate regulation and oversight.

- Whether the eggs and/or embryos are frozen or fresh.
    - CDC *Surveillance* report indicates that pregnancy and live birth rates are far greater for IVF cycles using fresh, rather than frozen, eggs and embryos. Data on the relative rates of fresh versus frozen reproductive tissue used and the corresponding adverse event rates may suggest that the risk to surrogates is too great, and that frozen egg and embryo use should be restricted.
- Whether the individuals providing gamete material have any infectious diseases.
    - While clinics and matching agencies screen reproductive tissues for infectious diseases and sexually transmitted infections (STIs), human and medical error are still possible. Surrogates agreeing to be implanted with these bodily tissues are subjected to the risk of infection from these tissues.

A. Screening

For either traditional or gestational surrogacy, the medical risk begins before the intended parents have even agreed to hire the surrogate. Typically, agencies require potential surrogates to undergo a thorough screening process,[19] where the surrogate must submit to several physical tests and exams and is asked to divulge highly personal details about her medical and sexual history, including any STI's. Some agencies further require that surrogates bring in sexual partners for STI testing. Agencies also request the names of several references with whom the surrogate's intention are discussed, potentially violating the surrogate's rights to keep her involvement in the pregnancy private.

The screening process for gestational surrogacy is even more invasive than traditional surrogacy. The surrogate is often asked to undergo a hysterosonogram or a hysterosalpingogram

[19] *See* Dr. Vladimir Troche. *Carrier Screening.* West Valley Fertility Center (September 2, 2009). http://www.wvfc.com/arizona-gestational-surrogacy.html

or both, diagnostic imaging tests that are meant to ensure her uterus is healthy for embryo implantation. Either procedure is painful and unpleasant for most women, and can be medically risky for some.

A hysterosonogram[20] uses a catether placed in the cervical canal or uterine cavity to image the uterus and fallopian tubes while fluid is injected into the catheter. This procedure carries a risk of bacterial infections, which can in rare circumstances lead to major surgery and render the surrogate unable to have future children. Other risks include bleeding, trauma to the cervix, fallopian tubes or adjacent structures, and allergic reactions. The procedure can also cause cramping, bleeding, dizziness, nausea or vomiting.

A hysterosalpingogram[21] is a similar procedure that instead uses iodine and radiation to image the reproductive organs. Risks of the procedure include infection, fainting, radiation exposure, allergic reactions to iodine and puncturing of the uterus. Allergic reaction, infection and fainting are the most common side effects, and in rare circumstances can lead to major surgery and tissue loss.

While the probabilities of these risks are low, these medical outcomes can be severe. The lack of regulation allows agencies and intended parents to require multiple, unnecessary tests before even hiring a surrogate. Where the surrogacy agreement stipulates for the intended parents to choose physicians and facilities, a desire to reduce costs can lead to potential surrogates being sent to low-quality medical facilities, where the risks are greater. The lack of information on the rates of injury in these processes, however, leaves us guessing about the degree of potential abuse and circumvents necessary policymaking.

B. Artificial Insemination Risks

In traditional surrogacy, AI is the biggest source of pre-pregnancy risk. Usually, one of two types of AI is employed to impregnate the surrogate. The most common and least expensive is intracervical insemination (ICI), but often intrauterine insemination (IUI) is used. In either procedure, a catheter is used to insert sperm into the cervix or uterus.[22] Risks include infection, multiple pregnancies, STI infection from the sperm, and any risks associated with fertility drugs

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[20] *See Sonohysterogram-Hysterosonogram.* Randy S. Morris, MD (June 23, 2009). http://www.ivf1.com/sonohysterogram/.

[21] *See* Jennifer S. Wright. *Risks of a Hysterosalpingogram.* eHow. http://www.ehow.com/about_5559137_risks-hysterosalpingogram.html##.

[22] *See Intrauterine Insemination.* Docshop.com. http://www.docshop.com/education/fertility/treatments/iui-ici/

prescribed.[23] The most common drug prescribed for artificial insemination is clomiphene citrate, or Clomid.[24] Clomid carries a risk of ovarian hyperstimulation, which in very rare cases is severe and life-threatening, as well as a risk of hot flashes, abdominal pain, mood problems, blurred vision, and other side effects.[25]

C. IVF risks

Gestational surrogates undergo a significant amount of hormonal treatment. The surrogate and egg donor (usually the mother) must match their menstrual cycles perfectly, because the embryo is implanted in the surrogate within days of the intended mother's ovulation. Intensive hormone therapy is used to regulate this process. As a result, it is likely that gestational surrogates are more likely to suffer adverse consequences than traditional surrogates, although there have been no studies on this. Typical medications prescribed during the IVF process include:[26, 27]

- Gonadotropin releasing hormone (GnRH) agonists (Synarel, Lupron), which inhibit the brain from secreting hormones that control the menstrual cycle. The ovaries enter into a state of rest, and the surrogate's cycle can be completely controlled. These medications prevent premature ovulation and allow the patient's cycle to be coordinated as needed. Lupron, a subcutaneous injection, and Synarel, a nasal spray, are often used as GnRH agonists, usually started one week before the gestational surrogate's period is expected or in the very beginning of the cycle. While these medications are usually well-tolerated, some women may have hot flashes, fatigue, headaches, irritability or nausea. Risks also include severe allergic reactions, infection and bleeding, among others.[28]
- Estrogen is the hormone that thickens the lining to the endometrium, the inner wall of the uterus, for more successful implantation. Estrodial can be given as an oral tablet,

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[23] *See* Mayo Clinic staff. *Risks.* MayoClinic.com. (August 29, 2008). http://www.mayoclinic.com/health/intrauterine-insemination/MY00104/DSECTION=risks

[24] *See FAQ: Intra-Uterine Insemination (IUI).* UCSF Medical Center. http://www.ucsfhealth.org/adult/medical_services/womens_health/fertility/fertilityIUI.html#4

[25] *See Clomiphene Citrate For Infertility.* WebMd. (December 23, 2008). http://www.webmd.com/infertility-and-reproduction/clomiphene-citrate-for-infertility

[26] *See Gestational Surrogacy and IVF Meds.* AllAboutSurrogacy.com. http://www.allaboutsurrogacy.com/gestational_surrogacy.htm

[27] *See Side Effects/Risks.* Surrogacy Dreams. http://www.surrogacydreams.com/db1/index.php?option=com_content&task=view&id=34&Itemid=69

[28] *See Lupron.* Drugs. (July 1, 2009). http://www.drugs.com/lupron.html

intramuscular injection, or patch on the skin. Intramuscular injections can be extremely painful, and sometimes cause infection. Long-term use, which can occur for women who undergo many surrogate pregnancies or many unsuccessful IVF cycles, can lead to hyperplasia, a risk factor for uterine cancer.[29] Long-term use can also increase the risk of breast cancer, uterine cancer, heart attack, stroke and serious blood clots, all potentially life-threatening conditions.[30] Some women may experience vaginal irritation, dizziness, lightheadedness, headache, stomach upset, bloating, nausea, weight changes, increased or decreased interest in sex, or breast tenderness.[31]

- Progesterone is the hormone produced by the ovary after ovulation. This medication can be given to improve the uterine lining, which may augment implantation of the embryo. It is usually started in the second half of the cycle, several days before the embryo transfer. Progesterone can be given as an intravaginal suppository, oral capsule, or an intramuscular injection. Side effects can include bloating, irritability, and breast tenderness, but more severe side effects may occur in a small subset of women.[32]
- Antibiotics (doxycycline) and/or Steroids (methylprednisone) may be used as anti-rejection tactics. Steroid use can have serious side effects, including weight gain, high blood pressure, glaucoma, cataracts, peptic ulceration, and major psychotic disturbances. Methylprednisolone and other corticosteroids can also mask signs of infection and impair the body's natural immune response to infection. Patients on corticosteroids are more susceptible to infections and can develop very serious illnesses.[33]

Many of the long-term health risks of hormonal medications are not well documented or well understood. While most studies find little evidence that the use of fertility medications heightens long-term risks of endocrine disorder, reproductive problems and cancer, some studies still suggest there may be a link.[34] Before the science is well understood, we cannot rule out the

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[29] *See Estradiol Cypionate IM.* WebMD. http://www.webmd.com/drugs/drug-14458-Estradiol+Cypionate+IM.aspx?drugid=14458&drugname=Estradiol+Cypionate+IM&source=0.
[30] *Id.*
[31] *See* MayoClinic.com, *supra* note 23..
[32] *See Progesterone Side Effects.* Drugs.com. http://www.drugs.com/sfx/progesterone-side-effects.html.
[33] *See* Omudhome Ogbru. *Methylprednisolone*. Drugs.com (November 16, 2007). http://www.medicinenet.com/methylprednisolone/article.htm.
[34] *See Possible Fertility Drug-Cancer Link Found.* CBSNews.com. (December 11, 2008). http://www.cbsnews.com/stories/2008/12/11/earlyshow/health/main4661991.shtml

possibility that women working as surrogates are risking their lives by ingesting potentially carcinogenous agents.

D. Risks Associated with Pregnancy Generally

A large portion of the risk associated with becoming a surrogate is the general risk associated with pregnancy. This includes but is not limited to: exhaustion, nausea, indigestion, constipation, weight gain, bloating, backaches, difficulty sleeping, breast pain, higher blood pressure, hormonal mood changes, stretch marks, loose skin, abdominal and vaginal muscle weakness, varicose veins, pre-eclampsia, placenta previa, gestational diabetes, anemia, embolism, cardiopulmonary arrest, placental abruption, molar pregnancy, future infertility, permanent disability, and death.[35]

E. Multiple pregnancies

Due to the use of fertility medication in traditional surrogacy and the practice of implanting of multiple embryos to improve pregnancy chances in IVF, surrogate pregnancies often result in multiples. Multiple pregnancy heightens many of the risks associated with pregnancy generally, which are listed above. Multiple pregnancies also increase the risk of miscarriage, anemia, urinary tract infections, high blood pressure and organ damage (preeclampsia), excessive bleeding (hemorrhage), increased chance of cesarean delivery, too much amniotic fluid (polyhydramnios), and problems with the placenta, such as placenta abruption or placenta previa.[36] These pregnancies are also far more risky for the infants that result, where 60% of multiple infants that result are delivered premature.[37]

F. Financial and Legal Risks

Many women who choose to become surrogates likely do not have the financial or educational resources for any kind of legal representation. While this practice has not been studied, it is highly likely they are represented by an attorney hired by the matching agency. This

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[35] *See Surrogate Mother Risks & Complications.* Egg Donor Surrogacy USA. http://www.eggdonorsurrogacyusa.com/surrogate_risks.php

[36] *See Risks of Multiple Pregnancy.* WebMD. (March 21, 2008). http://www.webmd.com/infertility-and-reproduction/guide/risks-of-multiple-pregnancy.

[37] *See* Stephanie Saul, *The Gift of Life, And Its Price*, The New York Times (October 10, 2009). http://www.nytimes.com/2009/10/11/health/11fertility.html?_r=1&scp=1&sq=60%%20premature%20twin%20births&st=cse.

opens the door for potential conflicts of interest, heightening the probability that the surrogacy contract will contain terms disproportionately unfavorable to the surrogate. Specifically, surrogates risk entering a contract that might leave them with an unwanted child in the event that the intended parents back out and no longer want custody after the birth. A major decision by the California Supreme Court mirrors this fact pattern,[38] as does an account on a popular surrogacy blog, where the candidate surrogate was persuaded to sign an contract reserving the right of the intended parents to refuse custody or parental rights of the resulting infant for any reason.[39] Other potential areas for exploitation in surrogacy contracts include requirements for strict adherence to certain risky medical protocols that enhance the probably of a birth, such as fertility treatment and multiple embryo transfer, and the unfavorable allocation of financial burden in the event of a medical emergency during pregnancy. In a context where medical insurance coverage is highly unstable, the potential for exploitation in contractual terms can have massive implications for surrogates without the adequate resources to attain competent legal representation. While no studies have been undertaken to determine whether such exploitation does in fact occur, anecdotal evidence suggests that it does. The great potential for abuse further necessitates stricter rules protecting the rights of surrogate workers.

4. <u>MILITARY SURROGACY</u> – Is there any evidence that women in military families are more likely to serve as surrogate mothers?

Several news reports in the last few years have claimed that many women living on military bases, particularly military wives, are choosing to become surrogates.[40] Specifically, criticism has mounted on TriCare, the military's health insurance program, for providing health coverage to surrogate workers. Unfortunately, the issue has not been studied, and thus far the only evidence is anecdotal. Nevertheless, reports indicate that many surrogacy agencies choose

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[38] *See In re Marriage of Buzzanca*, 61 Cal.App.4th 1410 (Cal. 1998).
[39] *See* Rayven Perkins. *My Surrogacy Nightmare.* Information On Surrogacy. http://www.information-on-surrogacy.com/surrogacy-nightmare.html
[40] *See* Lorraine Ali. *The Curious Lives of Surrogates.* (March 29, 2008). http://www.newsweek.com/2008/03/29/the-curious-lives-of-surrogates.html; *see also* Erin Einhorn. *Military Wives Cashing in as Surrogates.* (March 20, 2008). http://www.nydailynews.com/news/national/2008/03/31/2008-03-31_military_wives_cashing_in_as_surrogates-2.html; Stephanie Caballero. *Do Military Wives Make Better Surrogates?* Surrogacy Lawyer (April 2, 2008). http://surrogacylawyer.blogspot.com/2008/04/do-military-wives-make-better.html; Mike Pesca. *Military Wives Becoming Surrogacy Moms.* NPR (July 2, 2008). http://www.npr.org/templates/story/story.php?storyId=92126438; Susan Donaldson James. *Baby Carriers:Cold Cash or Warm Heart?*ABCNews (April 1, 2008). http://abcnews.go.com/Health/ReproductiveHealth/story?id=4561403&page=1.

to locate near army bases – citing specifically that several have popped up around San Diego's Camp Pendleton.[41] Reports have also surfaced that surrogacy agencies are seeking advertising space in military periodicals such as *Military Times* and *Military Spouse.* Online message boards and support groups that specifically cater to military women further suggest that military surrogacy is a real phenomenon.[42] Finally, TriCare recently responded to criticisms that it should not cover these pregnancies, releasing a powerpoint presentation in early 2010 informing providers of the applicable protocol should a pregnant patient admit to serving as a surrogate for another couple. This response suggests surrogacy is a real issue the military is coping with.[43]

It would not be surprising if surrogate agencies are in fact seeking out military wives – young women married to men in the military are particularly attractive targets. Because they are constantly relocating, finding and keeping a job is especially difficult. This poses an even greater challenge as many military families are already classified as low income: military employees typically earn only $16,000 to $29,000 per year[44]. Usually stay-at-home moms who have completed their families by the age of 28, military wives often see surrogacy as a relatively short-term way to supplement the family income. While a seemingly benign practice, the social pressures on military women to contribute to the family budget and the lack of other career opportunities creates massive potential for exploitation. These concerns indicate that military affiliation is one of the demographic factors that should be included in any study of surrogacy in the U.S., and that it should be and integrated into any regulatory policy under consideration.

5. <u>FINANCIAL ASPECTS</u> – What are the financial aspects of hiring a surrogate? How much does it cost intended parents? How much are surrogates paid? Who is profiting from this market?

The surrogacy market is only a sliver of what author Debora Spar has dubbed the "fertility-industrial complex."[45] This "Baby Business" implicates a wide range of stakeholders,

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[41] *See* Ali, supra note 40.
[42] *See* Surrogacy Moms Online (January 31, 2000). http://www.surromomsonline.com/answers/10.8.htm; SMO Message Boards (July 2000). http://www.surromomsonline.com/support/showthread.php?t=119331; *see also* Rick Maze. *DoD: Drop Surrogate Pregnancies from Tricare.* ArmyTimes.com (April 11, 2007). http://www.armytimes.com/news/2007/04/military_surrogatepregnancy_tricare_070411w/;
[43] *See Briefing: How to Bill Surrogacy.*UBO/UBU Conference (March 24, 2010). www.**tricare**.mil/ocfo/_docs/W-5-1510_How_to_Bill_**Surrogacy**1.ppt.
[44] *See* Ali, supra note 40.
[45] Debora L. Spar. *Fertility-industrial complex.* The Baby Business: How Money, Science, and Politics Drive the Commerce of Conception. Boston: Harvard Business School Publishing Corporation, 2006.

including hormone manufacturers, sperm and egg harvesters and donor banks, foreign adoption agencies, ART clinics, embryo banks, legal experts, surrogate matching agencies and the surrogate workers themselves. Overall, an estimated 10 million women spend approximately $3 billion every year in the attempt to produce a child. These are only estimates, however – no one knows for sure how many undocumented and unregulated fertility transactions occur. And surrogacy, especially traditional surrogacy, is especially susceptible to such extralegal transactions.

Despite this dearth of information, there are some estimates available on the cost of surrogacy. News articles have reported that surrogates can be paid anywhere between $12,000 and $25,000 per pregnancy, with the consensus rate falling at $20,000.[46] Yet the cost to intended parents can be much greater, running from $40,000 to $120,000 when medical and legal bills are included. These may seem like large sums, but these prices correspond to real pay as low as 50 cents to $3.00 per hour for surrogates. In other words, surrogates are typically paid far below any state's minimum wage. Given anecdotal evidence that women serving as surrogates come from families of the lowest income brackets, these paltry figures further suggest that surrogacy agreements exploit vulnerable women. Examining these figures demonstrates clearly how the lack of regulation over surrogacy contracts turns seemingly private transactions into *de facto* abusive employment practices. With the rate of the fertility market's expansion growing still, state governments must not remain silent.

6. <u>LIMITS</u> – What are the limits of the available information, and why?

There is very little available data on surrogacy in America. No statistics exist on traditional surrogacy, and the statistics on gestational surrogacy are extremely thin. The only data that is currently collected measures surrogacy rates by IVF cycle, rather than by patient, precluding a true understanding of the market. Furthermore, any attempt to track traditional surrogacy would be extremely difficult. Beyond the formal medical and contractual surrogacy contexts, many traditional surrogates may be using at-home artificial insemination procedures, failing to disclose to healthcare providers the true nature of the pregnancy, and acting without adequate legal representation or contractual arrangements. Finally, the lack of disclosure

[46] *See id.;* Elisabeth Eaves. *Want To Work For $3?*Forbes (July 24, 2009). http://www.forbes.com/2009/07/23/surrogate-motherhood-minimum-wage-opinions-columnists-elisabeth-eaves.html.

requirements for agencies matching surrogates and intended parents leaves the industry entirely unregulated and open to abuse and exploitation. With few state laws and only a tiny subset of surrogacy contracts being disputed in litigation, we have no information on a large proportion of the surrogacy market.

Furthermore, there is scant information indicating the potential risk of medical harm to surrogates. The lack of medical studies on rates of success and adverse reactions in surrogate pregnancies, including risks of STI infection and multiple pregnancies, leave us guessing as to what the actual degree of abuse or exploitation may be, and what regulations might be necessary in order to minimize the risk to which surrogate workers are subjected. Furthermore, if we cannot find adequate information on medical risks in undertaking this study, we can be sure that a surrogate also has no idea of the true risks of her decision. By definition, there can be no "*informed* consent."

Finally, no one is tracking the demographic characteristics of surrogates, their geographic location, or their pre-pregnancy state of health – all factors that might suggest parties seeking surrogates are targeting and exploiting vulnerable populations. One could imagine that parents seeking a low-cost option might agree to finance medical care for an uninsured women should she agree to bear a child. Furthermore, given the high rate of poverty among racial and ethnic minorities, there is a very real possibility they are disproportionately targeted for surrogacy work. Unfortunately, no study has yet endeavored to chart out the actual contours of the surrogacy market.

CONCLUSION

The legal, financial and medical implications of contracting to gestate a child are tremendous – ranging from severe medical risks and emotional trauma to potentially devastating financial and legal liabilities. Data and statics describing risky industries are essential for appropriate policies and safeguards, yet despite these concerns information on surrogacy in the U.S. remains severely limited. Nevertheless, what little information is available clearly indicates that an increasing number of surrogates are hired each year. Furthermore, the majority of these women are concentrated in jurisdictions that have failed to implement any legal rules safeguarding surrogate workers' medical and legal rights.

In fact, despite clear evidence from the CDC and SART documenting an accelerated expansion of the surrogacy market, few states legislatures have even looked at the issue. The

industry remains unexamined and its effects undocumented, with little to no information of record on the demographics, health or safety of the parties involved. Even in states where laws do exist, both medical practitioners and contracting parties often fail to comply, and enforcement is scant to nonexistent.

Increased oversight is needed. Regulatory agencies must impose mandates on matching agencies and IVF clinics to disclose annual rates, demographic characteristics, and the medical and legal outcomes of surrogacy agreements. Regulators must demand that information regarding the demographic characteristics of surrogate workers be included in these disclosures – including factors such as income and ethnicity – in order to address questions of exploitation that are paramount to ethical and social concerns.

The CDC, which is already involved in data collection and oversight of the ART industry, can easily expand its reporting requirements to include such factors. Nevertheless, there remain segments of the surrogacy market – especially those involving traditional surrogacy – that are largely beyond the purview of the CDC's current investigations. Legislatures and policymakers must address new avenues for expanding data collection and regulation over these undocumented surrogacy practices.

The findings of this report produce the undeniable conclusion that surrogacy is growing every year. The longer our state legislatures continue to ignore this exploding phenomenon, the greater the opportunity for exploitation, unsafe practices, abuse and fraud. Data collection is critical for locating these abuses and identifying the victims. But statistics are not enough. Information must then be used to craft meaningful legal and regulatory safeguards, and must be paired with improved enforcement of existing and future laws. As a nation that values and protects human rights, we must lend our attention and resources to ensure that our laws and values are upheld.

APPENDIX

Relevant State Case Law, Statutes and Pending Legislation Addressing Surrogacy[47,48]

State	Change since 2007?	Quick Summary	Citations
Alabama	No	Alabama law does not directly address surrogacy, but at least one court has acknowledged the parental rights of non-biological participants in a surrogacy arrangement. Statutes dealing with placing children for adoption and "baby-buying" specifically indicate that they do not apply to surrogate motherhood	*ALA. CODE §§ 26-10A-33, 34 (2009); Brasfield v. Brasfield, 679 So.2d 1091 (Ala. Civ. App. 1996).*
Alaska	No	The Alaska statutes are silent with regard to surrogacy agreements. The only surrogacy case was decided on statute of limitations grounds.	*In re T.N.F., 781 P.2d 973 (Alaska 1989).*
Arizona	Not on surrogacy, but **bill on egg donation passed April 2010**	Arizona statutes forbid "surrogate parenthood contracts," providing that the surrogate mother is the legal mother and that her husband, if she is married, is the father. In a 1994 case an Arizona Court of Appeals found the automatic assignment of legal motherhood unconstitutional on 14th Amendment Equal Protection grounds, but the exact scope of the remaining statute is unclear. **BILLS:** **AZ SENATE BILL 1306 and HR 2651 dictate information to be included as part of the informed consent process and prohibits the purchase, offer to purchase or advertisement for the purchase of human eggs (in effect, denying Arizona residents the option of using egg donation). Passed in April 2010.**	*ARIZ. REV. STAT. § 25-218 (2008); Soos v. Superior Court ex rel. County of Maricopa, 897 P.2d 1356 (Ariz. Ct. App. 1994).*
Arkansas	**Not directly – see summary**	State law generally holds surrogacy contracts valid and enforceable. It also has clear guidelines that outline legal parentage in several different surrogacy scenarios: (1) if the intended father is the sperm donor, and he is married to the intended mother, then they are both considered the legal parents; (2) if the intended father is the sperm donor and he is unmarried, then he is the sole parent; and (3) if an anonymous donor inseminated the traditional surrogate, then the intended mother is the legal parent. Case law suggests the courts are very willing to uphold surrogacy contracts. **However, in November 2008, voters in Arkansas approved a ballot measure making it illegal for unmarried, cohabiting individuals to adopt or provide foster care to minors, which may create obstacle for same-sex or unmarried couples facing surrogacy agreement challenges.**	*ARK. CODE ANN. §§ 9-10-201, 301, 304 (2009); In re Adoption of K.F.H., 844 S.W.2d 343 (Ark. 1993); In re Samant, 970 S.W.2d 249 (Ark. 1998).*
California	No but **bill on**	California is accepting of gestational surrogacy agreements. While the state has no statute directly addressing surrogacy, case	*CAL. FAM. CODE § 7600 et seq. (2009); Elisa B. v.*

[47] *See* Human Rights Campaign, *supra* note 16.
[48] Richard B. Vaughn, Esq., *Assisted Reproduction Legislative Update*, National Fertility Law Center (2010), http://blog.nflc.net/article-1271120649.html

	surrogacy pending	law indicates that genetic parents will first be assigned parental rights, which would make a traditional surrogate the legal mother. Where the surrogate has no genetic link, the intended parents are assigned parental rights. **BILLS:** **CA ASSEMBLY BILL 2426 would prevent non-attorney surrogacy practitioners from having direct access to their clients' funds. Non-attorney surrogate practitioners would be required to deposit their clients' unearned funds into either an: (1) independent and bonded escrow company, or (2) a trust account maintained by an attorney. This bill is currently pending.**	*Superior Court, 117 P.3d 660 (Cal. 2005); Johnson v. Calvert, 851 P.2d 776 (Cal. 1993); K.M. v. E.G., 117 P.3d 673 (Cal. 2005); Kristine H. v. Lisa R., 117 P.3d 690 (Cal. 2005); In re Marriage of Buzzanca, 72 Cal. Rptr. 2d 280 (Cal. Ct. App. 1998); In re Marriage of Moschetta, 30 Cal. Rptr. 2d 893 (Cal. Ct. App. 1994).*
Colorado	No	There are no Colorado statutes that deal directly with the issue of surrogacy. Colorado statute § 19-4-103 states that "[t]he parent and child relationship extends equally to every child and to every parent, regardless of the marital status of the parents." Additionally, statute § 19-4-106 governs parental rights with regard to children conceived through assisted reproduction; however, the statute explicitly excludes surrogacy agreements by addressing only women who seek "to conceive a child for [themselves], not as . . . surrogate[s]."	*COLO. REV. STAT. §§ 19-4-103, 106 (2008).*
Connecticut	No	The statutes are silent with regard to surrogacy agreements, but various cases have looked favorably on such agreements, including a case concerning a same-sex couple.	*Cassidy v. Williams, 2008 Conn. Super. LEXIS 1727 (Conn. Super. Ct. 2008)*; Doe v. Doe, 710 A.2d 1297 (Conn. 1998); Doe v. Roe, 717 A.2d 706 (Conn. 1998).* *At the time of this writing, this case is unreported and may be subject to further appellate review.
Washington, D.C.	No	Under D.C. law, both traditional (in which the surrogate mother is the biological contributor of the egg) and gestational (in which the surrogate mother is not the biological contributor of the egg) surrogacy agreements are prohibited and unenforceable. Violation of the statute is punishable by a fine of up to $10,000.00, or jail time of as much as one year, or both. However, it is important to note that this law prohibits only surrogacy agreements, and not the act of surrogacy itself.	*D.C. CODE §§ 16-401, 402 (2009); In re M.M.D., 662 A.2d 837 (D.C. 1995).*
Delaware	No	Delaware statutes are silent with respect to surrogacy. In a 1988 case, the Delaware Family Law Court held that The Delaware court held that "the receipt of money in connection with an adoption is barred by Delaware law," and the termination of parental rights through contractual agreement is forbidden. Every surrogacy agreement terminates the parental rights of someone who has a legal claim to parentage, so the precedent of *Hawkins* suggests that all surrogacy agreements are against the public policy of Delaware law.	*In re Hart, 806 A.2d 1179 (Del. Fam. Ct., 2001); Hawkins v. Frye, 1988 Del. Fam. Ct. LEXIS 31 (Del. Fam. Ct. 1988).*
Florida	No, but **bill pending**	Florida law explicitly allows both gestational surrogacy agreements (in which the surrogate mother is not the biological contributor of the egg) and traditional surrogacy agreements (in which the surrogate mother is the biological contributor of the egg), but neither is available to same-sex couples. Florida gestational surrogacy statutes impose strict requirements on the contracts, among them limiting involvement to "couple[s that] are legally married and are both 18 years of age or older." The	*FLA. STAT. § 63.212 (2009); FLA. STAT. §§ 742.11-16 (2009); Lofton v. Kearney, 358 F. 3d 804 (11th Cir. 2004); Lowe v. Broward County, 766 So. 2d 1199 (Fla. Dist. Ct. App. 2000); Wakeman v. Dixon,*

		law governing traditional surrogacy arrangements, which are referred to as "pre-planned adoption agreements," connects those contracts to state adoption law. Additionally, Florida law explicitly prohibits "homosexuals" from adopting. In 2004, this law was upheld in federal court by the 11th Circuit Court of Appeals in the case of *Lofton v. Kearney*. **BILLS:** **FL SENATE BILL 7062, the Florida Assisted Reproductive Technology Act, would define an "agency" as any organization or individual who provides a database, matching or third party reproductive service (although there are no requirements related to agency training, education, or licensure).** **The Act would require agencies to conduct mental health evaluations and criminal background checks on donors, gestational surrogates and intended parents every two years and would prohibit donors or gestational surrogates who are not US citizens or permanent residents. This bill died in committee but may re-emerge in the next legislative session.**	*921 So. 2d 669 (Fla. Dist. Ct. App. 2006).*
Georgia	No	No relevant law.	
Hawaii	No	No relevant law.	
Idaho	No	The Idaho statutes do not address surrogacy agreements, but case law indicates such contracts may be enforceable in the state. A 1986 adoption case articulated the "best interests of the child" standard, where the Idaho Supreme Court determined that biology was not the sole factor to be considered. Instead, the Court held that when the biological mother relinquishes custody, absent fraud, duress or undue influence in the adoption process, she should be bound to that choice.	*DeBernardi v. Steve B.D., 723 P.2d 829 (Idaho 1986).*
Illinois	No but **bill pending**	In 2004, the Illinois legislature passed the Gestational Surrogacy Act. Under the Act, the intended parents in a gestational surrogacy arrangement gain full custody upon the birth of the child. However, the Act also sets strict eligibility guidelines for both the surrogate and the intended parents. The surrogate must: (1) be at least 21 years of age; (2) have given birth to at least one child; (3) have completed a medical evaluation; (4) have completed a mental health evaluation; (5) have consulted with independent legal counsel regarding the terms and legal consequences of the gestational surrogacy; and (6) have a health insurance policy (throughout the pregnancy and for eight weeks after the birth) that covers major medical treatments and hospitalization. The intended parents must: (1) contribute at least one of the gametes (egg or sperm) required to produce the child; (2) have a medical need for the gestational surrogacy; (3) have completed a mental health evaluation; and (4) have consulted with independent legal counsel regarding the terms and legal consequences of the gestational surrogacy. The Act also includes several requirements that the surrogacy contract itself must meet. **BILLS:** **IL HOUSE BILL 1082 (2009) amends a variety of Illinois statutes and would require an insurer, upon request of an insured intended parent, to provide maternity coverage for a gestational surrogate as a dependent for a term that extends throughout the duration of the expected pregnancy and for eight weeks after the birth of the child.**	*750 ILL. COMP. STAT. ANN. 47/1 et seq. (2009); Petition of K.M., 653 N.E.2d 888 (Ill. App. Ct. 1995).*

		This bill is currently assigned to the Insurance Committee of the IL House of Representatives and would be effective immediately if passed; however, it appears this bill has effectively died in committee.	
Indiana	No	State law declares surrogacy contracts "void and unenforceable." Specifically, the law lists several broad contractual terms that, if any is included, void a surrogacy agreement. Such forbidden terms include requiring a surrogate: to provide a gamete (a mature sexual reproductive cell) to conceive a child; to become pregnant herself; or to waive her parental rights or duties. These provisions are typically at the heart of any traditional surrogacy agreement (in which the surrogate mother is the biological contributor of the egg) or gestational surrogacy agreement (in which the surrogate mother is not the biological contributor of the egg). However, it is important to note that this law prohibits only surrogacy agreements, and not the act of surrogacy itself.	*IND. CODE ANN. § 31-20-1-1 (2009); In re Adoption of K.S.P., 804 N.E.2d 1253 (Ind. Ct. App. 2004); In re Adoption of M.M.G.C., 785 N.E.2d 267 (Ind. Ct. App. 2003); In re Infant Girl W., 845 N.E.2d 229 (Ind. Ct. App. 2006).*
Iowa	No	There is no explicit statute dealing with surrogacy. However, Iowa Code § 710.11 criminalizes the purchase or sale of a human being; however, the statute specifically says: This section does not apply to a surrogate mother arrangement. For purposes of this section, a *"surrogate mother arrangement"* means an arrangement whereby a female agrees to be artificially inseminated with the semen of a donor, to bear a child, and to relinquish all rights regarding that child to the donor or donor couple. Although states such as Alabama have statutory language that excludes surrogacy from laws concerning adoption or "baby-buying," the language of the Iowa statute seems to suggest that surrogacy agreements are at least contemplated by the law and do not go against the public policy of the state.	*IOWA CODE § 710.11 (2008).*
Kansas	**No but bill pending**	There are no statutes regarding surrogacy. However, two attorney general opinions indicate that surrogate parenting agreements in general are unenforceable in the state. In 1982, the Kansas Attorney General wrote an opinion stating that a surrogate parent contract would be void as against public policy. The opinion warned against the commercialization and commoditization of motherhood, arguing that these contracts would be unenforceable as going against public policy until they receive legislative approval. In 1996, the Kansas Attorney General wrote an opinion discussing whether surrogate motherhood should be considered a "professional service," which would place it under the governance of a state statute that addresses fees in adoption proceedings. The statute in question permits reasonable fees for "legal and other professional services rendered in connection with the placement or adoption." The Attorney General concluded that surrogate motherhood does not fit into the definition of "professional service;" however, the opinion did note that it is permissible to provide reasonable living expenses for a surrogate mother during her pregnancy. **BILLS:** **KS SENATE BILL 509 creates women's health and embryo monitoring program to collect and retain in "perpetuity" 70 data items, much of which is already collected and reported**	*29 Op. Kan. Att'y Gen. No. 96-73 (Sept. 11, 1996), 1996 Kan. AG LEXIS 73; 54 Op. Kan. Att'y Gen. No. 82-150 (July 2, 1982), 1982 Kan. AG LEXIS 137.*

		by the CDC. In addition, this bill requires tracking all eggs retrieved, fertilized, transplanted, frozen, and discarded, the status of all embryos, the number and type of fetal reductions, method for monitoring the health of patients even after they are no longer patients, and a reporting of how clinics are paid (failure to report or falsely reporting can result in felony charges). **It is unlikely this bill will be acted upon in the current legislative session.**	
Kentucky	No	There is no statutory provision in Kentucky directly addressing the validity of surrogacy agreements, but a Kentucky Supreme Court case and an Attorney General opinion indicate that uncompensated agreements may be permissible.	*Op. Ky. Att'y Gen. No. OAG 81-18 (Jan. 26, 1981), 1981 Ky. AG LEXIS 399; Surrogate Parenting Assocs. v. Commonwealth ex rel. Armstrong, 704 S.W.2d 209 (Ky. 1986).*
Louisiana	No	Louisiana has a statute that holds compensated traditional surrogacy agreements (in which the surrogate mother is the biological contributor of the egg) void and unenforceable, but does not address uncompensated agreements or gestational surrogacy agreements. The relevant Louisiana statute establishes that "[a] contract for surrogate motherhood as defined herein shall be absolutely null and shall be void and unenforceable as contrary to public policy." The statute further states: "Contract for surrogate motherhood" means any agreement whereby a person not married to the contributor of the sperm agrees for valuable consideration to be inseminated, to carry any resulting fetus to birth, and then to relinquish to the contributor of the sperm the custody and all rights and obligations to the child.	*LA. REV. STAT. ANN. § 9:2713 (2009).*
Maine	No	Maryland law bans payment for adoption services. It also prohibits the sale or purchase of minors and punishes this act by a fine and/or jail time. The question as to whether or not these laws apply to surrogacy agreements is widely contested among politicians and legal academics in the state. A 2000 opinion by the Maryland Attorney General indicates that surrogacy contracts involving the payment of a fee to the birth mother are generally illegal and unenforceable based on existing state law. This implies that the state does not consider uncompensated surrogacy contracts to be illegal. The Attorney General's opinion also states that the payment of a surrogacy fee could not by itself bar approval of an adoption petition and that the decision to grant an adoption must turn on the best interests of the child.	*MD. CODE ANN., FAM. LAW § 5-327 (2009); MD. CODE ANN., CRIM. LAW § 3-603 (2009); 85 Op. Md. Att'y Gen. 348 (December 19, 2000), 2000 Md. AG LEXIS 31; Abby Brandel, Legislating Surrogacy: A Partial Answer to Feminist Criticism, 54 Md. L. Rev. 488 (1995).*
Maryland	No, but **bill pending**	While Maryland does not have a specific law that addresses surrogacy agreements, related laws might hold compensated agreements unenforceable. Maryland law bans payment for adoption services. It also prohibits the sale or purchase of minors and punishes this act by a fine and/or jail time. The question as to whether or not these laws apply to surrogacy agreements is widely contested among politicians and legal academics in the state. A 2000 opinion by the Maryland Attorney General indicates that surrogacy contracts involving the payment of a fee to the birth mother are generally illegal and unenforceable based on existing state law. This implies that the state does not consider uncompensated surrogacy contracts to be	*Citations: MD. CODE ANN., FAM. LAW § 5-327 (2009); MD. CODE ANN., CRIM. LAW § 3-603 (2009); 85 Op. Md. Att'y Gen. 348 (December 19, 2000), 2000 Md. AG LEXIS 31; Abby Brandel, Legislating Surrogacy: A Partial Answer to Feminist Criticism, 54 Md. L. Rev. 488 (1995).*

		illegal. The Attorney General's opinion also states that the payment of a surrogacy fee could not by itself bar approval of an adoption petition and that the decision to grant an adoption must turn on the best interests of the child. **BILLS:** **MD HOUSE BILL 281 and SENATE BILL 585 proposed to establish a commission on surrogate parenting to evaluate the health and social well being of children born as a result of surrogacy. This bill failed in committee.**	
Massachusetts	No, **but bill on surrogacy insurance pending**	Massachusetts statutes are silent with regard to surrogacy agreements, but various cases have looked favorably on such agreements. . In a 1998 case, the surrogate mother in a traditional surrogacy agreement (in which the surrogate mother is the biological contributor of the egg) decided in the sixth month of her pregnancy to keep the child. The Supreme Judicial Court of Massachusetts found that two elements must exist to validate a surrogacy agreement: the surrogate mother's consent to the surrogacy must last until four days after the birth; and the surrogate mother must receive no compensation. The 2001 case of *Culliton v. Beth Israel Deaconess Med. Ctr.* involved a gestational surrogacy agreement (in which the surrogate mother is not the biological contributor of the egg). In *Culliton,* the Supreme Judicial Court granted a joint request from the compensated gestational mother, the genetic mother, and the genetic father to have the genetic parents listed as the twins' parents on their birth certificates. **BILLS:** **MA SENATE BILL 485 would update the definition of infertility by shortening the time periods for trying to conceive required before for applicability of insurance coverage. This bill is still in committee.**	*Culliton v. Beth Israel Deaconess Med. Ctr., 756 N.E.2d 1133 (Mass. 2001); R.R. v. M.H., 689 N.E.2d 790 (Mass. 1998).*
Michigan	No but **bill on IVF is pending**	Michigan has very strict laws prohibiting surrogacy contracts. State law not only holds these agreements unenforceable, but also imposes fines (up to $50,000.00) and jail time (up to five years) on anyone who enters into such a contract. Michigan courts have upheld the validity of this law **BILLS:** **MI SENATE BILL 647-652 and companion bills HOUSE BILL 5129-5134, impose reporting requirements on assisted reproduction clinics in addition to those already in place, including tracking and reporting of all embryos. This bill standardizes informed consent for ART and restricts stem cell research which was approved last year in a Michigan voters' referendum. This bill has passed through both the House and Senate but is still pending.**	*MICH. COMP. LAWS §722.851-861 (2009); Doe v. Att'y Gen., 487 N.W.2d 484 (Mich. Ct. App. 1992); Doe v. Kelley, 307 N.W.2d 438 (Mich. Ct. App. 1981); Syrkowski v Appleyard, 362 N.W.2d 211 (Mich. 1985).*
Minnesota	**Bill passed in 2008, vetoed by governor; current bill pending before legislature**	In a 2007 case, a Minnesota Court of Appeals reviewed an appeal from a District Court judgment involving a gestational surrogacy agreement (in which the surrogate mother is not the biological contributor of the egg). The Plaintiff in the case was an HIV-positive gay male from New York who agreed to pay the Defendant surrogate $20,000.00 to gestate an embryo, which was created with a donor egg and the Plaintiff's sperm. The agreement included a clause, known as a 'choice-of-law provision,' calling for Illinois law to govern the contract (most of the medical procedures were performed in Illinois). When the child was born and the surrogate mother failed to transfer custody, the Plaintiff filed a paternity action in Minnesota. The	*P.G.M. v. J.M.A., 2007 Minn. App. Unpub. LEXIS 1189 (Minn. Ct. App. filed December 11, 2007); Posting of Andy Birkey to RH Reality Check, http://www.rhrealitycheck.org/blog/2008/05/16/surrogacy-bill-passes-minnesota-legislature (March 19, 2009, 07:00*

		Court affirmed the holding of the District Court, finding that the Plaintiff was the father of the child and denying the parental rights of the surrogate mother. The Court upheld the District Court's determinations that Illinois law applied and that the agreement did not violate the public policy of Minnesota. However, the opinion in this case is unpublished, and it may not be cited unless permitted by statute. **The lack of surrogacy statutes in Minnesota is not due to a lack of awareness or effort by the state government. On May 12, 2008, the legislature passed a bill that would allow state regulation of gestational surrogacy agreements. Importantly, the legislation used the gender-neutral language of "intended parents," and the effort by some state legislators to replace the words "parents" with "mother and father" failed. Unfortunately, the bill, which passed the Senate by a vote of 41-22 and the House by a vote of 86-46, was vetoed by Republican Governor Tim Pawlenty.** **CURRENT BILL:** **MN SF 436/HF 890 adds presumption of parentage to paternity/maternity laws in favor of all intended parents in third-party ART matters. This bill has passed through committees in both the MN house and senate and awaits floor votes in each.**	*EST);* ***Jonathan Kaminsky, Tim Pawlenty: Governor No, City Pages, July 22, 2008, http://www. citypages.com/2008-07-23/news/tim-pawlenty-governor-no/1.***
Mississippi	No	There are no statutory provisions or published cases dealing with the issue of surrogacy.	*MISS. CODE ANN. § 93-17-3 (2008)*
Missouri	No	Missouri law does not directly address surrogacy agreements; however, it is possible that they are in violation of the state's "child trafficking" laws. Missouri, the crime of "trafficking in children" is a felony, and it includes payment for "delivery or offer of delivery of a child . . . for purposes of adoption, or for the execution of consent to adopt or waiver of consent to future adoption or consent to termination of parental rights." A compensated surrogacy agreement might run afoul of this law.	*MO. REV. STAT. § 568.175 (2009).*
Montana	No	No statute or case law dealing with surrogacy.	
Nebraska	No	Nebraska state law declares that "[a] surrogate parenthood contract entered into shall be void and unenforceable." The law defines a surrogate parenthood contract as "a contract by which a woman is *compensated* for bearing a child of a man who is not her husband." (emphasis added). Nebraska law also states that "[t]he biological father of a child born pursuant to such a contract shall have all the rights and obligations imposed by law with respect to" a child born of a surrogate parenthood contract. This means that if a child is born of a compensated surrogacy agreement, then custody of that child lies jointly in the hands of the biological father and the gestational mother. The fact that Nebraska law only prohibits compensated surrogacy agreements suggests that uncompensated agreements are legal.	*NEB. REV. STAT. § 25-21,200 (2009); In re Adoption of Luke, 640 N.W.2d 374 (Neb. 2002).*
Nevada	No	Nevada law explicitly permits married couples to enter into a surrogacy agreement. However, it restricts the adopting parties in a surrogacy agreement to people "whose marriage is valid" under Nevada law. The statute defines "intended parents" as "a man and a woman, married to each other."	*NEV. REV. STAT. § 126.045 (2009); 2009 Nev. ALS 393 (2009).*
New Hampshire	No	New Hampshire law allows surrogacy. According to New Hampshire law, "'[i]ntended parents,' including an 'intended father' and 'intended mother,' means people who are married to each other, and who enter a surrogacy contract with a surrogate	*N.H. REV. STAT. ANN. §§ 168-B:1-B:32 (2009).*

		by which they are to become the parents of the resulting child." Additionally, there are certain eligibility requirements that all surrogacy agreements must meet, and they specifically mention the intended mother and intended father: "The intended mother shall be medically determined to be physiologically unable to bear a child without risk to her health or to the child's health;" "[t]he intended mother or the intended father shall provide a gamete to be used to impregnate the surrogate;" "[t]he intended mother or surrogate shall provide the ovum."	
New Jersey	No	New Jersey permits only uncompensated gestational surrogacy agreements (in which the surrogate mother is not the biological contributor of the egg).	*A.H.W. v. G.H.B., 772 A.2d 948 (N.J. Super. 2000); In the Matter of Adoption of Two Children by H.N.R., 666 A.2d 535 (N.J. Super. Ct. App. Div. 1995); In re Baby M, 537 A.2d 1227 (N.J. 1988).*
New Mexico	No	New Mexico law forbids "payment to a woman for conceiving and carrying a child." However, the law allows payment for medical and other similar expenses incurred "by a mother or the adoptee."	*N.M. STAT. § 32A-5-34 (2009).*
New York	No	All surrogacy agreements, regardless of the sexual orientation of the individuals involved, are void and unenforceable under New York law. Surrogacy agreements may be void and unenforceable, but that has not prevented New York courts from recognizing the parental rights of intended parents in a surrogacy situation. In a 1994 custody dispute, a New York Appellate Court found that a woman with no genetic connection to her children could still be their legal mother. In that case (*McDonald v. McDonald*), a woman gave birth to twins after gestating an embryo that was created from her husband's sperm and a donated egg. The Court relied heavily on the famous California case of *Johnson v. Calvert* (see the information on California) to reach their conclusion that the intended mother was the legal mother. In the 2004 case of *Doe v. New York City Bd. of Health,* the intended mother of triplets was not required to provide DNA evidence to be granted parental rights after the gestational surrogate (someone who is not genetically related to the child she is carrying) relinquished her parental rights.	*N.Y. DOM. REL. LAW § 122 (2009); In the Matter of the Adoption of Paul, 550 N.Y.S.2d 815 (N.Y. Fam. Ct. 1990); Doe v. New York City Bd. of Health, 782 N.Y.S.2d 180 (N.Y. Sup Ct. 2004); McDonald v. McDonald, 608 N.Y.S.2d 477 (N.Y. App. Div. 1994).*
North Carolina	No	North Carolina adoption law generally forbids compensation for consent to adopt or relinquishment of parental rights, but there are exceptions to this rule. For example, the law allows payments for an expecting mother's medical and related expenses during her pregnancy. Such payments may not be contingent on the relinquishment of parental rights or the placement of the child for adoption; however, the law also states that "[a] prospective adoptive parent may seek to recover a payment if the parent or other person receives or accepts it with the fraudulent intent to prevent the proposed adoption from being completed."	*N.C. GEN. STAT. § 48-2-301 (2009); N.C. GEN. STAT. §§ 48-10-102, 103 (2009).*
North Dakota	No	The language of North Dakota Code § 14-18-05 appears to render all surrogacy agreement (both traditional and gestational) void and unenforceable, and it establishes that the surrogate and her husband are the legal parents of the child. However, Code Section 14-18-08 explicitly states that "[a] child born to a	*N.D. CENT. CODE §§ 14-18-05, 08 (2009).*

		gestational carrier is a child of the intended parents for all purposes and is not a child of the gestational carrier and the gestational carrier's husband, if any." It appears that North Dakota law draws a distinction between "surrogates" and "gestational carriers."	
Ohio	**Yes – 2007 case**	Ohio surrogacy law is unsettled; however, various court decisions seem to indicate that some surrogacy agreements are considered lawful. In 1992, an Ohio Court of Appeals denied custody to the intended mother in a traditional surrogacy agreement (in which the surrogate mother is the biological contributor of the egg) because she had no biological tie to the child and because the contract was an oral agreement. The Court did not discuss how it would have ruled if the case contained a written contract, but it did conclude that the legality of surrogacy agreements in Ohio is "unsettled and open to considerable scrutiny." In 1994, a lower Ohio court held that the intended parents in a gestational surrogacy agreement (in which the surrogate mother is not the biological contributor of the egg) were the natural and legal parents of the resulting child. However, the court noted that "as a matter of public policy, the state will not enforce or encourage private agreements or contracts to give up parental rights." An Ohio Court of Appeals held in 1999 that it was in the best interests of a child conceived through a traditional surrogacy arrangement to use genetic testing to determine parentage. In the 2001 case of *Decker v. Decker,* a man who entered into an oral agreement with his sister to carry a child for him and his same-sex partner. The sister was inseminated by an anonymous donor, but during the pregnancy began to have doubts about the arrangement. The Court determined that the surrogate was the legal mother of the child for the following reasons: (1) the child had no biological connection to the same-sex couple; (2) there was no written agreement or certification of the verbal agreement by a family agency or court; and (3) biological parents may be denied custody only in the case of abandonment, valid contractual relinquishment of custody, or total inability to provide care or support. **In 2007, the Ohio Supreme Court held that a particular gestational surrogacy contract in question did not violate public policy, even when it prohibited the gestational surrogate from asserting parental rights. The Court reasoned that the gestational surrogate had no claim to legal parentage at the time of the agreement, and therefore she had no parental rights to assert.**	*OHIO REV. CODE ANN. § 3111.89 (2009); In re Adoption of Doe, 719 N.E.2d 1071, (Ohio Ct. App., 1998). Belsito v. Clark, 644 N.E.2d 760 (Ct. Com. Pl. 1994); Decker v. Decker, 2001 Ohio App. LEXIS 4389 (Ohio Ct. App. 2001); J.F. v. D.B., 879 N.E.2d 740 (Ohio 2007); Seymour v. Stotski, 611 N.E.2d 454 (Ohio Ct. App. 1992); Turchyn v. Cornelius, 1999 Ohio App. LEXIS 4129 (Ohio Ct. App. 1999)*
Oklahoma	No, but **bill pending on egg donation**	Oklahoma law prohibits the "acceptance, offer or payment of compensation in connection with the transfer of legal or physical custody or adoption of a minor child." In 1983, the Oklahoma Attorney General concluded that surrogate parenting contracts that provide compensation for the adoption of a child violate state law prohibiting trafficking in children. Still, Oklahoma adoption law permits the payment of reasonable medical expenses for the birth mother and the minor to be adopted, and it is possible that such reimbursement would be legal in the context surrogacy of a surrogacy agreement. **BILLS:** **OK HOUSE BILL 3077 would prohibit compensation to egg donors, but it died for lack of action by the OK Senate**	*10 OKLA. STAT. § 7505-3.2 (2009); 21 OKLA. STAT. § 866 (2003); Office of the Att'y Gen. of the State of Okla. No. 83-162 (Sept. 29, 1983), 1983 Okla. AG LEXIS 41.*

		committee. This bill is dormant at the moment but is expected to be re-introduced in the next legislative session.	
Oregon	No	The Oregon statute prohibiting "buying or selling a person" has an explicit exemption for "fees for services in an adoption pursuant to a surrogacy agreement." This appears to codify the conclusion of a 1989 opinion issued by the Attorney General, which indicated that the state may invalidate any agreement in which money is exchanged for the right to adopt a child (particularly when the birth mother contests it).	*OR. ADMIN. R. 413-120-0200(3) (2009); In the Matter of the Adoption of Baby A and Baby B, 877 P.2d 107 (Or. Ct. App. 1994); 46 Op. Atty. Gen. Ore. 221 (April 19, 1989), 1989 Ore. AG LEXIS 26.*
Pennsylvania	No	Pennsylvania surrogacy law is ambiguous. It appears that a compensated surrogacy agreement would be held unenforceable; however, an arrangement established through a legally recognized agency seems to be legal. The validity of informal arrangements is even less certain.	*In re Adoption of R.B.F. and R.C.F., 803 A.2d 1195, (Pa. 2002); Huddleston v. Infertility Ctr. of Am., 700 A.2d 453 (Pa. Super. Ct. 1997); J.F. v. D.B., 897 A.2d 1261 (Pa. Super. Ct. 2006); Ruth F. v. Robert B., Jr., 690 A.2d 1171 (Pa. Super. Ct. 1997).*
Rhode Island	**No, but law expires this July**	The state statute prohibiting human cloning has an explicit exception for the assisted reproductive technologies used in gestational surrogacy (in which the surrogate mother is not the biological contributor of the egg). **However, it should be noted that the Rhode Island legislature enacted a sunset clause, which states that the statute prohibiting cloning will expire on July 7, 2010.**	*R.I. GEN. LAWS §§ 23-16.4-2, 4 (2009).*
South Carolina	No	There are no provisions in South Carolina law regarding surrogacy, but the limited case law indicates an acceptance of surrogacy contracts.	*Mid-South Ins. Co. v. Doe, 274 F.Supp.2d 757 (D.S.C. 2003).*
South Dakota	No	There are no statutory provisions or published cases dealing with the issue of surrogacy.	
Tennessee	No but **bill pending on gamete donation**	The Tennessee Code defines "surrogate birth" as one of two arrangements: (1) "[t]he union of the *wife's* egg and the *husband's* sperm, which are then placed in another woman, who carries the fetus to term and who, pursuant to a contract, then relinquishes all parental rights to the child to the biological parents pursuant to the terms of the contract;" (emphasis added) or (2) "[t]he insemination of a woman by the sperm of a man under a contract by which the parties state their intent that the woman who carries the fetus shall relinquish the child to the *biological father and the biological father's wife* to parent" (emphasis added). The law also states that under these agreements, no adoption formal by the biological parents is necessary. However, the Code also says that the aforementioned language "shall be construed to expressly authorize the surrogate birth process in Tennessee unless otherwise approved by the courts or the general assembly." **BILLS:** **TN SENATE BILL 2136 and HOUSE BILL 2159, the Embryo Donation and Adoption Act, deems a child born from donated embryos as having been adopted and grants the same legal protections without court action. This bill also requires clinics to develop written contracts transferring ownership of embryos from donor to intended parents and to keep records for 21 years. This bill is in front of the**	*TENN. CODE ANN. § 36-1-102(48) (2009); Davis v. Davis, 842 S.W.2d 588 (Tenn. 1992).*

		judicial committee.	
Texas	No	Surrogacy agreements are heavily regulated in Texas, and among the constraints on such agreements, the law requires the intended parents to be married to each other. The law also requires that a surrogacy agreement be validated by a court; otherwise, such an agreement would be unenforceable.	*TEX. FAM. CODE ANN. §§ 160.754, 762.*
Utah	No	Surrogacy agreements are heavily regulated in Utah, and among the constraints on such agreements, the law requires the intended parents to be married to each other. The law also requires that one of the intended parents be genetically related to the child and that surrogacy agreements must be validated by a court.	*UTAH CODE ANN. § 78B-15-801 to -809 (2009); UTAH CODE ANN. §78-30-1(3) (2009);*
Vermont	No	There is no case law dealing directly with surrogacy, but at least one case indirectly indicated an acceptance of such agreements in Vermont. In the groundbreaking 1999 case that led to the creation of civil unions in Vermont, the state itself argued that restricting marriage to different-sex couples would serve the important goal of minimizing complications in surrogacy agreements. This suggests a basic acceptance of such agreements. Furthermore, in its holding the Court granted state-level benefits and responsibilities associated with marriage to same-sex couples, and such likely includes that acceptance of surrogacy.	*VT. STAT. ANN. tit. 15A § 1-102(b) (2009); Baker v. State, 170 Vt. 194 (Vt. 1999).*
Virginia	**No but bill pending**	Virginia statutes impose numerous restrictions on surrogacy agreements, including limiting formation of such agreements to a surrogate and "intended parents" defined as "a man and a woman, married to each other." Additionally, the law requires a circuit court order approving the agreement. **BILLS:** **VA SENATE BILL 69 reduced the time requirement for a gestational carrier to give her consent to intended parent's parentage to 3 days (and up to 180 days); allows matching of surrogates and intended parents but only where no compensation is involved; and applies only to married intended parents (single intended parents are not disallowed, they are just not specifically included in the language of this bill).**	*VA. CODE ANN. § 20-156 (2009).*
Washington	**No but bill pending**	Washington allows uncompensated surrogacy arrangements but deems illegal and unenforceable any agreement involving any payment to the surrogate mother other than medical and legal expenses. Washington statutes specify that compensated surrogacy arrangements are void and unenforceable as against public policy. Furthermore, such agreements are punishable as a gross misdemeanor. The law recommends that should a custody dispute arise between the surrogate mother and the intended parents, a court should resolve the matter by utilizing a multi-pronged balancing test, largely based upon the child's relationship with each parent. A parent-child relationship can be established by a valid surrogate parentage contract or an affidavit and physician's certificate wherein an egg donor or gestational surrogate (a surrogate who has no genetic relationship to the child) sets forth her intent to be the legal parent of the child. A 1989 opinion from the Attorney General confirmed this assessment of state law, and it also indicated that a surrogate parenting agreement is not enforceable if the surrogate withdraws her consent to relinquish her child before a	*WASH. REV. CODE § 26.26.101 (2009); WASH. REV. CODE §§ 26.26.210 et seq. (2009); 1989 Op. Wash. Att'y Gen. No. 4 (Feb. 17, 1989), 1989 Wash. AG LEXIS 41.*

		court has approved that consent. **BILLS:** **WA HOUSE BILL 2793 proposed to legalize compensated surrogacy in Washington, but it died for lack of action in the Washington Senate. This bill is likely to re-appear in the next legislative session.**	
West Virginia	No	State law prohibiting the purchase or sale of a child specifically mentions that "fees and expenses included in any agreement in which a woman agrees to become a surrogate mother" are not prohibited by the statute. This wording suggests that surrogacy arrangements may be enforceable.	*W. VA. CODE § 48-22-803(e)(3) (2009).*
Wisconsin	No	Wisconsin law does not directly address the legality of surrogacy contracts; however, at least one court case has recognized the parental rights of someone who is not genetically related to their child. In the Wisconsin statute pertaining to the collection of vital statistics, it states that the surrogate mother's name is to be added to the birth certificate until "a court determines parental rights." Once a court determines those rights, a new birth certificate with names of the intended parents may be issued; however, the statute does not lay out the factors a court should consider in making that decision.	*WIS. STAT. § 69.14(h) (2008); In Interest of Angel Lace M., 516 N.W.2d 678 (Wis. 1994); L.M.S. v. S.L.S., 312 N.W.2d 853 (Ct. App. 1981).*
Wyoming	No	There are no statutory provisions or published cases dealing with the issue of surrogacy.	