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Surrogacy in New York: Boon or Bane?

A discussion of the proposed legislation known as the "Child-Parent Security Act of 2017" (CPSA) which would lift the ban on surrogacy agreements in New York, with a look at the subtle and not so subtle benefits and burdens that may ensue if the legislation is passed.

By **Harriet Newman Cohen and Kristen E. Marinaccio** | July 27, 2018

New York, like many other states, enacted legislation prohibiting surrogacy agreements following the heartbreaking drama of Baby M. Three decades later, New York is one of just four states[1] that still bans surrogacy agreements—however, that soon may change. This article will discuss the proposed legislation known as the "Child-Parent Security Act of 2017" (CPSA) which would lift the ban on surrogacy agreements in New York. It will explore the subtle and not so subtle benefits and burdens that may ensue if the legislation is passed.

Understanding the Surrogacy Terminology

It is necessary to distinguish among various types of surrogacy. When a surrogate is also the egg donor, it is called a traditional (or genetic) surrogacy. A traditional surrogacy involves artificial insemination using the surrogate's egg(s) and the sperm of the intended father (or sperm donor). The use of the surrogate's egg(s) creates a genetic relationship between the child and the surrogate. If the surrogate is not the egg donor, there is no genetic relationship to the child, and it is called a gestational surrogacy. Gestational surrogacy involves implanting embryos created with the egg(s) of the intended mother (or egg donor) which have been fertilized with the sperm of the intended father (or sperm donor).

If a surrogate, whether traditional or gestational, receives compensation for her reproductive care and is also reimbursed her reasonable direct expenses, it is considered a compensated or commercial surrogacy. If the surrogate only receives compensation for her reasonable direct expenses, it is considered

uncompensated or altruistic surrogacy.

Baby M's Influence on N.Y. Law Makers

In the mid-1980's, before Baby M, many states including New York were considering enacting legislation to regulate surrogacy agreements.[2] By early 1987, a bill was pending in the New York Legislature.[3] That same year, just across state lines, in New Jersey, an emotional legal battle was being waged against a traditional surrogate, Mary Beth Whitehead, when she refused to surrender "Baby M" to the intended parents, Elizabeth and William Stern.[4] The dramatic media coverage of the Baby M case, which included images of the police forcibly removing the baby from Ms. Whitehead's arms, quickly caught the public's attention.[5] By June, 1987, facing fierce opposition from feminist and religious lobby groups, a seemingly antithetical coalition, the pending bill in New York was withdrawn.[6]

In 1988, the New York State Task Force on Life and the Law unanimously concluded that New York should discourage traditional and gestational surrogacy agreements.[7] In 1992, the New York State Legislature adopted that recommendation, declaring all surrogacy agreements void and unenforceable.[8]

The Law Today in New York

As it stands now, New York prohibits surrogacy contracts, whether traditional or gestational, compensated or uncompensated.

Intended parents and surrogates (including their spouses) are subject to a $500 fine for participating in a compensated surrogacy contract.[9] Third parties who assist in the formation of a compensated surrogacy contract and receive compensation are subject to a civil penalty of up to $10,000 and forfeiture of fees received. If the third party was previously subject to the civil penalty, he or she runs the risk of felony charges for a second offense. There are no fines or criminal sanctions associated with an uncompensated surrogacy arrangement, however, uncompensated surrogacy agreements, like compensated surrogacy agreements, are unenforceable, leaving both intended parents and surrogates without redress when an agreement goes awry.

There is no presumption that an intended parent is the legal parent of a child born through surrogacy in New York. The presumption is that the birth mother, meaning the surrogate, is the legal mother of a child born in New York—regardless of genetics.[10] Thus, a surrogate, without a genetic relationship to the child, may attempt to claim custody as the legal mother.[11] Even where there is no such claim, the intended parents must go through the judicial system to establish parentage. Non-genetically related intended parents must go through a formal adoption process.

For genetically-related intended parents, the process is a bit different. A genetically-related intended father may establish paternity, either during the surrogate's pregnancy or after the birth, through statutory acknowledgement or a filiation proceeding.[12] A genetically-related intended mother, however, must wait

until after the child's birth to establish parentage either through formal adoption[13] or by way of a declaratory judgment under CPLR §3001.[14] Delays in determinations of parentage are common, which can create a plethora of issues, including those relating to health insurance and inheritance rights.

Legalizing Commercial Surrogacy: The CPSA

The CPSA, if passed, would repeal New York's 26-year surrogacy ban and permit gestational surrogacy contracts,[15] so long as certain requirements are met. The bill does not cover traditional (genetic) surrogacy. Under the proposed legislation, a surrogate (variously referred to in the Act as "surrogate," "gestational carrier" and "gestating parent") must: (1) be 21 years old, (2) not provide the egg, (3) complete a medical evaluation with a health care practitioner relating to the anticipated pregnancy, (4) consult with independent legal counsel of her own choosing and her spouse, if applicable, which may be paid for by the intended parent, and (5) obtain a health insurance policy that extends throughout the pregnancy and for eight weeks post birth, covering major medical treatments and hospitalization, which also may be paid for by the intended parent.

An intended parent may be a single adult person, adult spouses, or any two adults who are intimate partners. The intended parent must undergo a legal consultation regarding the terms of the contract and the potential legal consequences.

The intended parent, the surrogate and the surrogate's spouse, if applicable, must sign the contract prior to the embryo transfer, and each of the parties must be represented by separate counsel. As currently drafted, non-access during the time of conception is not included as a necessary representation to be made by the "gestational carrier" as a term of the contract. However, the petition for a judgment of parentage must include such representation. Perhaps this is a drafting oversight.

The contract must state that the surrogate will undergo embryo transfer, attempt to carry and give birth to the child, and surrender custody of the resulting child(ren) to the intended parent(s) immediately upon birth. The contract must contain terms which state that the intended parent agrees to accept custody and assume sole responsibility of the resulting child(ren) immediately upon birth—regardless of number, gender, or mental or physical condition. There must also be language acknowledging that the surrogate has the right to use a health care provider of her own choosing and describe how the intended parent(s) will cover the medical expenses of the surrogate and child. The contract must clearly state that the rights and obligations of the intended parent are not assignable.

The contract may not, however, abridge a surrogate's right to make decisions safeguarding her health or the health of the fetus, including the right to terminate a pregnancy and the right to reduce the number of fetus(es). Reasonable compensation negotiated in good faith is permitted for the surrogate's services rendered, expenses and/or the medical risks incurred or to be incurred, as well as for her time and inconvenience. However, compensation may not be paid to purchase gametes (eggs or sperm) or embryos,

or to pay for the relinquishment of parental interest in a child. It also may not be conditioned on the purported quality or genome traits of gametes or embryos, actual genotypic or phenotypic characteristics of the donor or the child, or the health or condition of the child.

After execution of the contract but before the surrogate becomes pregnant, the surrogate, her spouse, or any intended parent may terminate the surrogacy contract by giving notice of termination to all parties. Proper termination releases the parties from all the obligations set forth in the contract, except that the intended parent remains responsible for the surrogate's incurred reimbursable expenses under the contract. Unless the terms of the contract provide otherwise, the surrogate is also entitled to keep all payments received.

The CPSA directs that any disputes regarding the rights and obligations under the contract are to be resolved in the New York State Supreme Court. However, the remedy of specific performance is not available for any term which requires the surrogate to be impregnated, terminate the pregnancy, or reduce the number of fetuses or embryos she is carrying.

Unlike now, there will be a legal avenue for both mother and father to establish parentage of a child born through gestational surrogacy prior to the child's birth as well as after the birth of the child. The parties may commence a proceeding for a judgment of parentage at any time after the gestational contract has been executed, which becomes effective upon birth. If the parties fail to obtain a judgment of parentage, a court will look to the best interests of the child, taking into account genetics and the intent of the parties to establish parentage. However, an absence of genetic connection to the intended parent will not be a sufficient basis to deny a judgment of legal parentage.

Is It Time for a Change in Public Policy?

Marriage equality, changing social norms with respect to family, and advancements in assistive reproductive technology (ART)[16] have shifted public discourse on surrogacy over the last three decades. Same-sex couples, couples suffering from infertility or health concerns, and women who decide to postpone motherhood or who in the past could not have children, now can and do through ART.[17] Surrogacy is seen as a "social good," and permitting surrogacy contracts gives a broader segment of society equitable access to family formation. At the same time, legitimate concerns and ethical considerations cannot be overlooked or minimized—such as the potential of health risks for surrogates and possible exploitation of women.

Among others, it is not clear whether the CPSA provides sufficient safeguards to reduce concerns surrounding informed consent. While requiring a surrogate to obtain a medical evaluation and legal counsel is a step in the right direction, it does necessarily prepare a woman for the potential emotional and medical risks associated with surrogacy or adequately protect her from exploitation.

While some argue that gestational surrogacy mitigates the emotional trauma a surrogate may suffer in relinquishing the child at birth because she is not the genetic mother, the lack of a genetic relationship does not necessarily obviate the distress a surrogate may feel upon surrendering the child she has carried for nine months.[18] There are also substantial, unanticipated health risks associated with gestational surrogacy

and pregnancy in general. Through the IVF process, multiple embryos are routinely implanted to ensure success, which often results in multiple births and comes with an increased risk of Caesarian sections, longer hospital stays, gestational diabetes, fetal growth restriction, pre-eclampsia, and premature birth.[19]

Surrogates are also at risk for prenatal diagnosis of fetal disease, which requires invasive surgery.[20] The drugs used to regulate the surrogate's menstrual cycle to ensure successful transfer of the embryos, come with multiple unpleasant and even life-threatening side effects, including, the risk of intracranial hypertension.[21] There is also the startling reality that, despite all of the medical advancements in the United States, more American women die of pregnancy-related complications than any other developed country.[22]

Many believe that the issues regarding informed consent, including the health risks and the socioeconomic gap between the surrogate and the intended parents are persuasive arguments in favor of continuing the ban on commercial surrogacy. Some opponents of the CPSA see a disturbing parallel between the fate of the handmaids in Margaret Atwood's tale of the Republic of Gilead and modern-day surrogates and look at surrogacy as a problematic commercial transaction, like the sale of organs and sex work, that proliferates the commodification of human life and preys upon the economically vulnerable. Equally unsettling may be the idea that women lack agency and cannot appreciate for themselves the associated risks or anticipate their response to pregnancy. To that point, those in favor of the proposed legislation may argue that restricting commercialized surrogacy is paternalistic and a violation of procreative freedom.[23]

Conclusion

The proposed legislation presents right-minded people with a dilemma. Proponents argue that legalizing surrogacy contracts is a step in the right direction, fostering, as it does, equitable access to family formation for people who wish to but cannot otherwise form a biological family. Opponents fear that legalizing these contracts will expose women and children to risk, and open a Pandora's box of unintended consequences. While the proposed legislation does not reach surrogacy agreements under which the surrogate carries a fetus resulting from her own ova being fertilized by the intended parent's sperm, thereby avoiding a Baby M tragedy, other complications, foreseen and unforeseen, but certainly unintended, remain. As with many changes in public policy, and particularly a 26-year-old public policy, the answers are not easy. It comes down to the following: Legalizing surrogacy arrangements in New York will be both a boon and a bane. Therein lies the dilemma.

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ENDNOTES:

1. See Ariz. Rev. Stat. §25–218 (2011), Ind. Code Ann. §31-20-1-1 (2006), Mich. Comp. Laws §§722.855–859 (1988).
2. See Surrogate Parenting In New York: A Proposal For Legislative Reform, New York Sen. Judiciary Comm., (Albany, NY; New York State Senate Judiciary Committee, Dec. 1986) (proposing regulation of contractual surrogacy).
3. S. 1429-A, 1987-1988 Regular Session, New York (Feb. 3, 1987).
4. In re Baby M, 537 A.2d 1227 (N.J. 1988).

5. See Katha Pollitt, *The Strange Case of Baby M, I think I Understand Judge Harvey Sorkow's Ruling in the Baby M Case*, The Nation, Jan. 2, 1988, available at www.thenation.com/article/strange-case-baby-m/.
6. See Jeffrey Schmalz, *Albany Surrogacy Bill is Withdrawn*, N.Y. Times, June 18, 1987.
7. New York State Task Force on Life and Health, Surrogate Parenting: Analysis and Recommendations for Public Policy (1998), www.health.ny.gov/regulations/task_force/reports_publications/docs/surrogateparenting.pdf
8. N.Y. Dom. Rel. Law §§121-124.
9. N.Y. Dom. Rel. Law §123(2)(A).
10. See Public Health Law §4130.
11. N.Y. Dom. Rel. Law §124.
12. NY Cls Family Ct Act §517, §542.
13. Neither the Family Court Act nor any other provision of the law provide for an order of maternity.
14. See T.V. (Anonymous) v. NY State Dept. of Health, 88 AD3d 290 (2d Dept 2011).
15. Child-parent security act, Assemb.B.A-6959A, Reg. Sess. 2017–18 §§581 (N.Y. 2017), available at http://legislation.nysenate.gov/pdf/bills/2017/A6959A.
16. See Jeff Wang and Mark V. Sauer*, In Vitro Fertilization (IVF): A Review of 3 Decades of Clinical Innovation and Technological Advancement*, Therapeutics And Clinical Risk Management, Vol. 2 (4): 355–364 (2006).
17. Gina Bellefante, *Surrogate Mothers' New Niche: Bearing Babies for Gay Couples*, N.Y. Times, May 27, 2005 available at www.nytimes.com/2005/05/27/us/surrogate-mothers-new-niche-bearing-babies-for-gay-couples.html.
18. In her 2014 film, *Breeders: A Subclass of Women?,* Jennifer Lahl presented the remarks of psychotherapist Nancy Verrier who spoke about the emotional bond of child-bearers and children that forms even without a genetic connection.
19. Mary Rose Somarriba, *The Overlooked Risks of Surrogacy for Women, Institute For Family Studies*, Nov. 22, 2017, available at ifstudies.org/blog/the-overlooked-risks-of-surrogacy-for-women.
20. Committee Opinion, The American College Of Obstetricians And Gynecologists, No. 660 (2016).
21. See Drugs Commonly Used for Women in Gestational Surrogacy Pregnancies, The Center For Bioethics And Culture Network, available at http://breeders.cbc-network.org/wp-content/uploads/2013/12/Drugs-Commonly-Used-for-Women-in-Gestational-Surrogacy-Pregnancies.pdf.
22. See Nina Martin, *Focus on Infants During Child Birth Leaves U.S. Moms in Danger*, NPR, May 12, 2017, available at www.npr.org/2017/05/12/527806002/focus-on-infants-during-childbirth-leaves-u-s-moms-in-danger (Every year in the U.S., 700 to 900 women die from pregnancy or childbirth-related causes, and some 65,000 nearly die—by many measures, the worst record in the developed world.); see also *Pregnancy Mortality Surveillance System, Centers For Disease Control And Protection*, available at www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html.
23. See Lorraine Sorrel, Baby M Again, Off Our Backs: A Women's News Journal, July 31, 1987. (Sorrel argued that allowing Mary Beth Whitehead to break her contract would mean that a "woman cannot be responsible for making reproductive decisions or motherhood is so sanctified…that women will rarely be allowed…other significant roles.").

P1 = As it stands now, New York prohibits surrogacy contracts, whether traditional or gestational, compensated or uncompensated.

P2 = Some opponents of the CPSA see a disturbing parallel between the fate of the handmaids in Margaret Atwood's tale of the Republic of Gilead and modern-day surrogates and look at surrogacy as a problematic commercial transaction.