REPORT OF THE
JOINT SUBCOMMITTEE ON

Surrogate Motherhood

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 10

COMMONWEALTH OF VIRGINIA
RICHMOND
1991

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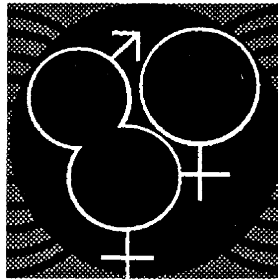

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I. Origin of the Study

In response to the national controversy surrounding the Stern-Whitehead custody dispute, better known as "the Baby M Case," a number of resolutions were introduced during the 1988 Session of the General Assembly calling for studies of surrogate motherhood. Two of these resolutions, SJR 3, patroned by Senator Thomas J. Michie, Jr., and HJR 118, patroned by Delegate Vincent F. Callahan, Jr., were approved, thereby establishing this study of surrogate motherhood and the new reproductive technologies.

The enabling resolutions noted that, because an estimated 10% to 15% of married couples in the United States experience infertility, and the use of new reproductive technologies has enabled many childless persons to become parents, society faces intricate dilemmas. The resolutions also observed that new reproductive technologies and surrogacy arrangements have increased public concern as to whether a mother can be forced to give up her baby upon entering into a contract, whether a woman should be permitted to receive compensation for serving as a surrogate mother, and awareness of the difficulties related to resolving the many perplexing legal issues such as custody disputes.

an estimated 10% to 15% of married couples in the U.S. experience infertility

The Joint Subcommittee was directed to determine the number of surrogacy contracts made in the Commonwealth and the potential for an increase in such contracts and arrangements; examine the various new reproductive technologies and assess their potential effects on health and social policy and planning; determine the need for regulation of such technologies; and determine whether surrogacy contracts or arrangements should be legal, and, if so, how such arrangements should be regulated. In accomplishing these goals, the Joint Subcommittee was instructed to analyze the constitutional issues of privacy and reproductive freedom, and to assess ways to protect the interests of children conceived through the application of the new reproductive technologies, the surrogate, the receiving parents, and any other adults who may participate in these arrangements. In addition, the Subcommittee was directed to examine the need to limit the number of inseminations and donations of sperm by one donor to avoid the risk of incestuous unions between the resulting children; the efficacy of maintaining genetic records; the psychological effects on surrogate mothers, children born of new technologies, and the receiving parents; the feasibility of developing mechanisms for the delivery of health and counseling services; the state laws pertaining to legal liability of parties involved in these arrangements; the legal status of children born as a result of such technologies vis-a-vis current state law regarding inheritance and the establishment of paternity, child support and custody, visitation rights, child welfare and protective services, adoption and child abandonment, and state and federal laws and regulations governing entitlements; the legal sufficiency of current state statutes on informed consent, human research, vital records, health statistics, anatomical gifts, and prohibited marriages; and other related issues deemed appropriate.

The resolutions called for the appointment of a nine-member committee consisting of two members of the House Committee on Health, Welfare and Institutions; one member of the House Committee for Courts of Justice; and one member of the House of Delegates at-large; two members of the Senate Committee on Education and Health and one member of the Senate Committee for Courts of Justice; and two members of the medical profession, one each having expertise in reproductive endocrinology and medical ethics.

The members so appointed were Senators Thomas J. Michie, Jr. of Charlottesville; Emilie F. Miller of Fairfax; and Wiley F. Mitchell, Jr. of Alexandria; Delegates Vincent F. Callahan of McLean; Bernard S. Cohen of Alexandria; Mary A. Marshall of Arlington; and Kenneth R. Melvin of Portsmouth; and two citizen members, Dr. John A. Board of Richmond and Dr. Julia E. Connelly of Gordonsville. Senator Thomas J. Michie served as chairman and Delegate Vincent F. Callahan served as vice chairman.

During the second year of the study, Senator Richard L. Saslaw of Springfield replaced Senator Wiley F. Mitchell, Jr., who retired from the General Assembly.

II. A Short Legislative History

In the first year of its study, the Joint Subcommittee received technical reports from staff covering the new reproductive technologies, as well as the social, ethical, and legal issues relating to surrogate motherhood. Testimony was received from three women who had served as surrogate mothers and from the mother of a woman who died while reportedly serving as a surrogate mother. The Joint Subcommittee also received extensive testimony from medical experts, representatives of various interested groups and organizations, and two ethicists. The Joint Subcommittee developed a general understanding of the capabilities of the new reproductive technologies and spent long hours discussing the many complicated issues. During this first year of the study, the Subcommittee decided to adopt a regulatory approach to surrogacy and the new reproductive technologies and developed a first draft of proposed legislation which was introduced as Senate Bill 685 of 1989. This bill was not pursued because the Joint Subcommittee had not finished its work and because of the difficulties inherent in explaining such complex issues during a short session. Therefore, the study was continued pursuant to SJR 178 of 1989 in order to concentrate on designing the legislation. The study was broadened to include the following: the disposal of excess embryos, sale of genetic materials, the transfer of cryogenically stored embryos to individuals who are genetically unrelated to the donors, and other related issues.

During the second year of the study, the legislation was revised over and over again. Every detail, every punctuation mark, and every nuance of every word was meticulously examined. The Joint Subcommittee also heard additional testimony from concerned citizens, including a Virginia woman who had a very positive experience while serving as a surrogate.

As a result of the Subcommittee's painstaking deliberations during this second year of the study, two identical bills, Senate Bill 14 (patron - Michie) and House Bill 23 (patron - Cohen), were introduced. A public hearing was held on Senate Bill 14 during the first week of the 1990 Session. These bills were carried over to the 1991 Session.

III. The New Reproductive Technologies

In virtually every society, regardless of its level of sophistication, children are valued as the standard bearers of the family, the future of the clan or the progeny of hope.

In many instances, infertile couples suffer great emotional stress, particularly if a family line or name appears to be in jeopardy. The extent and importance of infertility as a societal problem can be demonstrated by reports that two to three million couples in the United States experience difficulties in conceiving a baby. According to the Office of Technology Assessment, "[a]lthough there has been no increase in either the number of infertile couples or the overall incidence of infertility in the population, the number of office visits to physicians for infertility services rose from about 600,000 in 1968 to about 1.6 million in 1984." However, the OTA notes that among couples with wives between the ages of 20 and 24, infertility increased from 3.6% in 1965 to 10.6% in 1982. Available figures suggest that slightly over a third of infertile couples seek medical treatment and it has been estimated that "Americans spent . . . about $1 billion on medical care in 1987 to combat infertility" (*Infertility: Medical and Social Choices*, Congress of the United States, Office of Technology Assessment, 1988, 1-10).

The causes of infertility are many and involve psychological and physiological conditions. Among men, abnormal sperm or low sperm counts are the primary causes of infertility; however, other conditions such as absence of the vas deferens and seminal vesicles, undescended testicles, malfunction of the thyroid gland, obstructions of the vas deferens and varicose veins of the testis may also cause infertility in men. Among women, the primary causes of infertility are fallopian tube problems, e.g., blockage or scarring in the tubes which prevents the ovum from descending, problems with ovulation, infrequent ovulation, premature meno-

pause, etc., and endometriosis, a condition in which the tissue normally lining the uterus collects in the abdomen and adheres to various organs, causing lesions. Pelvic inflammatory disease caused by infection with sexually transmitted microorganisms as well as systemic diseases is the primary cause of tubal disorders in women. Sexually transmitted diseases can cause sterility in both men and women if the infection is not treated, and diseases such as gonorrhea and chlamydia account for approximately 20% of infertility cases.

Examples of the reproductive technologies relevant to this study are the following: artificial insemination, in vitro fertilization, gamete intrafallopian tube transfer, low tubal ovum transfer, and lavage for embryo transfer.

Artificial insemination (AI), the transfer by mechanical means of semen into the genital tract of a woman, is relatively inexpensive and is "one of the simplest and most successful infertility procedures" (Office of Technology Assessment, 1988, 126). There are two kinds of AI — artificial insemination by husband (AIH) and artificial insemination by donor (AID). Artificial insemination by husband is indicated in cases in which either spouse has an abnormality, or the husband has inadequate numbers of sperm or abnormal sperm. The first reported case of AIH took place in London during the 1770's (R. Snowden, G.D. Mitchell and E.M. Snowden, *Artificial Reproduction: A Social Investigation*, Institute of Population Studies, University of Exeter, George, Allen & Unwin, Boston, 1983).

The first reported case of artificial insemination by donor was performed in Philadelphia in 1884 (R. Snowden and G.D. Mitchell, *The Artificial Family: A Consideration of Artificial Insemination by Donor*, Institute of Population Studies, University of Exeter, George, Allen & Unwin, Boston, 1983). Examples of cases in which AID is indicated are when the husband has no semen or he carries some hereditary disease. In the past, the husband's sperm was frequently mixed with that of the donor in order to create the potential for the husband to be the genetic father. This practice has declined. Sperm donor programs place various limitations on the number of children which may be fathered by one donor. The donor is anonymous; however, his physical characteristics and ethnic background as well as educational level, occupation, and interests may be disclosed to the recipient and her husband. Because of the AIDS crisis, donors are tested for infection with human immunodeficiency virus at the time of donation, the sperm are frozen, the donor is tested again six months after the donation, and then the frozen sperm may be thawed and used.

In vitro fertilization is one of the newest of the reproductive technologies, one of the most expensive, and one having success rates ranging from 0% to 16% or better, depending on the program. Natural fertilization takes place in the fallopian tubes; therefore, in vitro fertilization is indicated when a woman has fallopian tube disorders, e.g., blocked or scarred tubes or no tubes, if the man has a sperm deficiency, or in some instances of immunological disease. If a fallopian tube disorder prevents the ovum from descending or the sperm from ascending, the gametes will never meet for fertilization to occur. In vitro fertilization requires hormone

stimulation of ovulation (one to two injections per day beginning on day two of the menstrual cycle) and the surgical removal of eggs from the ovary during ovulation using ultrasound assisted aspiration, i.e., with a long hollow needle, or using laparoscopy, i.e., visual examination with a lighted instrument on a thin, flexible rod which is inserted into the body through a small incision to guide aspiration of the mature eggs.

After examining the eggs to determine that they are mature, the eggs are placed in a nutrient medium (modified saline). Prior to this procedure, sperm are collected and processed, e.g., washed and counted. Some sperm (50,000/egg) are then added to the culture dish with each egg and the gametes are incubated for approximately 18 hours. The cultures are then examined to determine if fertilization has taken place, and, if so, the zygotes (fertilized eggs) are incubated again. The culture is checked again some hours later to determine if cell division has taken place, i.e., if the zygote has developed into an embryo. The two to sixteen cell embryo (approximately 48 to 52 hours after beginning the process) is transferred into the uterine cavity of the recipient and, if implantation occurs, pregnancy is achieved. Patients are advised to maintain bed rest for two days following the embryo transfer. Spontaneous abortions and miscarriages are frequent with IVF. In the usual procedure, from two to five fertilized eggs are transferred because the success rate is low and the greater the number of embryos transferred, the higher the probability of success. As some programs have become more successful, multiple pregnancies of five or more have occurred. This has raised difficult questions related to reduction of the pregnancies or possible poor outcomes because of low birth weights. Excess embryos which were not transferred may be frozen for use in future cycles if pregnancy does not occur.

Gamete intrafallopian tube transfer is a less sophisticated technique in which, during one procedure, the egg is removed surgically and the egg and the sperm are placed together in the fallopian tube. Fertilization can then take place in vivo. This procedure provides only slightly higher success rates than in vitro fertilization. This procedure is not as widely practiced as IVF and is not as publicized.

A similar procedure is **low tubal ovum transfer** in which the egg is surgically removed from the ovary and placed in the fallopian tube near the uterus. This procedure bypasses blocked or damaged areas of the fallopian tube and fertilization may then occur through intercourse or artificial insemination. In addition, medical experts have developed a variation on IVF in which zygotes (fertilized eggs) are transferred directly into the fallopian tube.

Lavage for embryo transfer is a procedure in which an embryo is washed out of the uterus of one woman (the genetic mother) and transferred into the uterus of another woman (the gestational mother). This technique is indicated in cases in which the wife can sustain a pregnancy, but does not produce eggs, or if genetic disease is present in the wife's family. Usually, the genetic mother is artificially inseminated with the sperm of the gestational mother's husband. The gestational mother would most frequently be the wife of the genetic father.

In addition to these techniques for conception, it is relevant to note that the advances being made in **cryopreservation** of sperm, eggs, and embryos will significantly increase the availability of gametes and embryos. At this time, cryopreservation of sperm is successful and sperm are routinely frozen for future use. Cryopreservation of embryos is also a reality with IVF programs frequently freezing excess embryos for future transfer. Technology related to freezing of ova is not as advanced; however, recent progress has been reported in achieving pregnancies using thawed ova.

medical technology has revolutionized the field of reproductive technology

Sperm donor programs have existed and been accepted practices for many years. However, **donor egg programs** have been hampered because it is necessary to use hormones to induce ovulation, surgery is required for retrieval of the mature eggs, and ova are seldom viable after freezing. The development of ultrasound assisted aspiration of eggs has lessened the invasiveness of retrieval. Therefore, technological advances in cryopreservation of ova may mean that donor egg programs will become more common. The option of obtaining IVF performed with a donor egg and either the husband's or a donor's sperm, followed by transfer of the resulting embryo, will increasingly become available to infertile women.

It is unquestionable that medical technology has revolutionized the field of reproductive biology. In the twelve years since the birth of Louise Brown — the world's first test-tube baby — a new era in human reproduction has emerged with the development of human embryos in the laboratory. Though success rates vary drastically among medical facilities which utilize such techniques, the actual IVF procedure is steadily improving. Using fertility drugs to increase egg production during ovulation is an accepted practice among physicians hoping to increase the success rates for IVF. By "harvesting" a number of eggs in a time period which until recently usually yielded only one, physicians can now fertilize a number of eggs at a time. Extra eggs and/or embryos can be cryogenically preserved for future use. Additionally, present technology now enables the mixing and matching of sperm and eggs among donors and recipients; thereby making it possible for a woman to bear a child which may not be genetically related to her. Within the near future, test-tube fertilization is likely to become commonplace. In time, the potential combinations of genetic material may only be limited by the imagination of the participants.

In 1932, Aldous Huxley essentially described in vitro fertilization in *Brave New World.* His intention was to project 600 years into the future. In slightly less than 60 years after the first publication of Huxley's controversial novel, many of the technological advances which he predicted are being realized. At this time, society is attempting to invent terms to describe relationships which have never existed before. As reproductive technology develops and the link between gestation and genetics is further disrupted, the potential for the creation of new genetic, biological, and familial relationships will increase.

IV. Social Issues Related to Surrogacy

The traditional definition of parenthood has been dramatically changed as a result of new reproduction methods, particularly surrogate motherhood. In the process of producing a baby, noncoital reproductive techniques can now involve up to five different parents: a genetic father (sperm donor), a genetic mother (egg donor), a surrogate-gestational mother to carry and bear the child, and finally, two adoptive parents who assume custody of the child upon birth. Further, many different combinations of donors, gestational mothers and intended parents can occur. However, in a majority of the surrogate births for which data exist, a woman hired as a surrogate filled the role of genetic as well as gestational mother. Such involvement presents "a legal, moral and social nightmare," says Doris J. Freed, head of the American Bar Association's family-law section committee on research.

Determining who will assume responsibility for a child born of surrogacy has become a difficult task for society and lawmakers. Efforts to develop a rational and objective assessment of the potential for surrogacy and the new reproductive technologies to remake society as we know it have placed legislators in the uncomfortable role of latter-day Solomons. Currently, state legislatures are faced with three possible options: prohibiting surrogacy, doing nothing, or regulating surrogate practices. An outright prohibition of surrogacy might not eliminate the practice, but could drive it underground or out-of-state, thus perpetuating the legal uncertainties which already exist. These legal uncertainties include, for example, issues related to eligibility for social security benefits, inheritance rights, obligation for support of the resulting children, and, of course, custody rights. Even if surrogacy is outlawed, the legal system still has an obligation to eliminate legal uncertainties to protect the innocent children born of surrogacy agreements. A do-nothing, or laissez faire, approach is problematic because it leaves children born of surrogate mothers in a sort of "legal limbo." Unless the law provides for who the parents of these children will be, the possibility of unanticipated custody disputes will always exist.

Unique problems exist with cases involving deformities in newborns delivered by a surrogate mother. A child born with physical or mental disability might be anathema to all involved, and in such a situation both the contracting parent(s) and the surrogate might refuse custody — casting the infant into a quagmire of legal and social dilemmas. When a Michigan surrogate, Judy Stiver, gave birth to a baby afflicted with microcephalia (abnormally small brain size), and as a consequence, probable severe mental retardation, Alexander Malahoff, the man contracting for the child, refused to assume custody. Malahoff insisted on blood tests to prove that he was not the genetic father. Malahoff had agreed to pay Stiver a $10,000 fee to be artificially inseminated with his sperm and to bear his child. Test results revealed that Malahoff was indeed not the

father; Stiver had continued to have sexual relations with her husband at approximately the same time as the inseminations with Malahoff's sperm. Subsequent accusations resulted in the parties suing each other, while the Stivers held custody of the child.

The Malahoff-Stiver case illustrates a fundamental concern in the surrogacy issue: What happens to an impaired child? Had Stiver's child been born healthy, Malahoff would have probably taken custody of the child and the contract would have been completed. Moreover, he might never have questioned the paternity of the child if the baby had been born healthy, without birth defects.

However, Malahoff contracted with Stiver for a normal child and he refused the child when the contract was not fulfilled. The parties to surrogacy arrangements may tend to ignore the law of averages and the possibility of nature's interference with an otherwise normal pregnancy. Further, with prenatal tests now available to determine the absence or presence of certain genetic disorders, e.g., Tay-Sachs disease or Down's syndrome, questions are certain to arise regarding the right to terminate the pregnancy.

There are many reasons for entering into surrogacy agreements. As previously noted, experts in the field of infertility treatment and national statistics indicate infertility affects 10% to 15% of the married population. An inability to conceive can be caused by a number of conditions in either or both partners. Additionally, a pregnancy may be inadvisable for health or genetic reasons. One or both partners may have a hereditary disease (such as diabetes) which could be passed on to a child. In some instances, enduring a pregnancy could be harmful or even life threatening to the woman. Therefore, although a variety of rationales exist for pursuing surrogacy, the predominant reason appears to be infertility, particularly infertility affecting the intended mother. Many couples who choose to enter surrogacy arrangements do so after efforts to achieve pregnancy by conventional means have failed or after repeated and expensive infertility treatments have proven futile. Although most surrogate pregnancies are currently initiated by married, heterosexual couples experiencing fertility problems, it should be noted that the number of single adults desiring children has increased steadily in the past decade.

Reproductive technology and surrogacy arrangements are expensive. Depending on the method used, each attempt at achieving pregnancy through technological means can cost thousands of dollars. Therefore, regulation of surrogate motherhood will only benefit the interests of a decided minority in the population, the upper class. Such regulation will not address the needs of middle-class and lower-class citizens who are also infertile, and whose yearnings for children are no less than those of their wealthier neighbors.

Another reason that people may have for contracting with a surrogate mother is frustration with attempts to adopt a child. Many couples have cited lengthy waiting lists, which can often take years to get through, as one difficulty with adoption agencies. Another problem for

some childless people is that they cannot meet the stringent eligibility requirements established in some states. Generally, couples over 35-years-old may have difficulties with adoption, while others with unfavorable personal backgrounds may be thwarted in their efforts. Criminal records, financial or marital instability, psychological problems, and, on occasion, an agency's perception of a couple's ability to raise a child — all are factors which may lead to denied requests for adoption. Married, heterosexual couples with a proven record of stability are the norm.

Some couples who would not face difficulties in adopting a child may not want to adopt because one or both of them are only interested in having a child who is genetically related. Many couples are simply not willing to accept any child except their own child. For these individuals, the desire to procreate in their own image is too great for them to overcome. By contrast, of those persons willing to adopt, a majority prefer newborn babies and, of course, infants are not necessarily available.

Indeed, many children available for adoption are not infants and few couples want to adopt children past the age of six. This may stem from the frequently expressed belief that by the sixth year a child has already developed traits and behavior patterns which cannot be altered. Further, aspiring parents who adopt a child past this age miss the child's developmental stage entirely, an experience which for many is an important aspect of being a parent. It is also worth noting that there appears to be a disproportionate number of white couples who want to adopt white babies, while the majority of adoptable babies are of other races.

When infertility is not a factor and adoption is undesirable, some women, both married and single, have expressed concerns about the "inconvenience" of pregnancy as a valid reason for hiring a surrogate mother. These women may be frightened of pregnancy for any number of reasons inherent in carrying a baby to term, including nausea and possible medical complications, an increase in weight and subsequent loss of figure, complications with the delivery (including Caesarean section), the pain and trauma of the delivery itself, and postpartum depression. Also, some women may not wish to abandon their careers, even temporarily, in order to bear a child. Significantly, these motivations for hiring a surrogate receive the least approval of any factor among many individuals on both sides of the surrogacy issue. The stated inconvenience of pregnancy is not viewed as a legitimate reason for hiring another woman to perform the task, nor do many proponents of surrogacy feel this is a just cause for utilizing surrogate methods. Some groups, particularly the National Organization for Women, have predicted that hiring surrogate mothers for the sake of convenience is only a step away from the exploitation of disenfranchised women for the benefit of the upper class.

A common defense currently made on behalf of surrogate motherhood is the belief that if a man is entitled to donate his sperm to a collection bank or other facility in exchange for money, then a woman should have an equal right to capitalize on her half of the reproductive process. One internationally recognized publication, *The Economist*, favors commercial surrogacy. Under the quintessential economic tenet of

supply and demand, the magazine concluded: "Commercial surrogacy would increase the supply of babies to parents who want them." As for potential harm to the child, *The Economist* maintained that this would be unlikely, stating that "such a child might more normally reflect that he (sic) would not have been born if the parents he knows had not wanted him so much that they paid out big money to get him" (*Economist*, January 1985).

A nationwide study conducted in 1985 by the American Psychiatric Association (APA) identified three common motivational factors in women who had chosen to serve as surrogates. The factor most frequently offered by respondents was financial remuneration. A surrogate mother can on average expect to receive approximately $10,000 for "her services." Obtaining such a large sum of money in one lump sum may be especially enticing to an indigent or otherwise financially struggling woman. The second most frequently offered reason was the desire of some of these women to be pregnant again. Many interviewed surrogates claimed they enjoy carrying a baby, some expressed the joy and sense of fulfillment they associate with pregnancy. Other women cited a heightened sense of sexuality during pregnancy. The pleasure derived through being pregnant is desirable to such women, not the notion of mothering a baby. The third characteristic revealed by the APA's study involves some surrogates' interests in resolving a prior pregnancy trauma, such as miscarriage, abortion of a fetus, or having previously given a baby up for adoption. Women citing this third factor stated that they felt a successful pregnancy would help them to resolve the emotions connected to the earlier situation. For these women, surrogacy served as a type of therapy for alleviating emotional problems.

Altruistic motivations were offered by some surrogates, who stated they were satisfied to "give the gift of life" to a childless couple. Some expressed empathy with the anguish and disappointment felt by infertile couples, while others have said their ability to conceive is a gift from God to be given to those less fortunate. However, a majority of the women interviewed for the APA study said that despite their altruistic intentions, the decision to be a surrogate would have been unlikely without the opportunity for compensation.

Commercial surrogacy arrangements present another set of social issues. Becoming an intended parent, via someone else serving as a surrogate, is certainly not an option for poor individuals. However, poor women may find becoming a surrogate mother attractive because of the potential for compensation. One of the most disturbing aspects of viewing surrogacy in terms of goods, and fees for services rendered, is that such commercialization reduces human reproduction to a technological process for producing saleable goods. However, many individuals argue that commercial surrogacy is an acceptable practice because the objective is to produce a child who is deeply wanted. This may be the essential difference between surrogate motherhood and its opposite procedure, abortion. With surrogacy, someone does want the child and through noncoital reproductive techniques is able literally to will it into existence. It might be argued that under these circumstances everyone involved wants the child. The intended parent(s) are frequently desperate to have a child which is

genetically related to at least one of them. The surrogate mother wants the child as well — either because she wants to receive the payment or because she wants to feel that she has helped others to achieve happiness.

Noncoital reproduction and surrogate motherhood may have the appearance of businesses in terms of the inherent contractual obligations. However, for many childless couples, surrogacy is the possible answer to their deepest, most personal desires. The emotional conflict inherent in any surrogacy arrangement pits the primeval desire to see oneself in one's child against the emotional anguish which may result when the surrogate mother is separated from the child, regardless of her genetic relationship to the child. After all, she has an intensely personal relationship with the fetus for nine months before birth.

To date, over half of all surrogate births in this country have been arranged through brokerage firms. For a fee (average cost: $8,000; range: $3,000 to $12,000), the surrogate broker will match a childless couple to a potential surrogate, prepare a contract stating the obligations of all parties, and serve as a liaison between the surrogate and the couple. Some firms strongly discourage or do not allow contact between the contracting parties. They theorize that it is easier to maintain the terms of the contract, i.e., transfer of custody and parental rights to the intended parents, if anonymity of the parties is preserved. As in any business, the predominant concern of commercial surrogacy brokers is to make money. Further, the exchange of money from hopeful couple to broker carries no guarantee, written or implied, that a successful pregnancy will result. Surrogate brokers have been quick to emphasize that they are selling a woman's services rather than a baby, in other words, "womb renting." For the brokers, this rationale is intended to avoid violations of laws prohibiting baby selling.

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Michigan attorney Noel Keane, one of the first individuals to develop and operate a surrogate brokerage in this country, has conceded that such businesses operate in a legal and social vacuum. Though not precisely illegal, surrogate brokering in many states is not deemed legal either, hence the controversy. According to the brochure for his agency, Keane "maintains the most extensive surrogate files in the country." He has also advised hopeful couples of the gray zone of legalities they could encounter during the course of a surrogacy arrangement. As of 1985, Keane had coordinated over 65 surrogate pregnancies for contracting couples, including William and Elizabeth Stern, plaintiffs in the much-publicized Baby M child custody case in New Jersey. In 1989, the publications advertising his services noted that over "300 babies have already been delivered and more than 150 couples are present clients awaiting the birth of their child." Keane has faced lawsuits from, among others, Mary Beth Whitehead — the surrogate who bore Baby M in March of 1986. Whitehead alleged that Keane misrepresented the terms of her contract with the Sterns and failed to provide her with sufficient counseling on giving up her child prior to the birth.

Most physicians in this country offering infertility services, particularly those associated with surrogacy, claim to advocate these

procedures for purely medical and humanitarian reasons. Some rightfully assert that they provide the enabling technology for couples who might otherwise be unable to have children. Therefore, these physicians are fulfilling the charge of their oaths to assist people in maintaining health and life. However, there are clearly other reasons such as the pursuit of knowledge and advancement of new reproductive technology. With each successful pregnancy utilizing new technologies, the body of knowledge on these techniques grows. In fact, since reproductive research has received very little traditional financial support, i.e., federal research grants, some of these scientists may be supported by the institutions in which they serve because of the lucrative market for treatment of infertility.

Additionally, statistics on success rates for the various techniques are variable, e.g., data indicate an average of four artificial insemination attempts is typical before conception occurs. The success rates for IVF range from 0 to 16% or more. However, the statistics are unreliable because the method of determining success varies from program to program with, for example, some programs counting every pregnancy regardless of outcome and some counting the number of babies born. Further, like the brokerage firms that expedite the surrogacy arrangements, physicians make no promises as to the success of a pregnancy or the birth of a healthy baby. At this time, the only guidelines governing the activities of the medical community in the area of reproductive technology are unofficial documents such as the ethical guidelines adopted by the American Fertility Society.

A fair analysis of the social ramifications of surrogacy requires that all conceivable benefits of this practice be weighed against the potential problems posed to society. The use of surrogate mothers could serve to alleviate much of the grief and depression frequently experienced by childless couples. However, the question is whether society is prepared to condone the separation of a surrogate mother from the child. There are a number of physicians and psychiatrists who claim such practices could be harmful to mother and child, while other practitioners have stated that there is no evidence to suggest long-term psychological harm will be suffered by a surrogate. Because there are few children on record past the age of ten who were born of a surrogate mother, it is impossible at the present time to analyze the long-term effects on these children. Virtually everyone expressing an opinion agrees that the best interests of the child should be paramount at all times. Therefore, issues related to compensation and termination of mothers' rights require analysis from the perspective of what is best for the children born of surrogacy arrangements, rather than from that of the contracting adults. This analysis demands a solution which balances individual rights and societal interests, e.g., preventing exploitation of indigent women and protecting traditional family values and parent/child relationships.

These considerations are further complicated by the fact that there are a number of possible combinations involving surrogate mothers and contracting individuals, and each situation can have several factors which make it unique. For instance, a gestational surrogate mother (one

who "rents her womb," but who has no genetic relationship to the child) presents different issues than a surrogate who submits to artificial insemination and thus provides one-half of the child's genetic background. In the first case, the surrogate has no genetic link to the child, but serves as an incubator for nine months. Therefore, society must recognize that any legislative response to surrogate motherhood must be tailored to address many individual circumstances.

Because the unusual circumstances of a surrogate birth might make a record of the child's origins desirable to the child in the future, accurate genealogical and genetic records could become essential. It could also become important to monitor surrogate births to prevent interbreeding among the population and to prevent the possibility of incestuous relationships. One solution which has been suggested would limit a surrogate's contractual offspring to two births. Another proposal would require or authorize the establishment of surrogate clearing houses — agencies operating like adoption centers, whereby a woman may serve as surrogate to a couple either for altruistic reasons (the child is freely given to an adopting couple) or for reasonable compensation for time and expenses incurred through pregnancy and birth.

If social acceptability is granted to surrogacy, it might be reasonable to conclude that a greater number of the population would be attracted to this method of reproduction. Further, although it is impossible to estimate how long this would take, inevitable competition among medical facilities for customers might result in a reduction in cost for surrogate procedures. If this were to occur, it could bring the option of surrogacy to a greater number of childless couples, further increasing the frequency and number of surrogate births. Increased competitiveness could bring a number of new factors to bear on this issue. In their efforts to provide superior services to the public, facilities might begin to offer choices and extra options from which individuals desirous of obtaining a child could select. If no policy decision is incorporated into law by either proscription or regulation, these options could include breeding for specific physical and intellectual characteristics or choices that are indeed inconceivable at this time.

Such activity is already occurring on a limited scale. Prospective parents hiring a surrogate can choose one from an agency's file of applicants whose physical, mental, and emotional characteristics meet their desires. A hiring couple who wishes to have a baby with blond hair and blue eyes could select a surrogate possessing these traits in order to increase their chances of producing a child with such features. Lists of sperm donors include the physical characteristics, ethnic backgrounds, occupations, and even the religious preferences of the donors. Therefore, a woman choosing a sperm donor has many criteria for guidance. Of course, at present these techniques are relatively crude hit-or-miss propositions; however, innovations in the field of human genetics which would make this option feasible are within the foreseeable future. Eventually, it may become possible for aspiring parents to select sperm and ova containing genetic traits such as specific facial structures to enhance a child's appearance, provide superior musculature, or ensure greater intellectual

capacity. Given the time and financial wherewithal to conduct research, such technological advances in human reproduction are within the realm of possibility.

A couple might ultimately be able to preselect all the desirable characteristics of their child, then hire a surrogate mother to carry the fetus. Further, the parental desire to provide a child with the best possible opportunities in life might make these selective breeding practices inevitable. Competition among medical and research facilities might extend to competition among the public in a never-ending effort to create the perfect human being. The ability to indulge in selective breeding could become limited only by desire and the financial resources of couples interested in these procedures. Additionally, once the desired genetic information for the child has been chosen, a couple could retain the services of a surrogate to handle the conception and pregnancy while they pursue other interests. The couple could then simply take custody of their child upon birth without having to concern themselves with anything more taxing than choosing features and options from a catalog.

V. Ethical Issues Related to Surrogacy

The fierce controversy raised by surrogacy and the new reproductive technologies has polarized medical experts, respected ethicists, and esteemed theologians because of the profound implications of these techniques for both medical and public policy. The collaborative nature of surrogacy and the new technologies has imbued the debate with "[p]rofessional, public, religious and personal opinions" (OTA, 1988, 203). Although the parameters of the debate are difficult to define, its focus has been primarily on issues related to the welfare of the resulting children; the right to procreate; the status of the embryo; the importance of marriage and the family, particularly the parent/child relationship; confidentiality; informed consent; protection for pregnant women; the effects on future generations; and the possible long-term social and personal consequences.

The controversy has centered on whether there is a fundamental right to procreate without governmental intrusion and, if there is such a right, the extent to which the state may regulate surrogacy and the new reproductive technologies in order to protect the common good. Is there a distinction between the right to coital reproductive freedom and the right to noncoital reproductive freedom? Why would the fact of infertility reduce an individual's or a couple's interest in asserting the right to reproductive freedom? And can a balance be struck between individual privacy rights and personal freedoms and the state's interest in protecting from harm those who are too weak to protect themselves?

Ethical discussions of reproductive technologies focus on the rights and responsibilities of the parties and address the issues on the basis of a liberty right and a welfare right. A liberty right is the freedom to make choices without interference from others. A welfare right is an entitlement which requires affirmative actions on the part of others in the form of obligations, responses, services or resources (OTA, 1988, 204).

> *"Moral philosophers generally distinguish between two types of rights:* ***negative (liberty) rights and positive (welfare) rights.*** *Applied to the question of procreation, a liberty right would encompass the "moral" freedom to reproduce, or to assist others in reproducing, without violating any countervailing "moral" obligations. A welfare right to reproduce would "morally" entitle one to be assisted by another party or parties in achieving the goal of reproduction"* (American Fertility Society Ethics Committee, "Ethical Considerations of the New Reproductive Technologies," *Fertility and Sterility,* 46: 2S-3S, 1986).

In the United States, the right of fertile couples and individuals to reproductive freedom is not particularly controversial. The choices to be made focus on whether or not to beget and bear children (*Fertility and Sterility* 46: 2S, 1986). However, when infertility is added to the equation, this right becomes modified by noncoital reproductive technologies and will, therefore, raise questions related to entitlement to the responses, actions, resources and services of others (OTA, 1988, 204). For example, there is presently a movement to promote the enactment of laws requiring insurance coverage for reproductive technologies. Such legislation was introduced during the 1990 Session of the General Assembly. The bill was carried over to the 1991 Session pending further consideration, including a study by the new Advisory Commission on Mandated Benefits to determine the costs and benefits of requiring health insurance coverage for reproductive technology. Claims of entitlement to treatment with sophisticated medical technology must always compete with claims of entitlement to basic health services. Amidst mounting anxiety about allocation of scarce resources and access to preventive/primary care, many thoughtful people express concern about rationing of care, fairness in the health care system, and the possible dichotomy between the quality of and access to health care provided to poor, and even middle class individuals, and that which is provided to those who are covered by insurance or who can afford to pay.

Among human societies, the family is the basic unit. The family provides the building block for order and the core of culture. Proponents of surrogacy state that this practice promotes the family as the traditional unit of society by enabling infertile couples to have children, thereby facilitating the development of the typical family consisting of loving parents with children. The proponents discount any potential psychological or identity problems among these children by asserting that the children will understand that, "but for this practice, they would never have been born" (*Surrogate Parenting: Analysis and Recommendations*

for Public Policy, The New York State Task Force on Life and the Law, May 1988, 75 - 78). In other words, that it is better for these children to have lived than never to have lived at all.

Opponents state that surrogacy can only be said to create families at the expense of disrupting other families since the gestational mother (regardless of her genetic relationship to the child) is expected to relinquish the child to the intended parents. They often believe that the resulting children are placed at risk by this practice, which they term "baby selling," and that it is not possible to design regulation which can minimize the potential harm. For some opponents, the potential for harm of commercial surrogacy extends to all children, not just to those produced through surrogacy. Some commentators have analogized surrogacy to slavery as the sale of human beings or in relationship to the disruption of the family promoted by both practices.

Proponents of surrogacy claim that resulting children will be much loved, because of the intensity of the desire of infertile couples to have them. Similarities between adoption and surrogacy are cited to emphasize that human relationships cannot be defined in terms of biological relationships. The ability of parents to nurture and love children who are not related to them is used to substantiate that the resulting children will be cared for lovingly by intended parents, at least one of whom will be genetically related to them.

Opponents of surrogacy note the significance of the parent/child relationship and question the psychological effects of genetic relationships which only run to one parent. Some view gestational surrogacy (when both gametes are contributed by the intended parents) as creating a different set of issues than genetic surrogacy (when the surrogate mother is bearing her child). Since, in gestational surrogacy, the resulting child truly is not genetically the child of the surrogate mother, then how is the woman's emotional attachment to the child affected? Wouldn't a resulting child who is genetically the child of both intended parents have a stronger sense of identity and belonging than the resulting child who has been "given up" by a genetic surrogate mother? Will some intended mothers feel "left out" of the relationship with the child when the child is not genetically related to them or resent resulting children who demonstrate significant likenesses to their genetic surrogate mothers? What effect will genetic surrogacy have on the relationship between the husband and wife and on the bonding between the intended parents and the child?

The report of the New York Task Force on Life and the Law states that "[t]hree elements have been identified as critical to informed consent" and identified these elements as: (1) sufficient information for intelligent decision making, (2) comprehension of the effects of the decision, and (3) freedom from undue influence in making the decision. The first two elements were identified as having generated the "greatest controversy" in relationship to surrogacy, even through many persons have questioned the role of compensation in influencing the decision to become a surrogate. A number of questions related to informed consent are raised such as: Is it possible for a woman to give informed consent to

relinquish a child before that child is born or even conceived? Is informed consent rendered impossible by the pregnancy and the "evolving relationship" between the surrogate mother and the child? Will coercion be a significant factor in some cases when a fee is offered? (New York State Task Force, 1988, 88.)

Surrogacy proponents aver that adult women have the power to enter into contracts, are able to understand the ramifications of surrogacy arrangements and to give informed consent to relinquishing the child prior to its birth. Therefore, contracts for surrogacy should be enforceable. Some proponents state that contracts for paid surrogacy will benefit both the intended parents and the surrogate mother, i.e., by assisting the intended parents in obtaining a child and by providing the surrogate mother income which she may not have been able to obtain otherwise.

However, opponents note that women are not allowed to sign away their rights to children under adoption laws during pregnancy and that the relationship between a woman and the child she carries for nine months is so intensely personal that it is impossible for an informed decision to be made prior to conception or during pregnancy. Although proponents may argue that enforceable contracts are necessary to validate women's ability to contract and to reinforce women's autonomy over their bodies, opponents counter that surrogacy strengthens gender discrimination and exploits poor women by paying them for the risks of pregnancy and the delivery of a child, thereby subjugating them to the wishes of wealthy men (Ruth Macklin, "Is There Anything Wrong with Surrogate Motherhood? An Ethical Analysis," *Law, Medicine & Health Care*, 16: 1-2, 1988, 57; Annas, 1988, 31).

Underlying the ethical considerations of surrogacy are issues related to the prevention of and treatment for infertility. Some experts describe surrogacy as an inadequate medical response to infertility and call for education and research in the prevention and treatment of the causal conditions. Other commentators note the vulnerability of infertile couples to hyped claims of success by infertility programs and the profound need for federal support of research in human reproduction (*Fertility and Sterility*, 46: 3, S1 (1986). Critics have stated the need for better education in prevention of sexually transmitted diseases, the establishment of standards of medical care and informed consent, laws related to exposure to toxins which may cause infertility, and societal changes to ameliorate the postponement of child-bearing (Nadine Taub, "Surrogacy: A Preferred Treatment for Infertility?" *Law, Medicine & Health Care*, 16: 1-2, 1988, 89 - 93).

Relevant Supreme Court Cases

The United States Supreme Court, in a line of important decisions between 1942 and 1977, addressed the fundamental right to procreate. The Court validated, in *Skinner v. Oklahoma*, 316 U.S. 535 (1942), that procreation is a basic or fundamental right which is necessary for the survival and existence of mankind. In *Griswold v. Connecticut*, 381 U.S. 479 (1965), the Court recognized a constitutionally protected "zone of privacy" as regards the use of contraceptives which is guaranteed by certain penumbras emanating from the Bill of Rights. In *Eisenstadt v. Baird*, 405 U.S. 438 (1972), the Court held that state law regarding access to contraceptives cannot differentiate between married and unmarried persons. In *Carey v. Population Services Intern.*, 431 U.S. 678 (1977), the Court expanded upon its reasoning in *Roe v. Wade*, 410 U.S. 113 (1973) to reinforce the concept of a "constitutionally protected right of decision in matters of childbearing." See *Carey v. Population Services Intern.*, 431 U.S., at 688.

It can be argued that surrogacy arrangements are protected by the right to make procreative choices under the due process clause of the 14th Amendment and the right of privacy (*Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942); *Griswold v. Connecticut*, 381 U.S. 479, 487 (1965); *Meyer v. Nebraska*, 262 U.S. 390, 399 (1923); *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972). However, in the cases cited, the Court was not examining the ramifications created by noncoital reproductive techniques. The Court was not confronted with procreative choices which could be made to overcome infertility, to prevent transmission of disease, or for personal reasons, or even for convenience.

The Challenges and Questions Presented

In the course of its two-year study, the Joint Subcommittee evaluated the diverse and inordinately complex problems that surrogacy and reproductive technology may pose to society if allowed to perpetuate in an open, unregulated environment. The first question which the Joint Subcommittee had to answer was whether to outlaw or regulate surrogacy contracts and surrogate brokerage firms (entities that accept compensation for recruiting or procuring surrogates or making surrogacy arrangements).

Finding answers to these basic questions meant addressing endless hypothetical issues. The right of married individuals to reproduce could be construed to limit state efforts to restrict these arrangements, i.e., constitutional questions could be raised by a total prohibition on surrogacy agreements. In a given instance, the right to procreate might not be accessible to an infertile woman or man without artificial insemination or embryo transfer and/or the services of a surrogate. Therefore, what limitations should or can the state place on surrogacy arrangements?

What policies, if any, should be implemented to address the activities of commercial agencies or brokers? Compensation of the surrogate? Do such commercial arrangements demean and exploit women by reducing them to "baby machines"? How equal is the bargaining power of the surrogate to that of the intended parents? Does the commercialization of surrogacy devalue human beings and make children a commodity? What distinctions are valid and pertinent between voluntary, altruistic and paid surrogacy? What are the implications of these distinctions? Is the argument valid that the woman is performing a service by renting her womb? Does payment for surrogacy violate basic principles of "personhood"?

The law is not presently equipped to handle disruption of the link between genetics and gestation. Therefore, what rights should a genetic parent have to his or her child when that child is born to an unrelated gestational mother? What should the rights of the unrelated gestational mother be? Should the rights of a genetic surrogate mother differ from those of an unrelated, gestational surrogate mother? Do some surrogacy arrangements constitute ways to bypass traditional adoption requirements because the intended parents cannot pass muster, or will these arrangements evolve to become ways to avoid traditional adoption protections for the child? How could this potential be avoided?

the law is not presently equipped to handle disruption of the link between genetics and gestation

What rights should the child have under various circumstances, e.g., under the inheritance laws? How can the state protect the interests of children born of the new reproductive technologies and avoid lengthy, unpleasant custody suits such as the Baby M case? Should traditional family law principles be maintained and enforcement of surrogacy arrangements be denied? Or should the law be specific, perhaps even to the extent of setting out the permissible contract clauses?

Should children born of surrogate mothers and the new reproductive technologies have access to medical information about their genetic parents? What records should be kept, and how should this record keeping be structured in order to limit the possibilities of inbreeding and to maintain needed genetic histories? Should the identities of gamete donors always be protected? Is there a right to privacy related to protecting this information, or are there instances in which confidentiality considerations may be secondary to the welfare of the child? What effects would any provisions on disclosure/confidentiality have on the availability of donor gametes? Why should it be permissible under Virginia law to sell sperm, but not permissible to sell ova? Does the state have a compelling interest to regulate the sale of eggs in view of the invasive nature of ova retrieval and the necessity of hormonal intervention?

What, if any, is the legal status of a frozen embryo? How can questions raised during divorce proceedings concerning the ownership and control of frozen embryos, such as those which have already occurred in a recent Tennessee case, be resolved?

These questions are far from inclusive; yet few of these questions have easy answers and there is little or no legal precedent or school of accepted legal thought which can be brought to bear.

VII. Findings and Recommendations: Analysis of the Proposed Legislation

The legislation developed by the Joint Subcommittee Studying Surrogate Motherhood and the New Reproductive Technologies was intended to provide a reasonable system of regulation for surrogate motherhood without intrusion into the private and, arguably, constitutionally protected reproductive choices of individuals. Although unanimous agreement was impossible to attain, Senate Bill 14 and House Bill 23 were specifically intended to impose heavy responsibilities on the parties in order to serve as a deterrent to all except those individuals who were truly committed to becoming parents, but were prevented from achieving this goal because of infertility.

The title of the Act, "Status of Children of Assisted Conception," was chosen to indicate some consistency with the proposal of the same name as drafted by the National Conference of Commissioners on Uniform State Laws. However, the Virginia proposal differs substantially from the proposed Uniform Act.

The Virginia Act must be read as a whole. Each section must be understood in its relationship to the other sections. Even within sections, there are provisions which were written specifically because of their relationships to other parts of the section. For example, § 20-156, the first section of the Act, sets forth the definitions in alphabetical order. Definitions are set out for the technical terms, including surrogacy contract, surrogate, and assisted conception, which includes artificial insemination, the use of frozen embryos, and other noncoital reproductive technologies, such as in vitro fertilization. These definitions were carefully structured to be scientifically valid and to provide guidance to the court. Most of the terms included in this section were chosen because they are used in other sections of the proposal. However, in several instances, a term was included primarily because it was used in one or more other definitions, e.g., "gamete," "embryo," "embryo transfer," "in vitro," "in vivo," and "in vitro fertilization" are terms used in the definition of "assisted conception." Similarly, "in vitro" is defined in order to facilitate the understanding of the process of in vitro fertilization. Further, since reproductive technology allows many infertile couples to have a child who is genetically related to one or both of them through the services of a surrogate, terms had to be invented to describe relationships which were heretofore taken for granted. Therefore, the bills speak of "gestational mother," "resulting child," and "intended parents."

The Joint Subcommittee wanted the provisions of its proposal to be controlling in any litigation occurring in Virginia involving a surrogacy agreement, custody of a child conceived through reproductive

technology, or the disposition of frozen embryos after dissolution of marriage. Many of the circumstances described to the Joint Subcommittee involved activities which took place in two or more states, e.g., contract signed in New York, IVF performed in Michigan, and baby born in Virginia. Further, although a growing number of states are enacting laws on this matter, some of these new laws were not appealing to the Subcommittee. For these reasons, § 20-157, the conflict of laws section, was intended to instruct courts to follow the requirements of the Virginia Act, "without exception," in any action brought in Virginia courts to enforce or adjudicate any rights or responsibilities arising under the Act. The Joint Subcommittee borrowed the concept of the omnibus clause from the law on liability insurance for motor vehicles and concluded § 20-157 with a "surrogacy omnibus clause" which states that any "provision in a surrogacy contract that attempts to reduce the rights or responsibilities" of any of the parties, including any resulting child, must be reformed to include the requirements of the Act.

The bills set forth procedures for determining the parentage of children produced through assisted conception in § 20-158. Cryopreservation of gametes and embryos now makes it possible for an individual to become a genetic parent long after death or the dissolution of a marriage. Therefore, the effects of death and dissolution of marriage are addressed in § 20-158 A. A child who is genetically the child of a wife and husband, with the husband's consent, would be the child of that wife and husband regardless of the death of either party or the filing for divorce or annulment during the ten-month period immediately preceding the birth. However, death or dissolution of marriage would negate parentage unless in utero implantation of an embryo occurs before notice of the death or dissolution of the marriage can be reasonably communicated to the physician performing the procedure or the person contributing the gamete has consented in writing to be the parent. A party to a divorce or annulment would be able to consent to be the parent after the filing of the action.

It is important to note that in utero implantation of an embryo is a naturally occurring phenomena which takes place after the performance of any reproductive technology. Therefore, the parentage determinations related to death or dissolution of marriage which are set forth in § 20-158 A would apply regardless of whether artificial insemination, in vitro fertilization, or some other form of noncoital reproductive technology is utilized.

The Joint Subcommittee wanted to design this legislation to provide flexible solutions for disputes over custody or ownership of frozen embryos in order to avoid placing Virginia courts in the difficult position of deciding such issues without legislative guidance. Therefore, subsection B of § 20-158 addresses the disposition of frozen embryos in any case of dissolution of a marriage or death of a spouse. This provision prohibits access to or possession of the embryos by the parties to a divorce or annulment of a marriage or the surviving spouse in the case of death of a spouse unless there is an agreement between the parties to the contrary. The entity having possession of the embryos would not be under an obligation to maintain them.

Because reproductive technology may be used to produce children under circumstances other than surrogacy, the Subcommittee developed a provision governing such parentage. The Act declares the gestational mother the mother of the child and her husband the father (see § 20-158 C 1 and 2) except under court approved surrogacy contracts or valid contracts which have not been court approved. Donors of gametes would not be the parents of any child conceived through assisted conception (see § 20-158 C 3). These provisions are consistent with present law and tradition including the presumption in §§ 32.1-257 and 64.1-7.1 of the *Code of Virginia* that a child born through artificial insemination is the child of the mother's husband, if he has consented to the artificial insemination.

Subsection D of § 20-158 sets forth the requirements for determination of parentage under a court approved contract. Following the entry of an order for a new birth certificate pursuant to subsection E of § 20-160, the intended parents will be the parents of a child borne by a surrogate (see § 20-138 D 1). However, if the court vacates the order approving the contract, after the surrogate gives notice of termination, the surrogate and her husband are the parents of the child.

Subsection E of § 20-158 sets forth the requirements for determination of parentage under a valid surrogacy contract which has not been approved by a court. This subsection provides that the gestational mother is the child's mother and establishes the conditions under which the intended father is the legal father. If either of the intended parents is a genetic parent of the resulting child, the intended father will be the child's father unless three conditions are met as follows: the surrogate is married, her husband is a party to the surrogacy contract, and the surrogate exercises her right to retain custody and parental rights to the child (see § 20-158 E 2 and 3). Therefore, under this type of contract, if a single surrogate decides to keep the child and there is a genetic relationship between the child and one or both of the intended parents, then the intended father will be vested with full legal obligations for the child. In addition, the surrogate will be the legal mother of the child under the following circumstances: if neither of the intended parents is the genetic parent of the child or she decides to keep the child (see § 20-158 D 3). In other words, she will not be able to transfer custody and parental rights to the intended parents unless there is a genetic relationship between the child and at least one of the intended parents (see § 20-158 D 3). If she is married, and her husband is party to the contract, her husband will be the father of the child if she decides to keep the child regardless of the genetic relationships (see § 20-158 D 2 and 3). The intended parents will become the parents of the child upon the signing and filing of a surrogate consent and report form in accordance with this act (see §§ 20-158 D 4 and 20-162 A).

Pursuant to either kind of contract, procedures are established for the transfer of parentage to intended parents and the issuance of a new birth certificate, if at least one of the intended parents is genetically related to the child (see § 20-158 D relating to determination of parentage pursuant to a court approved contract, § 20-160 E relating to the order for a new birth certificate pursuant to a court approved contract, § 20-158 E relating to determination of parentage pursuant to a surrogacy contract that has not

been approved by a court and § 20-162 A 3 and 4 relating to the conditions for filing the surrogate consent and report form and its required attachments). In any case in which medical evidence cannot be produced to substantiate that at least one of the intended parents is genetically related to the child, the intended parents may only acquire parental rights through adoption proceedings (see §§ 20-158 D and 20-160 E relating to the court approved contracts and §§ 20-158 E and 20-162 A 3 and 4 relating to the contracts which are not approved by the court).

Section 20-159 specifically notes that surrogacy contracts are permissible when in compliance with this act. Two procedures for valid surrogacy contracts are provided, i.e., a court approved agreement between the intended parents and the surrogate and her husband (§ 20-160) and a noncourt approved agreement (§ 20-162). For either contract to be valid, the intended parents must be a man and woman married to each other (see definition of "intended parents" in § 20-156).

The court approved agreement is similar to that established in the Uniform Act for surrogacy contracts. Because the court procedure may be attractive to individuals who are not acquainted or related, elaborate protections are provided. The parties will petition the circuit court in which at least one of them resides prior to initiating any reproductive technology. A signed, acknowledged copy of the contract must accompany the petition. A guardian ad litem will be appointed to represent the interest of any resulting child and the court may appoint counsel to represent the surrogate. All records will be confidential and subject to inspection in the same manner as adoptions, and all proceedings will be held in camera. The court will have exclusive and continuing jurisdiction over the matters arising from the surrogacy contract until any resulting child is six months old (see § 20-160 A).

This type of contract would provide protection for parties who are not acquainted by allowing married couples to enter into contracts with married surrogates and their husbands, when the intended mother is infertile or has some comparable medical condition and at least one of the intended parents is expected to be the genetic parent of any resulting child (see § 20-160 B 6, 8, and 9). Home studies of both couples are required (see § 20-160 B 2) and all parties would be required to meet the standards of fitness applicable to adoptive parents (see § 20-160 B 3). All parties must also receive counseling concerning the effects of the surrogacy (see § 20-160 B 11) and submit to physical examinations and psychological evaluations (see § 20-160 B 7). The court must determine that the agreement would not be substantially detrimental to the interests of any of the affected persons (see § 20-160 B 12). The contract must include "adequate provisions" for the payment of reasonable medical and ancillary costs and for allocation of responsibility for these costs in the event of termination of the pregnancy or the contract or breach of the contract (see § 20-160 B 5).

Subsection C of § 20-160 requires that all court costs, counsel fees, and other costs and expenses associated with the court procedure, including the costs of the home study, be assessed against the intended parents, unless the contract stipulates otherwise. Subsection D of § 20-160

authorizes the parties to agree to compensation and renders such provisions enforceable. The funds must be placed in escrow and paid in full unless the agreement contains other reasonable terms for adjusting or prorating the compensation in the event of termination of the contract or pregnancy or breach of the contract.

After birth of the child, the intended parents have seven days in which to notify the court of the birth. The court will then order the issuance of a new birth certificate naming the intended parents as the parents of the child upon receiving this notice and finding that there is a genetic relationship between the child and at least one of the intended parents (see § 20-160 E).

The contract may be terminated before pregnancy occurs by any of the parties or the court (see § 20-161 A). The surrogate may terminate the contract within six months after the last performance of assisted conception by filing written notice with the court (see § 20-161 B). In other words, the surrogate has the right to terminate the contract until approximately the sixth month of pregnancy. It is specifically noted that the surrogate will incur no liability to the intended parents for exercising her right to terminate the contract unless the contract provides otherwise. Since there is court oversight of the contract, the potential for exploitation of the surrogate through egregious contract provisions is remote.

Several instances of surrogacy arrangements between family members or close friends were described to the Joint Subcommittee. The Joint Subcommittee was concerned about the status of children resulting from these arrangements and was convinced that there would be individuals who, for a variety of reasons, would not access the court procedure. Therefore, this proposed act includes a provision governing the requirements for contracts which are not approved by the court in order to protect the status of any resulting children (see § 20-162). The surrogate, her husband, if any, and the intended parents must be parties to the agreement and the contract must be acknowledged (see § 20-162 A 1 and A 2).

Although the intended parents will not be provided the level of protection granted by the court approved contracts, this type of contract might be appealing to individuals who are related to or friends of the surrogate. Under this type of contract, the intended parents only become the parents of any resulting child when the surrogate relinquishes her parental rights and she must wait until the child is twenty-five days old to do so (see § 20-162 A 3). In the event the surrogate decides to keep the child and either of the intended parents is a genetic parent of the resulting child, the intended father will be the legal father of the child unless the surrogate is married and her husband, if any, is a party to the contract (see § 20-158 E 2 and § 20-162 A 4). If neither of the intended parents is a genetic parent of the resulting child or the surrogate exercises her right to retain the custody and parental rights to the child, the surrogate is the mother and her husband, if any and a party to the contract, is the father (see § 20-158 E 3).

Pursuant to a contract which does not have court approval, when the child is twenty-five days old, the surrogate may relinquish her

parental rights by signing a surrogate consent and report form naming the intended parents as the parents of the child (see § 20-162 A 3 and A 4). The form must be filed within sixty days after the birth, along with copies of the contract and a certificate from the physician who performed the assisted conception, stating the genetic relationships between the child, the surrogate, and the intended parents (see § 20-162 A 3 and 4). If there is no genetic relationship between the child and the intended parents or the form is not timely filed, the intended parents may only obtain parental rights through adoption proceedings (see § 20-162 A 4).

The Joint Subcommittee wished to avoid the potential for individuals entering into surrogacy contracts to obtain children because such individuals could not meet the requirements of the adoption law; therefore, without a genetic relationship to the child, the intended parents must pursue adoption. The members also felt that it was desirable to have two parents responsible for the child. For this reason, the court approved agreement must be with a married surrogate mother and her husband must be party to the agreement. In addition, under the noncourt approved agreement, the intended father will be the legal father, if a single mother decides to retain custody of the child and there is a genetic relationship between either of the intended parents and the child.

without a genetic relationship to the child, the intended parents must pursue adoption

In order to protect the surrogate mother and the child, the intended parents incur the same obligations under the noncourt approved contract as with the court approved contract for assuming the reasonable medical and ancillary costs (see §§ 20-160 B 5 and 20-162 B 4). Both types of contracts must include specific provisions concerning the allocation of responsibility for reasonable medical and ancillary costs in the event of termination of the pregnancy or the contract or breach of the contract (see §§ 20-160 B 5 and 20-162 B 4). In the event the contract which has not been approved by the court does not include this allocation of responsibility, the proposed act would statutorily establish such allocation according to the facts of the situation, e.g., the intended parents would be responsible for all these costs for a period of six weeks following the termination, if they consent in writing to terminate the contract (see § 20-162 C).

In addition, these noncourt approved contracts must include, or will be deemed to include, provisions noting that: (1) the intended parents only become the parents of any resulting child when the surrogate relinquishes her parental rights and a new birth certificate is established; (2) the relevant law is incorporated in the agreement; (3) all of the parties have read and understood the contract; (4) all of the parties understand their rights and responsibilities and have knowingly and voluntarily entered into the contract; and (5) agreements for compensation are enforceable and must be paid in full unless the parties have agreed to reasonable terms for adjusting or prorating the compensation in the event of termination of the pregnancy or contract or breach of the contract (see § 20-162 B 1, 2, and 3).

Although the Joint Subcommittee did not wish to take a position in favor of compensation for the surrogate mother, a majority of the members were not in favor of prohibiting such payments. Therefore,

the matter of compensation to the surrogate mother is left up to the contracting parties, regardless of whether court approved or not.

Certain miscellaneous provisions applying to all surrogacy contracts are set forth in § 20-163. For example, pursuant to either type of contract, the surrogate must be solely responsible for the clinical management of the pregnancy (see § 20-163 A). The marriage of a surrogate after the execution of a contract would not affect the validity of the contract and the new husband would not be considered a party to the agreement unless he consented in writing (see § 20-163 B). Upon the transfer of custody and parental rights and responsibilities to the intended parents, they become the legal parents of the child regardless of the physical appearance or health of the child or even whether it is born alive (see § 20-163 C). A child of a surrogate is presumed to result from the performance of the reproductive technology if born to her within 300 days after its performance (§ 20-163 D). This presumption is conclusive unless an action to contest it is filed within two years of the birth of the child. Health care providers are provided immunity from liability for recognizing the surrogate as the mother or the intended parents as the parents of any resulting child (see § 20-163 E). Many of these miscellaneous provisions are borrowed from the Uniform Act.

Section 20-164 reinforces the rights of the resulting child to receive benefits or inherit through those individuals determined by this act as his parents.

During the Joint Subcommittee's discussions, which were frequently extended, a consensus was reached that commercial brokering of surrogacy agreements should be prohibited. Therefore, surrogate brokers, i.e., entities that accept compensation for recruiting or procuring surrogates or making surrogacy arrangements, are prohibited with a violation of this prohibition punishable as a Class 1 misdemeanor (see § 20-165 A). In addition, the broker may be liable to the parties for three times the amount of compensation he has been paid to arrange the contract (see § 20-165 B). The services of an attorney in giving legal advice or preparing a contract are not violations of this prohibition (see § 20-165 C).

Section 32.1-261 of the vital records law is amended to authorize the State Registrar to issue new birth certificates in the names of the intended parents if all of the requirements for transfer of custody and parental rights are met. Consistent with the present exception for the sale of sperm, the prohibition of sale of body parts statute is amended to allow the sale of ova (see § 32.1-289.1 in the proposed act). The State Board of Social Services is authorized to establish fees for the home studies required for the court approved contracts (see § 63.1-236.1 in the proposed act).

VIII. Conclusion

The Joint Subcommittee wishes to make it clear that its members do not advocate surrogacy. However, after receiving much testimony and engaging in long debate, the Joint Subcommittee is convinced that the present uncertain state of the law is unsatisfactory because the incidence of surrogacy arrangements appears to be increasing as reproductive technology advances. The Joint Subcommittee came to believe that the only logical, rational approach to the issues before it was to develop guidelines for governing these agreements, and that a proactive stance would be more beneficial to the citizens of Virginia, particularly the women and children, than to wait until courts are faced with making difficult decisions on these matters.

As already stated, the Joint Subcommittee was faced with three possible options: prohibiting surrogacy, doing nothing, or regulating surrogate practices. An outright prohibition of surrogacy might not eliminate the practice, but could drive it underground or out-of-state, thus perpetuating the legal uncertainties which already exist. These legal uncertainties include, for example, issues related to eligibility for social security benefits, inheritance rights, obligation for support of the resulting children, and, of course, custody rights. Even if surrogacy is outlawed, the legal system still has an obligation to eliminate legal uncertainties to protect the innocent children born of surrogacy agreements. A do-nothing, or laissez faire, approach is problematic because it leaves children born of surrogate mothers in a sort of "legal limbo." Unless the law provides for who the parents of these children will be, the possibility of unanticipated custody disputes will always exist.

The proposed legislation would serve to regulate rather than prohibit the practice of surrogate motherhood in the Commonwealth. The decision to recommend regulation was based primarily on the belief of a majority of the subcommittee members that any prohibition of surrogacy would be likely to drive such practices underground, while doing little to address the complex problems. The Joint Subcommittee reasoned that regulation would protect women from exploitation and protect children by ensuring their status.

One of the primary concerns of the Joint Subcommittee was to ensure, as much as possible, that any child born of a surrogacy agreement would have two parents who would be legally responsible for him.

Assurance of two parents for any resulting child was accomplished by statutorily conferring parentage on the husband of the surrogate in any instance in which a married surrogate mother exercises her right to retain custody and parental rights to the child. Therefore, any husband of

a surrogate must be a party to the contract in order to place him on notice of this potential legal responsibility. Further, the intended father would be the legal father of any resulting child if an unmarried surrogate retains custody and either of the intended parents is genetically related to the child. The Joint Subcommittee was convinced that, by statutorily making any husband of any surrogate potentially the legal father of the resulting child, all couples regardless of the kind of contract desired would seek out married women to serve as surrogate mothers. The Joint Subcommittee reasoned that couples would wish to avoid the risk of the intended father becoming the legal father of the child without having sole custody transferred to the intended parents.

The Joint Subcommittee believes that the Commonwealth has a legitimate, overriding interest in controlling surrogacy arrangements. Further, the Joint Subcommittee maintains that the state's interests in surrogate motherhood can be assured without encroaching upon constitutionally protected rights of privacy and procreative freedom of choice.

The approach to the issues adopted by the majority of the Joint Subcommittee in this legislation is intended to incorporate reasonable procedures allowing for a variety of individual choices while providing protection for the interests of any resulting children and assurances for the welfare of surrogate mothers. However, the proposed Act is not designed to expedite or condone surrogacy agreements, but to provide, in the opinion of a majority of the members of the Subcommittee, a strict and fair regulatory scheme for a practice which is not going to disappear and must be acknowledged as a reality.

The Joint Subcommittee wishes to express its appreciation to the many citizens and experts who have assisted with this study by generously contributing their time, knowledge and opinions.

Respectfully submitted,

Thomas J. Michie, Jr., *Chairman*
Vincent F. Callahan, Jr., *Vice Chairman*
Emilie F. Miller
Richard L. Saslaw
Bernard S. Cohen
Mary A. Marshall
Kenneth R. Melvin
Dr. John A. Board
Dr. Julia E. Connelly

COMMONWEALTH OF VIRGINIA
HOUSE OF DELEGATES
RICHMOND

VINCENT F. CALLAHAN, JR.
6220 NELWAY DRIVE
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THIRTY-FOURTH DISTRICT

COMMITTEE ASSIGNMENTS:
PRIVILEGES AND ELECTIONS
APPROPRIATIONS
CORPORATION, INSURANCE AND BANKING
RULES

STATEMENT OF VINCENT F. CALLAHAN, JR. CONCERNING THE REPORT OF THE JOINT SUBCOMMITTEE STUDYING SURROGATE MOTHERHOOD

May 27, 1990

I am in general agreement with the report and commend my colleagues on the committee and the staff for their efforts in producing such a comprehensive and well-researched analysis of the problem and a legislative solution of far-reaching consequences.

I must take exception, however, with the lack of any prohibition against compensation for the surrogate mother. To me this leaves the door open for commercial surrogacy, regardless of any safeguards against it contained in legislation. To merely object to such a practice is not enough; a legal prohibition should be an integral part of any laws on the subject.

Vincent F. Callahan, Jr.

Statement of Delegate Kenneth R. Melvin

Although I have agreed to append my name to this report, I wish to make it clear that I do not agree with all of the decisions of the Joint Subcommittee.

Statement of Senator Emilie F. Miller

I wish to make it clear that, although I approve this report and agree that it accurately reflects the Joint Subcommittee's proceedings, I do not support the current proposed legislation. During the course of this study, it was emphasized that the Joint Subcommittee did not advocate or support surrogate motherhood; however, we were convinced that the practice will continue and must be regulated. Therefore, our goal was to develop a viable proposal to fill the legal void. I believe that the proposal developed during the first year of the Joint Subcommittee's deliberations reflected this consensus and provided an appropriate regulatory scheme for surrogate motherhood. I object to the revision of this original proposal to include the court approved contract because of my concern that involving the courts will create the public perception that the Joint Subcommittee wishes to place the imprimatur of the Commonwealth on surrogate motherhood.

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In re Baby M, 109 N.J. 396, 537 A. 2d 1227 (N.J. 1988)

Meyer v. Nebraska, 262 U.S. 390 (1923)

Roe v. Wade, 410 U.S. 113 (1973)

Skinner v. Oklahoma, 316 U.S. 535 (1942)

Appendices

Enabling Resolution - 1988
Senate Joint Resolution No. 3
House Joint Resolution No. 118

Enabling Legislation - 1989
Senate Joint Resolution No. 178

Preliminary Legislation - 1989
Senate Bill No. 685

Legislation - 1990
Senate Bill No. 14
House Bill No. 23

1988 SESSION

SENATE JOINT RESOLUTION NO. 3

Establishing a joint subcommittee to study surrogate motherhood.

Agreed to by the Senate, March 11, 1988
Agreed to by the House of Delegates, March 9, 1988

WHEREAS, an estimated ten to fifteen percent of married couples in the nation experience infertility, and the use of new reproductive technologies and procedures has enabled such persons to become biological or surrogate parents; and

WHEREAS, many other childless persons are entering into arrangements to become parents, and surrogate parenting, the contracting of a surrogate to bear the baby for the biological or adoptive parents for remuneration or otherwise, facilitates this end; and

WHEREAS, new reproductive technologies present intricate and complex dilemmas for theologians, geneticists, attorneys, physicians and society in general, such as whether access to certain health care should be limited; and

WHEREAS, although surrogacy contracts generally contain the financial and pregnancy term responsibilities of the couple, the procuror, and the surrogate, the new reproductive technologies have produced uncertainty about the legal status of children born as a result of these arrangements, the legal sufficiency of surrogacy contracts in providing for the necessary health and medical care of the surrogate, and of state laws regarding the responsibilites and rights of the surrogate and the receiving parents; and

WHEREAS, greater public awareness of these technologies and arrangements has heightened concern as to whether a mother can be forced to give up her baby even though she has entered into a surrogacy contract, the efficacy of such contracts and procedures, and further legal questions regarding the limits of the right to privacy, given the need to avoid genetic mismatches and the possibility of prohibited marriages among the offspring of these arrangements; and

WHEREAS, breach of contract, as in the "Baby M" case, has raised perplexing legal, ethical and moral issues, precipitating considerable controversy and national debate over the new reproductive technologies and their potential social effects; and

WHEREAS, it is not certain whether current Virginia law makes surrogate motherhood illegal in the Commonwealth and there are no state regulatory provisions for surrogacy contracts and for the qualifications of brokers for surrogate contracts; and

WHEREAS, because longstanding legal rules governing legitimacy, illegitimacy and paternity have been undergoing substantial change in recent years, and there is a need to establish a state policy concerning the legality of surrogacy contracts and a mechanism for resolving the varied medical, ethical, legal and social problems resulting from such contracts; and

WHEREAS, it is not known whether state law is sufficient to address legal issues inherent in other new procedures in reproductive technology, such as artificial insemination by donor (AID), in vitro fertilization (IVF) with sperm, ova or embryo, embryo transfer and cryopreservation of sperm and embryo; and

WHEREAS, elected officials and the public are unfamiliar with these new reproductive technologies, their social impact and their potential for litigation, thereby hindering effective health and fiscal planning, and the enactment of appropriate statutes to minimize the adverse social effects of surrogacy contracts and other pregnancy arrangements such as "baby selling" and fetal tissue transplants; and

WHEREAS, an understanding of the new reproductive technologies, their potential social impact, and a thorough review of Virginia laws relative to the health, social and legal issues raised by these procedures would enable the Legislature to determine whether surrogacy shall be illegal in Virginia, and to establish state policies for the resolution of problems which may result from the application of such technologies; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That a joint subcommittee be established to study surrogate motherhood. The joint subcommittee shall be composed of nine members to be appointed as follows: two members of the Senate Committee on Education and Health and one member of the Senate Committee for Courts of Justice to be appointed by the Senate Committee on Privileges and Elections, two members of the House Committee on Health, Welfare and Institutions, one member of the House Committee for Courts of Justice and one member of the House of Delegates at-large to be appointed by the Speaker of the House, and two members of the medical profession to be appointed by the Governor, one of whom shall have expertise in reproductive endocrinology as determined by the American Board of Obstetrics and Gynecology, and one of whom shall have expertise in medical ethics. The joint subcommittee shall provide for input from other individuals with expertise in medical research, constitutional law, child

welfare and adoption, contract law, health planning, the behavioral sciences and professional counseling, and medical and social ethics.

The joint subcommittee shall study the medical, legal and social issues raised by surrogate parenting, giving particular attention to:

1. Determining the number of surrogacy contracts made in the Commonwealth and the potential for an increase in such contracts and arrangements;

2. Examining the various new reproductive technologies and assessing their potential effect on health and social policy planning in the Commonwealth;

3. Determining the need for the regulation of such technologies to prevent genetic mishaps and breeding for personal convenience;

4. Determining whether surrogacy contracts shall be legal in Virginia, and if so, how such contracts shall be governed and whether surrogate brokerage shall be lawful;

5. Analyzing the constitutional issues of privacy, protection of the interests of the children conceived through the application of these technologies, the surrogate, the receiving parents and any other adult participants in the new conception and birth processes, and the potential health and social effects of such contracts in the Commonwealth;

6. Assessing the need to limit the number of inseminations and donations to avoid the risk of incestuous unions between the children of such procedures and for genetic tracing;

7. Determining the psychological effect of such procedures on the surrogate, the child conceived by such technologies, and the receiving parents, and assess the need for and feasibility of providing a mechanism for the delivery of appropriate health and counseling services;

8. Reviewing the relevant state laws and policies pertaining to the legal liability of parties involved in executing consent agreements and surrogacy contracts, determining the legal status of children born as a result of such technology vis-a-vis current state law regarding the establishment of paternity, inheritance, state and federal laws and regulations on child support and custody, parental and grandparental visitation rights, child welfare and protective services (e.g. adoption, child abandonment), and the legal sufficiency of current state statutes on informed consent, human research, vital records and health statistics, anatomical gifts, and prohibited marriages relative to surrogacy and other new reproductive technologies; and

9. Other related issues deemed appropriate by the joint subcommittee.

All agencies of the Commonwealth shall provide assistance upon request in the manner deemed appropriate by the joint subcommittee.

The joint subcommittee shall complete its work in time to submit its findings and recommendations to the Governor and to the 1989 General Assembly.

The indirect costs of this study are estimated to be $15,440; the direct costs of this study shall not exceed $11,220.

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President of the Senate

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Speaker of the House of Delegates

Approved:

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Governor

1988 SESSION

HOUSE JOINT RESOLUTION NO. 118

Establishing a joint subcommittee to study surrogate motherhood.

Agreed to by the House of Delegates, March 4, 1988
Agreed to by the Senate, March 2, 1988

WHEREAS, an estimated ten to fifteen percent of married couples in the nation experience infertility and the use of new reproductive technologies and procedures has enabled such persons to become biological or surrogate parents; and

WHEREAS, many other childless persons are entering into arrangements to become parents, and surrogate parenting, the contracting of a surrogate to bear the baby for the biological or adoptive parents for remuneration or otherwise, facilitates this end; and

WHEREAS, new reproductive technologies present intricate and complex dilemmas for theologians, geneticists, attorneys, physicians and society in general, such as whether access to certain health care should be limited; and

WHEREAS, although surrogacy contracts generally contain the financial and pregnancy term responsibilities of the couple, the procuror, and the surrogate, the new reproductive technologies have produced concern about the uncertain legal status of children born as a result of these arrangements, the legal sufficiency of surrogacy contracts in providing for the necessary health and medical care of the surrogate, and of state laws regarding the responsibilities and rights of the surrogate and the receiving parents; and

WHEREAS, greater public awareness of these technologies and arrangements has heightened concern as to whether a mother can be forced to give up her baby even though she has entered into a surrogacy contract, the efficacy of such contracts and procedures, and further legal questions regarding the limits of the right to privacy, given the need to avoid genetic mismatches and the possibility of prohibited marriages among the offspring of these arrangements; and

WHEREAS, breach of contract, as in the "Baby M" case, has raised perplexing legal, ethical and moral issues, precipitating considerable controversy and national debate over the new reproductive technologies and their potential social effects; and

WHEREAS, it is not certain whether current Virginia law makes surrogate motherhood illegal in the Commonwealth, and there are no state regulatory provisions for surrogacy contracts and for the qualifications of brokers for surrogate contracts; and

WHEREAS, because longstanding legal rules governing legitimacy, illegitimacy and paternity have been undergoing substantial change in recent years, and there is a need to establish a state policy concerning the legality of surrogacy contracts and a mechanism for resolving the varied medical, ethical, legal and social problems resulting from such contracts; and

WHEREAS, it is not known whether state law is sufficient to address legal issues inherent in other new procedures in reproductive technology, such as artificial insemination by donor (AID), in vitro fertilization (IVF) with sperm, ova or embryo, embryo transfer and cryopreservation of sperm and embryo; and

WHEREAS, elected officials and the public are unfamiliar with these new reproductive technologies, their social impact and their potential for litigation, thereby hindering effective health and fiscal planning, and the enactment of appropriate statutes to minimize the adverse social effects of surrogacy contracts and other pregnancy arrangements such as "baby selling" and fetal tissue transplants; and

WHEREAS, an understanding of the new reproductive technologies, their potential social impact, and a thorough review of Virginia laws relative to the health, social and legal issues raised by these procedures would enable the Legislature to determine whether surrogacy shall be illegal in Virginia, and to establish state policies for the resolution of problems which may result from the application of such technologies; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That a joint subcommittee be established to study surrogate motherhood. The joint subcommittee shall be composed of nine members to be appointed as follows: two members of the House Committee on Health, Welfare and Institutions, one member of the House Committee for Courts of Justice and one member of the House of Delegates at-large to be appointed by the Speaker of the House, two members of the Senate Committee on Education and Health and one member of the Senate Committee for Courts of Justice to be appointed by the Senate Committee on Privileges and Elections, and two members of the medical profession to be appointed by the Governor, one of whom shall have expertise in reproductive endocrinology as determined by the American Board of Obstetrics and Gynecology, and one of whom shall have expertise in medical ethics. The joint subcommittee shall provide for input from other individuals with expertise in medical research, constitutional law, child

welfare and adoption, contract law, health planning, the behavioral sciences and professional counseling, and medical and social ethics.

The joint subcommittee shall study the medical, legal and social issues raised by surrogate parenting, giving particular attention to:

1. Determining the number of surrogacy contracts made in the Commonwealth and the potential for an increase in such contracts and arrangements;

2. Examining the various new reproductive technologies and assessing their potential effect on health and social policy planning in the Commonwealth;

3. Determining the need for the regulation of such technologies to prevent genetic mishaps and breeding for personal convenience;

4. Determining whether surrogacy contracts shall be legal in Virginia, and if so, how such contracts shall be governed and whether surrogate brokerage shall be lawful;

5. Analyzing the constitutional issues of privacy, protection of the interests of the children conceived through the application of these technologies, the surrogate, the receiving parents and any other adult participants in the new conception and birth processes, and the potential health and social effects of such contracts in the Commonwealth;

6. Assessing the need to limit the number of inseminations and donations to avoid the risk of incestuous unions between the children of such procedures and for genetic tracing;

7. Determining the psychological effect of such procedures on the surrogate, the child conceived by such technologies, and the receiving parents, and assess the need for and feasibility of providing a mechanism for the delivery of appropriate health and counseling services;

8. Reviewing the relevant state laws and policies pertaining to the legal liability of parties involved in executing consent agreements and surrogacy contracts, determining the legal status of children born as a result of such technology vis-a-vis current state law regarding the establishment of paternity, inheritance, state and federal laws and regulations on child support and custody, parental and grandparental visitation rights, child welfare and protective services (e.g. adoption, child abandonment), and the legal sufficiency of current state statutes on informed consent, human research, vital records and health statistics, anatomical gifts, and prohibited marriages relative to surrogacy and other new reproductive technologies; and

9. Other related issues deemed appropriate by the joint subcommittee.

All agencies of the Commonwealth shall provide assistance upon request in the manner deemed appropriate by the joint subcommittee.

The joint subcommittee shall complete its work in time to submit its findings and recommendations to the Governor and to the 1989 General Assembly.

The indirect costs of this study are estimated to be $15,440; the direct costs of this study shall not exceed $11,220.

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President of the Senate

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Speaker of the House of Delegates

Approved:

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Governor

1989 SESSION

SENATE JOINT RESOLUTION NO. 178

Continuing the joint subcommittee studying surrogate motherhood.

Agreed to by the Senate, January 31, 1989
Agreed to by the House of Delegates, February 22, 1989

WHEREAS, Senate Joint Resolution 3 and House Joint Resolution 118, introduced during the 1988 Session of the Virginia General Assembly, established a joint subcommittee to study surrogate motherhood, a unique interpersonal arrangement that enables individuals who are unable to have a child to become parents; and

WHEREAS, the joint subcommittee was directed to determine the number of surrogacy contracts made in the Commonwealth and the potential for an increase in such arrangements; determine whether surrogacy contracts and surrogate brokerage shall be legal in Virginia, and, if so, how such practices shall be governed; examine the various new reproductive technologies and assess the potential effect of such technologies on health and social policy planning in the Commonwealth; analyze the constitutional issues of privacy, protection of children born of new reproductive technologies, the surrogate, the receiving parents and any other adult participants in these arrangements, the potential health and social effects of such arrangements on the Commonwealth and any other related issues deemed appropriate; and

WHEREAS, during the course of its work the joint subcommittee received testimony from medical experts engaged in reproductive technology and research, representatives of religious faiths in the Commonwealth, personal testimony from concerned citizens of the Commonwealth and surrogate mothers residing in other states, and representatives of state and national organizations; and

WHEREAS, in its deliberations the joint subcommittee identified policy issues and came to understand many issues other than surrogate motherhood such as the sale of embryos, sperm and ova; and

WHEREAS, the joint subcommittee developed legislation to address a number of these issues for recommendation to the 1989 Session of the General Assembly; and

WHEREAS, however, due to the complexity of the legal, social, moral and ethical issues posed by the new reproductive technologies, which may substantially impact the fabric of society, further assessment of these issues in a thorough and judicious manner would be in the interests of sound public policy; and

WHEREAS, it is the consensus of the joint subcommittee that the need for and the development and implementation of a comprehensive response to the issues posed by the new reproductive technologies deserves careful planning and consideration; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the joint subcommittee studying surrogate motherhood be continued. The current membership of the joint subcommittee shall continue to serve. The joint subcommittee shall in its deliberations evaluate the issues related to the new reproductive technologies including, but not limited to, disposal of excess embryos, sale of genetic materials, genetic record keeping, limitations on the use of a single donor's genetic materials, the transfer of cryogenically stored embryos to individuals who are genetically unrelated to the donor(s) and other related issues deemed appropriate by the joint subcommittee.

The joint subcommittee shall complete its work in time to submit its findings and recommendations to the Governor and to the 1990 General Assembly.

The indirect costs of this study are estimated to be $13,465; the direct costs of this study shall not exceed $8,100.

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6 **SENATE BILL NO. .... HOUSE BILL NO. ....**

7 A BILL to amend and reenact §§ 32.1-261 and 32.1-289.1 of the Code of Virginia and to
8 amend the Code of Virginia by adding in Title 20 a chapter numbered 9, consisting of
9 sections numbered 20-156 through 20-161, relating to vital records, anatomical gifts and
10 surrogate motherhood; penalty.
11 Be it enacted by the General Assembly of Virginia:
12 1. That §§ 32.1-261 and 32.1-289.1 of the Code of Virginia are amended and reenacted and
13 that the Code of Virginia is amended by adding in Title 20 a chapter numbered 9,
14 consisting of sections numbered 20-156 through 20-161, as follows:

15 *CHAPTER 9.*

16 *SURROGATE MOTHERHOOD ACT.*

17 *§ 20-156. Definitions.—As used in this chapter unless the context requires a different*
18 *meaning:*
19 *"Child" means one or more children born pursuant to a surrogacy contract.*
20 *"Compensation" means payment of any valuable consideration for services but does*
21 *not include the payment of reasonable medical and ancillary costs.*
22 *"Cryopreservation" means freezing and storing of gametes and embryos for possible*
23 *future use in reproductive technology.*
24 *"Donor" means any individual unrelated by marriage to the recipient who contributes*
25 *the sperm or egg used in any reproductive technology.*
26 *"Gamete" means either a sperm or an ovum.*
27 *"Gestational mother" means the woman who gives birth to a child, regardless of her*
28 *genetic relationship to the child.*
29 *"Embryo" means the organism resulting from the union of a sperm and an ovum from*
30 *first cell division until approximately the end of the second month of gestation.*
31 *"Embryo transfer" means the placing of a viable embryo into the uterus of a*
32 *gestational mother.*
33 *"Infertility" means the inability to conceive after one year of unprotected sexual*
34 *intercourse.*
35 *"Intended parent or parents" means any person or persons who enter into a surrogacy*
36 *contract with a surrogate mother under the terms of which the parental rights to a child*
37 *to be carried by the surrogate mother are to be transferred to the intended parent or*
38 *parents, regardless of the genetic relationships between the intended parent or parents, the*
39 *surrogate mother and the child. At least one of the intended parents must be the genetic*
40 *parent of any resulting child.*
41 *"In vitro" means any process which can be observed in an artificial environment such*
42 *as a test tube or tissue culture plate.*
43 *"In vitro fertilization" means the fertilization of ova by sperm in an artificial*
44 *environment.*
45 *"In vivo" means any process occurring within the living body.*
46 *"Ovum" means the female gamete or reproductive cell prior to fertilization.*
47 *"Reasonable medical and ancillary costs" means the payment of the costs of the*
48 *performance of any reproductive technology, the costs of prenatal maternal health care,*
49 *the costs of maternal and child health care for a reasonable post partum period of not*
50 *less than six months, and the reasonable costs for medications, maternity clothes, and any*
51 *additional costs for housing and other living expenses attributable to the pregnancy.*
52 *"Reproductive technology" means any intervening medical technology used to achieve*
53 *pregnancy, whether in vivo or in vitro, which replaces sexual intercourse completely or*
54 *partially as the means of conception. Such intervening medical technology includes, but*

may not be limited to, conventional medical and surgical treatment as well as noncoital reproductive technology such as artificial insemination by husband, artificial insemination by donor, cryopreservation of gametes and embryos, in vitro fertilization, uterine embryo lavage, embryo transfer, gamete intrafallopian tube transfer, and low tubal ovum transfer.

"Sperm" means the male gametes or reproductive cells, which impregnate the ova.

"Surrogacy arrangement" means an oral or written agreement, promise, understanding or other accord not conforming with the provisions of this chapter between the intended parent or parents, a surrogate mother and a surrogate father, if any, in which the surrogate mother agrees to be impregnated through the use of any reproductive technology or naturally through sexual intercourse, to carry any resulting fetus and to relinquish to the intended parent or parents the custody of and parental rights to any resulting child.

"Surrogacy contract" means a written agreement conforming with the provisions of this chapter between the intended parent or parents, a surrogate mother and a surrogate father, if any, in which the surrogate mother agrees to be impregnated through the use of any reproductive technology or naturally through sexual intercourse, to carry any resulting fetus and to relinquish to the intended parent or parents the custody of and parental rights to any resulting child.

"Surrogate broker" means any person, partnership, corporation or other entity accepting compensation for recruiting or procuring surrogate mothers, or for developing surrogacy arrangements between intended parents and surrogate mothers or who otherwise arranges, induces or assists any intended parent or intended parents or surrogate mother to enter into a surrogacy contract or arrangement. The services of an attorney in giving legal advice or in preparing a surrogacy contract shall not be deemed to be within this definition.

"Surrogate father" means any man married to and living with any woman who agrees to be a surrogate mother.

"Surrogate mother" means any woman at least eighteen years of age, who agrees to bear a child carried for intended parents, regardless of the genetic relationship between such woman and the child.

§ 20-157. Virginia law to control; surrogacy omnibus clause.—The provisions of this chapter shall control, without exception, in any case involving a child born in this Commonwealth of a surrogacy contract or arrangement, in the case of any surrogacy contract or arrangement made or performed, in whole or in part, in this Commonwealth, in any case in which any party to the contract or arrangement resides in this Commonwealth, in any custody, support, inheritance or parentage action involving a surrogacy contract or arrangement and in any attempt to enforce or adjudicate any surrogacy contract or arrangement in the courts of this Commonwealth.

Any provision in a surrogacy contract or arrangement which attempts to reduce the rights of the surrogate mother or any resulting child shall be construed to include the requirements set forth in this chapter.

§ 20-158. Surrogate brokers prohibited; penalty.—It shall be unlawful for any person, partnership, corporation or other entity to act as a surrogate broker in this Commonwealth. Any violation of this prohibition shall be punishable upon conviction as a Class 1 misdemeanor. In addition, in the discretion of the court, any person convicted of violating this provision may be subject to a civil penalty not to exceed $10,000 for each violation.

§ 20-159. Surrogacy contract requirements.—Every surrogacy contract shall be signed and acknowledged by an officer or other person authorized by law to take acknowledgements and shall:

1. Incorporate by reference the provisions of this chapter;

2. State that, prior to the signing of the surrogacy contract, the parties have been instructed about Virginia law and fully understand their rights and responsibilities;

3. State that the parties have freely given voluntary and informed consent to the

requirements of the surrogacy contract;

4. State that, prior to signing the surrogacy contract, the intended parent or parents, the surrogate mother and the surrogate father, if any, have submitted to physical examinations and psychological evaluations by practitioners licensed to perform such services pursuant to Title 54.1 of this Code;

5. Contain adequate provisions to guarantee the payment of reasonable medical and ancillary costs either in the form of insurance, cash, escrow, bonds or other arrangements satisfactory to the parties;

6. Include any surrogate father as a party to the surrogacy contract.

No surrogacy contract shall be invalid because it provides for the payment of compensation to the surrogate mother.

§ 20-160. Rights and responsibilities of the parties.—The parties to a surrogacy contract or arrangement shall have the following rights and responsibilities:

1. If neither of the intended parents is a genetic parent of any resulting child, they may only obtain parental rights to the resulting child through the proceedings for adoption in this Commonwealth as set forth in Chapter 11 of Title 63.1 of this Code.

2. The intended parent or parents, the surrogate mother and the surrogate father, if any, shall have access to the records of any physical examinations and psychological evaluations.

3. The surrogate mother shall be solely responsible for the clinical management of the pregnancy including the administration of any tests to the fetus such as amniocentesis and any decision with respect to the termination of the pregnancy.

4. The intended parents shall be responsible for the payment of all reasonable medical and ancillary expenses for the surrogate mother and any resulting child incurred during the performance of the reproductive technology, during the pregnancy and for a reasonable post partum period of not less than six months.

5. The intended parent or parents shall have the custody of, parental rights to and full responsibilities for any child resulting from a surrogacy contract upon the relinquishing of the custody of and parental rights to any such child by the surrogate mother regardless of the child's health, physical appearance, any mental or physical handicap, and regardless of whether the child is born alive.

5. At any time not less than ten days after the birth of the child, the surrogate mother may relinquish her parental rights to the child to the intended parent or parents by signing a surrogate parent consent and report form obtained from the State Registrar of Vital Records which shall be acknowledged by an officer or other person authorized by law to take acknowledgements. A copy of the surrogacy contract or arrangement shall be attached to the form.

6. It shall be the responsibility of the intended parent or parents to file the surrogate parent consent and report form with the State Registrar. A certificate from the physician who performed the reproductive technology shall be filed with the consent and report form. This certificate shall state the genetic relationships between the intended parent or parents, the surrogate mother and the child and shall name the reproductive technology used.

7. Upon the filing of the surrogate parent consent and report form, a new birth certificate shall be established by the State Registrar for the child giving the names of the intended parent or parents as the parent or parents of the child as provided in § 32.1-261. The State Registrar of Vital Records shall not be required to establish a new birth certificate as provided in this section and § 32.1-261 without court order unless the surrogate parent consent and report form is received within sixty days of the birth of the child.

8. In any case in which the surrogate mother does not relinquish her parental rights to the resulting child to the intended parent or parents within sixty days of the birth of the child, the child shall thereafter be the child of the surrogate mother and the intended father or the surrogate father, if any. Any termination of parental rights after such date

1 *shall be with court approval and shall be conducted in accordance with the adoption laws*
2 *of this Commonwealth.*
3 *§ 20-161. Determination of parentage.—The parentage of any child resulting from a*
4 *surrogacy contract shall be determined as follows:*
5 *1. The gestational mother of a child is the child's mother.*
6 *2. The intended father of a child is the child's father unless there is a surrogate father*
7 *and the surrogate mother exercises her right to retain custody of and parental rights to*
8 *the child.*
9 *3. The surrogate father, if any, is conclusively presumed to be the child's father, if the*
10 *surrogate mother exercises her right to retain custody of and parental rights to the child.*
11 *4. A donor is not the parent of a child conceived through reproductive technology*
12 *unless the donor is also party to a surrogacy contract as one of the intended parents.*
13 § 32.1-261. New birth certificate established on proof of adoption, legitimation or
14 determination of paternity.—A. The State Registrar shall establish a new certificate of birth
15 for a person born in this Commonwealth upon receipt of the following:
16 1. An adoption report as provided in § 32.1-262, a report of adoption prepared and filed
17 in accordance with the laws of another state or foreign country, or a certified copy of the
18 decree of adoption together with the information necessary to identify the original
19 certificate of birth and to establish a new certificate of birth; except that a new certificate
20 of birth shall not be established if so requested by the court decreeing the adoption, the
21 adoptive parents, or the adopted person if eighteen years of age or older.
22 2. A request that a new certificate be established and such evidence as may be
23 required by regulation of the Board proving that such person has been legitimated or that
24 a court of the Commonwealth has, by final order, determined the paternity of such person.
25 The request shall state that no appeal has been taken from the final order and that the
26 time allowed to perfect an appeal has expired.
27 *3. A surrogate parent consent and report form as required by § 20-160. The report*
28 *shall contain sufficient information to identify the original certificate of birth and to*
29 *establish a new certificate of birth in the name or names of the intended parent or*
30 *intended parents.*
31 B. When a new certificate of birth is established pursuant to subsection A of this
32 section, the actual place and date of birth shall be shown. It shall be substituted for the
33 original certificate of birth. Thereafter, the original certificate and the evidence of
34 adoption, paternity or legitimation shall be sealed and filed and not be subject to inspection
35 except upon order of a court of this Commonwealth or in accordance with § 32.1-252.
36 B1. Upon receipt of a report of an amended decree of adoption, the certificate of birth
37 shall be amended as provided by regulation.
38 C. Upon receipt of notice or decree of annulment of adoption, the original certificate of
39 birth shall be restored to its place in the files and the new certificate and evidence shall
40 not be subject to inspection except upon order of a court of this Commonwealth or in
41 accordance with § 32.1-252.
42 D. The State Registrar shall establish and register a Virginia certificate of birth for a
43 person born in a foreign country and for whom a final order of adoption has been entered
44 in a court of this Commonwealth when the State Registrar receives an adoption report as
45 provided in § 32.1-262 and a request that such a certificate be established and registered;
46 however, a Virginia certificate of birth shall not be established or registered if so
47 requested by the court decreeing the adoption, the adoptive parents or the adopted person
48 if eighteen years of age or older. After registration of the birth certificate in the new
49 name of the adopted person, the State Registrar shall seal and file the report of adoption
50 which shall not be subject to inspection except upon order of a court of this
51 Commonwealth or in accordance with § 32.1-252. The birth certificate shall show the true
52 or probable foreign country of birth and shall state that the certificate is not evidence of
53 United States citizenship for the child for whom it is issued or for the adoptive parents.
54 E. If no certificate of birth is on file for the person for whom a new certificate is to

be established under this section, a delayed certificate of birth shall be filed with the State Registrar as provided in § 32.1-259 or § 32.1-260 before a new certificate of birth is established, except that when the date and place of birth and parentage have been established in the adoption proceedings, a delayed certificate shall not be required.

§ 32.1-289.1. Sale of body parts prohibited; exceptions; penalty.—With the exception of hair, *ova*, blood and other self-replicating body fluids, it shall be unlawful for any person to sell, to offer to sell, to buy, to offer to buy or to procure through purchase any natural body part for any reason including, but not limited to, medical and scientific uses such as transplantation, implantation, infusion or injection. Nothing in this section shall prohibit the reimbursement of expenses associated with the removal and preservation of any natural body parts for medical and scientific purposes. This section shall not apply to any transaction pursuant to Article 3 (§ 32.1-298 et seq.), Chapter 8 of this title.

Any person engaging in any of these prohibited activities shall be guilty of a Class 6 felony.

Official Use By Clerks

Passed By The Senate		**Passed By The House of Delegates**	
without amendment	☐	without amendment	☐
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐

Date: ______________________ Date: ______________________

Clerk of the Senate Clerk of the House of Delegates

LD0848125

SENATE BILL NO. 14

Offered January 10, 1990
Prefiled January 9,1990

A BILL to amend and reenact §§ 32.1-261, 32.1-289.1, and 63.1-236.1 of the Code of Virginia and to amend the Code of Virginia by adding in Title 20 a Chapter numbered 9, consisting of sections numbered 20-156 through 20-165, relating to assisted conception; penalty.

Patrons—Michie and Saslaw; Delegates: Cohen and Byrne

Referred to the Committee for Courts of Justice

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-261, 32.1-289.1, and 63.1-236.1 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Title 20 a Chapter numbered 9, consisting of sections numbered 20-156 through 20-165, as follows:

CHAPTER 9.

STATUS OF CHILDREN OF ASSISTED CONCEPTION.

§ 20-156. Definitions.—As used in this chapter unless the context requires a different meaning:

"Assisted conception" means a pregnancy resulting from any intervening medical technology, other than the pregnancy of a woman resulting from the insemination of her ovum using her husband's sperm, whether in vivo or in vitro, which replaces sexual intercourse completely or partially as the means of conception. Such intervening medical technology includes, but is not limited to, conventional medical and surgical treatment as well as noncoital reproductive technology such as artificial insemination by donor, cryopreservation of gametes and embryos, in vitro fertilization, uterine embryo lavage, embryo transfer, gamete intrafallopian tube transfer, and low tubal ovum transfer.

"Child" means one or more children born pursuant to a surrogacy contract.

"Compensation" means payment of any valuable consideration for services in excess of reasonable medical and ancillary costs.

"Cryopreservation" means freezing and storing of gametes and embryos for possible future use in assisted conception.

"Donor" means an individual, other than a surrogate, unrelated by marriage to the recipient who contributes the sperm or egg used in assisted conception.

"Gamete" means either a sperm or an ovum.

"Gestational mother" means the woman who gives birth to a child, regardless of her genetic relationship to the child.

"Embryo" means the organism resulting from the union of a sperm and an ovum from first cell division until approximately the end of the second month of gestation.

"Embryo transfer" means the placing of a viable embryo into the uterus of a gestational mother.

"Infertile" means the inability to conceive after one year of unprotected sexual intercourse.

"Intended parents" means a man and a woman, married to each other, who enter into an agreement with a surrogate under the terms of which they will be the parents of any child born to the surrogate through assisted conception regardless of the genetic relationships between the intended parents, the surrogate, and the child.

"In vitro" means any process that can be observed in an artificial environment such as a test tube or tissue culture plate.

"In vitro fertilization" means the fertilization of ova by sperm in an artificial environment.

"In vivo" means any process occurring within the living body.

"Ovum" means the female gamete or reproductive cell prior to fertilization.

1 *"Reasonable medical and ancillary costs" means the costs of the performance of*
2 *assisted conception, the costs of prenatal maternal health care, the costs of maternal and*
3 *child health care for a reasonable post partum period, the reasonable costs for medications*
4 *and maternity clothes, and any additional costs for housing and other living expenses*
5 *attributable to the pregnancy.*
6 *"Sperm" means the male gametes or reproductive cells, which impregnate the ova.*
7 *"Surrogacy contract" means an agreement between intended parents, a surrogate, and*
8 *her husband, if any, in which the surrogate agrees to be impregnated through the use of*
9 *assisted conception, to carry any resulting fetus, and to relinquish to the intended parents*
10 *the custody of and parental rights to any resulting child.*
11 *"Surrogate" means any adult woman who agrees to bear a child carried for intended*
12 *parents.*
13 *§ 20-157. Virginia law to control; surrogacy omnibus clause.—The provisions of this*
14 *chapter shall control, without exception, in any action brought in the courts of this*
15 *Commonwealth to enforce or adjudicate any rights or responsibilities arising under this*
16 *chapter.*
17 *Any provision in a surrogacy contract that attempts to reduce the rights or*
18 *responsibilities of the intended parents, surrogate, or her husband, if any, or the rights of*
19 *any resulting child shall be reformed to include the requirements set forth in this chapter.*
20 *§ 20-158. Effects of death or dissolution of marriage; parentage .—A. Any child*
21 *resulting from the insemination of a wife's ovum using her husband's sperm, with his*
22 *consent, is the child of the husband and wife notwithstanding that, during the ten-month*
23 *period immediately preceding the birth, either party died or filed for a divorce or*
24 *annulment.*
25 *However, any person who dies before in utero implantation of an embryo resulting*
26 *from the union of his sperm or her ovum with another gamete, whether or not the other*
27 *gamete is that of the person's spouse, is not the parent of any resulting child unless (i)*
28 *implantation occurs before notice of the death can reasonably be communicated to the*
29 *physician performing the procedure or (ii) the person consents to be a parent in writing*
30 *executed before the implantation.*
31 *In addition, any person who is a party to an action for divorce or annulment*
32 *commenced by filing before in utero implantation of an embryo resulting from the union*
33 *of his sperm or her ovum with another gamete, whether or not the other gamete is that*
34 *of the person's spouse, is not the parent of any resulting child unless (i) implantation*
35 *occurs before notice of the filing can reasonably be communicated to the physician*
36 *performing the procedure or (ii) the person consents to be a parent in writing executed*
37 *before or after the implantation.*
38 *B. In the absence of an agreement between the parties to the contrary, an embryo*
39 *resulting from the union of the sperm or ovum of a party to an action for divorce or*
40 *annulment of a marriage with another gamete, with the consent of the other party,*
41 *whether or not the gamete is that of the other party, is not the property of either party*
42 *and neither party shall be granted access to or possession of such embryo pending or*
43 *upon dissolution of the marriage. In the absence of an agreement to the contrary between*
44 *the entity having physical custody or possession of the embryo and the parties, upon*
45 *receipt of notice of death of a person who contributed the sperm or ovum used to*
46 *produce the embryo or for whom the embryo was produced, such entity shall be under no*
47 *obligation to maintain the embryo and shall not grant access to or possession of the*
48 *embryo to the surviving spouse or to either of the parties to the dissolution.*
49 *C. Except and as provided in subsections A, B, D, and E of this section, the parentage*
50 *of any child resulting from the performance of assisted conception shall be determined as*
51 *follows:*
52 *1. The gestational mother of a child is the child's mother.*
53 *2. The husband of the gestational mother of a child is the child's father,*
54 *notwithstanding any declaration of invalidity or annulment of the marriage obtained after*

1 *the performance of assisted conception, unless he commences an action within two years*
2 *after he discovers or, in the exercise of due diligence, reasonably should have discovered*
3 *the child's birth in which the mother and child are parties and in which it is determined*
4 *that he did not consent to the performance of assisted conception.*
5 *3. A donor is not the parent of a child conceived through assisted conception.*
6 *D. After the approval of a surrogacy contract by the court as provided in subsection B*
7 *of § 20-160, the parentage of any resulting child shall be determined as follows:*
8 *1. Upon the entry of an order as provided in subsection E of § 20-160, the intended*
9 *parents shall be the parents of any resulting child and the surrogate and her husband*
10 *shall not be the parents of the child.*
11 *2. If, after notice of termination by the surrogate, the court vacates the order*
12 *approving the agreement pursuant to subsection B of § 20-161, the surrogate is the*
13 *mother of the resulting child and her husband is the father, and the intended parents may*
14 *only obtain parental rights through adoption as provided in Chapter 11 (§ 63.1-220 et seq.)*
15 *of Title 63.1.*
16 *E. In the case of a surrogacy contract that has not been approved by a court as*
17 *provided in § 20-160, the parentage of any resulting child shall be determined as follows:*
18 *1. The gestational mother is the child's mother.*
19 *2. If either of the intended parents is a genetic parent of the resulting child, the*
20 *intended father is the child's father unless (i) the surrogate is married, (ii) her husband is a*
21 *party to the surrogacy contract, and (iii) the surrogate exercises her right to retain*
22 *custody and parental rights to the resulting child pursuant to § 20-162.*
23 *3. If neither of the intended parents is a genetic parent of the resulting child or the*
24 *surrogate exercises her right to retain custody and parental rights to the resulting child,*
25 *the surrogate is the mother and her husband, if any, and if he is a party to the contract,*
26 *is the child's father and the intended parents may only obtain parental rights through*
27 *adoption as provided in Chapter 11 (§ 63.1-220 et seq.) of Title 63.1.*
28 *4. After the signing and filing of the surrogate consent and report form in conformance*
29 *with the requirements of subsection A of § 20-162, the intended parents are the parents of*
30 *the child and the surrogate and her husband, if any, shall not be the parents of the child.*
31 *§ 20-159. Surrogacy contracts permissible.—A. A surrogate, her husband, if any, and*
32 *prospective intended parents may enter into a written agreement whereby the surrogate*
33 *may relinquish all her rights and duties as parent of a child conceived through assisted*
34 *conception, and the intended parents may become the parents of the child as provided in*
35 *subsection D or E of § 20-158.*
36 *B. Surrogacy contracts may be approved by the court as provided in § 20-160. Any*
37 *surrogacy contract that has not been approved by the court as provided in § 20-160 shall*
38 *be governed by the provisions of §§ 20-156 through 20-159 and §§ 20-162 through 20-165.*
39 *§ 20-160. Court approved surrogacy contracts; petition and hearing for approval of*
40 *surrogacy contract; requirements; orders.—A. Prior to the performance of assisted*
41 *conception, the intended parents, the surrogate, and her husband may join in a petition to*
42 *the circuit court of the county or city in which at least one of the parties resides. The*
43 *surrogacy contract shall be signed by all the parties and acknowledged before an officer or*
44 *other person authorized by law to take acknowledgments.*
45 *A copy of the contract shall be attached to the petition. The court shall appoint a*
46 *guardian ad litem to represent the interests of any resulting child and may appoint*
47 *counsel to represent the surrogate.*
48 *All hearings and proceedings conducted under this section shall be held in camera, and*
49 *all court records shall be confidential and subject to inspection only under the standards*
50 *applicable to adoptions as provided in § 63.1-235. The court conducting the proceedings*
51 *shall have exclusive and continuing jurisdiction of all matters arising out of the surrogacy*
52 *contract until any child born after entry of an order under subsection B of this section is*
53 *six months old.*
54 *B. The court shall hold a hearing on the petition and shall enter an order approving*

1 *the surrogacy contract, authorizing the performance of assisted conception for a period of*
2 *twelve months after the date of the order, and may discharge the guardian ad litem and*
3 *attorney for the surrogate upon finding that:*
4 *1. The court has jurisdiction in accordance with § 20-157;*
5 *2. A local department of social services or welfare or a licensed child-placing agency*
6 *has conducted a home study of the intended parents, the surrogate, and her husband, and*
7 *has filed a report of this home study with the court;*
8 *3. The intended parents, the surrogate, and her husband meet the standards of fitness*
9 *applicable to adoptive parents;*
10 *4. All the parties have voluntarily entered into the surrogacy contract and understand*
11 *its terms and the nature, meaning, and effect of the proceeding;*
12 *5. The agreement contains adequate provisions to guarantee the payment of reasonable*
13 *medical and ancillary costs either in the form of insurance, cash, escrow, bonds, or other*
14 *arrangements satisfactory to the parties, including allocation of responsibility for such*
15 *costs in the event of termination of the pregnancy, termination of the contract pursuant*
16 *to § 20-161, or breach of the contract by any party;*
17 *6. The surrogate is married and has had at least one pregnancy, and has experienced*
18 *at least one live birth, and that medical evidence supports that bearing another child does*
19 *not pose an unreasonable risk to her physical or mental health or that of any resulting*
20 *child;*
21 *7. Prior to signing the surrogacy contract, the intended parents, the surrogate, and her*
22 *husband have submitted to physical examinations and psychological evaluations by*
23 *practitioners licensed to perform such services pursuant to Title 54.1 of this Code and that*
24 *the court and all parties have been given access to the records of the physical*
25 *examinations and psychological evaluations;*
26 *8. The intended mother is infertile, unable to bear a child, or is unable to do so*
27 *without unreasonable risk to the unborn child or to the physical or mental health of the*
28 *intended mother or the child. This finding shall be supported by medical evidence;*
29 *9. At least one of the intended parents is expected to be the genetic parent of any*
30 *child resulting from the agreement;*
31 *10. The husband of the surrogate is a party to the surrogacy agreement;*
32 *11. All parties have received counseling concerning the effects of the surrogacy by a*
33 *qualified health care professional or social worker and a report containing conclusions*
34 *about the capacity of the parties to enter into and fulfill the agreement has been filed*
35 *with the court; and*
36 *12. The agreement would not be substantially detrimental to the interests of any of the*
37 *affected persons.*
38 *C. Unless otherwise provided in the surrogacy contract, all court costs, counsel fees,*
39 *and other costs and expenses associated with the hearing, including the costs of the home*
40 *study, shall be assessed against the intended parents.*
41 *D. A provision in any such contract that provides for compensation to the surrogate*
42 *shall be enforceable and compensation shall be placed in escrow and paid in full unless*
43 *the parties have agreed on reasonable terms for adjusting or prorating the compensation*
44 *in the event of termination of the pregnancy, termination of the contract pursuant to §*
45 *20-161, or breach of the contract by any party.*
46 *E. Within seven days of the birth of any resulting child, the intended parents shall file*
47 *a written notice with the court that the child was born to the surrogate within 300 days*
48 *after the last performance of assisted conception. Upon the filing of this notice and a*
49 *finding that at least one of the intended parents is the genetic parent of the resulting*
50 *child as substantiated by medical evidence, the court shall enter an order directing the*
51 *State Registrar of Vital Records to issue a new birth certificate naming the intended*
52 *parents as the parents of the child pursuant to § 32.1-261.*
53 *If evidence cannot be produced that at least one of the intended parents is the genetic*
54 *parent of the resulting child, the court shall not enter an order directing the issuance of a*

new birth certificate naming the intended parents as the parents of the child, and the surrogate and her husband shall be the parents of the child.

§ 20-161. Termination of court approved surrogacy contract.—A. Subsequent to an order entered pursuant to subsection B of § 20-160, but before the surrogate becomes pregnant through the use of assisted conception, the court for cause, or the surrogate, her husband, or the intended parents may terminate the agreement by giving written notice of termination to all other parties and by filing notice of the termination with the court. Upon receipt of the notice, the court shall vacate the order entered under subsection B of § 20-160.

B. Within 180 days after the last performance of any assisted conception, the surrogate may terminate the agreement by filing written notice with the court. The court shall vacate the order entered pursuant to subsection B of § 20-160 upon finding, after notice to the parties to the agreement and a hearing, that the surrogate has voluntarily terminated the agreement and that she understands the effects of the termination.

Unless otherwise provided in the contract as approved, the surrogate shall incur no liability to the intended parents for exercising her rights of termination.

§ 20-162. Contracts not approved by the court; requirements.—A. In the case of any surrogacy agreement for which prior court approval has not been obtained pursuant to § 20-160, the provisions of this section and §§ 20-156 through 20-159 and §§ 20-163 through 20-165 shall apply. Such surrogacy contracts shall be valid and enforceable only as follows:

1. The surrogate, her husband, if any, and the intended parents shall be parties to any such surrogacy contract.

2. The contract shall be in writing, signed by all the parties, and acknowledged before an officer or other person authorized by law to take acknowledgments.

3. Upon expiration of twenty-five days following birth of any resulting child, the surrogate may relinquish her parental rights to the intended parents, if at least one of the intended parents is the genetic parent of the child, by signing a surrogate consent and report form naming the intended parents as the parents of the child. The form shall be obtained from the State Registrar of Vital Records and shall be signed and acknowledged before an officer or other person authorized by law to take acknowledgments. The form, a copy of the contract, and a certificate from the physician who performed the assisted conception stating the genetic relationships between the child, the surrogate, and the intended parents shall be filed with the State Registrar within sixty days after the birth.

4. Upon the filing of the surrogate consent and report form and the required attachments, a new birth certificate shall be established by the State Registrar for the child naming the intended parents as the parents of the child as provided in § 32.1-261. However, the State Registrar of Vital Records shall not establish a new birth certificate as provided in this subdivision and § 32.1-261 without court order unless the surrogate consent and report form is received within sixty days after the birth of the child and the physician's certificate provides medical evidence that at least one of the intended parents is the genetic parent of the child.

B. Any contract governed by the provisions of this section shall include or, in the event such provisions are not explicitly covered in the contract or are included but are inconsistent with this section, shall be deemed to include the following provisions:

1. The intended parents shall be the parents of any resulting child only when the surrogate relinquishes her parental rights as provided in subdivision A 3 of this section and a new birth certificate is established as provided in subdivision A 4 of this section and § 32.1-261;

2. Incorporation of this chapter and a statement by each of the parties that they have read and understood the contract, they know and understand their rights and responsibilities under Virginia law, and the contract was entered into knowingly and voluntarily;

3. A provision in any contract that provides for compensation to the surrogate shall be enforceable and compensation shall be paid in full unless the parties have agreed on

1 *reasonable terms for adjusting or prorating the compensation in the event of termination*
2 *of the pregnancy, termination of the contract, or breach of the contract by any party; and*
3 *4. A guarantee by the intended parents for payment of reasonable medical and*
4 *ancillary costs either in the form of insurance, cash, escrow, bonds, or other arrangements*
5 *satisfactory to the parties, including allocation of responsibility for such costs in the event*
6 *of termination of the pregnancy, termination of the contract, or breach of the contract by*
7 *any party.*
8 *C. Under any contract that does not include an allocation of responsibility for*
9 *reasonable medical and ancillary costs in the event of termination of the pregnancy,*
10 *termination of the contract, or breach of the contract by any party, the following*
11 *provisions shall control:*
12 *1. If the intended parents and the surrogate and her husband, if any, and if he is a*
13 *party to the contract, consent in writing to termination of the contract, the intended*
14 *parents are responsible for all reasonable medical and ancillary costs for a period of six*
15 *weeks following the termination.*
16 *2. If the pregnancy is terminated by an elective abortion or the surrogate terminates*
17 *the contract during the pregnancy, the intended parents shall be responsible for one-half of*
18 *the reasonable medical and ancillary costs incurred prior to the elective abortion or*
19 *termination.*
20 *3. If, after the birth of any resulting child, the surrogate fails to relinquish parental*
21 *rights to the intended parents pursuant to a contract which has not received prior court*
22 *approval, the intended parents shall be responsible for one-half of the reasonable medical*
23 *and ancillary costs incurred prior to the birth.*
24 *§ 20-163. Miscellaneous provisions related to all surrogacy contracts.—A. The surrogate*
25 *shall be solely responsible for the clinical management of the pregnancy including the*
26 *administration of any test to the fetus such as amniocentesis and any decision with*
27 *respect to the termination of the pregnancy.*
28 *B. After the entry of an order under subsection B of § 20-160 or upon the execution of*
29 *a contract pursuant to § 20-162, the marriage of the surrogate shall not affect the validity*
30 *of the order or contract and her husband shall not be deemed a party to the contract in*
31 *the absence of his explicit written consent.*
32 *C. Following the entry of an order pursuant to subsection D of § 20-160 or upon the*
33 *relinquishing of the custody of and parental rights to any resulting child and the filing of*
34 *the surrogate consent and report form as provided in § 20-162, the intended parents shall*
35 *have the custody of, parental rights to, and full responsibilities for any child resulting*
36 *from the performance of assisted conception from a surrogacy agreement regardless of the*
37 *child's health, physical appearance, any mental or physical handicap, and regardless of*
38 *whether the child is born alive.*
39 *D. A child born to a surrogate within 300 days after assisted conception pursuant to*
40 *an order under subsection B of § 20-160 or a contract under § 20-162 is presumed to*
41 *result from the assisted conception. This presumption is conclusive as to all persons who*
42 *fail to file an action to test its validity within two years after the birth of the child. The*
43 *child and the parties to the contract shall be named as parties in any such action. The*
44 *action shall be filed in the court that issued or a court that could have issued an order*
45 *under § 20-160.*
46 *E. Health care providers shall not be liable for recognizing the surrogate as the mother*
47 *of the resulting child before receipt of a copy of an order entered under § 20-160 or a*
48 *copy of the contract, or for recognizing the intended parents as the parents of the*
49 *resulting child after receipt of such order or copy of the contract.*
50 *§ 20-164. Relation of parent and child.—A child whose status as a child is declared or*
51 *negated by this chapter is the child only of his parent or parents as determined under this*
52 *chapter and, when applicable, Chapter 3.1 (§ 20-49.1 et seq.) of this title for all purposes*
53 *including, but not limited to, (i) intestate succession; (ii) probate law exemptions,*
54 *allowances, or other protections for children in a parent's estate; and (iii) determining*

eligibility of the child or its descendants to share in a donative transfer from any person as a member of a class determined by reference to the relationship.

§ 20-165. Surrogate brokers prohibited; penalty; liability of surrogate brokers.—A. It shall be unlawful for any person, firm, corporation, partnership, or other entity to accept compensation for recruiting or procuring surrogates or to otherwise arrange or induce intended parents and surrogates to enter into surrogacy contracts in this Commonwealth. A violation of this section shall be punishable as a Class 1 misdemeanor.

B. Any person who acts as a surrogate broker in violation of this section shall, in addition, be liable to all the parties to the purported surrogacy contract in a total amount equal to three times the amount of compensation to have been paid to the broker pursuant to the contract. One-half of the damages under this subsection shall be due the surrogate and her husband, if any, and if he is a party to the contract, and one-half shall be due the intended parents.

An action under this section shall be brought within five years of the date of the contract.

C. The provisions of this section shall not apply to the services of an attorney in giving legal advice or in preparing a surrogacy contract.

§ 32.1-261. New birth certificate established on proof of adoption, legitimation or determination of paternity.—A. The State Registrar shall establish a new certificate of birth for a person born in this Commonwealth upon receipt of the following:

1. An adoption report as provided in § 32.1-262, a report of adoption prepared and filed in accordance with the laws of another state or foreign country, or a certified copy of the decree of adoption together with the information necessary to identify the original certificate of birth and to establish a new certificate of birth; except that a new certificate of birth shall not be established if so requested by the court decreeing the adoption, the adoptive parents, or the adopted person if eighteen years of age or older.

2. A request that a new certificate be established and such evidence as may be required by regulation of the Board proving that such person has been legitimated or that a court of the Commonwealth has, by final order, determined the paternity of such person. The request shall state that no appeal has been taken from the final order and that the time allowed to perfect an appeal has expired.

3. An order entered pursuant to subsection E of § 20-160. The order shall contain sufficient information to identify the original certificate of birth and to establish a new certificate of birth in the names of the intended parents.

4. A surrogate consent and report form as authorized by § 20-162. The report shall contain sufficient information to identify the original certificate of birth and to establish a new certificate of birth in the names of the intended parents.

B. When a new certificate of birth is established pursuant to subsection A of this section, the actual place and date of birth shall be shown. It shall be substituted for the original certificate of birth. Thereafter, the original certificate and the evidence of adoption, paternity or legitimation shall be sealed and filed and not be subject to inspection except upon order of a court of this Commonwealth or in accordance with § 32.1-252.

B1. Upon receipt of a report of an amended decree of adoption, the certificate of birth shall be amended as provided by regulation.

C. Upon receipt of notice or decree of annulment of adoption, the original certificate of birth shall be restored to its place in the files and the new certificate and evidence shall not be subject to inspection except upon order of a court of this Commonwealth or in accordance with § 32.1-252.

D. The State Registrar shall establish and register a Virginia certificate of birth for a person born in a foreign country and for whom a final order of adoption has been entered in a court of this Commonwealth when the State Registrar receives an adoption report as provided in § 32.1-262 and a request that such a certificate be established and registered; however, a Virginia certificate of birth shall not be established or registered if so requested by the court decreeing the adoption, the adoptive parents or the adopted person

if eighteen years of age or older. After registration of the birth certificate in the new name of the adopted person, the State Registrar shall seal and file the report of adoption which shall not be subject to inspection except upon order of a court of this Commonwealth or in accordance with § 32.1-252. The birth certificate shall show the true or probable foreign country of birth and shall state that the certificate is not evidence of United States citizenship for the child for whom it is issued or for the adoptive parents.

E. If no certificate of birth is on file for the person for whom a new certificate is to be established under this section, a delayed certificate of birth shall be filed with the State Registrar as provided in § 32.1-259 or § 32.1-260 before a new certificate of birth is established, except that when the date and place of birth and parentage have been established in the adoption proceedings, a delayed certificate shall not be required.

§ 32.1-289.1. Sale of body parts prohibited; exceptions; penalty.— With the exception of hair, *ova*, blood , and other self-replicating body fluids, it shall be unlawful for any person to sell, to offer to sell, to buy, to offer to buy , or to procure through purchase any natural body part for any reason including, but not limited to, medical and scientific uses such as transplantation, implantation, infusion , or injection. Nothing in this section shall prohibit the reimbursement of expenses associated with the removal and preservation of any natural body parts for medical and scientific purposes. This section shall not apply to any transaction pursuant to Article 3 (§ 32.1-298 et seq.) ~~,~~ *of* Chapter 8 of this title.

Any person engaging in any of these prohibited activities shall be guilty of a Class 6 felony.

§ 63.1-236.1. Fees for adoption services.—Notwithstanding the provisions of § 14.1-114, the ~~circuit~~ court with jurisdiction over any adoption matter shall assess a fee against the petitioner, in accordance with regulations and fee schedules established by the State Board, for *home studies*, investigations, visits , and reports provided by the appropriate department of social services pursuant to §§ *20-160*, *63.1-220.3*, 63.1-223, 63.1-228 , or § 63.1-236. The State Board shall establish regulations and fee schedules, which shall include (i) standards for determining the petitioner's or applicant's ability to pay and (ii) a scale of fees based on the petitioner's or applicant's income and family size and the actual statewide average cost of the services provided. The fee charged shall not exceed the actual cost of the service. The fee shall be collected by the court or the department of social services prior to the entry of any final order. The court shall transfer such fee to the appropriate department of social services.

Official Use By Clerks

Passed By The Senate		**Passed By The House of Delegates**	
without amendment	☐	without amendment	☐
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐
Date: ____________		Date: ____________	
Clerk of the Senate		Clerk of the House of Delegates	

1990 SESSION

LD1015440

HOUSE BILL NO. 23

Offered January 10, 1990

Prefiled January 10, 1990

A BILL to amend and reenact §§ 32.1-261, 32.1-289.1, and 63.1-236.1 of the Code of Virginia and to amend the Code of Virginia by adding in Title 20 a Chapter numbered 9, consisting of sections numbered 20-156 through 20-165, relating to assisted conception; penalty.

Patrons—Cohen and Byrne; Senators: Michie and Saslaw

Referred to the Committee on Health, Welfare and Institutions

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Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-261, 32.1-289.1, and 63.1-236.1 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Title 20 a Chapter numbered 9, consisting of sections numbered 20-156 through 20-165, as follows:

CHAPTER 9.

STATUS OF CHILDREN OF ASSISTED CONCEPTION.

§ 20-156. Definitions.—As used in this chapter unless the context requires a different meaning:

"Assisted conception" means a pregnancy resulting from any intervening medical technology, other than the pregnancy of a woman resulting from the insemination of her ovum using her husband's sperm, whether in vivo or in vitro, which replaces sexual intercourse completely or partially as the means of conception. Such intervening medical technology includes, but is not limited to, conventional medical and surgical treatment as well as noncoital reproductive technology such as artificial insemination by donor, cryopreservation of gametes and embryos, in vitro fertilization, uterine embryo lavage, embryo transfer, gamete intrafallopian tube transfer, and low tubal ovum transfer.

"Child" means one or more children born pursuant to a surrogacy contract.

"Compensation" means payment of any valuable consideration for services in excess of reasonable medical and ancillary costs.

"Cryopreservation" means freezing and storing of gametes and embryos for possible future use in assisted conception.

"Donor" means an individual, other than a surrogate, unrelated by marriage to the recipient who contributes the sperm or egg used in assisted conception.

"Gamete" means either a sperm or an ovum.

"Gestational mother" means the woman who gives birth to a child, regardless of her genetic relationship to the child.

"Embryo" means the organism resulting from the union of a sperm and an ovum from first cell division until approximately the end of the second month of gestation.

"Embryo transfer" means the placing of a viable embryo into the uterus of a gestational mother.

"Infertile" means the inability to conceive after one year of unprotected sexual intercourse.

"Intended parents" means a man and a woman, married to each other, who enter into an agreement with a surrogate under the terms of which they will be the parents of any child born to the surrogate through assisted conception regardless of the genetic relationships between the intended parents, the surrogate, and the child.

"In vitro" means any process that can be observed in an artificial environment such as a test tube or tissue culture plate.

"In vitro fertilization" means the fertilization of ova by sperm in an artificial environment.

"In vivo" means any process occurring within the living body.

"Ovum" means the female gamete or reproductive cell prior to fertilization.

1 *"Reasonable medical and ancillary costs" means the costs of the performance of*
2 *assisted conception, the costs of prenatal maternal health care, the costs of maternal and*
3 *child health care for a reasonable post partum period, the reasonable costs for medications*
4 *and maternity clothes, and any additional costs for housing and other living expenses*
5 *attributable to the pregnancy.*
6 *"Sperm" means the male gametes or reproductive cells, which impregnate the ova.*
7 *"Surrogacy contract" means an agreement between intended parents, a surrogate, and*
8 *her husband, if any, in which the surrogate agrees to be impregnated through the use of*
9 *assisted conception, to carry any resulting fetus, and to relinquish to the intended parents*
10 *the custody of and parental rights to any resulting child.*
11 *"Surrogate" means any adult woman who agrees to bear a child carried for intended*
12 *parents.*
13 *§ 20-157. Virginia law to control; surrogacy omnibus clause.—The provisions of this*
14 *chapter shall control, without exception, in any action brought in the courts of this*
15 *Commonwealth to enforce or adjudicate any rights or responsibilities arising under this*
16 *chapter.*
17 *Any provision in a surrogacy contract that attempts to reduce the rights or*
18 *responsibilities of the intended parents, surrogate, or her husband, if any, or the rights of*
19 *any resulting child shall be reformed to include the requirements set forth in this chapter.*
20 *§ 20-158. Effects of death or dissolution of marriage; parentage .—A. Any child*
21 *resulting from the insemination of a wife's ovum using her husband's sperm, with his*
22 *consent, is the child of the husband and wife notwithstanding that, during the ten-month*
23 *period immediately preceding the birth, either party died or filed for a divorce or*
24 *annulment.*
25 *However, any person who dies before in utero implantation of an embryo resulting*
26 *from the union of his sperm or her ovum with another gamete, whether or not the other*
27 *gamete is that of the person's spouse, is not the parent of any resulting child unless (i)*
28 *implantation occurs before notice of the death can reasonably be communicated to the*
29 *physician performing the procedure or (ii) the person consents to be a parent in writing*
30 *executed before the implantation.*
31 *In addition, any person who is a party to an action for divorce or annulment*
32 *commenced by filing before in utero implantation of an embryo resulting from the union*
33 *of his sperm or her ovum with another gamete, whether or not the other gamete is that*
34 *of the person's spouse, is not the parent of any resulting child unless (i) implantation*
35 *occurs before notice of the filing can reasonably be communicated to the physician*
36 *performing the procedure or (ii) the person consents to be a parent in writing executed*
37 *before or after the implantation.*
38 *B. In the absence of an agreement between the parties to the contrary, an embryo*
39 *resulting from the union of the sperm or ovum of a party to an action for divorce or*
40 *annulment of a marriage with another gamete, with the consent of the other party,*
41 *whether or not the gamete is that of the other party, is not the property of either party*
42 *and neither party shall be granted access to or possession of such embryo pending or*
43 *upon dissolution of the marriage. In the absence of an agreement to the contrary between*
44 *the entity having physical custody or possession of the embryo and the parties, upon*
45 *receipt of notice of death of a person who contributed the sperm or ovum used to*
46 *produce the embryo or for whom the embryo was produced, such entity shall be under no*
47 *obligation to maintain the embryo and shall not grant access to or possession of the*
48 *embryo to the surviving spouse or to either of the parties to the dissolution.*
49 *C. Except and as provided in subsections A, B, D, and E of this section, the parentage*
50 *of any child resulting from the performance of assisted conception shall be determined as*
51 *follows:*
52 *1. The gestational mother of a child is the child's mother.*
53 *2. The husband of the gestational mother of a child is the child's father,*
54 *notwithstanding any declaration of invalidity or annulment of the marriage obtained after*

1 *the performance of assisted conception, unless he commences an action within two years*
2 *after he discovers or, in the exercise of due diligence, reasonably should have discovered*
3 *the child's birth in which the mother and child are parties and in which it is determined*
4 *that he did not consent to the performance of assisted conception.*
5 *3. A donor is not the parent of a child conceived through assisted conception.*
6 *D. After the approval of a surrogacy contract by the court as provided in subsection B*
7 *of § 20-160, the parentage of any resulting child shall be determined as follows:*
8 *1. Upon the entry of an order as provided in subsection E of § 20-160, the intended*
9 *parents shall be the parents of any resulting child and the surrogate and her husband*
10 *shall not be the parents of the child.*
11 *2. If, after notice of termination by the surrogate, the court vacates the order*
12 *approving the agreement pursuant to subsection B of § 20-161, the surrogate is the*
13 *mother of the resulting child and her husband is the father, and the intended parents may*
14 *only obtain parental rights through adoption as provided in Chapter 11 (§ 63.1-220 et seq.)*
15 *of Title 63.1.*
16 *E. In the case of a surrogacy contract that has not been approved by a court as*
17 *provided in § 20-160, the parentage of any resulting child shall be determined as follows:*
18 *1. The gestational mother is the child's mother.*
19 *2. If either of the intended parents is a genetic parent of the resulting child, the*
20 *intended father is the child's father unless (i) the surrogate is married, (ii) her husband is a*
21 *party to the surrogacy contract, and (iii) the surrogate exercises her right to retain*
22 *custody and parental rights to the resulting child pursuant to § 20-162.*
23 *3. If neither of the intended parents is a genetic parent of the resulting child or the*
24 *surrogate exercises her right to retain custody and parental rights to the resulting child,*
25 *the surrogate is the mother and her husband, if any, and if he is a party to the contract,*
26 *is the child's father and the intended parents may only obtain parental rights through*
27 *adoption as provided in Chapter 11 (§ 63.1-220 et seq.) of Title 63.1.*
28 *4. After the signing and filing of the surrogate consent and report form in conformance*
29 *with the requirements of subsection A of § 20-162, the intended parents are the parents of*
30 *the child and the surrogate and her husband, if any, shall not be the parents of the child.*
31 *§ 20-159. Surrogacy contracts permissible.—A. A surrogate, her husband, if any, and*
32 *prospective intended parents may enter into a written agreement whereby the surrogate*
33 *may relinquish all her rights and duties as parent of a child conceived through assisted*
34 *conception, and the intended parents may become the parents of the child as provided in*
35 *subsection D or E of § 20-158.*
36 *B. Surrogacy contracts may be approved by the court as provided in § 20-160. Any*
37 *surrogacy contract that has not been approved by the court as provided in § 20-160 shall*
38 *be governed by the provisions of §§ 20-156 through 20-159 and §§ 20-162 through 20-165.*
39 *§ 20-160. Court approved surrogacy contracts; petition and hearing for approval of*
40 *surrogacy contract; requirements; orders.—A. Prior to the performance of assisted*
41 *conception, the intended parents, the surrogate, and her husband may join in a petition to*
42 *the circuit court of the county or city in which at least one of the parties resides. The*
43 *surrogacy contract shall be signed by all the parties and acknowledged before an officer or*
44 *other person authorized by law to take acknowledgments.*
45 *A copy of the contract shall be attached to the petition. The court shall appoint a*
46 *guardian ad litem to represent the interests of any resulting child and may appoint*
47 *counsel to represent the surrogate.*
48 *All hearings and proceedings conducted under this section shall be held in camera, and*
49 *all court records shall be confidential and subject to inspection only under the standards*
50 *applicable to adoptions as provided in § 63.1-235. The court conducting the proceedings*
51 *shall have exclusive and continuing jurisdiction of all matters arising out of the surrogacy*
52 *contract until any child born after entry of an order under subsection B of this section is*
53 *six months old.*
54 *B. The court shall hold a hearing on the petition and shall enter an order approving*

the surrogacy contract, authorizing the performance of assisted conception for a period of twelve months after the date of the order, and may discharge the guardian ad litem and attorney for the surrogate upon finding that:

1. The court has jurisdiction in accordance with § 20-157;

2. A local department of social services or welfare or a licensed child-placing agency has conducted a home study of the intended parents, the surrogate, and her husband, and has filed a report of this home study with the court;

3. The intended parents, the surrogate, and her husband meet the standards of fitness applicable to adoptive parents;

4. All the parties have voluntarily entered into the surrogacy contract and understand its terms and the nature, meaning, and effect of the proceeding;

5. The agreement contains adequate provisions to guarantee the payment of reasonable medical and ancillary costs either in the form of insurance, cash, escrow, bonds, or other arrangements satisfactory to the parties, including allocation of responsibility for such costs in the event of termination of the pregnancy, termination of the contract pursuant to § 20-161, or breach of the contract by any party;

6. The surrogate is married and has had at least one pregnancy, and has experienced at least one live birth, and that medical evidence supports that bearing another child does not pose an unreasonable risk to her physical or mental health or that of any resulting child;

7. Prior to signing the surrogacy contract, the intended parents, the surrogate, and her husband have submitted to physical examinations and psychological evaluations by practitioners licensed to perform such services pursuant to Title 54.1 of this Code and that the court and all parties have been given access to the records of the physical examinations and psychological evaluations;

8. The intended mother is infertile, unable to bear a child, or is unable to do so without unreasonable risk to the unborn child or to the physical or mental health of the intended mother or the child. This finding shall be supported by medical evidence;

9. At least one of the intended parents is expected to be the genetic parent of any child resulting from the agreement;

10. The husband of the surrogate is a party to the surrogacy agreement;

11. All parties have received counseling concerning the effects of the surrogacy by a qualified health care professional or social worker and a report containing conclusions about the capacity of the parties to enter into and fulfill the agreement has been filed with the court; and

12. The agreement would not be substantially detrimental to the interests of any of the affected persons.

C. Unless otherwise provided in the surrogacy contract, all court costs, counsel fees, and other costs and expenses associated with the hearing, including the costs of the home study, shall be assessed against the intended parents.

D. A provision in any such contract that provides for compensation to the surrogate shall be enforceable and compensation shall be placed in escrow and paid in full unless the parties have agreed on reasonable terms for adjusting or prorating the compensation in the event of termination of the pregnancy, termination of the contract pursuant to § 20-161, or breach of the contract by any party.

E. Within seven days of the birth of any resulting child, the intended parents shall file a written notice with the court that the child was born to the surrogate within 300 days after the last performance of assisted conception. Upon the filing of this notice and a finding that at least one of the intended parents is the genetic parent of the resulting child as substantiated by medical evidence, the court shall enter an order directing the State Registrar of Vital Records to issue a new birth certificate naming the intended parents as the parents of the child pursuant to § 32.1-261.

If evidence cannot be produced that at least one of the intended parents is the genetic parent of the resulting child, the court shall not enter an order directing the issuance of a

1 *new birth certificate naming the intended parents as the parents of the child, and the*
2 *surrogate and her husband shall be the parents of the child.*
3 *§ 20-161. Termination of court approved surrogacy contract.—A. Subsequent to an*
4 *order entered pursuant to subsection B of § 20-160, but before the surrogate becomes*
5 *pregnant through the use of assisted conception, the court for cause, or the surrogate, her*
6 *husband, or the intended parents may terminate the agreement by giving written notice of*
7 *termination to all other parties and by filing notice of the termination with the court.*
8 *Upon receipt of the notice, the court shall vacate the order entered under subsection B of*
9 *§ 20-160.*
10 *B. Within 180 days after the last performance of any assisted conception, the surrogate*
11 *may terminate the agreement by filing written notice with the court. The court shall*
12 *vacate the order entered pursuant to subsection B of § 20-160 upon finding, after notice to*
13 *the parties to the agreement and a hearing, that the surrogate has voluntarily terminated*
14 *the agreement and that she understands the effects of the termination.*
15 *Unless otherwise provided in the contract as approved, the surrogate shall incur no*
16 *liability to the intended parents for exercising her rights of termination.*
17 *§ 20-162. Contracts not approved by the court; requirements.—A. In the case of any*
18 *surrogacy agreement for which prior court approval has not been obtained pursuant to §*
19 *20-160, the provisions of this section and §§ 20-156 through 20-159 and §§ 20-163 through*
20 *20-165 shall apply. Such surrogacy contracts shall be valid and enforceable only as follows:*
21 *1. The surrogate, her husband, if any, and the intended parents shall be parties to any*
22 *such surrogacy contract.*
23 *2. The contract shall be in writing, signed by all the parties, and acknowledged before*
24 *an officer or other person authorized by law to take acknowledgments.*
25 *3. Upon expiration of twenty-five days following birth of any resulting child the*
26 *surrogate may relinquish her parental rights to the intended parents, if at least one of the*
27 *intended parents is the genetic parent of the child, by signing a surrogate consent and*
28 *report form naming the intended parents as the parents of the child. The form shall be*
29 *obtained from the State Registrar of Vital Records and shall be signed and acknowledged*
30 *before an officer or other person authorized by law to take acknowledgments. The form, a*
31 *copy of the contract, and a certificate from the physician who performed the assisted*
32 *conception stating the genetic relationships between the child, the surrogate, and the*
33 *intended parents shall be filed with the State Registrar within sixty days after the birth.*
34 *4. Upon the filing of the surrogate consent and report form and the required*
35 *attachments, a new birth certificate shall be established by the State Registrar for the*
36 *child naming the intended parents as the parents of the child as provided in § 32.1-261.*
37 *However, the State Registrar of Vital Records shall not establish a new birth certificate as*
38 *provided in this subdivision and § 32.1-261 without court order unless the surrogate*
39 *consent and report form is received within sixty days after the birth of the child and the*
40 *physician's certificate provides medical evidence that at least one of the intended parents*
41 *is the genetic parent of the child.*
42 *B. Any contract governed by the provisions of this section shall include or, in the*
43 *event such provisions are not explicitly covered in the contract or are included but are*
44 *inconsistent with this section, shall be deemed to include the following provisions:*
45 *1. The intended parents shall be the parents of any resulting child only when the*
46 *surrogate relinquishes her parental rights as provided in subdivision A 3 of this section*
47 *and a new birth certificate is established as provided in subdivision A 4 of this section*
48 *and § 32.1-261;*
49 *2. Incorporation of this chapter and a statement by each of the parties that they have*
50 *read and understood the contract, they know and understand their rights and*
51 *responsibilities under Virginia law, and the contract was entered into knowingly and*
52 *voluntarily;*
53 *3. A provision in any contract that provides for compensation to the surrogate shall be*
54 *enforceable and compensation shall be paid in full unless the parties have agreed on*

1 *reasonable terms for adjusting or prorating the compensation in the event of termination*
2 *of the pregnancy, termination of the contract, or breach of the contract by any party; and*
3 *4. A guarantee by the intended parents for payment of reasonable medical and*
4 *ancillary costs either in the form of insurance, cash, escrow, bonds, or other arrangements*
5 *satisfactory to the parties, including allocation of responsibility for such costs in the event*
6 *of termination of the pregnancy, termination of the contract, or breach of the contract by*
7 *any party.*
8 *C. Under any contract that does not include an allocation of responsibility for*
9 *reasonable medical and ancillary costs in the event of termination of the pregnancy,*
10 *termination of the contract, or breach of the contract by any party, the following*
11 *provisions shall control:*
12 *1. If the intended parents and the surrogate and her husband, if any, and if he is a*
13 *party to the contract, consent in writing to termination of the contract, the intended*
14 *parents are responsible for all reasonable medical and ancillary costs for a period of six*
15 *weeks following the termination.*
16 *2. If the pregnancy is terminated by an elective abortion or the surrogate terminates*
17 *the contract during the pregnancy, the intended parents shall be responsible for one-half of*
18 *the reasonable medical and ancillary costs incurred prior to the elective abortion or*
19 *termination.*
20 *3. If, after the birth of any resulting child, the surrogate fails to relinquish parental*
21 *rights to the intended parents pursuant to a contract which has not received prior court*
22 *approval, the intended parents shall be responsible for one-half of the reasonable medical*
23 *and ancillary costs incurred prior to the birth.*
24 *§ 20-163. Miscellaneous provisions related to all surrogacy contracts.—A. The surrogate*
25 *shall be solely responsible for the clinical management of the pregnancy including the*
26 *administration of any test to the fetus such as amniocentesis and any decision with*
27 *respect to the termination of the pregnancy.*
28 *B. After the entry of an order under subsection B of § 20-160 or upon the execution of*
29 *a contract pursuant to § 20-162, the marriage of the surrogate shall not affect the validity*
30 *of the order or contract and her husband shall not be deemed a party to the contract in*
31 *the absence of his explicit written consent*
32 *C. Following the entry of an order pursuant to subsection D of § 20-160 or upon the*
33 *relinquishing of the custody of and parental rights to any resulting child and the filing of*
34 *the surrogate consent and report form as provided in § 20-162, the intended parents shall*
35 *have the custody of, parental rights to, and full responsibilities for any child resulting*
36 *from the performance of assisted conception from a surrogacy agreement regardless of the*
37 *child's health, physical appearance, any mental or physical handicap, and regardless of*
38 *whether the child is born alive.*
39 *D. A child born to a surrogate within 300 days after assisted conception pursuant to*
40 *an order under subsection B of § 20-160 or a contract under § 20-162 is presumed to*
41 *result from the assisted conception. This presumption is conclusive as to all persons who*
42 *fail to file an action to test its validity within two years after the birth of the child. The*
43 *child and the parties to the contract shall be named as parties in any such action. The*
44 *action shall be filed in the court that issued or a court that could have issued an order*
45 *under § 20-160.*
46 *E. Health care providers shall not be liable for recognizing the surrogate as the mother*
47 *of the resulting child before receipt of a copy of an order entered under § 20-160 or a*
48 *copy of the contract, or for recognizing the intended parents as the parents of the*
49 *resulting child after receipt of such order or copy of the contract.*
50 *§ 20-164. Relation of parent and child.—A child whose status as a child is declared or*
51 *negated by this chapter is the child only of his parent or parents as determined under this*
52 *chapter and, when applicable, Chapter 3.1 (§ 20-49.1 et seq.) of this title for all purposes*
53 *including, but not limited to, (i) intestate succession; (ii) probate law exemptions,*
54 *allowances, or other protections for children in a parent's estate; and (iii) determining*

1 *eligibility of the child or its descendants to share in a donative transfer from any person*
2 *as a member of a class determined by reference to the relationship.*
3 *§ 20-165. Surrogate brokers prohibited; penalty; liability of surrogate brokers.—A. It*
4 *shall be unlawful for any person, firm, corporation, partnership, or other entity to accept*
5 *compensation for recruiting or procuring surrogates or to otherwise arrange or induce*
6 *intended parents and surrogates to enter into surrogacy contracts in this Commonwealth.*
7 *A violation of this section shall be punishable as a Class 1 misdemeanor.*
8 *B. Any person who acts as a surrogate broker in violation of this section shall, in*
9 *addition, be liable to all the parties to the purported surrogacy contract in a total amount*
10 *equal to three times the amount of compensation to have been paid to the broker*
11 *pursuant to the contract. One-half of the damages under this subsection shall be due the*
12 *surrogate and her husband, if any, and if he is a party to the contract, and one-half shall*
13 *be due the intended parents.*
14 *An action under this section shall be brought within five years of the date of the*
15 *contract.*
16 *C. The provisions of this section shall not apply to the services of an attorney in*
17 *giving legal advice or in preparing a surrogacy contract.*
18 § 32.1-261. New birth certificate established on proof of adoption, legitimation or
19 determination of paternity.—A. The State Registrar shall establish a new certificate of birth
20 for a person born in this Commonwealth upon receipt of the following:
21 1. An adoption report as provided in § 32.1-262, a report of adoption prepared and filed
22 in accordance with the laws of another state or foreign country, or a certified copy of the
23 decree of adoption together with the information necessary to identify the original
24 certificate of birth and to establish a new certificate of birth; except that a new certificate
25 of birth shall not be established if so requested by the court decreeing the adoption, the
26 adoptive parents, or the adopted person if eighteen years of age or older.
27 2. A request that a new certificate be established and such evidence as may be
28 required by regulation of the Board proving that such person has been legitimated or that
29 a court of the Commonwealth has, by final order, determined the paternity of such person.
30 The request shall state that no appeal has been taken from the final order and that the
31 time allowed to perfect an appeal has expired.
32 *3. An order entered pursuant to subsection E of § 20-160. The order shall contain*
33 *sufficient information to identify the original certificate of birth and to establish a new*
34 *certificate of birth in the names of the intended parents.*
35 *4. A surrogate consent and report form as authorized by § 20-162. The report shall*
36 *contain sufficient information to identify the original certificate of birth and to establish a*
37 *new certificate of birth in the names of the intended parents.*
38 B. When a new certificate of birth is established pursuant to subsection A of this
39 section, the actual place and date of birth shall be shown. It shall be substituted for the
40 original certificate of birth. Thereafter, the original certificate and the evidence of
41 adoption, paternity or legitimation shall be sealed and filed and not be subject to inspection
42 except upon order of a court of this Commonwealth or in accordance with § 32.1-252.
43 B1. Upon receipt of a report of an amended decree of adoption, the certificate of birth
44 shall be amended as provided by regulation.
45 C. Upon receipt of notice or decree of annulment of adoption, the original certificate of
46 birth shall be restored to its place in the files and the new certificate and evidence shall
47 not be subject to inspection except upon order of a court of this Commonwealth or in
48 accordance with § 32.1-252.
49 D. The State Registrar shall establish and register a Virginia certificate of birth for a
50 person born in a foreign country and for whom a final order of adoption has been entered
51 in a court of this Commonwealth when the State Registrar receives an adoption report as
52 provided in § 32.1-262 and a request that such a certificate be established and registered;
53 however, a Virginia certificate of birth shall not be established or registered if so
54 requested by the court decreeing the adoption, the adoptive parents or the adopted person

1 if eighteen years of age or older. After registration of the birth certificate in the new
2 name of the adopted person, the State Registrar shall seal and file the report of adoption
3 which shall not be subject to inspection except upon order of a court of this
4 Commonwealth or in accordance with § 32.1-252. The birth certificate shall show the true
5 or probable foreign country of birth and shall state that the certificate is not evidence of
6 United States citizenship for the child for whom it is issued or for the adoptive parents.
7 E. If no certificate of birth is on file for the person for whom a new certificate is to
8 be established under this section, a delayed certificate of birth shall be filed with the State
9 Registrar as provided in § 32.1-259 or § 32.1-260 before a new certificate of birth is
10 established, except that when the date and place of birth and parentage have been
11 established in the adoption proceedings, a delayed certificate shall not be required.
12 § 32.1-289.1. Sale of body parts prohibited; exceptions; penalty.— With the exception of
13 hair, *ova,* blood , and other self-replicating body fluids, it shall be unlawful for any person
14 to sell, to offer to sell, to buy, to offer to buy , or to procure through purchase any natural
15 body part for any reason including, but not limited to, medical and scientific uses such as
16 transplantation, implantation, infusion , or injection. Nothing in this section shall prohibit
17 the reimbursement of expenses associated with the removal and preservation of any natural
18 body parts for medical and scientific purposes. This section shall not apply to any
19 transaction pursuant to Article 3 (§ 32.1-298 et seq.) ~~,~~ *of* Chapter 8 of this title.
20 Any person engaging in any of these prohibited activities shall be guilty of a Class 6
21 felony.
22 § 63.1-236.1. Fees for adoption services.—Notwithstanding the provisions of § 14.1-114,
23 the ~~circuit~~ court with jurisdiction over any adoption matter shall assess a fee against the
24 petitioner, in accordance with regulations and fee schedules established by the State Board,
25 for *home studies,* investigations, visits , and reports provided by the appropriate department
26 of social services pursuant to §§ *20-160, 63.1-220.3,* 63.1-223, 63.1-228 , or § 63.1-236. The
27 State Board shall establish regulations and fee schedules, which shall include (i) standards
28 for determining the petitioner's or applicant's ability to pay and (ii) a scale of fees based
29 on the petitioner's or applicant's income and family size and the actual statewide average
30 cost of the services provided. The fee charged shall not exceed the actual cost of the
31 service. The fee shall be collected by the court or the department of social services prior
32 to the entry of any final order. The court shall transfer such fee to the appropriate
33 department of social services.
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without amendment	☐	without amendment	☐
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐

Date: ____________________ Date: ____________________

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