Contracting Pregnancy

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ABSTRACT: Several states recently have passed laws that permit and regulate gestational surrogacy, changing course from the prohibitions that characterized an earlier era. These statutes require mental health counseling before pregnancy and legal representation for all parties to the contract. Scholars and practitioners alike herald this legislation as the way forward in protecting the interests of both intended parents and surrogates.

State law, however, may not resolve a recurrent tension over who controls prenatal decision making in gestational surrogacy agreements. Intended parents want authority to make decisions regarding the pregnancy. Contract provisions cater to that desire and support the broader assumption that parents should seek as much prenatal information as possible. Yet surrogates have the right, by statute and as patients, to manage their prenatal care.

Analyzing the most controversial terms of surrogacy contracts—those governing prenatal testing, prenatal behavior, and abortion—this Article demonstrates that neither statutory rights nor contractual remedies adequately address disputes over prenatal care. Rather, mental health professionals who provide pre-pregnancy counseling and lawyers who draft surrogacy contracts have greater effect on parties' expectations and conduct. Lawyers, in implementing surrogacy contracts, help build trust between parties that induces compliance with otherwise unenforceable terms. When there is a conflict between the parties, lawyers diffuse it.

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This Article identifies the consequences of relational contracting for surrogacy, including shielding parties' behavior from view and entrenching the power of fertility agencies and brokers. It concludes by suggesting how law might challenge the dominance of professionals and agencies by opening the fertility market to a broader population of participants.

I. INTRODUCTION

In the 2018 case, *P.M. v. T.B.*, the Supreme Court of Iowa decided for the first time that gestational surrogacy contracts are enforceable under state law and do not violate public policy.[1] The court held that invalidating surrogacy contracts would deprive infertile couples of opportunities to raise genetically related children and undercut surrogates' freedom to contract.[2]

1. P.M. v. T.B., 907 N.W.2d 522, 535–39 (Iowa 2018).
2. *Id.* at 525.

The Iowa court followed a national trend of upholding gestational surrogacy contracts, under which surrogates become pregnant, after in vitro fertilization ("IVF"), with children to whom they are not genetically related.[3] Prenatal care and decision-making was one reason why the relationship between the parties in *P.M.*, who met on Craigslist, erupted in a court battle.[4] The surrogate believed that the intended parents—the couple seeking the services of a surrogate—had failed to pay for what was promised in the contract.[5] The intended parents accused the surrogate of failing to communicate information about her pregnancy and then about the child's birth.[6] As the relationship deteriorated, and resulted in a dispute about parentage, the intended parents sent texts and Facebook messages to the surrogate with racial epithets and statements such as, "we are paying you, we hired you, and we are in charge."[7] In another exchange, an intended parent wrote by text: "A carrier shouldn't act like that as the doctors told me they should be saying yes ma'am[.] Whatever you guys want to do."[8] The court held that the surrogacy contract was valid, and to decide otherwise "would deprive infertile couples of the opportunity to raise their own biological children and would limit the personal autonomy of women willing to serve as surrogates to carry and deliver a baby to be raised by other loving parents."[9]

In response to conflicts like those that arose in *P.M.*, states have enacted laws to ensure that surrogates and intended parents are a good match and to

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3. As of 2017, 95 percent of contracts were for gestational surrogacy, rather than traditional surrogacy arrangements in which the surrogate's own egg is fertilized and thus the surrogate is genetically related to the resulting child. SITAL KALANTRY ET AL., CORNELL INT'L HUMAN RIGHTS: POLICY ADVOCACY CLINIC, SHOULD COMPENSATED SURROGACY BE PERMITTED OR PROHIBITED? 5 (2017), *available at* https://cpb-us-e1.wpmucdn.com/blogs.cornell.edu/dist/2/7529/files/2017/08/Kalantry_Report_2017-2cxp2jo.pdf [https://perma.cc/C7MB-8HVZ].

4. *P.M.*, 907 N.W.2d at 525–27.

5. *Id.* at 527. This Article refers to "intended parents" although, in many states, an individual may contract with a gestational surrogate.

6. *Id.* at 527–28. The appellant's brief also alleges that the intended parents attempted to block the surrogate's husband from attending prenatal appointments: "Three days later, C.M. demanded that T.B.'s husband no longer accompany her to doctor's visits, disregarding T.B.'s needs as a pregnant mother." Defendants-Counterclaimants-Appellants' Final Brief at *19, *P.M.*, 907 N.W.2d 522 (No. 17-0376), 2017 WL 10982206, at *19.

7. *P.M.*, 907 N.W.2d at 527 (quoting a text from C.M. to T.B.). The brief submitted by Appellants detailed communications between the parties, in which the intended father posted a racist message slurring the surrogate's husband as "a dirty Mexican." Defendants-Counterclaimants-Appellants' Final Brief, *supra* note 6, at *20. The intended mother "sent an email to T.B. and T.B.'s attorney, triggering a lengthy exchange, during which C.M. called T.B. the 'N' word." *P.M.*, 907 N.W.2d at 527. The surrogate ceased all contact and delivered twins (one died several days after birth) and did not inform the intended parents. *Id.* at 528. The surrogate sought to invalidate the contract based on her relationship to the child and her belief that the intended parents were not fit to assume custody, in part because of their racist remarks. *Id.* at 527–28. The intended parents' disturbing behavior would have been invisible but for the litigation over the custody of the resulting child.

8. *Id.* at 527.

9. *Id.* at 525.

notify contracting parties of their mutual obligations, among other aims. These laws require mental health counseling, sometimes in a joint session with the surrogate and intended parents, and legal representation for all sides.[10] Consider proposed legislation in Michigan, which would allow gestational surrogacy in a state that presently criminalizes surrogacy arrangements.[11] The bill, if enacted, would require each party to have the advice of counsel (intended parents may pay for the surrogate's representation) and mandate that all parties have their mental health professionally evaluated before the pregnancy.[12] As the Michigan bill illustrates, "the tide has turned" from prohibiting surrogacy to permitting it,[13] subject to the oversight of health and legal professionals and informed by the recommendations of professional organizations.[14]

There is a gap, however, between what recently enacted laws seek to accomplish—balancing the interests of intended parents and gestational surrogates—and how professionals actually draft and apply contract provisions governing prenatal care. Surrogacy agreements routinely include clauses mandating prenatal testing, restricting prenatal behavior, and contemplating abortion after testing. At the same time, state statutes guarantee that surrogates can make medical or healthcare decisions and require intended parents to assume "responsibilit[y] of resulting children . . . regardless of the number, gender or mental or physical condition."[15] The

10. *See infra* notes 56–57, 61 and accompanying text.

11. Michigan criminalizes all surrogacy parentage arrangements with fines of up to $50,000, as well as up to five years in jail. MICH. COMP. LAWS §§ 722.855–.859 (2019).

12. S.B. 1082, 99th Leg., Reg. Sess., §§ 5(1)(d)–(e), 5(2)(a)–(b), 9(4) (Mich. 2018).

13. Steven H. Snyder, *Reproductive Surrogacy in the United States of America: Trajectories and Trends*, *in* HANDBOOK OF GESTATIONAL SURROGACY: INTERNATIONAL CLINICAL PRACTICE AND POLICY ISSUES 281 (E. Scott Sills ed., 2016) ("The tide has turned, and the strong trend in US state surrogacy legislation is now to permit and effectively regulate surrogacy, not prohibit it.").

14. S.B. 1082, 99th Leg., Reg. Sess., § 7(1)(b) (Mich. 2018) (requiring gestational surrogacy contracts to "[s]pecify that all evaluations, medical procedures, and treatment must be conducted in accordance with the guidelines published by the American Society for Reproductive Medicine or the American Congress of Obstetricians and Gynecologists, or a successor organization").

15. ME. REV. STAT. ANN. tit. 19-A, § 1932(3)(J)(4) (2018) ("The intended parent or parents must . . . accept parental rights and responsibilities of all resulting children immediately upon birth regardless of the number, gender or mental or physical condition of the child or children."); *see, e.g.*, *id.* § 1932(3)(J)(3) ("The gestational carrier has the right to use the services of a health care provider of her choosing to provide her care during her pregnancy."); *see also* D.C. CODE § 16-406(a)(4)(C) (Supp. 2019) ("[T]he surrogate shall maintain control and decision-making authority over the surrogate's body."); *id.* § 16-406(a)(5) ("[T]he [intended] parent or parents shall . . . [a]ccept physical custody of the child immediately after the child's birth, regardless of the child's gender or mental or physical condition or the number of children . . . ."); AM. BAR ASS'N MODEL ACT GOVERNING ASSISTED REPROD. art. VII, § 701(3) (AM. BAR ASS'N 2019) ("A Surrogacy Agreement may not limit the right of the Gestational or Genetic Surrogate to make any health and welfare decisions regarding the Surrogate and the Surrogate's pregnancy.").

rights of surrogates and duties of intended parents can be in tension: Surrogates have a right to make healthcare decisions affecting the pregnancy, but intended parents must assume responsibility of any child born. In part because of this responsibility, one way intended parents seek to manage the surrogate's pregnancy is by requiring prenatal testing as a contractual duty. And innovations in genetic screening promise to make prenatal testing more desirable and more routine. In the near future, a new genetic screen, offered early in pregnancy, will expand the prenatal information patients can learn.

State statutes rely on intermediaries—mental health professionals and lawyers—to resolve conflicts over prenatal decision-making when they arise. Health professionals deliver information through counseling and, in the process, often discover points of disagreement between intended parents and surrogates. To diffuse conflicts, lawyers deliver what intended parents want during the surrogate's pregnancy, which is influence over testing and terminating a pregnancy, but must respect the wishes of the surrogate who ultimately controls much of the prenatal information that intended parents seek. Disagreements among parties are often unseen because they are unlitigated, making it difficult to know, given the private nature of negotiations, who typically wins and loses in disputes over prenatal care.[16]

Before describing this Article's organization, two caveats: First, I will not repeat well-known debates on the compensatory or commodifying aspects of surrogacy.[17] I accept that surrogacy can be financially and emotionally rewarding in some circumstances and exploitative or unduly costly in others.

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16. Most surrogacy agreements conclude without dispute. KALANTRY ET AL., *supra* note 3, at 21 (noting that only 0.1 percent of contract disputes end up in court); Lina Peng, *Surrogate Mothers: An Exploration of the Empirical and the Normative*, 21 AM. U. J. GENDER SOC. POL'Y & L. 555, 563 (2013) ("Out of 25,000 surrogacy arrangements estimated to have taken place since the 1970s, less than one percent of surrogate mothers have changed their minds and less than one-tenth of one percent of surrogacy cases end up in court battles." (citations omitted)).

17. For a comprehensive treatment of markets for assisted reproductive technologies ("ART"), which acknowledges but does not focus on commodification or exploitation debates, see, for example, Michele Goodwin, *Reproducing Hierarchy in Commercial Intimacy*, 88 IND. L.J. 1289, 1290 (2013) ("[T]he attention to the advancements in reproductive technologies and the communities they benefit may obscure externalities worth studying. In fact, reductive refrains capture a significant aspect of the socioeconomic critique of ART services with arguments about the 'commodification of life' and baby selling dominating the discourse. Desperately missing are more nuanced analytics." (citations omitted)); Jill Elaine Hasday, *Intimacy and Economic Exchange*, 119 HARV. L. REV. 491, 494 (2005); and Pamela Laufer-Ukeles, *Mothering for Money: Regulating Commercial Intimacy*, 88 IND. L.J. 1223, 1251 (2013). There is a substantial amount of scholarship on surrogacy contracts. For a sampling of commentary on surrogacy contracting, see MARTHA A. FIELD, SURROGATE MOTHERHOOD: THE LEGAL AND HUMAN ISSUES 75–109 (expanded ed. 1988); Anita L. Allen, *The Black Surrogate Mother*, 8 HARV. BLACKLETTER J. 17 (1991); Lori B. Andrews, *Surrogate Motherhood: The Challenge for Feminists*, 16 LAW MED. & HEALTH CARE 72 (1988); Richard A. Epstein, *Surrogacy: The Case for Full Contractual Enforcement*, 81 VA. L. REV. 2305 (1995); Hon. Richard A. Posner, *The Ethics and Economics of Enforcing Contracts of Surrogate Motherhood*, 5 J. CONTEMP. HEALTH L. & POL'Y 21 (1989); and Debra Satz, *Markets in Women's Reproductive Labor*, 21 PHIL. & PUB. AFF. 107 (1992).

Surrogacy is a big business, costing as much as $120,000 from start to finish for each arrangement.[18] The procreative decisions implicated by surrogacy can be some of the most important events in an individual's life. Second, I do not assess the constitutionality of contract provisions that govern prenatal testing or abortion decisions. Many scholars have analyzed how surrogacy contracts implicate intended parents' right to procreate and affect surrogates' constitutional rights to privacy and liberty.[19] The arguments that follow assume that surrogacy contracts do not categorically violate existing constitutional doctrines.

Instead, this Article concentrates on the clinical and contractual practices that mediate conflicts over prenatal screening, prenatal care, and abortion. Even in jurisdictions where courts have deemed certain surrogacy provisions unenforceable—for constitutional, public policy, or other reasons—parties continue to draft terms as though they were legally binding.[20] Lawyers operate in many jurisdictions without certainty that courts will enforce their clients' contracts.[21] And the professionals who draft surrogacy contracts include language, often drawn from model contracts, that contradicts state efforts to level the playing field for parties.[22] The inclusion of pregnancy-behavior clauses is illustrative. Despite statutory protections for surrogates' autonomy rights, including their decisions over testing and termination, contracts routinely seek to control surrogates' behavior during pregnancy.[23] This

18. REBECCA A. CLARK ET AL., PLANNING PARENTHOOD: STRATEGIES FOR SUCCESS IN FERTILITY ASSISTANCE, ADOPTION, AND SURROGACY 177 (2009); Susannah Snider, *Payment Options for Fertility Treatments*, U.S. NEWS & WORLD REP. (July 16, 2019, 3:09 PM), https://money.usnews.com/money/personal-finance/family-finance/articles/payment-options-for-fertility-treatments [https://perma.cc/WEM2-44KG]; *see* Jennifer Jackson, *California Egg Toss: The High Costs of Avoiding Unenforceable Surrogacy Contracts*, 15 J. HIGH TECH. L. 230, 253 (2015) ("A gestational carrier surrogacy arrangement costs intended parents roughly $125,990.").

19. *See, e.g.*, I. Glenn Cohen, *The Constitution and the Rights Not to Procreate*, 60 STAN. L. REV. 1135, 1148–67 (2008); *see also* Martha A. Field, *Compensated Surrogacy*, 89 WASH. L. REV. 1155, 1177–81 (2014); Holly Jones, Note, *Contracts for Children: Constitutional Challenges to Surrogacy Contracts and Selective Reduction Clauses*, 70 HASTINGS L.J. 595, 603–18 (2019).

20. *See* Deborah L. Forman, *Abortion Clauses in Surrogacy Contracts: Insights from a Case Study*, 49 FAM. L.Q. 29, 34 (2015) ("Although contracts often contain abortion and selective reduction provisions . . . practitioners routinely describe these as unenforceable, even while advocating their inclusion in the contract.").

21. This uncertainty is not surprising given the relative newness of state regulation, and, as noted below, 18 states have no statute governing surrogacy. Fertility professionals have therefore operated in an "unstable environment" because "policies are inconsistent, incomplete, and sometimes incorrect." EMILY GALPERN, ASSISTED REPRODUCTIVE TECHNOLOGIES: OVERVIEW AND PERSPECTIVE USING A REPRODUCTIVE JUSTICE FRAMEWORK 18 (2007); Brittany Salyars, Note, *Surrogacy and Parental Rights: A Need for Uniformity in the Law*, 68 DRAKE L. REV. DISCOURSE 101, 105 (2018); *see infra* note 52 and accompanying text.

22. KALANTRY ET AL., *supra* note 3, at 12 ("Even in . . . [s]tates, where both compensated and uncompensated surrogacy agreements are unenforceable but not criminally sanctioned, surrogacy is sometimes practiced . . . [and] [a]ttorneys even provide advice on these non-binding documents.").

23. For a discussion of model contract provisions and recent legislation, see *infra* Section III.A.

Article demonstrates how lawyers and counselors, working with for-profit agencies and reproductive endocrinology providers, address disagreements over prenatal information and decision making by relying on contractual language but not resorting to court. Moreover, the largely unregulated fertility industry, which supports contract practices, has a substantial financial interest in ensuring the parties' relationship does not fall apart.[24]

This Article proceeds as follows. In the first Part of the Article, I describe screening and testing innovations that have expanded access to prenatal genetic information and perpetuated beliefs in genetic essentialism. I rely on the example of early prenatal screening to highlight the increasing availability of prenatal information and to set the stage for how surrogacy arrangements ensure intended parents gain access to that information. In the second Part, I analyze state laws and contractual practices that address pre-pregnancy counseling, prenatal screening and testing, the surrogate's behavior during pregnancy, and abortion. The third and final Part of the Article argues that new state statutes, as well as recent court decisions, addressing surrogacy contracts do not sufficiently account for the crucial role of professionals who facilitate surrogacy arrangements, especially the healthcare providers and lawyers who frequently work with or through fertility agencies.

Attention to how the fertility business operates, this Article concludes, is missing from conversations about how states should regulate surrogacy. Although important, a new generation of surrogacy laws focuses on protecting the interests of intended parents and the autonomy of surrogates but does not necessarily create incentives for parties and their intermediaries to realize those protections. Going forward, policymakers should examine the role of industry actors to understand whether contracting practices systematically result in lopsided deals, and they should take steps to enable a broader population of people to avail of assisted reproductive technologies.

II. PRENATAL SCREENING AND GENETIC ESSENTIALISM

The desire to obtain prenatal information in surrogacy arrangements turns on the availability of prenatal testing and, specifically, the introduction of reliable, early prenatal genetic screening.[25] Non-invasive prenatal testing ("NIPT") relies on cell-free fetal DNA collected from a pregnant woman's

24. *See* June Carbone & Jody Lyneé Madeira, *Buyers in the Baby Market: Toward a Transparent Consumerism*, 91 WASH. L. REV. 71, 77–79 (2016) ("[T]he combination of private support, lack of restrictions, and paying patients has allowed the United States to develop a large, profitable fertility industry—one whose potential impact is likely to grow.").

25. Henry T. Greely, *Get Ready for the Flood of Fetal Gene Screening*, 469 NATURE 289, 289 (2011); Jaime S. King, *And Genetic Testing for All . . . The Coming Revolution in Non-Invasive Prenatal Genetic Testing*, 42 RUTGERS L.J. 599, 599–600 (2011); Rachel Rebouché, *Testing Sex*, 49 U. RICH. L. REV. 519, 519 (2015) [hereinafter Rebouché, *Testing Sex*].

bloodstream at nine or ten weeks of gestation.[26] Over the past decade, NIPT has become a regular part of clinical use for identifying chromosomal anomalies and fetal sex.[27] Henry Greely writes that soon NIPT "should be able to test for single gene mutations or even provide a whole genome sequence . . . . This is currently too expensive and uncertain for clinical use, but that will change."[28] As gene sequencing technology advances, NIPT will be able to identify a wide range of genetic characteristics beyond aneuploidies (an abnormal number of chromosomes in a cell) and sex-linked characteristics.[29]

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26. Stephanie A. Devaney et al., *Noninvasive Fetal Sex Determination Using Cell-Free Fetal DNA: A Systematic Review and Meta-analysis*, 306 JAMA 627, 627 (2011). Unlike traditional methods of testing such as amniocentesis and chorionic villus sampling ("CVS"), NIPT poses no risk to the fetus and occurs in the first trimester. *See* Rowan Jacobsen, *A Future of Genetically Engineered Children is Closer than You'd Think*, MOTHER JONES (Sept./Oct. 2017), https://www.motherjones.com/politics/2017/08/a-future-of-genetically-engineered-children-is-closer-than-youd-think [https://perma.cc/8H72-K7UA] (stating NIPT has "become popular so quickly . . . because it's less invasive than traditional pregnancy screening techniques"). NIPT has over 99 percent accuracy, with recent research suggesting accuracy as early as six or seven weeks of gestation. Devaney et al., *supra*, at 627–28, 631, 633. Invasive tests are more accurate than NIPT because they collect cells directly from the fetus. Jade Bennett et al., *Non-invasive Prenatal Diagnosis for BRCA Mutations—A Qualitative Pilot Study of Health Professionals' Views*, 25 J. GENETIC COUNSELING 198, 198 (2016) ("[C]onsidered an advanced screening test due to the small false positive rate."); Zuzana Deans et al., *For Your Interest? The Ethical Acceptability of Using Non-Invasive Prenatal Testing to Test 'Purely for Information*,' 29 BIOETHICS 19, 19 (2015) (describing the procedure as non-invasive prenatal testing, despite the fact that it is "still often regarded as only an 'advanced screening' method").

27. Sonia M. Suter, Reproductive Testing for Breast/Ovarian Cancer Risk 13 (2019) (unpublished manuscript) (on file with the author) ("[NIPT] was first used to detect fetal sex for purposes of assessing the risk of sex-linked genetic conditions and paternally inherited dominant genetic conditions, like achondroplasia. More recently, it has been used to detect aneuploidies with a high degree of accuracy, making it an 'advanced screening test.'").

28. HENRY T. GREELY, THE END OF SEX AND THE FUTURE OF HUMAN REPRODUCTION 86 (2016); *see* Wynter K. Miller & Benjamin E. Berkman, *The Future of Physicians' First Amendment Freedom: Professional Speech in an Era of Radically Expanded Prenatal Genetic Testing*, 76 WASH. & LEE L. REV. 577, 591 (2019) ("Since its clinical introduction in 2011, a handful of commercial providers have established a robust market for NIPT." (footnote omitted)). NIPT is now covered by major health insurance plans and it is also covered by Medicaid in some states when medically indicated (based on advanced maternal age, family history, or serum or ultrasound positive screens). *The Centers for Medicare and Medicaid Services Establishes 2017 Pricing for Aneuploidy and Microdeletion Testing*, NATERA (Dec. 1, 2016), https://www.natera.com/press-releases/centers-medicare-and-medicaid-services-establishes-2017-pricing-aneuploidy-and [https://perma.cc/UY4G-9QEK] (discussing Medicaid coverage); Sarah Elizabeth Richards, *A Safe Prenatal Genetic Test Is Gaining Popularity with Young Moms-to-be and Their Doctors*, WASH. POST (Jan. 5, 2019, 7:00 AM), https://www.washingtonpost.com/national/health-science/a-safe-prenatal-genetic-test-is-gaining-popularity-with-young-moms-to-be-and-their-doctors/2019/01/04/746516a2-f4f2-11e8-bc79-68604ed88993_story.html [https://perma.cc/XG93-NXYP](mentioning health insurance coverage). *But see* Alanna Autler, *Prenatal Testing Leads to Unexpected, Staggering Bills for Some Parents*, CBS DFW (Aug. 15, 2019, 1:08 PM), https://dfw.cbslocal.com/2019/08/15/prenatal-testing-leads-to-unexpected-staggering-bills-for-some-parents [https://perma.cc/R5DU-GUNY]. Several companies have marketed at-home prenatal testing kits for fetal sex.

29. Deans et al., *supra* note 26, at 20–21 (addressing the future impact of whole genome sequencing and the conditions that NIPT will be able to identify in the future); Tom Shakespeare

NIPT has already made a major impact on prenatal care; it is increasingly accurate, affordable, and desirable.[30] But the expansion of NIPT does not necessarily resolve the dilemmas of interpreting genetic information, which, as many scholars across disciplines have noted, seemingly offers easy answers to complicated questions.[31] The results of genetic screening depend on probabilities, and the detection of a chromosomal anomaly does not tell a person about the onset, severity, or penetration of the condition.[32] A series of genetic interactions and environmental factors determine whether and to what extent a condition manifests, and whether genes turn on or off. As Dorothy Roberts makes clear, in the broader context of genetic testing,

> [t]elling consumers that their DNA can predict their chance of getting diabetes, doing well on a test, or winning a marathon simply falsifies what DNA does. Having a gene that a computer has linked to a disease or a trait may not even be relevant because it could be overridden by other mutations that were not tested or whose impact remains unknown.[33]

With NIPT, prospective parents may be able to learn more prenatal genetic information, but some of that information will have unknown significance or ambiguous implications for resulting children.[34] Some conditions that NIPT

& Richard Hull, *Termination of Pregnancy After Non-Invasive Prenatal Testing (NIPT): Ethical Considerations*, 6 J. PRAC. ETHICS 32, 33–34 (2018) (noting that whole genome sequencing is becoming cheaper and can identify a range of genetic conditions as well as variants of unknown significance).

30. *See* Steven Salzberg, *A DNA Sequencing Breakthrough That Many Expectant Moms Will Want*, FORBES (Mar. 9, 2014, 8:00 AM), www.forbes.com/sites/stevensalzberg/2014/03/09/a-dna-sequencing-breathrough-that-many-expectant-moms-will-want [https://perma.cc/M985-BKGQ]; Michael Specter, *The Gene Factory*, NEW YORKER (Dec. 30, 2013), https://www.newyorker.com/magazine/2014/01/06/the-gene-factory [https://perma.cc/GQB8-PTKU].

31. Kaja Finkler, *Family, Kinship, Memory and Temporality in the Age of the New Genetics*, 61 SOC. SCI. & MED. 1059, 1060 (2005) ("Unlike in the past, when ideas about heredity may have been understood in terms of 'like begets like,' the new genetics engenders the idea of causation." (footnote omitted)).

32. *Id.*; *see* Bennett et al., *supra* note 26, at 199; *see also* Bret D. Asbury, *Counseling After CRISPR*, 21 STAN. TECH. L. REV. 1, 19 (2018). NIPT, when applied beyond aneuploidies, such as Down syndrome, or single gene disorders, like cystic fibrosis, to multifactorial conditions—for example, diabetes or heart disease—may only reveal a propensity to develop a medical condition or express a trait. Peter A. Benn & Audrey R. Chapman, *Ethical Challenges in Providing Noninvasive Prenatal Diagnosis*, 22 CURRENT OPINION OBSTETRICS & GYNECOLOGY 128, 128–29 (2010).

33. DOROTHY ROBERTS, FATAL INVENTION: HOW SCIENCE, POLITICS, AND BIG BUSINESS RE-CREATE RACE IN THE TWENTY-FIRST CENTURY 204 (2011) [hereinafter ROBERTS, FATAL INVENTION]; *see also* GREELY, *supra* note 28, at 71–72.

34. *See* Greer Donley et al., *Prenatal Whole Genome Sequencing: Just Because We Can, Should We?*, 42 HASTINGS CTR. REP. 28, 40 n.34 (2012); Miller & Berkman, *supra* note 28, at 579–80 (predicting that, with the introduction of prenatal whole genome sequencing, "[g]enetic information will become far more accessible, but its contents will be less understood").

will reveal are treatable after birth or *in utero*, while others will occur later in life (Huntington's disease, for example) or might never develop.[35]

Yet popular writings, as well as some legal and medical scholarship, embrace genomic science as the key to understanding one's identity. This might help explain the understandable but at times unquestioned embrace of prenatal testing and screening. "Genetic essentialism" is the belief "that our genes and our DNA are the essence, the core, the most important constituent part of who we are as human beings."[36] Leslie Bender has criticized this view, explaining that "[i]t ignores the ways our cells and environments interrelate, the ways our physiological system functions as a whole organism, and the ways our minds and hearts affect our being."[37] Naomi Cahn expressed a similar concern that fertility services in particular "raise the danger of overemphasizing one's genetic identity" by promoting "the concept that a person is the sum of her genes."[38]

Beliefs about the importance of genetic ties and genetic characteristics, however, are socially constructed and racially coded, and these beliefs inform decisions about prenatal testing and screening.[39] Mirroring broader healthcare disparities, NIPT's use is stratified by socioeconomic status, income, geography, and race.[40] Even as access to NIPT has expanded because

35. Asbury, *supra* note 32, at 16 (increasing availability of *in utero* treatment of genetic disease); Bennett et al., *supra* note 26, at 200 (testing NIPT for the BRCA gene); Deans et al., *supra* note 26, at 22–23 (analyzing NIPT for late onset disorders). For an overview of perinatal treatment, see Colleen Malloy et al., *The Perinatal Revolution*, 34 ISSUES L. & MED. 15, 28–29 (2019) (noting future *in utero* treatments for some of the conditions NIPT identifies).

36. Leslie Bender, *Genes, Parents, and Assisted Reproductive Technologies: ARTs, Mistakes, Sex, Race, & Law,* 12 COLUM. J. GENDER & L. 1, 4 (2003).

37. *Id.*; *see also* Dorothy E. Roberts, *The Genetic Tie*, 62 U. CHI. L. REV. 209, 219 (1995) [hereinafter Roberts, *The Genetic Tie*] (discussing the scholarship of Rochelle Cooper Dreyfuss and Dorothy Nelkin).

38. *See* Naomi Cahn, *The New Kinship*, 100 GEO. L.J. 367, 418 (2012).

39. ROBERTS, FATAL INVENTION, *supra* note 33, at 210 ("Race is treated as a key—even essential—classification in the genetic research and testing that informs biocitizenship."); *see also* Roberts, *The Genetic Tie*, *supra* note 37, at 222–23 (discussing the social invention of race and the increasing emphasis on prenatal testing, among other reproductive technologies). Khiara Bridges argued that surrogacy's "disproportionate use by white persons function[s] to venerate white reproduction; meanwhile, other coercive reproductive policies aimed at black women function to discourage, disparage, and denounce black reproduction." Khiara M. Bridges, Windsor*, Surrogacy, and Race*, 89 WASH. L. REV. 1125, 1135 (2014).

40. Deans et al., *supra* note 26, at 25 ("Testing for non-medical traits using NIPT is likely to be considered outside the remit of either private health insurance or a state-funded health service, possibly rendering this kind of testing a luxury only for those who can afford it."); *see also* Bernard M. Dickens, *Ethical and Legal Aspects of Noninvasive Prenatal Genetic Diagnosis*, 124 INT'L J. GYNECOLOGY & OBSTETRICS 181, 182 (2014) (describing disparities in NIPT and genetic counseling). *See generally* Rachel Rebouché & Scott Burris, *The Social Determinants of Health*, *in* OXFORD HANDBOOK OF U.S. HEALTH LAW (I. Glenn Cohen et al. eds., 2016) (analyzing the role of income in determining individuals' and populations' ability to gain access to health resources); Radhika Rao, *Equal Liberty: Assisted Reproductive Technology and Reproductive Equality*, 76 GEO. WASH. L. REV. 1457 (2008) (assessing socio-economic and racial disparities in ART generally).

of changes in health insurance coverage,[41] genetic testing has been and continues to be tied to race and income.[42] As Roberts explains, "wealthy white women have access to technologies designed to produce genetically screened babies, [while] an assortment of laws and policies discourage women of color from having babies at all."[43] In the context of gestational surrogacy, the main beneficiaries of NIPT are intended parents, who typically have financial resources at their disposal.[44] Moreover, those who can afford prenatal testing face social pressures to screen a pregnancy and to learn as much information about potential children as possible.[45] Roberts and others also highlight the negative judgements of people who chose *not* to terminate pregnancies after learning of various fetal conditions.[46] Genetic essentialism underpins both the

41. *See, e.g.*, Diana W. Bianchi et al., *DNA Sequencing Versus Standard Prenatal Aneuploidy Screening*, 370 NEW ENG. J. MED. 799, 806 (2014) (describing research that supports NIPT for people at low risk of carrying fetuses with genetic abnormalities); *see also* TEX. MEDICAID & HEALTHCARE P'SHIP, NON-INVASIVE PRENATAL TESTING (NIPT), *available at* http://www.tmhp.com/Manuals_HTML1/TMPPM/Archive/2016/Vol2_Gynecological_and_Reproductive_Health_Services_Handbook.20.065.html [https://perma.cc/2Q68-SMFN] (describing recommendations and the testing process for Medicaid-covered NIPT).

42. ROBERTS, FATAL INVENTION, *supra* note 33, at 202, 210; Michele Goodwin, *A View from the Cradle: Tort Law and the Private Regulation of Assisted Reproduction*, 59 EMORY L.J. 1039, 1066 (2010) (analyzing race preferences and hierarchies in ART generally: "[n]ot all ART families have been received with warm embrace").

43. ROBERTS, FATAL INVENTION, *supra* note 33, at 213. In FATAL INVENTION, Roberts noted how genetic technologies, like genetic testing, are now marketed to women of color: "The recent expansion of both reproductive genetic screening and race-based biomedicine signals a dramatic change in the racial politics of reproductive technologies . . . the high-tech fertility business, including genetic screening services, no longer appeals to an exclusively white clientele." *Id.* at 214; *see also* Dorothy E. Roberts, *Race, Gender, and Genetic Technologies: A New Reproductive Dystopia?*, 34 SIGNS 783, 786 (2009).

44. As discussed in Part IV, gestational surrogates tend to be white and financially stable. *See infra* note 220. Khiara Bridges explains that previous writings on surrogacy

> imagined a dystopic future in which there exists a 'breeder class' composed of indigent black women, their reproductive capacities readily available for purchase by infertile, wealthy white couples who seek to use black women's bodies to overcome their own physical limitations and to have children that were their genetic progeny.

Bridges, *supra* note 39, at 1134. That vision did not come to pass, although, as Bridges notes, it is important to consider why surrogates are predominantly white: "[C]ritical thinkers about race may be disturbed by that very fact: *women of color are not being commissioned to act as surrogates*. We have to wonder why. It might be that the reproductive capacities of white women are simply more highly valued than those of women of color." *Id.* at 1140.

45. *See* Rachel Rebouché & Karen Rothenberg, *Mixed Messages: The Intersection of Prenatal Genetic Testing and Abortion*, 55 HOW. L.J. 983, 986 (2012).

46. ROBERTS, FATAL INVENTION, *supra* note 33, at 217 ("Using reprogenetics to select the traits of children may become more of a general duty than a privileged choice . . . [pregnant women] are typically expected to opt for abortion to select against any disabling traits identified by genetic testing."); *see* Karen H. Rothenberg, *The Law's Response to Reproductive Genetic Testing: Questioning Assumptions About Choice, Causation, and Control*, 8 FETAL DIAGNOSIS & THERAPY 160, 160–63 (1993) (summarizing literature on the pressure pregnant women feel to have prenatal testing); *see also* R. Alta Charo & Karen H. Rothenberg, *"The Good Mother": The Limits of Reproductive*

assumption that people will terminate certain pregnancies and the castigation of those who choose not to have an abortion. Although NIPT's influence on the termination of pregnancies is unclear, most writing in the area assumes that as NIPT reveals more information about fetal health and fetal characteristics, patients will choose to end pregnancies based on that information.[47] NIPT, so early in pregnancy and on a path of offering more information, could "mak[e] it tempting to test simply to know," based on the premise that procuring all available genetic information is beneficial.[48]

Existing links between technology and prenatal decision-making suggest a powerful role for NIPT with respect to gestational surrogacy. Genetic essentialism underpins the dominant expectation that gestational surrogacy contracts should include clauses on prenatal testing and supports the belief that contracts should place all manner of pregnancy-related decisions in the hands of intended parents. Contracting with someone else to carry a pregnancy provides a distinctive opportunity for expressing those desires through law. As I discuss in the next Part, statutes on surrogacy allow parties to contract for prenatal testing, and the contracts they draft vest intended parents with the power to screen for certain genetic conditions. In pursuit of genetically curated children, surrogacy law and clinical practice intersect to deliver prenatal information that promises to proliferate in an era of NIPT.[49]

Accountability and Genetic Choice, *in* WOMEN AND PRENATAL TESTING: FACING THE CHALLENGES OF GENETIC TECHNOLOGY 105, 105–07 (Karen H. Rothenberg & Elizabeth J. Thomson eds., 1994) (discussing the social influences and pressures on pregnant person's choices regarding testing).

47. A negative result may discourage pregnant women from pursuing invasive testing, which would confirm or refute a prenatal diagnosis. False negatives yielded by NIPT would not result in termination because a fetal condition might go undiscovered. Rebouché, *Testing Sex*, *supra* note 25, at 531–34 (noting disagreements about how or if NIPT will influence the prevalence or occurrence of abortion). The same concern—NIPT leading to an increase in abortion—could manifest with false positives (incorrect identification of a disorder); however, in the context of NIPT, false positives are rare and current clinical practice is to confirm a positive NIPT screen with amniocentesis or CVS. Bennett et al., *supra* note 26, at 198.

48. Suter, *supra* note 27, at 44–45 ("[P]arents might tend to overestimate the value of obtaining the information and underestimate the full relational implications, particularly if they consider the risks and benefits only in medical terms. The tendency, therefore, may be to focus primarily on the positive value of obtaining this information, making it tempting to test simply to know."). In the context of NIPT, Zuzana Deans and her colleagues have argued that testing purely for informational purposes "will not always be appropriate," especially if carried out for trivial reasons or for certain non-medical traits. Deans et al., *supra* note 26, at 23.

49. Pre-pregnancy testing of embryos occurs through pre-implantation genetic diagnosis ("PGD"). At present, but perhaps not for long, PGD is cost prohibitive for many people. *See generally* GREELY, *supra* note 28 (exploring possible consequences of the proliferation of PGD, dubbed by Greely "Easy PGD"). This Article focuses on NIPT because PGD remains cost-prohibitive for most intended parents whereas NIPT is decreasing in cost and increasingly available.

III. THE REGULATION OF GESTATIONAL SURROGACY CONTRACTS

This Part describes contemporary surrogacy regulation and examines the prevalent language in surrogacy contracts on pre-pregnancy counseling, prenatal care, and termination of pregnancy. It notes a recurrent tension in both statutes and contracts between intended parents' desire to manage the pregnancy and surrogates' rights as patients. In each Section below, I explore how law and contract try to resolve that tension and explain why, without a fuller examination of how agreements are implemented by health and legal professionals (an examination I provide in the final Part of this Article), statutes and contracts tell only a partial story of what happens when disputes arise over prenatal care.

A. SURROGACY CONTRACTS UNDER STATE LAW

Forty-six states currently permit gestational surrogacy contracts, either through statute or case law.[50] Two of those states—Louisiana and Nebraska—permit uncompensated surrogacy only,[51] although contracts may provide for the surrogate's lost wages or educational opportunities, insurance, attorney fees, medical expenses, pregnancy-related expenses, other living expenses, housing subsidies, and food costs.[52] Of four states that currently ban surrogacy contracts, New York and Michigan punish compensated surrogacy as a crime and will not enforce uncompensated agreements; both states, however, are considering bills to permit compensated surrogacy.[53] The other

50. *See* Douglas NeJaime, *The Nature of Parenthood*, 126 YALE L.J. 2260 app. E (2017); *see also* Joseph F. Morrissey, *Surrogacy: The Process, the Law, and the Contracts*, 51 WILLAMETTE L. REV. 459, 486 (2015); CREATIVE FAMILY CONNECTIONS, THE UNITED STATES SURROGACY LAW MAP: STATE-BY-STATE GESTATIONAL SURROGACY LAW AND STATUTES, *available at* https://www.creativefamilyconnections.com/us-surrogacy-law-map [https://perma.cc/DQ9S-TEVP].

51. LA. STAT. ANN. § 9:2720(c) (2016) (explicitly prohibiting compensated surrogacy); NEB. REV. STAT. § 25-21 (2007).

52. I. Glenn Cohen & Katherine L. Kraschel, *Gestational Surrogacy Agreements: Enforcement and Breach*, *in* HANDBOOK OF GESTATIONAL SURROGACY, *supra* note 13, at 85, 87. Moreover, contemporary courts have not scrutinized the nature and amount of payment received by surrogates for living or non-medical expenses. In one study, surrogates described compensation for lost wages as their most important financial concern. Zsuzsa Berend, *The Emotion Work of a "Labor of Love:" An Ethnographic Account of Surrogacy Arrangements in the United States*, *in* HANDBOOK OF GESTATIONAL SURROGACY, *supra* note 13, at 63.

53. MICH. COMP. LAWS §§ 722, 855–59 (1988); N.Y. DOM. REL. LAW § 122 (McKinney 2010). In 2017 and in 2019, the New York legislature considered a bill that would have permitted gestational surrogacy, but subject to certain constraints on the intended parents and eligibility requirements for a surrogate. *See* Assemb. B. 1071C, 2019–2020 Leg., Reg. Sess. (N.Y. 2019) *available at* https://www.nysenate.gov/legislation/bills/2019/a1071/amendment/c [https://perma.cc/9S3K-29CM]; S.B. 2071, 2019–2020 Leg., Reg. Sess. (N.Y. 2019), *available at* https://www.nysenate.gov/legislation/bills/2019/s2071/amendment/b [https://perma.cc/AH6P-M8TM]; KALANTRY ET AL., *supra* note 3, at 7. The New York bill tracks the approach of new legislation passed in Maine, Washington, and New Jersey, described in the text. The proposed legislation has been the subject of debate, particularly among feminists. Vivian Wang, *Surrogate Pregnancy Battle Pits Progressives Against Feminists*, N.Y. TIMES (June 12, 2019), https://

two states that ban surrogacy contracts, Arizona and Indiana, do not punish people involved in surrogacy arrangements but will not enforce surrogacy agreements, whether compensated or not.[54]

Almost two dozen states that permit surrogacy do so by statute, and more states are likely to regulate surrogacy through legislation in the future.[55] In allowing gestational surrogacy in general, state statutes have imposed a variety of requirements on surrogates and intended parents.[56] To name a few, surrogates must meet age thresholds or have given birth previously; in some states, intended parents must be married, infertile, or state residents.[57]

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www.nytimes.com/2019/06/12/nyregion/surrogate-pregnancy-law-ny.html [https://perma.cc/Z5ZT-QX9F]. For the Michigan bill, see *supra* Part I.

54. ARIZ. REV. STAT. § 25-218 (LexisNexis 2011); IND. CODE § 31-20-1-1 (2006). In jurisdictions that will not enforce surrogacy contracts, lawyers in the state are careful to draft agreements with clear choice of law provisions and to work with gestational surrogates, brokers, and clinics who are not residents of the state. In 2020, Indiana will consider a bill that would repeal the prohibition of surrogacy agreements and enact the Indiana Gestational Surrogacy Act. This bill tracks the protections for intended parents and surrogates described in this Part. H.B. 1413, 121st Gen. Assemb., 2d Reg. Sess. (Ind. 2020); *see* Ind. Code § 31-20-1-1 (2006).

55. Seventeen states do not have legislation prohibiting, permitting, or regulating surrogacy; most of those states have case law permitting surrogacy. *See Surrogacy Laws*, SURROGACY EXPERIENCE, https://www.thesurrogacyexperience.com/u-s-surrogacy-law-by-state.html [https://perma.cc/R645-RGD6] (showing an interactive map and providing a summary of gestational surrogacy laws in the United States). Courts have determined parties' parental rights by applying tests based on the intent of the parties or best interests of the child. *See* Johnson v. Calvert, 851 P.2d 776, 782 (Cal. 1993) (holding, in a dispute between a gestational surrogate and intended parents, that "she who intended to bring about the birth of a child that she intended to raise as her own—is the natural mother under California law"). *But see In re* Baby M., 537 A.2d 1227, 1238 (N.J. 1988) (holding that surrogacy contracts were unenforceable after a traditional surrogate sued for custody of the resulting child; the father received custody and the surrogate mother received visitation based on the court's interpretation of the best interests of the child). Even in states without permissive statutes or case law, Deborah Forman notes that "[l]awyers routinely obtain prebirth orders naming intended parents as the legal parents of children born from surrogacy . . . ." Forman, *supra* note 20, at 33 n.20 (citing Diane S. Hinson & Maureen McBrien, *Surrogacy Across America*, 34 FAM. ADVOC. 32 (2011)).

56. *See, e.g.*, UNIF. PARENTAGE ACT § 802 (UNIF. LAW COMM'N 2017) (requiring that surrogates be at least "21 years of age," "given birth to at least one child," undergo mental and medical examinations, and have independent counsel paid for by the intended parents).

57. The 2017 UPA draws from various state approaches. *Id.* § 802 cmt. ("Most of these recently adopted surrogacy provisions include similar requirements regarding age, medical and mental health evaluations, and independent counsel . . . [a]nother requirement . . . is that the surrogate have 'given birth to at least one live child.'"(citing D.C. CODE § 16-405(a)(2) (2019) and ME. REV. STAT. ANN. tit. 19-A, § 1931(1)(B) (2018))). Marriage equality established under *Obergefell v. Hodges* has called into question the explicit and de facto exclusion of same-sex couples or LGBTQ individuals from contracting as intended parents. Obergefell v. Hodges, 135 S. Ct. 2584, 2598 (2015); *see also* NeJaime, *supra* note 50, at 2376–81 (citing LA. STAT. ANN. § 9:2720.2(1)(2018), which requires use of gametes by both intended parents). In 2019, the Utah Supreme Court held that after *Obergefell*, a provision in the Utah Uniform Parentage Act "requir[ing] that medical evidence . . . show[] that the intended mother is medically incapable of bearing a child" contravened the due process and equal protection rights of same-sex male parents because it requires "at least one of the intended parents is female." *In re* Gestational Agreement, 449 P.3d 69, 82–84 ¶¶ 44, 55 (Utah 2019).

Courtney Joslin provides a comprehensive typology of how states now regulate surrogacy, detailing the differing treatment of intended parents and surrogates across state lines and among states with divergent political affiliations.[58]

Though surrogacy laws vary state to state, surrogacy practices make those distinctions less salient. Contracting parties routinely cross state lines to obtain services, facilitated by national fertility agencies; contracts include choice of law provisions; and detailed guides (online and in print) advise intended parents how to navigate the differences in states' laws.[59] The emerging regulatory picture is thus complicated. Seeking to clarify surrogacy's legal status, states increasingly pass laws that formalize the rights of intended parents and protect the autonomy of surrogates.[60] To ensure these aims are met, new legislation requires "psychological evaluation" and independent legal counsel for all parties.[61] Although targeting important issues in surrogacy contracts—seeking to clarify the stakes of contracts and ensure that parties are fit to enter an agreement—new laws do not necessarily reach the practices that have shaped surrogacy in the absence of legislative guidance. This is not only a matter of historical inertia, with states recently moving from prohibition to statutory permission, it also reflects technological advances, increased demand, and the interests of the fertility industry.

B. COUNSELING, PRENATAL SCREENING, AND DECISIONS DURING PREGNANCY

State surrogacy statutes focus on prenatal care and decision-making in a few notable ways. Drawing from the guidance of professional organizations, state laws require medical and psychological evaluation of surrogates as well as counseling or evaluation for intended parents. Statutes also permit

58. Courtney G. Joslin, (*Not) Just Surrogacy*, CALIF. L. REV. (forthcoming 2021) (manuscript at 8, 57), *available at* https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3561081 [https://perma.cc/LX2Z-682V] (noting, in a typology of rights and duties for intended parents and surrogates, that "control and surveillance of pregnant bodies run the political gamut").

59. Hillary L. Berk, *The Legalization of Emotion: Managing Risk by Managing Feelings in Contracts for Surrogate Labor*, 49 LAW & SOC'Y REV. 143, 153 (2015) [hereinafter Berk, *The Legalization of Emotion*] (noting that based on over 100 interviews with surrogacy attorneys, "two significant findings are that: (1) legal prohibitions do not prevent the practice and (2) surrogacy contracting has become multijurisdictional"); CREATIVE FAMILY CONNECTIONS, *supra* note 50.

60. Intended parents have circumvented state requirements, as well as the cost of U.S. surrogacy, by contracting for gestational surrogacy in another country. It is beyond the scope of this Article to analyze the market for international surrogacy and its relationship to U.S. demand for gestational surrogacy services. *See* Seema Mohapatra, *Stateless Babies & Adoption Scams: A Bioethical Analysis of International Commercial Surrogacy*, 30 BERKELEY J. INT'L L. 412, 413 (2012) ("International, or global, surrogacy is a booming business.").

61. *See, e.g.*, Assemb. B. 1704, 218th Leg., 2018 Sess. § (5)(a)(4)–(5), (b)(1)–(2) (N.J. 2018) (codified in scattered sections of N.J. REV. STAT. § 9:17) (permitting the intended parents to pay for the surrogate's representation); *see also* D.C. CODE §§ 16-405(a)(4)–(5), (b)(1)(B), -406(a)(3) (2017) (requiring "affirmation [that] all parties . . . ha[d] independent legal counsel" and that parties undertake joint counseling as well as separate "mental health evaluation" for the surrogate).

contracts to specify how a surrogate's prenatal care and prenatal screening is delivered and authorize restrictions on surrogate behavior that might harm the fetus. At the same time, state laws guarantee that surrogates can choose their treating physician and make all decisions concerning their pregnancy. Statutory provisions addressing remedies, as will be explained below, attempt to provide clarity about the consequences of violating contract terms even though the likelihood of their enforcement is uncertain at best.

1. Statutory and Professional Guidance on Prenatal Care

Medical and psychological evaluation of a potential surrogate seeks to assess the surrogate's physical and mental fitness.[62] Many statutes obligate intended parents to submit to psychological evaluation or mental health counseling as well.[63] For example, the 2018 New Jersey Gestational Carrier Act mandates psychological screenings for all parties as a requirement for a surrogacy contract's validity.[64] Similarly, in Maine, New Hampshire, Delaware, and Illinois, intended parents must undergo "a mental health evaluation" before a contract is executed.[65] Perhaps reflecting a new trend in regulation, the recent Washington D.C. statute requires surrogates and intended parents to "complete[] . . . a joint consultation with a mental health professional regarding issues that could arise during the surrogacy."[66]

Some statutes explicitly regulate the surrogate's medical care and behavior during pregnancy. For instance, Florida's statute directs surrogates "to submit to reasonable medical evaluation and treatment and to adhere to reasonable medical instructions."[67] Several state laws recognize contracts with terms for "[t]he gestational carrier's agreement to undergo all medical exams, treatments, and fetal monitoring procedures that the physician

62. *See, e.g.*, DEL. CODE ANN. tit. 13, § 8-806(a)(4) (West 2013); UTAH CODE ANN. § 78B-15-803(2)(d), (f) (LexisNexis 2005); VA. CODE ANN. § 20-160(B)(7) (West 2019); AM. BAR ASS'N MODEL ACT GOVERNING ASSISTED REPROD. § 201(2)(i) (AM. BAR ASS'N 2019).

63. CLARK ET AL., *supra* note 18, at 39–40, 64, 154. See, for example, New Hampshire's language on "physical medical evaluation" of surrogates which must follow "guidelines set forth by the American Society for Reproductive Medicine . . . ." N.H. REV. STAT. ANN. § 168-B:9(iii)–(iv) (LexisNexis 2014); *see also* AM. SOC'Y FOR REPROD. MED., THIRD-PARTY REPRODUCTION: A GUIDE FOR PATIENTS 16 (2018), *available at* https://www.reproductivefacts.org/globalassets/rf/news-and-publications/bookletsfact-sheets/english-fact-sheets-and-info-booklets/third-party_reproduction_booklet_web.pdf [https://perma.cc/B8RC-LAQ5] ("The carrier and intended parents should meet with the [mental health professional] to discuss the type of relationship they would like to have and expectations they have regarding a potential pregnancy.").

64. *See, e.g.*, Assemb. B. 1704, 218th Leg., 2018 Sess. § (5)(a)(4)–(5), (b)(1)–(2) (N.J. 2018).

65. DEL. CODE ANN. tit. 13, §§ 8-806(b)(1), -807(b)(2)(ii) (West 2013); 750 ILL. COMP. STAT. 47/20(b)(3) (2018); ME. REV. STAT. ANN. tit. 19-A, § 1931(2)(A) (2016); N.H. REV. STAT. ANN. § 168-B:8(i) (LexisNexis 2014).

66. D.C. CODE § 16-405(a)(5).

67. FLA STAT. ANN. § 63.213(2)(b) (West Supp. 2019).

recommends for the success of the pregnancy."[68] This language expresses the expectation that a surrogate will take prenatal tests and is coupled with intended parents' responsibility for "resulting children . . . regardless of the number, gender or mental or physical condition."[69]

As for during-pregnancy behavior, state statutes allow contract provisions requiring the surrogate "to abstain from any activities that the intended parent or parents or the physician reasonably believes to be harmful to the pregnancy and future health of the child."[70] This includes, but is not limited to, "smoking, drinking alcohol, using nonprescribed drugs, using prescription drugs not authorized by a physician aware of the gestational carrier's pregnancy, exposure to radiation, or any other activities proscribed by a health care provider."[71] At the same time, many statutes include general protection for a surrogate's right to make her own healthcare decisions. Maine's law, for example, provides that "[a] gestational carrier agreement may not limit the right of the gestational carrier to make decisions to safeguard her health."[72] Likewise, D.C.'s act states "that at all times during the pregnancy and until delivery, regardless of whether the court has issued an order of parentage, the surrogate shall maintain control and decision-making authority over the surrogate's body."[73] And many statutes include an explicit right for the surrogate to choose her own physician, while others condition the surrogate's physician choice on consultation with the intended parents.

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68. DEL. CODE ANN. tit. 13, § 8-807(d)(1) (West Supp. 2019); *see* 750 ILL. COMP. STAT. 47/25 (c)(3) (2018); NEV. REV. STAT. § 126.750(5)(b) (2017); OKLA. STAT. tit. 10 § 557.6(D)(1) (2019) (permitting contracts that ask a surrogate "to undergo all medical examinations, treatments and fetal monitoring procedures recommended for the success of the pregnancy by the physician providing care to the gestational carrier during the pregnancy"); *see also* Joslin, *supra* note 58 (manuscript at 31) (discussing laws that "permit contract clauses that *limit* or *override* the medical decision-making authority of the person acting as a surrogate with respect to her own body").

69. *See, e.g.*, ME. REV. STAT. ANN. tit. 19-A, §1932(3)(J)(4) (Supp. 2018).

70. DEL. CODE ANN. tit. 13, § 8-807(d)(2); 750 ILL. COMP. STAT. 47/25 (d); NEV. REV. STAT. § 126.750(5)(b); OKLA. STAT. tit. 10 § 557.6(D)(2); Joslin, *supra* note 58 (manuscript at 33) (noting that abstention clauses "could cover—and very often do cover—issues as far ranging as kind of food the person acting as a surrogate must eat, whether she can use a microwave, and whether and how much she can exercise").

71. DEL. CODE ANN. tit. 13, § 8-807(d)(2); 750 ILL. COMP. STAT. 47/25 (d); NEV. REV. STAT. § 126.750(5)(b). It is worth noting the many ways law demands particular behavior from people with low-incomes and pregnant people of color, through Medicaid or in criminal law, for example. *See generally* Michele Goodwin, *Fetal Protection Laws: Moral Panic and the New Constitutional Battlefront*, 102 CALIF. L. REV. 781 (2014) (discussing criminal laws that target the behavior of low-income pregnant women).

72. ME. REV. STAT. ANN. tit. 19-A, § 1932(5) (2019); *see also* FLA STAT. ANN. § 742.15(3)(a) (West 2019) (providing "that the gestational surrogate shall be the sole source of consent with respect to clinical intervention and management of the pregnancy").

73. D.C. CODE § 16-406(a)(4)(C) (2019). A recent report noted that the D.C. legislation has been a model for other states and represents best practices across states. KALANTRY ET AL., *supra* note 3, at 12.

For the latter, the Illinois and Delaware statutes guarantee "[t]he right of the gestational [surrogate/carrier] to utilize the services of a [physician/health care provider] of her choosing, after consultation with the intended parents, to provide her care during the pregnancy."[74] New Jersey also protects the right of a surrogate to choose her own treating physician, but requires her to notify the intended parents in writing (who are, as in other states, responsible for her healthcare costs) of her choice.[75] State laws thus send mixed messages: Surrogates should decide important aspects of their pregnancy care while ceding some control of their choices to intended parents during pregnancy.

Many of the state laws mentioned in this Section deem an arrangement valid if the parties meet pre-pregnancy evaluation and counseling requirements. But even if those requirements are not met, the contract may still be enforceable as a general matter. Most laws contemplate a judicial solution to any resulting dispute based on a court's assessment of the parties' intent.[76] The New Jersey statute provides an example: "In the event that any of the requirements of [the statute] are not met, a court of competent jurisdiction shall determine parentage based on the parties' intent."[77]

Tensions between the involvement of intended parents and the autonomy of surrogates are mirrored in the advice of professional organizations, which provide detailed guidance to state legislatures and are cited by state laws as standards that should be followed. The American Society for Reproductive Medicine ("ASRM") Recommendations for Practice Utilizing Gestational Carriers endorse screening for mental health issues and counseling for all parties before signing an agreement.[78] The ASRM Recommendations balance a surrogate's right to refuse or to accept medical interventions, including screening or testing, against the intended parents' "right to information" and provisions governing "behavior during pregnancy and methods for resolving conflicts (e.g., eating habits, prescription drugs,

74. DEL. CODE ANN. tit. 13, § 8-807(c)(3); 750 ILL. COMP. STAT. 47/25(c)(3). Although the language in these two statutes is nearly identical, the Illinois statute uses "surrogate" and "physician," whereas the Delaware statute uses "carrier" and "health care provider."

75. New Jersey Gestational Carrier Agreement Act, 2018 N.J. LAWS § (6)(b)(1)(c).

76. *See, e.g.*, 750 ILL. COMP. STAT. 47/25(e); NEV. REV. STAT. § 126.780(2); AM. BAR ASS'N MODEL ACT GOVERNING ASSISTED REPROD. art. VII, § 712 (AM. BAR ASS'N 2019) ("In the event of noncompliance with this Article, the appropriate Court of competent jurisdiction shall determine the respective rights and obligations of the parties to any Surrogacy Arrangement based solely on evidence of the parties' original intent.").

77. New Jersey Gestational Carrier Agreement Act § (6)(d).

78. American Society for Reproductive Medicine, *Recommendations for Practice Utilizing Gestational Carriers: An ASRM Practice Committee Guideline*, 97 FERTILITY & STERILITY 1301, 1304 (2012) ("The psychosocial evaluation and counseling should consider the impact of the pregnancy on family and community dynamics."). *See generally* AM. SOC'Y FOR REPROD. MED., *supra* note 63 (recommending consultation of an attorney knowledgeable in reproductive law and stating that gestational surrogacy contracts may include provisions regarding the expected behavior of the surrogate to ensure a healthy pregnancy).

alcohol)."[79] The American Bar Association's 2008 Model Act Governing Assisted Reproductive Technology likewise suggests that surrogacy contracts include clauses requiring a gestational surrogate to undergo all medical exams a physician recommends.[80] Yet the ABA Model Act also states: "A gestational agreement may not limit the right of the gestational carrier to make decisions to safeguard her health or that of the embryo(s) or fetus," or to terminate a pregnancy.[81] The same is true of a new version of the ABA Model Act, updated in 2019, which protects the right of the surrogate "to make any health and welfare decisions regarding the Surrogate and the Surrogate's pregnancy including continuation or termination of the pregnancy."[82]

A significant and recent development influencing the content of surrogacy contracts is the Uniform Law Commission's approval of the Uniform Parentage Act ("UPA") of 2017,[83] which has been introduced in several states and adopted by three.[84] Similar to the state laws described above, the UPA requires that both surrogates and intended parents undergo medical evaluations and mental health consultations before entering into the contract, and it requires representation by independent counsel.[85] The UPA does not include an explicit duty to undergo prenatal tests; instead, it requires contracts to detail how intended parents will cover surrogacy-related care for the surrogate and the resulting child or children.[86] The UPA emphasizes surrogates' rights to autonomy, providing that "[t]he agreement must permit

79. *Id.* at 1306.

80. AM. BAR ASS'N MODEL ACT GOVERNING ASSISTED REPROD. TECH. art. VII, § 703 (AM. BAR ASS'N 2008) (balancing the rights of surrogates and intended parents; requiring the surrogate (not the intended parents) to complete a mental health evaluation).

81. *Id.* § 701.

82. AM. BAR ASS'N MODEL ACT GOVERNING ASSISTED REPROD. art. VII, § 703 (AM. BAR ASS'N 2019).

83. UNIF. PARENTAGE ACT art. 8 (UNIF. LAW COMM'N 2017). The UPA 2017 distinguishes between traditional surrogacy—in which the surrogate is genetically related to the resulting child or children—and gestational surrogacy—in which the surrogate has no genetic relationship with the resulting child or children. The UPA 2000 authorized gestational surrogacy arrangements, though not traditional surrogacy. UNIF. PARENTAGE ACT art. 8 cmt. (UNIF. LAW COMM'N 2000) (amended 2002).

84. The UPA has been adopted by California, Vermont, and Washington. In 2019, the UPA was introduced in Pennsylvania, Connecticut, Rhode Island, and Massachusetts. *Parentage Act*, UNIF. LAW COMM'N (2020), https://www.uniformlaws.org/committees/community-home?CommunityKey=c4f37d2d-4d20-4be0-8256-22dd73af068f [https://perma.cc/BW6L-VUXG]; *see* Salyars, *supra* note 21, at 129–130; Daniel Schwartz, Comment, *Gestational Surrogacy Contracts: Making a Case for Adoption of the Uniform Parentage Act*, 33 WIS. J.L. GENDER & SOC'Y 131, 140 (2018).

85. UNIF. PARENTAGE ACT § 802(a)(3)–(b)(4) (UNIF. LAW COMM'N 2017). The UPA requires that "[T]he intended parent or parents must pay for independent legal representation for the surrogate." *Id.* § 803(8). The UPA 2017 imposes additional safeguards or requirements on gestational surrogacy agreements. *Id.* art. 8, pt. 2.

86. *Id.* § 804(a)(6).

the surrogate to make all health and welfare decisions regarding herself and her pregnancy."[87]

All three models—the UPA, the ABA Model Act, and the ASRM Recommendations—offer process protections with the end goals of conferring parentage on intended parents and preventing exploitation of gestational surrogates. However, these models and state statutes cannot entirely resolve the conflicting interests of intended parents and the rights of surrogates when there is a disagreement about prenatal care. When disagreements or disputes arise, some statutes include definitions of and consequences for non-compliance. Nevada's law defines non-compliance as "when [a surrogate or intended parents] breach any provision of the gestational agreement or fail to meet any of the requirements of [the statute]."[88] The New Hampshire statute addresses the potential effects of non-compliance: A contract should include "how, if the gestational carrier breaches a provision of this chapter or of the gestational carrier agreement, and such a breach causes harm to the resulting child, the gestational carrier will cover her potential liability for such harm."[89] Consider this provision alongside contract terms that include an "agreement to undergo all medical examinations, treatments and fetal monitoring procedures recommended for the success of the pregnancy."[90] Under New Hampshire's law, refusing prenatal testing that could have identified a harmful fetal condition might create liability for a surrogate.[91]

Against this backdrop of statutory regulation, contracts routinely and explicitly require prenatal testing and prohibit certain during-pregnancy activities. As the next Section makes clear, contractual language is often expressed in more strident and mandatory terms than contemplated by the model acts, professional guidance, and state laws.

87. *Id.* § 804(a)(7).

88. NEV. REV. STAT. § 126.780 (2017).

89. N.H. REV. STAT. ANN. § 168-B:11(IV)(e) (2017).

90. *See, e.g.*, NEV. REV. STAT. § 126.750(5)(a).

91. N.H. REV. STAT. ANN. § 168-B:18. A bill proposed in Minnesota appears to anticipate this type of liability. S.F. 1152, 91st Leg., 1st Reg. Sess. (Minn. 2019). The bill includes provisions on prenatal screening and during-pregnancy behavior in the vein of statutes described above —permission to "undergo all medical examinations, treatments, and fetal monitoring that her physician recommends for the success of the pregnancy" and "to abstain from any activities that her physician reasonably believes to be harmful to the pregnancy and future health of the child . . . ." *Id.* § 257.92(e)(1)–(2). Parties may also pursue damages except "no person is civilly or criminally liable for nonnegligent actions taken." *Id.* § 257.96. This covers the screening and behavior provisions in the statute. However, the "provision does not prevent liability or actions . . . based on negligent, reckless, willful, or intentional acts that result in damages to any party." *Id.*

2. Contractual Language on Prenatal Care and Its Enforcement

Gestational surrogacy contracts govern all manner of prenatal healthcare decision making.[92] Boilerplate contracts are available online and in handbooks for intended parents and their attorneys.[93] These handbooks instruct intended parents "to be highly involved in the pregnancy so that you know about the fetal environment."[94] The trend in state statutory law is to permit contracts with terms controlling prenatal testing, prenatal care, and counseling, but the actual language used in contracts is far more detailed with respect to prenatal care and during-pregnancy behavior than is contemplated by most state laws.

Model contracts in handbooks and available online contradict the protections that state statutes provide.[95] Many contracts allow intended parents to control a surrogate's medical care, usually on the recommendation of the treating physician.[96] Contracts also state that the intended parents may choose the treating physician and give intended parents a right to all timely and relevant information about the surrogate's pregnancy.[97] In one form contract, the provision on prenatal information reads: "The Surrogate and the Intended Parents agree to provide each other and all Responsible Physicians with access to the results of all relevant medical and psychological tests and to execute any additional documents necessary to assure that access."[98] Relatedly, contracts impose duties on surrogates that restrict their behavior, such as avoiding travel, stressful situations, or sexual intercourse during the third trimester of pregnancy (even though, by that time, the fetus'

92. *See generally* AM. SOC'Y FOR REPROD. MED., *supra* note 63 (discussing various healthcare decisions that are dictated by terms in surrogacy contracts); Brittney Kern, *"You are Obligated to Terminate This Pregnancy Immediately": The Contractual Obligations of a Surrogate to Abort Her Pregnancy*, 36 WOMEN'S RTS. L. REP. 344 (2015) (same).

93. Model agreements, mirroring a number of state laws, include duties to undergo tests for sexually transmitted infections (applicable to the surrogate's spouse as well), mental health assessments, and physical examinations in addition to prenatal testing. *See, e.g.*, 6F NICHOLS CYCLOPEDIA OF LEGAL FORMS ANN. § 148:79 (rev. Nov. 2019).

94. CLARK ET AL., *supra* note 18, at 96.

95. *See, e.g.*, N.J. STAT. ANN. § 9:17-61(b) (West 2019) ("It is the intent and purpose of the Legislature to: . . . (2) Protect all parties involved in gestational carrier agreements . . . .").

96. Forman, *supra* note 20, at 36.

97. *See* FLA STAT. ANN. § 63.213(3)(b) (West 2012); TEX. FAM. CODE ANN. § 160.754(g) (West 2014); VA. CODE ANN. § 20-163(a) (West 2017); *see also* Forman, *supra* note 20, at 34–35; Kristian Foden-Vencil, *An Explicit Contract Makes Surrogacy Viable for an Oregon Woman*, NAT'L PUB. RADIO (July 9, 2015, 4:19 AM), https://www.npr.org/sections/health-shots/2015/07/09/417116553/an-explicit-contract-makes-surrogacy-viable-for-an-oregon-woman [https://perma.cc/QX9Z-M298].

98. Morrissey, *supra* note 50, at 527 (providing sample language on intended parents' rights to prenatal information); *see also* AMI S. JAEGER, 2 CHILD CUSTODY AND VISITATION: PREPARING COLLABORATIVE REPRODUCTION AGREEMENTS § 11A.08 (referencing contract provisions governing the "[r]elease and sharing of medical records and information").

genetic relationship to an intended parent is not at issue).[99] In her extensive study of contract practices across jurisdictions, Hillary Berk found that

> [w]hen drafting surrogacy contracts, lawyers insert extensive lists of rules the surrogate must follow based on past agreements, and particular demands of the intended parents. Intended parents have ample power since they pay for the transaction. Contract rules may include the degree of an intended parents' surveillance over the surrogate, restrictions on the surrogate's daily activities, or requiring the surrogate to consume solely organic foods and supplements while prohibiting caffeine, sugar, or fast food throughout the pregnancy. Some rules require that the surrogate engage in a particular activity—like acupuncture or going to the gym—or prohibit her from doing so—such as bans on microwaves, hairspray, manicures, or changing cat litter.[100]

Because contract provisions "requiring" certain behaviors and restricting some activities are in tension with surrogates' autonomy rights, most contracts state that surrogates retain all rights to manage their medical information and care.[101] In this vein, agreements typically guarantee the surrogate's right of "sole consent" to testing, other medical procedures, and prenatal decision making.[102] But this language directly contradicts the rest of the contract. To address this contradiction, contracts include severability clauses or language that generally acknowledges that some provisions may not be enforceable in a court of law.[103]

Specifically, clauses that require surrogates to undergo prenatal testing are recommended by model contracts and handbooks. Sample contracts list the screening and testing the surrogate agrees to undertake, such as ultrasound and blood screening, as well as amniocentesis or chorionic villus

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99. *See, e.g.*, MELISSA A. TARTAGLIA, ADOPTION & SURROGACY IN FLORIDA: THE LEGAL AND PRACTICAL SOURCEBOOK FOR LAYPERSONS AND LAWYERS 247 (2011); 31 CALIFORNIA LEGAL FORMS–TRANSACTION GUIDE § 100.222 (2020) [hereinafter CALIFORNIA LEGAL FORMS] (stating, in a model contract, "Surrogate agrees to obtain prenatal examinations at least [*specify, e.g.*, once per month] during pregnancy, and any other physical examinations and medical tests . . . , and shall follow all medical instructions given to her by her obstetrician."); *see also* Forman, *supra* note 20, at 47 (noting contract language that restricts travel in the last months of pregnancy).

100. Berk, *The Legalization of Emotion*, *supra* note 59, at 156–57.

101. *See* Abigail Lauren Perdue, *For Love or Money: An Analysis of the Contractual Regulation of Reproductive Surrogacy*, 27 J. CONTEMP. HEALTH L. & POL'Y 279, 306–08 (2011); *see also* Berk, *The Legalization of Emotion*, *supra* note 59, at 151.

102. Meryl B. Rosenberg, *Critical Legal Considerations for All Parties to Surrogacy Arrangements*, 34 FAM. ADVOC. 23, 24 (2011).

103. *See* Hillary L. Berk, *Savvy Surrogates and Rock Star Parents: Compensation Provisions, Contracting Practices, and the Value of Womb Work*, 45 LAW & SOC. INQUIRY 1 (forthcoming 2020) (on file with author) [hereinafter Berk, *Savvy Surrogates*].

sampling ("CVS") if necessary.[104] NIPT has begun to appear in contracts as an additional form of prenatal screening, though its relatively recent introduction into clinical practice suggests there is a lag time for its incorporation. But it is only a matter of time until NIPT appears in boilerplates and model contracts available on the internet. Even without an explicit reference to NIPT, clauses currently refer to non-exclusive lists of prenatal testing, such as "any other procedure or test(s) used to diagnose severe fetus abnormality."[105] Because NIPT occurs early in pregnancy and relies on a painless blood sample, some contracts may characterize it as less burdensome than CVS or amniocentesis and thus less of an encroachment on the surrogate's bodily autonomy. Future contracts may treat NIPT like an ultrasound or blood-based screening—a non-invasive intervention that will not give rise to additional compensation as an invasive procedure would.[106]

When a surrogate or an intended parent breaches the agreement, contracts often obligate parties to repay any fees and expenses, as well as reasonable attorneys' fees. Whether most surrogates can reimburse intended parents as a practical matter has been a subject of debate.[107] Moreover, there are scarce examples of litigation concerning the breach of contract terms governing prenatal care. The reasons for a scarcity of examples are discussed in the next Sections. Suffice it to say that courts will not require specific performance of a clause governing personal behavior or medical care. Indeed, model acts like the UPA prohibit specific performance of an agreement to submit to medical procedures.[108] In addition, parties risk destroying their relationship and ending an arrangement if they were to sue for breach *during* a pregnancy.[109]

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104. *See, e.g.*, JAEGER, *supra* note 98, § 11A.08 (noting contracts should include "[p]renatal testing including amniocentesis, termination of pregnancy, miscarriage, multiple pregnancy and selective reduction").

105. *See, e.g.*, Forman, *supra* note 20, at 34 (detailing the provision of a contract that dealt with prenatal testing and the discovery of fetal abnormalities) (original author corrections omitted) (quoting Gestational Surrogacy Agreement, Exhibit A to Memorandum of Law in Opposition to Defendant's Motion to Dismiss, I G.8 (Stoyanov v. Kelley, Complaint ¶¶ 3, 5–6 (May 10, 2012)); *see also* TARTAGLIA, *supra* note 99, at 247 (providing an example of a contractual duty to undergo amniocentesis, CVS, and "other tests designed to detect genetic and congenital abnormalities").

106. Berk, *Savvy Surrogates*, *supra* note 103 (manuscript at 15) (noting contracts that provide additional payment for invasive procedures). Because a positive NIPT result would typically be confirmed by CVS or amniocentesis, references to invasive testing in contracts remain relevant. *See supra* note 47 and accompanying text.

107. *See, e.g.*, Forman, *supra* note 20, at 45.

108. UNIF. PARENTAGE ACT § 812 (c)–(d) (UNIF. LAW COMM'N 2017); AM. BAR ASS'N MODEL ACT GOVERNING ASSISTED REPROD. art. VII § 714 (AM. BAR ASS'N 2019) (prohibiting specific performance as a remedy for breach if the agreement limits the rights of the surrogate to make decisions regarding her own health).

109. Rather, courts have upheld or struck down gestational surrogacy contracts based on the state's public policy doctrine. *See* J.F. v. D.B., 879 N.E.2d 740, 741–42 (Ohio 2007); *In re* Baby S., 128 A.3d 296, 305 (Pa. Super. Ct. 2015) (holding that the absence of a legislative mandate in

The tensions between surrogates' rights as patients and intended parents' interests in a resulting child can cause a relationship to break down, although available evidence suggests that most agreements do not.[110] But it is difficult to know what happens when conflicting interests in controlling prenatal behavior and information produce disputes because those disagreements are managed within the confidential arrangement between the parties. When conflicts come to the fore, it is often over the decision to terminate the pregnancy after the relationship between intended parents and gestational surrogates has already deteriorated.[111]

C. ABORTION DECISIONS

1. Statutory and Professional Guidance on Abortion Decisions

Although statutes explicitly address the role of prenatal testing and prenatal behavior, state laws do not govern *how* contracts may address abortion; rather, statutes deal mostly with what contracts *cannot* require of surrogates. Statutes and recommendations of professional organizations offer scant guidance on addressing decisions to terminate a pregnancy. The ASRM, for instance, recommends that parties come to an "agreement" over the "[p]ossibility of abortion in the event of an abnormal fetus."[112] And states have addressed the issue of abortion decisions with vague statutory language that mirrors the ASRM guidelines. New Hampshire requires "[t]he express written agreement of all parties as to how decisions regarding termination of the pregnancy shall be made."[113]

State statutes, however, prohibit specific performance as a remedy to a surrogate's refusal to terminate a pregnancy.[114] For example, Maine, like other states, explicitly excludes specific performance of abortion terms:

Pennsylvania undermined the intended mother's argument that surrogacy arrangements contradict clear ethical or moral standards under the state's public policy doctrine); *In re* Baby, 447 S.W.3d 807, 833–37 (Tenn. 2014). *But cf. In re* Matter of Doe, 372 P.3d 1106, 1108 (Idaho 2016) (holding that an out-of-state traditional surrogacy contract contravened public policy because a state statute barred out-of-state adoptions).

110. *See* Forman, *supra* note 20, at 49–52 (discussing the role of lawyers, mental health professionals, and fertility agencies in communicating expectations and information to surrogates and intended parents).

111. Surrogacy contracts have captured headlines when intended parents attempt to enforce termination of pregnancy provisions. In 2013, a surrogate fled to Michigan, where surrogacy contracts are unenforceable, after the intended parents requested she terminate a pregnancy with severe fetal anomalies. Deborah Forman recounts that repeated ultrasounds revealed numerous fetal abnormalities, such as cleft palate, brain cyst, misplaced internal organs, and heart abnormalities, and that the surrogate offered to terminate the pregnancy for $15,000, which the intended parents refused to pay. Forman, *supra* note 20, at 29.

112. American Society for Reproductive Medicine, *supra* note 78, at 1305–06.

113. *See, e.g.*, N.H. REV. STAT. ANN. § 168-B:11(IV)(f) (LexisNexis 2017).

114. *See* Forman, *supra* note 20, at 42–45 (considering the case for damages after breach); *see also* Deborah S. Mazer, Note, *Born Breach: The Challenge of Remedies in Surrogacy Contracts*, 28 YALE J.L. & FEMINISM 211, 235–37 (2016) (arguing for liquidated damages).

"Specific performance is not an available remedy for a breach by the gestational carrier of any term in a gestational carrier agreement that requires the gestational carrier to be impregnated or to terminate a pregnancy."[115] The UPA captured this point of consensus and added that it "does not enlarge or diminish the surrogate's right to terminate her pregnancy."[116] Instead, the UPA aims to "clarif[y] that certain forms of specific performance are precluded, including a court order requiring a surrogate be impregnated, terminate or not terminate a pregnancy."[117] Scholarship in the area agrees that requiring specific performance of a termination provision would violate surrogates' constitutional rights to privacy and liberty.[118]

2. Contractual Language on Abortion and Its Enforcement

Despite prohibitions on specific performance, the agreements parties sign commonly contemplate a duty to end a pregnancy following prenatal testing.[119] Indeed, termination provisions in surrogacy contracts were at issue in the earliest, most iconic cases.[120] Evidence from studies of current

115. ME. REV. STAT. ANN. tit. 19-A, § 1938(5) (2018); *see also* NEV. REV. STAT. § 126.710(3) (2017) ("A gestational agreement is enforceable only if it satisfies the requirements of NRS 126.750.").

116. UNIF. PARENTAGE ACT § 804 (a)(7) (UNIF. LAW COMM'N 2017).

117. *Id.* § 812(d) cmt.

118. Forman, *supra* note 20, at 41; *see also* 750 ILL. COMP. STAT. 47/50(b) (2018) ("There shall be no specific performance remedy available for a breach by the gestational surrogate of a gestational surrogacy contract term that requires her to be impregnated."). Courts do not order specific performance of personal services. 71 AM. JUR. 2D *Specific Performance* § 179 (2020). The exception to this rule is a personal service with "a unique and peculiar value" that cannot be remedied by money damages; however, most have argued that the exception does not apply if specific performance would unreasonably interfere with privacy or personal liberty. Forman, *supra* note 20, at 40; *see also* Cohen & Kraschel, *supra* note 52, at 89. *But see* Julia Dalzell, Comment, *The Enforcement of Selective Reduction Clauses in Surrogacy Contracts*, 27 WIDENER COMMONWEALTH L. REV. 83, 105 (2018) ("Reproduction would qualify as an exceptional case or circumstance holding unique value—the life of a child. Damages are likely not enough to 'cover' the distress and burden of upbringing an unintended child or a child with severe disabilities. Therefore, specific performance is a more appropriate remedy." (footnotes omitted)).

119. *See* Kaiponanea T. Matsumura, *Public Policing of Intimate Agreements*, 25 YALE J.L. & FEMINISM 159, 161–62 (2013) (describing a surrogacy contract of the son of politician, Mitt Romney, which "requir[ed] the surrogate to 'abort, or not to abort, in accordance with the intended parents' decision'" upon discovery of a physical, genetic, or chromosomal abnormality (quoting *Mitt Romney's Son Signed 'Abortion' Clause in Surrogate Birth Contract*, TMZ (Sept. 21, 2012, 8:00 AM), https://www.tmz.com/2012/09/20/mitt-romney-son-tagg-abortion-clause-surrogate-birth-agreement-contract-bill-handel [https://perma.cc/Q4VS-T29Y])). For an example of abortion antipathy in state legislation, see S.B. 920, 2020 Leg., Reg. Sess. (Va. 2020) (pending bill that would invalidate any gestational surrogacy contract that requires an abortion or selective reduction).

120. *See supra* text accompanying note 55 (describing the iconic cases *In re Baby M.* and *Johnson v. Calvert*); *see also* CAROL SANGER, ABOUT ABORTION: TERMINATING PREGNANCY IN TWENTY-FIRST-CENTURY AMERICA 198–99 (2017) (noting paragraph 13 of the contract in the *Baby M.* case allowed for abortion "because 'the child has been determined by [the inseminating physician] to be physiologically abnormal'").

contractual language suggests that abortion clauses share similarities across jurisdictions regardless of what state law provides.[121]

Contract provisions typically address abortion in two ways. First, a clause governs involuntary termination—miscarriage or stillbirth—with corresponding duties, such as payment to the surrogate for pain and discomfort or to conclude the agreement.[122] Second, and more controversially, contract provisions address the voluntary termination of pregnancy, either when the surrogate wishes to abort or when intended parents request that a surrogate abort.[123] A request by intended parents for pregnancy termination usually is contingent on physician advice and on medical indications discovered through prenatal testing.[124] For instance, some agreements limit intended parents' requests for abortion to situations in which a physician recommends the termination and to protect the health of the surrogate or the fetus.[125] Contracts provide for additional payment after termination of the pregnancy on top of base compensation.[126]

Contracts also stipulate that intended parents may request termination of the pregnancy after discovering various prenatal conditions.[127] Contractual

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121. California is a jurisdiction hospitable to surrogacy and thus houses many of the country's larger fertility agencies. Under the California Family Code, if the gestational surrogate and the intended parent(s) enter into a contract that meets certain informational requirements (including date, names of donors and parties, coverage of medical expenses and health insurance coverage, description of surrogate's liabilities) and present it to a court, the intended parent(s) are listed on the birth certificate and assume all parental rights. CAL. FAM. CODE § 7962 (West 2020).

122. *See* Jill Wieber Lens, *Tort Law's Devaluation of Stillbirth*, 19 NEV. L.J. 955, 1002–03 (2019). *See generally* TARTAGLIA, *supra* note 99 (collecting the language of various surrogate contracts).

123. Glenn Cohen and Katherine Kraschel note that no court has considered a breach of contract claim when the surrogate has aborted the pregnancy over the intended parents' objections. Cohen & Kraschel, *supra* note 52, at 91.

124. *See* CALIFORNIA LEGAL FORMS, *supra* note 99, § 100.222 ("Surrogate agrees that she will not abort the fetus unless, in the professional medical opinion of her physician, abortion is necessary for her health [*add if desired:*, or unless amniocentesis reveals the presence in the fetus of genetic or congenital defects]." (alteration in original)).

125. Forman, *supra* note 20, at 34 (stating contracts "anticipate two potential scenarios: a fetus suffering from serious birth defects or a multiple pregnancy, where fetal reduction may be recommended to improve the outcome for the remaining fetus(es)" and "contracts provide that the intended parents have the right to make all termination decisions").

126. Berk, *Savvy Surrogates*, *supra* note 103 (manuscript at 13) (noting compensation can cover '"gestational services,' 'inconvenience,' 'pain and suffering,' or as one Texas lawyer characterized it, 'wear and tear on the female body'").

127. *See* JAEGER, *supra* note 98, § 11A.08; 2 KATHRYN KIRKLAND, CALIFORNIA FAMILY LAW PRACTICE AND PROCEDURE § 36.09 (2d ed. 2018); *Sample GS Contract*, ALL ABOUT SURROGACY, https://www.allaboutsurrogacy.com/sample_contracts/GScontract1.htm [https://perma.cc/V2P9-A8S8] ("If the fetus(es) has been determined by any designated physician to be physically or psychologically abnormal, the decision to abort the pregnancy or not to abort the pregnancy shall be the sole decision of the Genetic Father and Intended Mother."). Contracts also specify fetal characteristics that should not be the basis for voluntarily terminating the pregnancy, such as the sex of the fetus. *See, e.g.*, Morrissey, *supra* note 50, at 531–34.

language can range from open ended or for any reason to "extreme medical circumstances."[128] At present, parties typically limit termination for reason of serious medical condition. This is unsurprising given the time, expense, and hope that intended parents invest in the process. Some handbooks for intended parents suggest that parties should list the types of medical conditions that would trigger a clause on voluntary termination.[129] But the trend appears to leave words like "condition," "anomaly," "defect[]," or "abnormalit[y]" undefined.[130] Thus, current contractual language, even without mentioning NIPT, can already accommodate the range of conditions NIPT can and will reveal.

NIPT could encourage parties to specify fetal conditions or disabilities that correspond to developments in screening techniques. However, including a list of fetal disorders or traits subject to a voluntary abortion clause raises complicated legal and bioethical questions. Taking legal questions first, a number of states have passed laws to prohibit abortion on the ground of fetal disability, regardless of whether the pregnancy is part of a surrogacy arrangement. These laws are in direct response to the uptake of NIPT. For example, when the U.S. District Court for the Southern District of Indiana enjoined a 2016 state law that banned abortion "solely because the fetus has been diagnosed with, or has a potential diagnosis of, Down syndrome or any other disability,"[131] the court noted that an impetus for the law was NIPT:

> The State presents evidence that these provisions were passed in light of technological developments that allow the diagnosis or potential diagnosis of fetal disabilities to be made early in a pregnancy. In particular, cell-free fetal DNA testing is able to screen for several genetic abnormalities, including Down syndrome, as early as ten weeks into the pregnancy.[132]

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128. *Id.* at 532.

129. *See, e.g.*, AM. SOC'Y FOR REPROD. MED., *supra* note 63, at 16 (recommending counseling for gestational surrogates that should include discussion of "prenatal diagnostic interventions, fetal reduction and therapeutic abortion, and managing the relationship while respecting the carrier's right to privacy"); Perdue, *supra* note 101, at 307–08.

130. *See* CALIFORNIA LEGAL FORMS, *supra* note 99, § 100.222(2). Most contracts (and surrogacy statutes) require intended parents to take custody of the resulting child regardless of any anomalies detected by testing. *See, e.g.*, FLA. STAT. ANN. § 742.15(3)(d) (West 2016). However, some agreements will seek to relieve the intended parents from responsibility in cases of breach by the surrogate, although these provisions, like specific performance clauses governing surrogates' behavior, might be unenforceable.

131. Planned Parenthood of Ind. & Ky., Inc. v. Comm'r Ind. State Dep't of Health, 265 F. Supp. 3d 859, 862 (S.D. Ind. 2017); *see* IND. CODE §§ 16-34-4-6, 16-34-4-7 (2016), *invalidated by* Planned Parenthood of Ind. & Ky., Inc. v. Comm'r of Ind. State Dep't. of Health, 888 F.3d 300 (7th Cir. 2018). The Indiana law's reference to "potential diagnosis of any other disability" could describe a predisposition to genetic diseases, including those that only develop in adulthood. IND. CODE § 16-34-4-7.

132. *Planned Parenthood of Ind. & Ky.*, 265 F. Supp. 3d at 862.

On appeal, the U.S. Court of Appeals for the Seventh Circuit rejected the state's argument that genetic screening will result in discrimination against fetuses with disabilities and held that the provision was an unconstitutional restriction on an individual's right to pre-viability abortion.[133] A similar law passed in North Dakota (which banned abortion because of "any physical disfigurement, scoliosis, dwarfism, Down syndrome, albinism, amelia, or any other type of physical or mental disability, abnormality, or disease") and the U.S. Court of Appeals for the Eighth Circuit enjoined it on the same grounds—an unconstitutional restriction on women's right to pre-viability abortion.[134] These laws demonstrate that when state legislators address new technological developments like NIPT, anti-abortion animus can easily become their focus. On the one hand, state legislators want to help or at least not hinder gestational surrogacy. On the other hand, some lawmakers routinely legislate against abortion. State regulation, at present, has not used surrogacy statutes as vehicles for abortion restrictions; however, states are increasingly legislating at the intersection of abortion and genetic testing.[135]

As for bioethical questions, memorializing which fetal characteristics justify an abortion could entrench stereotypes about and prejudice against persons with disabilities.[136] Bioethicists have speculated about how NIPT will affect abortion decisions outside of the surrogacy contracts context:

> What makes this kind of prenatal screening problematic[] is the fact that there is no health benefit to be expected from the testing. There is no treatment for any of the conditions that can be tested for.

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133. *Planned Parenthood of Ind. & Ky.*, 888 F.3d at 307 ("The State urges that . . . it has compelling interests in prohibiting discrimination of particular fetuses in light of technological advances in genetic screening . . . . We cannot reweigh a woman's privacy right against the State's interest. The Supreme Court has been clear: the State may inform a woman's decision before viability, but it cannot prohibit it." (citations omitted)).

134. H.B. 1305, 63d Leg. Assemb., Reg. Sess. §§ 1(6), 2(1)(b) (N.D. 2013); *see* LA. STAT. ANN. 40:1061.1.2 (2016) (prohibition to terminate "solely because the unborn child has been diagnosed with either a genetic abnormality or a potential for a genetic abnormality"); *see also* MKB Mgmt. Corp. v. Stenehjem, 795 F.3d 768 (8th Cir. 2015) (striking down the entire bill but not discussing the provision on fetal disability). A challenge to the Louisiana law ultimately was dismissed on the ground that the plaintiffs had no standing because all abortions were banned at 20 weeks. June Med. Servs. v. Gee, 280 F. Supp. 3d 849, 863–64 (M.D. La. 2017). In December 2019, the Sixth Circuit affirmed a preliminary injunction of an Ohio law banning abortion on the basis of a Down syndrome diagnosis. Preterm-Cleveland v. Himes, 944 F.3d 630, 631 (6th Cir. 2019) (holding there is a categorical right to pre-viable abortion). In January 2020, the Sixth Circuit decided to hear the appeal *en banc*.

135. *See* Rebouché & Rothenberg, *supra* note 45, at 985; *see also* Rebouché, *Testing Sex*, *supra* note 25, at 575 (noting that state laws do not typically seek to control what prenatal information parents may learn; contrasting that to the policies of other countries that permit prenatal testing for only certain conditions).

136. *See* Giovanni Rubeis & Florian Steger, *A Burden from Birth? Non-Invasive Prenatal Testing and the Stigmatization of People with Disabilities*, 33 BIOETHICS 91, 92 (2019) (noting "NIPT is not regarded as a value-neutral medical procedure but as a discriminatory practice that aims at the reduction of the births of children with disabilities").

> Therefore, the procedure is simply a means of decision-making and selection for the pregnant woman or the reproduction partners. Following this approach, NIPT is directed at selecting worthy lives over those that are deemed unworthy. Therefore, a normalization of elective abortion due to minor abnormalities or even sex may be a consequence of the easy availability of NIPT.[137]

Related to gestational surrogacy, concerns about the use of prenatal genetic testing when controlled or heavily influenced by intended parents might be exacerbated. An intended parent is not pregnant and does not make testing decisions as a pregnant person might, perhaps feeling distance between themselves and the pregnancy without the physical experience of gestation. Moreover, intended parents, as consumers of reproductive services, may have a stronger impulse to "creat[e] . . . perfect child[ren] . . . [who are] products one selects."[138] Genetic essentialism is not just the belief that one's identity is tethered to a genetic profile. It is also the desire to have children that are the best expression of one's genes, and genetic screening can be a tool for realizing that desire.

Contract clauses address the surrogate's right to decide to terminate the pregnancy.[139] Although some contracts discuss permissible reasons for abortion, others include language suggesting that termination provisions are enforceable (even when they are not) or ask a surrogate to waive her right to abortion.[140] Many contracts also require, rather than request, that surrogates waive their constitutional right to an abortion.[141] A contract available in a Minnesota form book provides:

> Notwithstanding the [surrogate's constitutional right to an abortion], it is Gestational Carrier's express intent to contractually waive, and she does hereby expressly contractually waive, that constitutional right, and Gestational Carrier hereby expressly grants Genetic Parents the exclusive right and sole discretion whether to

137. *Id.* at 92 (citations omitted).

138. *Id.* at 95.

139. "To the extent that surrogacy contracts have acquired 'boilerplate' language, the surrogate's right to terminate the pregnancy even when there is no imminent danger to her health has become part of the standard form." Teresa Donaldson, Note, *Whole Foods for the Whole Pregnancy: Regulating Surrogate Mother Behavior During Pregnancy*, 23 WM. & MARY J. WOMEN & L. 367, 391 (2017); *see* AM. BAR ASS'N MODEL ACT GOVERNING ASSISTED REPROD. art. VII, § 701(3) (AM. BAR ASS'N 2019) (agreeing to serve as a gestational surrogate "does not enlarge or diminish the surrogate's right to terminate or to continue the pregnancy").

140. Berk, *Savvy Surrogates*, *supra* note 103 (manuscript at 22); *see supra* Section III.B. *See generally* Cathy Hwang, *Faux Contracts*, 105 VA. L. REV. 1025 (2019) [hereinafter Hwang, *Faux Contracts*] (arguing that parties include unenforceable and non-binding agreements to work out what each party wants from the deal and to cultivate a positive relationship for future contracts).

141. Berk, *Savvy Surrogates*, *supra* note 103 (manuscript at 22). Berk also notes that 83 percent of contracts she reviewed "plainly state that the surrogate retains her fundamental constitutional right to carry, or not carry, a pregnancy to term." *Id.* (manuscript at 21).

> terminate a pregnancy by abortion or continue a pregnancy. Gestational Carrier expressly agrees to execute any necessary addenda, waivers, consents, or other related documents to reaffirm her contractual waiver of this constitutional right and to make this waiver effective once a pregnancy is confirmed. All parties expressly acknowledge that it is unclear whether this contractual waiver will be enforced as intended by a court of competent jurisdiction.[142]

The validity of waiving one's abortion right has been the subject of scholarly debate.[143] As the last line of the contractual provision quoted above makes plain, contracts acknowledge that courts may not enforce a waiver provision. Nevertheless, surrogacy contracts routinely attach financial liability to breach of abortion clauses.[144] When the surrogate breaches, either by refusing abortion or having an abortion outside of the contract's parameters, penalties can take the form of reimbursement for certain fees or expenses paid.[145]

NIPT could affect contractual language on abortion. When a surrogate terminates a pregnancy, intended parents often offer compensation for undergoing the abortion procedure. NIPT could influence the amount of financial responsibility in each instance. Imagine the not-too-distant future in which NIPT can be reliably administered before ten weeks of pregnancy, permitting the use of medication abortion.[146] Shorter pregnancies could reduce the expenses incurred by the parties.[147] Early termination might also shorten the reliance of the intended parents on the pregnancy's development, and thus decrease the amount owed for breach of voluntary abortion clauses, if courts enforced them.

Contemporary writings increasingly urge that damages are a proper remedy for non-compliance with an abortion provision.[148] Deborah Mazer

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142. *Id.* (manuscript at 20); *see* Cohen & Kraschel, *supra* note 52, at 89–91 (citing cases that struck down or upheld contracts with the performance of an abortion as consideration in non-surrogacy contexts).

143. *Compare* Larry Gostin, *A Civil Liberties Analysis of Surrogacy Arrangements*, 17 J. CONTEMP. HEALTH L. & POL'Y 432, 444–46 (2001) (arguing that an abortion right is not waivable because it is inalienable), *with* Kevin Yamamoto & Shelby A.D. Moore, *A Trust Analysis of a Gestational Carrier's Right to Abortion*, 70 FORDHAM L. REV. 93, 160–63 (2001) (arguing that an abortion right is waivable).

144. Samantha Lollo, *Our Baby, Her Choices: The Need for Enforcement of Gestational Surrogate Contracts*, 56 FAM. CT. REV. 180, 182–83 (2018) (surveying damage remedies in surrogacy contracts).

145. *See* CALIFORNIA LEGAL FORMS, *supra* note 99, § 100.222(2) ("If Surrogate obtains an abortion under any other circumstances, this Agreement shall terminate, and Surrogate shall reimburse Intended Parents for all payments, other than medical expenses, received to that date.").

146. *See* Bianchi et al., *supra* note 41, at 804–07.

147. Both medication and procedural (also called surgical) abortions are safe and have few health risks. *See* Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292, 2311 (2016).

148. Mazer, *supra* note 114, at 211 (summarizing arguments for applying damages in surrogacy). Mazer reasons that, "Experienced surrogacy lawyers can guide their clients through

argues for a liquidated damages clause "that adequately compensates for a potential breach" when "the intended parents are strongly averse to raising a child with genetic defects, and the surrogate is strongly averse to abortion in the case of genetic defects."[149] Mazer asserts that liquidated damages are an appropriate remedy because parties could determine reasonable compensation for anticipated or actual harm caused by the breach.[150] Measuring harm because of a child's birth will pose ethical difficulties —challenges studied in the context of wrongful birth claims.[151] And returning to implications for disability rights, placing a value on the "actual harm" of raising a child with a disability has troubling implications.

Although courts will not order specific performance of abortion clauses, courts have provided little guidance on the availability of other remedies.[152] *Cook v. Harding*, a case decided by a California federal district court in 2016, provides an example of a dispute over a selective reduction clause.[153] In that case, Surrogacy International, a California-based surrogacy broker, matched a Californian gestational surrogate, Cook, with an intended father in Georgia, C.M.[154] Acting as C.M.'s attorney, the owner of Surrogacy International drafted a 75-page surrogacy agreement that gave C.M. the decision whether to reduce a multiple pregnancy.[155] C.M. paid for an attorney to represent

these difficult personal and bioethical questions and help the client assess the value of a breach to them." *Id.* at 236. There is also an established literature arguing for the enforceability of surrogacy contracts and suggesting that surrogacy is akin to any number of other contractual negotiations. *See* Epstein, *supra* note 17, at 2305; Posner, *supra* note 17, at 21. *See generally* AM. BAR ASS'N MODEL ACT GOVERNING ASSISTED REPROD. art. VII, § 714 (AM. BAR ASS'N 2019) (stating both parties are "entitled to all remedies available at law or equity in the event of a breach of the Surrogacy Agreement").

149. Mazer, *supra* note 114, at 236. Compare the comment offered by the 2017 UPA on liquidated damages: "Except in a case involving fraud, neither a gestational surrogate nor the surrogate's spouse or former spouse, if any, is liable to the intended parent or parents for a penalty or liquidated damages, for terminating a gestational surrogacy agreement under this section." UNIF. PARENTAGE ACT § 808(c) (UNIF. LAW COMM'N 2017).

150. Mazer, *supra* note 114, at 235–36.

151. DOV FOX, BIRTH RIGHTS AND WRONGS: HOW MEDICINE AND TECHNOLOGY ARE REMAKING REPRODUCTION AND THE LAW 40–43 (2019) (assessing the application of tort remedies, such as a wrongful birth claim, in cases of reproductive negligence). Moreover, courts may view a liquidated damages clause as an impermissible penalty if the sum owed is "unreasonably large." RESTATEMENT (SECOND) OF CONTRACTS § 356(1) (AM. LAW. INST. 1981).

152. For example, the trial court in *Baby M.* held that the contract was enforceable but the termination provision was not. *In re* Baby M., 537 A.2d 1227, 1237–38 (N.J. 1988); *see also* MODEL ACT GOVERNING ASSISTED REPROD., art. VII, § 714.

153. Cook v. Harding, 190 F. Supp. 3d 921, 928–29 (C.D. Cal. 2016).

154. *Id.* at 928.

155. *Id.* Selective reduction typically occurs just after confirmation that multiple embryos transferred through IVF have implanted in the womb. A physician injects one or more implanted embryos with potassium chloride and those fetuses are resorbed in the uterus lining. In anticipation of selective reduction, contracts set out the maximum number of embryos to be implanted and contracts also stipulate reasons for which intended parents can or cannot elect to reduce the pregnancy, such as the sex of the embryo. Dalzell, *supra* note 118, at 86–87. Selective

Cook, the surrogate, from The Fertility Law Firm, which routinely worked with Surrogacy International.[156] Cook became pregnant with triplets after all three transferred embryos implanted. C.M. invoked the agreement's selective reduction clause, but Cook refused because of her beliefs against abortion.[157] Acting as C.M.'s lawyer, the surrogacy broker tried to convince Cook to abort one of the three fetuses, and "informed Cook in writing that, by refusing to reduce, she was in breach of the contract and liable for money damages."[158]

After the birth of the triplets, Cook lost her custody claim in state court, and the federal district court abstained from considering her constitutional challenge to California's surrogacy law.[159] The federal court noted the importance of enforcing the intended father's right to parent, granting him custody and legal parentage, and prohibiting the gestational surrogate from contesting the father's fitness.[160] Neither party brought a contract claim even though the intended father owed the surrogate compensation and reimbursement for medical and other expenses, and the surrogate under the contract was financially liable upon failure to surrender custody.[161] Applying abstention doctrine, the federal district court did not rule on the contract's validity, letting the state court's holding stand,[162] and opined, in dicta, on the terms relevant to parentage. Indeed, parentage is the issue that parties ask courts to resolve because of the necessity of establishing responsibility for a child's care.[163] But the questions of contract law raised by the *Cook* case remain

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reduction is an abortion although it is typically not called an abortion. *See* Radhika Rao, *Selective Reduction: "A Soft Cover for Hard Choices" or Another Name for Abortion?*, 43 J.L. MED. & ETHICS 196, 196 (2015).

156. *Cook*, 190 F. Supp. 3d at 928.

157. *Id.* at 929. C.M. believed he was financially incapable of supporting three children, having "depleted his life savings paying for the infertility doctors, surrogacy broker, the anonymous ova donor, the attorneys, and Cook's surrogate trust account." *Id.* at 928. C.M. also argued that triplets were medically dangerous for Cook and the resulting children. *Id.* at 929.

158. *Id.*

159. The federal district court dismissed Cook's equal protection and due process claims and abstained from ruling on the constitutionality of the surrogacy law in California. *Id.* at 938.

160. Following Cook's argument that C.M. "could not adequately care for even one of the [b]abies," the federal district court remarked, in dicta, that C.M.'s financial limitations were irrelevant to establishing his parental rights under the contract: "The court is at a loss to imagine an intended parent in this state who would contract with a gestational surrogate, knowing that the woman could, at her whim, 'decide' that the intended parent or parents are not up to snuff and challenge their parenting abilities in court." *Id.* at 929, 932 n.9.

161. Cook asserted parental rights in violation of the agreement. *See id.* at 932. C.M. withheld the compensation he owed Cook, totaling $19,000. *Id.* at 929.

162. *See id.* at 938.

163. *See* Gillian K. Hadfield, *An Expressive Theory of Contract: From Feminist Dilemmas to a Reconceptualization of Rational Choice in Contract Law*, 146 U. PA. L. REV. 1235, 1241–42 (1998) (noting feminist arguments against "putting mother-child relations into a contractual structure"); *see also* Matsumura, *supra* note 119, at 183 (arguing that courts' unwillingness to apply contract doctrine to matters related to ART reflects a deep-seated unwillingness to apply contract law to definitions of family).

unresolved and underappreciated: Is C.M. excused from paying Cook the remaining $19,000 he owed under the contract?[164] Should Cook pay C.M. some amount of damages for contesting custody when she waived the right to bring a custody claim? By what method should a court assess damages? How should doctrines like unconscionability apply to these queries?

What law requires, what contracts include, what courts will do, and how parties act vary significantly. The next and final Part of this Article explains how established institutional actors, working through processes of contract formation, determine how gestational surrogacy unfolds. The tension between protections in law and contract practices on the ground is mediated by healthcare professionals and lawyers both before and during pregnancy.

IV. CONTRACTUAL ENFORCEMENT IN CLINICS AND CONFERENCE ROOMS

In *P.M. v. T.B.*, the Iowa case described in this Article's introduction, the surrogate's brief explained:

> T.B. [the surrogate] never met anyone who acted as a "surrogate," never knew anyone who "hired" a surrogate, never read anything about surrogacy, and, therefore, never knew anything about the experience. T.B. did not consult an attorney, a doctor, or any other professional before she met with P.M. and C.M. [the intended parents], who assured T.B. that they could afford to pay all costs of the arrangement. No licensed agency or other professional managed the arrangement.[165]

In *P.M.*, the intended parents hired a lawyer to draft a written contract because their fertility clinic required one before performing the embryo transfer. Neither the surrogate nor the intended parents had counseling of any kind, and it is unclear what information the parties received about the consequences involved.[166] Although the Iowa Supreme Court upheld this contract, the contract formation process was far from what professional organizations and recent state statutes appear to prefer.

In both *P.M.* and *Cook v. Harding*, relationships between the parties fractured over issues of prenatal decision making. Outside the courtroom, health and legal professionals seek to mitigate conflicts over prenatal testing, behavior, and termination. This Part moves beyond the language of statutes and contracts in order to sketch the complex involvement of various professionals in the lived practice of surrogacy contracting. As this Part elaborates, parties frequently receive mental health counseling and evaluation at an early stage, under the guidance of institutional actors. The

164. Considered through the prism of contract law, C.M. may have been excused from paying the remaining total because Cook had materially breached the contract.

165. Defendants-Counterclaimants-Appellants' Final Brief, *supra* note 6, at *9 (citations omitted).

166. *Id.* at *9–10.

ostensible purposes of such services are to assess the parties' fitness, to ensure they are a good match, and to structure their interactions as they develop. However, pre-pregnancy counseling is often arranged by an agency or a reproductive endocrinologist. Intended parents are the main contacts for agencies as well as reproductive endocrinologists, and the counseling is structurally aligned with serving their interests. By contrast, pregnancy-related care occurs at a different point in time, when parties' informational control has shifted. During the pregnancy, an obstetrician ("OB") is the professional who communicates health information and administers care, not a reproductive endocrinologist. And an OB's delivery of informed consent occurs with the surrogate as a patient, not the intended parents.

These various stages of providing health services and information though medical professionals is mediated by lawyers who draft and implement contracts in order to cultivate trust between intended parents and the surrogate. This trust is the basis for exercising power over and balancing power between the parties. Lawyers manage intended parents' desires to control the surrogate's pregnancy while recognizing surrogates' right to make their own health decisions. Neither party will sue the other during pregnancy unless that party wants the relationship to end altogether. As a matter of incentives and professional practice, lawyers try to avoid such an impasse by applying a contract's terms, even when those terms exert only practical rather than legal force.

Limitations on parties' ability to enforce agreements define the field of relational contracts, or contracts in which "un(der)-enforceability is not necessarily a bug but a feature of contract."[167] As explained below, contracts are described as relational when parties rely on trust in each other, rather than on courts, in order to see their arrangements succeed. Forms of relational contracting occur in numerous commercial transactions, with the potential benefits of reducing disputes over issues that are not 'deal-breakers' and preserving parties' autonomy to arrange their own affairs. At the same time, intermediaries' efforts to build and maintain trust can shelter the parties' contract practices from public scrutiny. The surrogacy industry operates without much governmental regulation, imposing no duty on fertility agencies to disclose their practices, and contracts commonly have confidentiality clauses. These institutional practices entrench the discretion of fertility centers, agencies and brokers, as well as OBs and mental health professionals.[168]

Moreover, unlike in other commercial contexts, surrogacy is often characterized as altruistic. Indeed, until relatively recent statutory changes,

167. Jonathan C. Lipson, *Promising Justice: Contract (as) Social Responsibility*, 2019 WIS. L. REV. 1109, 1146 [hereinafter Lipson, *Promising Justice*].

168. FOX, *supra* note 151, at 39 (estimating 470 fertility centers and over 1,700 reproductive endocrinologists in a "fragmented [fertility] industry of mostly regional competition").

financial compensation for surrogacy was not allowed in most jurisdictions. But as in other commercial contexts, multiple incentives —including money, reputation, and ethics—influence the professional practice that shape surrogacy contracts. Those incentives vary based on medical technology, geography, income, and interpersonal commitments. Maximizing profit may be a primary factor for some industry actors, but other parties and professionals who engage in gestational surrogacy also respond to exceedingly complicated motives and values in this field of public importance.

The first step in understanding the practice of surrogacy contracting is to map the purposes and goals of professional counselors and OBs before and during pregnancy. The next step is to examine the work of lawyers who seek to manage and resolve conflicts over prenatal information as the surrogate's pregnancy develops.

A. MENTAL HEALTH COUNSELING AND INFORMED CONSENT

Healthcare professionals aim to address potential conflicts between parties over prenatal care. Consistent with the statutes described in Part II, information concerning pregnancy is communicated at moments when intended parents and surrogates exercise different levels of access and control. Before pregnancy, mental health professionals play an important role, and, during and after pregnancy, OBs become the primary healthcare intermediaries.

Recall that contemporary statutes require mental health evaluation or counseling before pregnancy, which can be delivered by a variety of mental health professionals, including psychologists, psychiatrists, psychotherapists, and clinical social workers. Even without a statutory mandate, fertility agencies and clinics facilitate counseling for intended parents and surrogates to assess whether clients are suitable candidates for the gestational surrogacy process and a good match for one another. In this regard, the mental health professional plays the role of both evaluator and gatekeeper.[169] Pre-pregnancy counseling provides a forum to discuss prenatal testing, behavior during pregnancy, options for termination, and how the parties will set boundaries in their relationship.[170] The importance of coming to an agreement on these topics is reflected in statutory provisions calling for joint consultation "regarding issues that could arise during the surrogacy."[171]

169. Emily Koert & Judith C. Daniluk, *Psychological and Interpersonal Factors in Gestational Surrogacy*, *in* HANDBOOK OF GESTATIONAL SURROGACY, *supra* note 13, at 74–75; Andrea Mechanick Braverman, *Mental Health Counseling in Third-Party Reproduction in The United States: Evaluation, Psychoeducation, or Ethical Gatekeeping?*, 104 FERTILITY & STERILITY 501, 502 (2015).

170. Koert & Daniluk, *supra* note 169, at 75.

171. D.C. CODE § 16-405(a)(5) (2019) ("An individual seeking to serve as a surrogate shall enter into a written surrogacy agreement and, at the time that the surrogacy agreement is executed, shall . . . [h]ave completed, with the intended parent or parents, a joint consultation

Mental health professionals often provide counseling as members of teams working with fertility agencies or clinics. But there are no uniform standards for what pre-pregnancy counseling should include. Agencies or clinics are not required to describe their referral process, and website descriptions may or may not yield information about the content or quality of the counseling offered. These observations are not criticisms of the services clinical social workers, psychiatrists, and psychologists provide; describing those services is hampered by informational obscurity and circumstantial variability.

At the pre-pregnancy stage, the intended parents ostensibly drive the process of arranging for mental health counseling and working with a reproductive endocrinologist.[172] Mental health professionals describe their services as providing psychosocial education for clients about the emotional and mental strain that the process of surrogacy can impose.[173] Pre-pregnancy or early counseling sessions are not only occasions to match contracting parties, but also to help set expectations of what might follow. Specifically, these are forums to discuss potential points of disagreement. For example, counseling can attempt to reassure intended parents that surrogates will agree to prenatal screening, share prenatal information, and terminate the pregnancy if necessary.[174]

Mental health assessments clear the way for IVF and the work of reproductive endocrinologists. After a successful embryo transfer occurs, prenatal care transitions from a provider specializing in fertility care to an OB. As noted, state laws provide that surrogates have the right to choose their physician, but it is less clear how that choice is influenced by intended parents, by the residence of the parties, or by cost. OBs have independent practices, even though agencies may refer clients to their office. The OB owes a duty of care to the surrogate, not the intended parents, and the OB delivers informed consent for prenatal care once a surrogate is pregnant (as does a reproductive

with a mental health professional regarding issues that could arise during the surrogacy."). Some fertility agencies also provide joint counseling as part of their services.

172. It is beyond the scope of this Article to map, in detail, the relationships between the various professionals that facilitate surrogacy before pregnancy and at the inception of pregnancy.

173. One psychologist working in the fertility industry commented that patients receiving fertility services need an "opportunity to think through the sort of social and emotional aspects of a choice." JODY LYNEÉ MADEIRA, TAKING BABY STEPS: HOW PATIENTS AND FERTILITY CLINICS COLLABORATE IN CONCEPTION 205 (2018) [hereinafter MADEIRA, TAKING BABY STEPS].

174. The advice of The National Fertility Association provides an example; its online advice website, "The Role of the Fertility Counselor," stresses that counseling sessions are the place to reach an agreement about potential difficult situations and decisions that might arise during pregnancy. Tara Simpson, *The Role of the Fertility Counselor*, RESOLVE: NAT'L FERTILITY ASS'N, https://resolve.org/what-are-my-options/surrogacy/the-role-of-the-fertility-counselor [https://perma.cc/A3HA-UZW2].

endocrinologist for IVF, embryo transfer, and related procedures).[175] In both pre- and during-pregnancy contexts, informed consent aims to deliver sufficient information to the patient so she can make voluntary and free decisions.[176] However, the purpose of patient or client communication differs between the offices of mental health professionals and physicians.[177] Whereas pre-pregnancy counseling seeks to surface points of disagreement or misunderstanding, informed consent offered by an OB explores the risks and benefits of treatment.[178]

OBs and their staff are the healthcare professionals who discuss testing and termination with surrogates early in pregnancy and as circumstances develop.[179] Indeed, prenatal screening is an early service an OB provides because the transfer of care from reproductive endocrinologists to OBs occurs around the time that screening methods, including NIPT, are recommended.[180] As noted in the first Part of this Article, scientific advances in NIPT will reveal an ever-longer spectrum of information, from serious

175. *See* MADEIRA, TAKING BABY STEPS, *supra* note 173, at 187–92, 222. Informed consent delivered by a reproductive endocrinologist happens at any number of points before IVF. Madeira documents that physicians, often using educational tools (in addition to consent forms) and adopting a variety of conversational approaches, seek consent at the first consultation as well as shortly before the procedure—"complet[ing] . . . paperwork any time from months to days before the treatment." *Id.* at 209.

176. Rebouché, *Testing Sex*, *supra* note 25, at 235; *see* Asbury, *supra* note 32, at 22–23 ("[P]renatal genetic counselors should, during a relatively brief encounter, do their best to explain a) the basics of the indicated abnormality; b) the statistical probability that the fetus actually has it; c) the potential presentations of the abnormality; d) the fetus's spectrum of potential life outcomes (which can be considerable); and e) the potential social and psychological risks of terminating or maintaining the pregnancy." (footnotes omitted)).

177. *See* Braverman, *supra* note 169, at 502 (defining the duties of the counselor as "psychoeducational, evaluation, and de facto gatekeeper for ethical issue (e.g., ethical gatekeeper)"). As one agency website explains, counseling before embryo transfer can help build the foundation for delivering informed consent if during-pregnancy complications arise. Simpson, *supra* note 174.

178. The elements of informed consent typically include a patient's ability to understand and voluntarily decide on treatment; disclosure of material information that the patient understands; and patient authorization of a treatment plan. MADEIRA, TAKING BABY STEPS, *supra* note 173, at 187. Counseling should also be non-directive, but many have noted that, in practice, "it is inevitable that the counselor's assumptions about the potential personal, economic, and social impacts of the information she might disclose inform both the information she selects to include in a consultation and how she frames it." Asbury, *supra* note 32, at 21 (footnotes omitted); *cf.* ALEXANDRA MINNA STERN, TELLING GENES: THE STORY OF GENETIC COUNSELING IN AMERICA 95 (2012) (discussing the emphasis in genetic counseling on empowering the patients to take control over their lives).

179. Forman, *supra* note 20, at 50 (noting that "the physician's responsibility must extend to ensuring that both intended parents and the surrogate have considered and discussed" the possibility of termination).

180. Clinical practice around NIPT suggests that physicians are hesitant to adopt testing innovations without confirmation from their professional communities about the ethics and implications of doing so. Bennett et al., *supra* note 26, at 200–02.

medical conditions to genes associated with non-medical traits.[181] Risks are indeterminate and expressed by probabilities; innovations in reproductive technology, as Jody Madeira writes, present consistent challenges for informed consent and patient education.[182] Whatever information might emerge, the OB (or a member of the OB's office) will have the task of explaining the results of the prenatal screening and attendant options to the patient.

The transfer of medical responsibilities to an OB changes the process' focus from the intended parents to the surrogate. That is, while intended parents initiate the process, which begins in the offices of counselors and reproductive endocrinologists—often coordinated by a fertility clinic or matching agency—pregnancy care places the surrogate at the center of decision making. The OB and the surrogate's relationship does not have to include the intended parents. Unless a surrogate signs, and the physician implements, a waiver of rights under the contract and under the Health Insurance Portability and Accountability Act, an OB is not permitted to share details about the surrogate's pregnancy, such as results from prenatal testing, with intended parents.[183] State statutes also contemplate that the OB acts on behalf of the surrogate, who has the right to make medical decisions.

Contracts, as noted, attempt to shift back some decision making to intended parents by having parties pledge to share information and decisional authority. And professional organizations are sympathetic to collaboration among parties and physicians. The American College of Obstetricians and Gynecologists ("ACOG") issued advice to physicians about their role in providing prenatal care to surrogates. An ACOG Committee Opinion explains that the physician's responsibility is to "communicate clearly to the patient the primacy of her right to autonomous decision making related to her health and her pregnancy, which includes the right to choose what information she does and does not wish to receive or share."[184] However,

181. Jacobsen, *supra* note 26 (summarizing advances in genetic testing and the future of germline editing).

182. MADEIRA, TAKING BABY STEPS, *supra* note 173, at 206–07.

183. *See* AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, NO. 660, COMMITTEE OPINION: FAMILY BUILDING THROUGH GESTATIONAL SURROGACY 5 (2016) *available at* https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2016/03/family-building-through-gestational-surrogacy.pdf [https://perma.cc/Z6YU-VXX4] ("There must be a clear understanding of how appropriate medical details related to the health of the fetus will be communicated to the intended parent(s) during the pregnancy, keeping in mind that such communications must take place only with the express consent of the pregnant patient."). Confidentiality of patient information also applies to IVF treatment. MADEIRA, TAKING BABY STEPS, *supra* note 173, at 192. Illinois enacted a law in August 2019 that prohibits denial of intended parents' entry into a delivery room when "the gestational surrogate is being induced or in labor," unless the gestational surrogate's life or health could be jeopardized, the gestational surrogacy contract prohibits entry, or "other good cause," such as an intended parent's presence "causing a disturbance or other security concerns." 210 ILL. COMP. STAT. 85/6.27 (2019).

184. AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, *supra* note 183, at 4.

ACOG also envisions the physician's role as a quasi-conflict manager, "who counsel[s] women . . . [and] encourage[s] them to discuss with the intended parent(s) as many foreseeable decision-making scenarios in pregnancy as possible," which "should be formally documented in the gestational surrogacy contract."[185] The ACOG Opinion continues:

> Once the gestational carrier is pregnant, it is helpful for the obstetrician-gynecologist to be familiar with pertinent preconditions and contingencies in her contract with the intended parent(s) that may specifically address certain aspects of her care. For example, an anticipatory plan often is made regarding prenatal genetic screening and response to abnormal findings on any ultrasound studies, pathology, or laboratory tests.[186]

According to the ACOG Opinion, physicians should understand their patients' contractual duties before pregnancy and during pregnancy. Encouraging OBs to become familiar with surrogacy contracts might be one way to manage differences of opinion between parties about testing or termination. However, it may be unrealistic to expect that physicians, as part of their practices, will interpret and apply their patients' surrogacy agreements. OBs have no duty to ensure that contingency plans in pregnancy care comply with a contract or with intended parents' expectations. Contractual language can be dense, and OBs are not attorneys. Lawyers, rather, mediate the transition from mental health counselors to OBs by drafting a contract that governs testing and termination decisions. Lawyers intervene again if conflict between parties arises after the commencement of pregnancy.

B. LEGAL PROFESSIONALS' MANAGEMENT OF SURROGACY CONTRACTS

This Section delves deeper into fertility lawyers' role in mediating tensions between intended parents whose contracts promise prenatal information and surrogates who receive prenatal information as patients. Lawyers seek to keep clients out of court and in the agreements they negotiated. Taking a less charitable view, contracts also attempt to impose intended parents' expectations on surrogates, regardless of whether contractual terms are legally enforceable. But like the practices of mental health counselors and OBs, much is unknown about what occurs in lawyers' offices and conference rooms. And there are gaps in understanding lawyers' motives and incentives, as tied to their duties as legal professionals but also influenced by their connections to fertility agencies and clinics.

Fertility agencies provide referrals to attorneys, and lawyers increasingly work directly or exclusively with agencies that assemble teams of professionals

185. *Id.* at 4–5.
186. *Id.* at 5.

to assist clients.[187] Legal professionals participate before, during, and after the pregnancy, from establishing escrow accounts for surrogates' payments to executing legal instruments that establish parental legal rights and duties. Perhaps most importantly, lawyers draft the contract. Although intended parents commence the process, surrogates should have the advice of independent legal counsel per agency practice and potentially under their state's statute.[188] Intended parents almost always pay for the surrogate's attorney, consistent with statutory language and the UPA.[189]

The attorney's role in drafting the contract may help explain why contracts continue to include language that simultaneously guarantees surrogate autonomy while promising intended parents the right to make pregnancy decisions. Courts are unlikely to enforce these provisions (for instance, requiring the surrogate to terminate a pregnancy), which rarely result in damages (compensation for failure to abort a pregnancy, for example). But lawyers draft contractual provisions governing prenatal decisions with practical and strategic objectives in mind, even when they know that those terms are difficult if not impossible to enforce. Their objective is to build trust and establish the relationship between the parties: How a contract is drafted affects how parties implement and enforce it.[190] In this vein,

187. *See, e.g.*, *Legal Expertise and Guidance*, CONCEIVEABILITIES, https://www.conceiveabilities.com/parents/legal-services-offered [https://perma.cc/YW5Y-24FL] (highlighting a fertility agency offering services across states and describing the work of the in-house lawyer). Like health care entities generally, brokers and clinics have consolidated to realize the financial advantages of consolidation. Carbone & Madeira, *supra* note 24, at 80. Specifically, fertility clinics have incentives to join networks for in-house financing, marketing, management of pharmaceuticals, and health-information technology. *Id.* at 81–82. And, relevant to NIPT, scientific advances present incentives to utilize new technology in order to realize more profit. *Id.* at 99.

188. In jurisdictions that do not require legal representation for the surrogate, like Iowa and as seen in the *P.M. v. T.B.* case, after a lawyer for the intended parents drafts the contract, the surrogate could seek legal advice about the contract's terms from the same attorney (subject to rules of professional responsibility). In practice, many agencies require that a surrogate seek legal advice about the contract before she signs it. Courtney Joslin notes that attorneys specializing in fertility services have been architects of state legislation: "[S]urrogacy attorneys who represent intended parents were the primary drafters of the legislation in Illinois and in California." Joslin, *supra* note 58 (manuscript at 53) (footnotes omitted).

189. For example, the Washington State Uniform Parentage Act, which became effective January 2019, states, "The intended parent or parents must pay for independent legal representation for the woman acting as a surrogate." WASH. REV. CODE § 26.26A.710(8) (2019). Likewise, the 2017 UPA sets out that "the intended parent or parents must pay for independent legal representation for the surrogate." UNIF. PARENTAGE ACT § 803(8) (UNIF. LAW COMM'N 2017); *see also* Schwartz, *supra* note 84, at 131.

190. Cathy Hwang draws from the "robust modern contracts literature, in which scholars have shown, compellingly, that there is often a link between how a contract is drafted, *ex ante*, and how it will be litigated, *ex post*." Hwang, *Faux Contracts*, *supra* note 140, at 1033 n.28 (emphasis added) (citing Albert Choi & George Triantis, *Strategic Vagueness in Contract Design: The Case of Corporate Acquisitions*, 119 YALE L.J. 848 (2010)). Moreover, "other scholars have also shown that attention paid to the front-end contract drafting process can also reduce back-end enforcement costs." *Id.* at 1039.

gestational surrogacy agreements track patterns noticed by contract scholars writing about relational contracting.[191]

Relational contracting focuses on "the commitment that [parties] have made to one another, and the conventions that the trading community establishes for such commitments."[192] Simply put, relational contracting ties performance of an agreement to the relationship between the parties. "[F]ear of reputational or relational sanctions" drives compliance with a contract despite difficult-to-enforce or conflicting provisions.[193] This concept has been applied to a broad array of contexts, from the cotton industry to cattle ranching. Surrogacy, however, differs from the industries studied by scholars such as Lisa Bernstein and Robert Ellickson.[194] Those authors have shown that relational contracting is powerful because *the parties* negotiating an agreement are repeat players in insular fields. Thus, reputation matters a great deal.

In gestational surrogacy, the parties to a contract are not repeat players; most surrogates and intended parents will enter into a contract only one or two times, and rarely with each other again.[195] Rather, lawyers' reputations and relationships are at stake in a network of providers of fertility services —a "reputational ecosystem."[196] As an analogy, Jonathan Lipson has shown, in the bankruptcy context, that lawyers play a crucial role in communicating the risks of noncompliance and providing the authoritative interpretation of a deal.[197] Likewise, fertility lawyers rely on the authority of a surrogacy contract to stymie potential disagreements even when legal remedies are uncertain.

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191. *Id.* at 1044.

192. Robert W. Gordon, *Macaulay, Macneil, and the Discovery of Solidarity and Power in Contract Law*, 1985 WIS. L. REV. 565, 578. For foundational work on relational contracting, see Charles J. Goetz & Robert E. Scott, *Principles of Relational Contracts*, 67 VA. L. REV. 1089, 1091 (1981); and Stewart Macaulay, *Non-Contractual Relations in Business: A Preliminary Study*, 28 AM. SOC. REV. 55, 56–59 (1963). For more recent analysis, see Jay M. Feinman, *Relational Contract Theory in Context*, 94 NW. U. L. REV. 737, 741 (2000); and Robert E. Scott, *The Promise and the Peril of Relational Contract Theory*, *in* REVISITING THE CONTRACTS SCHOLARSHIP OF STEWART MACAULAY 105, 108 (Braucher et al. eds., 2013).

193. Hwang, *Faux Contracts*, *supra* note 140, at 1041 (quoting Scott Baker & Albert Choi, *Contract's Role in Relational Contract*, 101 VA. L. REV. 559, 561 (2015)).

194. *See generally* Lisa Bernstein, *Private Commercial Law in the Cotton Industry: Creating Cooperation Through Rules, Norms, and Institutions*, 99 MICH. L. REV. 1724 (2001) (discussing the cotton industry); Robert C. Ellickson, *Of Coase and Cattle: Dispute Resolution Among Neighbors in Shasta County*, 38 STAN. L. REV. 623 (1986) (discussing cattle ranching).

195. Ian Macneil argued that traditional contract theory failed to appreciate complex, ongoing relationships that change over time, and instead framed contracts as discrete transactions. Ian R. Macneil, Commentary, *Restatement (Second) of Contracts and Presentation*, 60 VA. L. REV. 589, 594 (1974). Arguably, surrogacy agreements, although there is usually only one contract between parties, have some of the characteristics that Macneil describes because they last over the course of a pregnancy with provisions that apply to the parties' future relationship.

196. Hwang, *Faux Contracts*, *supra* note 140, at 1064.

197. Lipson, *Promising Justice*, *supra* note 167, at 1152–53; *see* Jonathan C. Lipson, *Bargaining Bankrupt: A Relational Theory of Contract in Bankruptcy*, 6 HARV. BUS. L. REV. 239, 278–80 (2016);

Although intended parents and surrogates are not repeat players, relational contractual explanations may illuminate their motivations. Cathy Hwang recently applied theories of relational contracting to what she calls "faux contracts," or contracts that are "heavily negotiated but [with] rarely triggered formal contracts and enforcement mechanisms."[198] She describes the benefit of a faux contract as allowing parties "to decouple ex ante contracting from ex post enforcement."[199] Though a court might not enforce a contract's terms, Hwang provides examples of lengthy, tailored, and sophisticated contracts that create a framework for how parties will conduct their relationship during the life of the contract.[200]

Faux contracting is relevant to gestational surrogacy because, like the norms that persuade parties to adhere to contracts in other difficult-to-regulate industries, parties rely on trust and reciprocity to implement obligations that a court may never enforce.[201] For example, contracts can obligate a surrogate to give weekly reports, to allow intended parents to attend all medical appointments, and to terminate a pregnancy if a serious medical condition arises. But intended parents will not sue for breach if they miss one doctor's appointment, just as no court would enforce a provision requiring a surrogate to terminate a pregnancy. The contract, however, confers legitimacy on the parties' expectations, and the parties will think of and treat that contract as legally binding.[202]

The glue that holds the surrogacy arrangement together is "a sense of moral obligation" based on the relationship developed during contract

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see also Hwang, *Faux Contracts*, *supra* note 140, at 1071 (noting the reputational investments of lawyers advising clients in drafting term sheets for mergers and acquisitions).

198. Hwang, *Faux Contracts*, *supra* note 140, at 1044; *see also* Cathy Hwang, *Deal Momentum*, 65 UCLA L. REV. 376, 389 (2018) [hereinafter Hwang, *Deal Momentum*] ("existing explanations for why parties use preliminary agreements rely on formal enforcement as an important part of the story" but that explanation does not capture why contracts persist despite any credible threat of enforcement).

199. Hwang, *Faux Contracts*, *supra* note 140, at 1025.

200. Hwang, for instance, focuses on drafting non-binding term sheets in mergers and acquisitions to illustrate how "parties [can] harness the organizational and clarification benefits of creating a contract, while excluding most consequences of breach." *Id.* at 1027.

201. *See generally* ROBERT C. ELLICKSON, ORDER WITHOUT LAW: HOW NEIGHBORS SETTLE DISPUTES (1991) (explaining that relational contracting emphasizes the social, community, and business norms that are meaningful to an ongoing relationship); Lisa Bernstein, *Opting Out of the Legal System: Extralegal Contractual Relations in the Diamond Industry*, 21 J. LEGAL STUD. 115 (1992) (discussing the role of reputation bonds in contractual commitments); Tess Wilkinson-Ryan & David A. Hoffman, *The Common Sense of Contract Formation*, 67 STAN. L. REV. 1269 (2015) (explaining "that people sometimes feel bound to exchanges when the law would release them" due to "[n]orms of promise keeping and reciprocity, interpersonal courtesy, and community reputation").

202. *See* Berk, *The Legalization of Emotion*, *supra* note 59, at 148, 159; *see also* Hwang, *Deal Momentum*, *supra* note 198, at 382 (referring to the importance of contract provisions as "signposts").

negotiations—a relationship that lawyers facilitate.[203] Perceptions about *how* parties reached their agreement affect the quality of their relationship and the likelihood of their performance of the contract's terms. If parties are satisfied with the process of contract formation, they may be more willing to comply with the agreement.[204] As Tess Wilkinson-Ryan and David Hoffman have shown in a series of experiments on contracting behavior, a sense of obligation felt by parties often is more important than legal enforceability.[205]

According to studies that describe the attitudes of surrogates and intended parents, the parties' sense of trust and mutually shared sense of obligation carries significant weight.[206] Gestational surrogates in Zsuzsa Berend's research consistently described their roles in relational terms.[207] Berend notes: "Surrogates take contract negotiations seriously even in states where such contracts are not legally recognized. . . . [C]ontract negotiations work out all the details of the agreement and also signal—at least to surrogates—the emotional compatibility of the parties and foreshadow the relationship."[208] Another study "found that surrogates can place a great deal of importance on this relationship which can determine how they perceive their surrogacy experience."[209] Surrogates and intended parents alike explain their participation in surrogacy by reference to their interpersonal relationships, and they resist any insinuation that they were motivated by financial gain or buying procreative services.[210] Studies of surrogate attitudes

203. Hwang, *Deal Momentum*, *supra* note 198, at 409.

204. *See* Wilkinson-Ryan & Hoffman, *supra* note 201, at 1286–87.

205. *See id.* at 1279, 1298–1300.

206. Kim L. Armour, The Lived Experiences of Intended Parents During Surrogate Pregnancy and Transition to Parenthood in Relation to the United States Healthcare System 103 (Apr. 25, 2012) (published dissertation, University of Texas at Tyler) (on file with the University of Texas at Tyler, Nursing and Theses Dissertations) (reflecting on interviews with intended parents: "Clearly relationships were critical for intended parents as they built a foundation for this journey of surrogate pregnancy. Many participants discussed stories of both positive and negative encounters, yet all participants agreed to the importance of building a relationship with their surrogate and other parties that were involved in the process.").

207. Berend, *supra* note 52, at 64–66.

208. *Id.* at 64 (footnote omitted).

209. Vasanti Jadva et al., *Surrogate Mothers 10 Years On: A Longitudinal Study of Psychological Well-Being and Relationships with the Parents and Child*, 30 HUM. REPROD. 373, 374 (2015) [hereinafter Jadva et al., *Surrogate Mothers*]. Surrogates report high levels of cooperation between parties and particularly with intended mothers: "None of the women reported having a relationship characterized by 'major conflict or hostility' with either the commissioning mother or the commissioning father." Vasanti Jadva et al., *Surrogacy: The Experiences of Surrogate Mothers*, 18 HUM. REPROD. 2196, 2199 (2003) [hereinafter Jadva et al., *Surrogacy: The Experiences*]. Studies of surrogate mental health, after an arrangement has concluded, indicate "that the majority of surrogates do not experience psychological problems." Jadva et al., *Surrogate Mothers*, *supra*, at 374.

210. Berend, *supra* note 52, at 64–66.

"have largely found that the majority of surrogates are primarily motivated by a wish to help a childless couple, with few mentioning financial motives."[211]

Lawyers draft contracts that serve the ends of relationship building, and lawyers rely on the trust established between parties to encourage (and, at times, pressure) surrogates to share prenatal information and decision making with intended parents throughout the pregnancy.[212] During pre-pregnancy negotiations, parties agree in advance to terms that regulate testing and termination, and contractual language attempts to impose an obligation to comply. After the contract is signed, attorneys intervene when a sense of legal or moral obligation is not enough to resolve conflicts over terms that are otherwise unenforceable or will be difficult to enforce. Lawyers also intercede when a party believes the implementation of an agreement has unfair consequences.[213]

In this vein, Hillary Berk describes the primary role of fertility lawyers "as 'facilitators' . . . [who] absorb, suppress, and avert crucial uncertainties that might otherwise elevate transaction costs, risk, and discord."[214] Parties report disagreements to lawyers who diffuse conflicts by reference to the contract and through refereeing the dispute.[215] According to Berk's survey of surrogacy lawyers across the country, attorneys spend much of their practice balancing the power that surrogates and intended parents have over each other—enabling intended parents' desire for control but also protecting a surrogate's privacy and independence.[216] Perhaps this is not so different than an attorney's role in other dispute resolution settings. What is striking in the surrogacy context are the gaps in information about the work of fertility lawyers.

The attorneys interviewed by Berk recounted that intended parents routinely tried to control surrogates' behavior. Indeed, contract language may embolden intended parents to intensify bodily surveillance of the surrogate in ways repugnant to her decisional autonomy. But when parents became too

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211. Jadva et al., *Surrogate Mothers*, *supra* note 209, at 374. In one study, 91 percent of participants reported "wanting to help a childless couple" among the reasons to become a surrogate; only three percent indicated that payment played *any* role in their decision. Jadva et al., *Surrogacy: The Experiences*, *supra* note 209, at 2199.

212. Berk, *The Legalization of Emotion*, *supra* note 59, at 148 (describing contracts as a series of "symbolic representations and . . . cultural displays"); *see also* David A. Hoffman & Zev J. Eigen, *Contract Consideration and Behavior*, 85 GEO. WASH. L. REV. 351, 365 (2017) (noting the importance of the process of contract formation).

213. Wilkinson-Ryan & Hoffman, *supra* note 201, at 1271. For some parties, the trust established in contract formation might lead to "tak[ing] fewer precautions, [or] seeking less information" that would otherwise be relevant to future decisions. *Id.*

214. Berk, *The Legalization of Emotion*, *supra* note 59, at 148.

215. Berk describes how surrogacy lawyers rely on "the web of formal restrictions in contracts, along with informal practices like 'triage.'" *Id.* at 156.

216. *Id.* "[T]riage," according to Berk's study, is deployed by lawyers "to prevent emotional attachment, resentment, or alienation in the surrogate mother and handle feelings like vulnerability, anxiety, and jealousy in the intended parents." *Id.*

controlling or demanding, surrogates withheld information or blocked parents from attending prenatal care appointments. Both actions could be in non-compliance with a contract: Intended parents usually agree to respect the surrogate's autonomy, and the surrogate usually agrees to provide parents with prenatal information. When this reciprocity does not occur, lawyers deploy tactics that fall across a spectrum from persuasion to coercion. At one end, contracts contemplate remedies for breach, and lawyers can threaten consequences for non-compliance even if they know consequences like money damages will not materialize. Parties' beliefs in and commitments to the contractual arrangement make this a powerful tool. At the other end, lawyers reported counseling clients to adopt different approaches and attitudes not just to comply with the contract, but also to preserve the parties' relationship.[217] Viewed in this way, lawyers' self-described "triage" role, according to Berk, helps ensure that the arrangement succeeds and manages, through the contract, the emotions and attachments of the parties.[218]

This management—or manipulation, depending on how one views it—comes with a financial reward for lawyers and the fertility agencies to which lawyers may be connected. When do agencies and lawyers build trust, and when do they, as intended parents interviewed in one study recounted, "instill fear . . . and [make] assurances that they c[an]not keep"?[219] The question inspires a closer look at other recurrent institutional actors—fertility agencies, for one—that structure the process for parties.

C. REGULATING GESTATIONAL SURROGACY

Why do most surrogacy arrangements appear to be "carried out without a hitch"? Many commentators reason that parties' interests usually align.[220] In the vast majority of cases, intended parents want custody of a resulting child, and surrogates do not want custody.[221] Litigation over a contract may be too

217. *Id.* at 156–58, 161.

218. Epstein, *supra* note 17, at 2316, 2335 (describing the roles of lawyers and physicians as "intermediaries" and "third-party buffer[s]" in surrogacy arrangements). The importance of intermediaries is a source of commentary, with analogies for the surrogacy context, in commercial contracts. *See* Hwang, *Deal Momentum*, *supra* note 198, at 402, 411.

219. Armour, *supra* note 206, at 104.

220. Joanna L. Grossman, *The Complications of Surrogacy: A New Jersey Court Refuses to Uphold a Surrogacy Arrangement, but Awards Full Custody to the Intended Father*, JUSTIA: VERDICT (Jan. 10, 2012), https://verdict.justia.com/2012/01/10/the-complications-of-surrogacy [https://perma.cc/5JZP-4YF4].

221. Interestingly, as shown in the *P.M.* and *Cook* litigation, surrogates abandon their claims to additional compensation lest courts believe their interests in any children born are not altruistic. The guidance of the ASRM also presumes, or at least values, a sense of altruism on the part of surrogates; in listing the reasons intended parents might reject a surrogate, the ASRM's recommendations list the "[f]ailure to exhibit altruistic commitment to become a gestational carrier." American Society for Reproductive Medicine, *supra* note 78, at 1307; *see* Hasday, *supra* note 17, at 511–12 (noting that, in the surrogacy context, limiting compensation to only medical or living expenses distinguishes surrogacy from "selling or purchasing a child").

risky and too costly, and it is uncertain what terms a court would enforce and what remedy would result. These explanations, however, do not completely explain how the practices of surrogacy contracting help ensure that parties see agreements through or elucidate the role of legal professionals who make the parties' relationship work. The fact that disputes are not resolved through court decisions or litigation does not necessarily indicate the frequency with which conflict arises.[222]

One explanation for why surrogacy arrangements hold together is the power intended parents hold over the surrogate. To be sure, intended parents, as the payors for services and the fees of the professionals involved, exercise significant control over the process. A number of recently passed state statutes attempt to foster equality between the parties. Laws increasingly prescribe legal representation for surrogates that is independent from intended parents' representation. And, indeed, process and informational safeguards for surrogates are typically the points at which law focuses.[223] However, focusing only on intended parents' bargaining advantages might miss the complexity of the relationships at play. As the last Section argued, intended parents' interests do not entirely dominate or structure the surrogacy process. Power fluctuates depending on the point in pregnancy. Generalizations about the relationship between intended parents and surrogates may have limited utility: Contracts are typically confidential, practices vary from place to place, and the field is technologically dynamic, as the example of NIPT makes clear.

An explanation focused only on intended parents also understates the bargaining power of surrogates. This is not to minimize the vulnerability of surrogates, or the financial limitations that may affect their bargaining position.[224] But many surrogates, in the United States at least, are middle-class, married, white, with at least one child, and in their late twenties or early

222. *See, e.g.*, Emma Cummings, Comment, *The [Un]Enforceability of Abortion and Selective Reduction Provisions in Surrogacy Agreements*, 49 CUMB. L. REV. 85, 87, 103–04 (2018) (noting a recent dispute between intended parents and a surrogate that settled out of court).

223. Jill Hasday predicted the direction of state surrogacy legislation in an important article, *Intimacy and Economic Exchange*. *See* Hasday, *supra* note 17, at 526. She argued that rather than require surrogates to forgo compensation, laws should protect surrogates from exploitation through guarantees of independent counsel, paid for by the intended parents, and through mandatory disclosure about the risks associated with surrogacy. *Id.*

224. Blurring the line between exchange and altruism, or a characterization of commodification as exploitation, draws from a rich feminist debate. On one side are scholars who challenge the perception that procreative services, when commodified, lose special value associated with intimate and family relationships; on the other are writers who contest bifurcating family or intimate relationships and market or commercial interests. For a summary of both views, see Jody Lyneé Madeira, *Conceiving of Products and the Products of Conception: Reflections on Commodification, Consumption, ART, and Abortion*, 43 J.L. MED. & ETHICS 293, 295–97 (2015); and Matsumura, *supra* note 119, at 190–95, 212–15 (discussing a contract-based view of "traditional gender relationships").

thirties.[225] As noted in Part II, legislation often mandates—and professional guidance advises—that surrogates must be of a certain age or have already given birth; these requirements are intended, in part, to protect surrogates from financial and other forms of exploitation.[226] Laws include provisions that surrogates be "financially secure" and may not be recipients of public assistance.[227] Many of these requirements mimic existing industry norms and standards.[228]

The parties' bargaining power rises and falls as they interact with institutions and professionals, which have their own interests and incentives. One contribution of this Article is to demonstrate how institutional players cause these power dynamics to shift and change. Establishing some level of equality between parties can be in the best interest of fertility agencies in particular. Fertility specialists have their reputations and brand at stake in matching intended parents with surrogates and in having arrangements

225. Janice C. Ciccarelli & Linda J. Beckman, *Navigating Rough Waters: An Overview of Psychological Aspects of Surrogacy*, 61 J. SOC. ISSUES 21, 30–31 (2005) (gestational surrogates are typically "in their twenties or thirties, White, Christian, married, and have children of their own"); *see* Dov Fox, *Thirteenth Amendment Reflections on Abortion, Surrogacy, and Race Selection*, 104 CORNELL L. REV. ONLINE 114, 125 (2019) ("American surrogates are less likely to be illiterate, economically vulnerable, or otherwise disadvantaged when negotiating terms of their reproductive work."); Koert & Daniluk, *supra* note 169, at 70; Peng, *supra* note 16, at 560 ("The profile of surrogate mothers emerging from the empirical research in the United States and Britain does not support the stereotype of poor, single, young, ethnic minority women whose family, financial difficulties, or other circumstances pressure her into a surrogacy arrangement. Nor does it support the view that surrogate mothers are naively taking on a task unaware of the emotional and physical risks it might entail. Rather, the empirical research establishes that surrogate mothers are mature, experienced, stable, self-aware, and extroverted non-conformists who make the initial decision that surrogacy is something that they want to do." (quoting Karen Busby & Delaney Vun, *Revisiting* The Handmaid's Tale*: Feminist Theory Meets Empirical Research on Surrogate Mothers*, 26 CANADIAN J. FAM. L. 13, 51–52 (2010))); *see also* Mazer, *supra* note 114, at 227 ("In reality, the motivations and demographics of surrogates are more diverse."). Other scholarship highlights differences in ages, education or income levels, and life experiences between intended parents and surrogates. *But see* Berk, *The Legalization of Emotion*, *supra* note 59, at 151 ("[C]ritics of surrogacy emphasize the . . . control of pregnant bodies that varies by class, race, place, and lack of power."); Hasday, *supra* note 17, at 519–20 (citing "evidence . . . that surrogate mothers typically occupy a relatively low socioeconomic status").

226. *See supra* Section III.B (discussing surrogate requirements).

227. See, for example, a bill pending in Minnesota that, among other prerequisites, requires that a surrogate must be "financially secure" and cannot be the recipient of public assistance. S.F. 1152, 91st Leg., 1st Reg. Sess. (Minn. 2019) (defining "financially secure" as "meaning the gestational surrogate's household, excluding a homestead mortgage and automobile loan payments, has less than $10,000 of debt at the time of the creation of the gestational surrogacy contract").

228. Some agencies impose requirements of financial security, such as barring surrogates who receive state assistance or surrogates living below the federal poverty level or otherwise not financially independent. *Have a Baby Through Surrogacy*, CTR. SURROGATE PARENTING, L.L.C., https://www.creatingfamilies.com/parent [https://perma.cc/6X4S-GJTN] ("We ensure that all CSP surrogates have chosen this path because of a desire to help someone else have a child of their own. Monetary gain is not their primary motivator . . . .").

succeed;[229] some agencies, depending on the services they offer, also can face various forms of liability.[230] Fertility agencies, for instance, advertise their collaborations with healthcare providers in preparing communication tools for parties before and during pregnancy.[231] In this vein, "the surrogacy industry has developed strong baseline protections" for all parties, and, according to Sital Kalantry, specifically for surrogates.[232]

Fertility agencies, as well as clinics taking on agency-like roles, exert a lot of power over the process. Yet those entities largely are unaddressed by recent state laws. This Article does not attempt to set out a framework for regulating agencies. Instead, it offers a concluding observation: If wealthy intended parents exercise more control than surrogates over the process, it is not just because they are resource rich; it is because their wealth allowed them to participate on the powerful side of an industry with a cadre of professionals to assist them.

The income disparities between those who can and cannot participate as intended parents in surrogacy are stark. Many people who are infertile and may desire to become parents cannot afford fertility services. It is well documented that the population of people with the highest infertility rates are low-income people of color.[233] Note that in *P.M. v. T.B.*, the purpose of T.B. entering into a surrogacy arrangement was so she could afford an IVF cycle for herself and her husband. Her health insurance would not cover fertility services—she bargained for the cost of IVF in exchange for serving as a gestational surrogate.[234] Disparities in wealth come into further focus because surrogacy arrangements falter without the assistance of expensive

229. Typically, when there are problems with intermediaries' actions, commentators refer to the costs of professional disciplinary actions and, in the context of relational contracting, reputational damage. Hwang, *Faux Contracts*, *supra* note 140, at 1070–71.

230. This Article does not consider tort litigation against fertility agencies and attorneys, except to note that cases have established a duty of care between agencies or lawyers and their clients. Stiver v. Parker, 975 F.2d 261, 272 (6th Cir. 1992) (holding that a duty of care existed when an attorney, who operated a matching service for intended parents and surrogates, "exercised control, drafting the contracts, organizing the transactions between the parties and professionals, and monitoring the contract compliance"); *see* Huddleston v. Infertility Ctr. of Am., Inc., 700 A.2d 453, 460 (Pa. Super. Ct. 1997) (finding a "special relationship" can exist between the agency coordinating surrogacy services, its client-participants, and the child the surrogacy creates); *see also* Dov Fox, *Reproductive Negligence*, 117 COLUM. L. REV. 149, 214–15, 228 (2017) ("What entitles the recipients of donor, IVF, and other services to make enforceable claims against doctors, pharmacists, sperm banks, fertility clinics, embryologists, and genetic counselors who assist them is that these specialists voluntarily assume a duty of reproductive care.").

231. Forman, *supra* note 20, at 52; *see also* Jody Lyneé Madeira & Barbara Andraka-Christou, *Paper Trails, Trailing Behind: Improving Informed Consent to IVF Through Multimedia Applications*, 3 J.L. & BIOSCIENCES 2, 2–28 (2016).

232. Sital Kalantry, *Regulating Markets for Gestational Care: Comparative Perspectives on Surrogacy in the United States and India*, 27 CORNELL J.L. & PUB. POL'Y 685, 685 (2018).

233. *See* GALPERN, *supra* note 21, at 7–8.

234. Often, insurance coverage of fertility services, such as IVF, depends on diagnosis of infertility. *Id.* at 6.

agencies and attorneys. The parties in *P.M.* were not sophisticated purchasers of surrogacy services; they met through an ad on Craigslist.[235]

The expansion of prenatal screening, and its potential to make testing and termination clauses more salient for parties, has the capacity to entrench existing practices of gestational surrogacy contracting. Parties with resources—those with the assistance of skilled lawyers, counselors, agencies, and physicians—will negotiate around or buy their way out of conflict. Their disagreements will remain largely invisible and infrequently appear in court documents or in newspapers. Their motivations may seem natural given the value placed on genetic relationships and prenatal information.

One question, then, for those interested in confronting the inequalities that characterize fertility markets, is what role law and policy should play in creating access for underserved populations and meaningful alternatives to for-profit services. State laws could impede the growth of for-profit agencies. A Minnesota bill, though permitting gestational surrogacy, would prohibit for-profit surrogacy agents and require all surrogacy agencies to be formed as non-profit organizations subject to state rules. Those non-profits agents could still "receive compensation for facilitating a gestational surrogacy arrangement."[236] While requiring surrogacy agencies to operate as non-profits could provide some transparency and accountability, the prospect of compensation might reinforce incentives that align with those of for-profit entities.

Other policy measures seek to reduce the financial burden of fertility treatments and surrogacy. Several bills pending before statehouses would amend insurance codes to require insurance plans to provide gestational surrogates the same coverage for pregnancy care and childbirth as any other pregnant person.[237] In Nevada, a recent law stipulates that health care plans cannot "deny, limit or seek reimbursement for maternity care because the

235. In *P.M.*, the intended parents, "[t]he Montovers[,] said they have also incurred enormous legal and medical fees, the latter of which approach more than $2 million that they can't pay. They are raising money online." Mike Kilen, *Who is Baby H's Parent? Iowa Legal Battle Pits Surrogate Against Couple Who Hired Her*, DES MOINES REG., https://www.desmoinesregister.com/story/news/2017/08/29/who-baby-hs-parent-iowa-legal-battle-pits-surrogate-against-couple-who-hired-her/580737001 [https://perma.cc/SJS5-TBYF] (last updated Sept. 5, 2017, 12:01 PM). In *Cook*, the court, after noting that the intended father "depleted his life savings" paying for surrogacy services, described him as a "fifty year old postal worker who is single, deaf, and lives with his two elderly parents." Cook v. Harding, 190 F. Supp. 3d 921, 928 (C.D. Cal. 2016).

236. S.F. 1152, 91st Leg., 1st Reg. Sess. § 257.97(a) (Minn. 2019). Moreover, the provision does not apply to licensed attorneys representing the parties in a gestational surrogacy contract unless the attorney also is acting as a surrogacy agent. *Id.* § 257.97(d).

237. S.B. 242, 80th Leg. Assemb., Reg. Sess. (Or. 2019). A new Indiana bill prohibits an insurer from denying or limiting coverage of maternity care because an individual is acting as a gestational surrogate. H.B. 1413, 121st Gen. Assemb., 2d Reg. Sess. (Ind. 2020); *see also* IND. CODE ANN. § 31-20-1-1 (West 2018).

insured is acting as a gestational carrier."[238] Because intended parents pay the costs of the surrogate's health care, these measures provide financial relief for intended parents who would otherwise arrange insurance coverage on the surrogate's behalf.

New laws may allow more people to gain access to surrogacy services. But they may not disrupt the professional networks that have vital influence on what surrogacy costs and how people contract for it. Disruption may be a difficult task to accomplish through state regulation, especially when market forces push toward the status quo. An additional avenue for reform, which future writing could explore, would be to change the nature of surrogacy contracting through market incentives that affect lawyers' and agencies' actions. Some of those incentives already exist. As noted above, fertility agencies adopted protective measures, such as requiring mental health screenings, before state laws did. And there are accessible platforms for the dissemination of information about the surrogacy process that can encourage transparency in industry standards. Consider current websites with user reviews that rate and describe the nature and quality of the professional services parties received. Shared information among broader populations, though admittedly having limitations, could shape the reputations of agencies and lawyers, and thus influence the way in which those professionals conduct their businesses.

The ability to enter a gestational surrogacy contract can look like a privilege available only to those with resources. However, fertility agencies and state policy could do more to embrace a shared commitment to reproductive equality. Gestational surrogacy has enabled individuals who have been subject to longstanding discrimination to become parents; it has been vitally important to the formation of LGBTQ families.[239] Going forward, law and

238. Assemb. B. 472, 2019 Leg., 80th Sess. (Nev. 2019). However, not all states are moving in the direction of expanding insurance coverage of surrogates' pregnancies. The United States District Court for the District of Maine interpreted a health insurance plan, which denied expenses of surrogacy, as a denial of "*all* expenses associated with a pregnancy by means of a surrogate—from the costs of preparing a surrogacy agreement, to in vitro fertilization, to pre-natal care, to delivery, and to post-birth care for the mother and child—is grounded in the common understanding of surrogacy." Roibas v. EBPA, LLC, 346 F. Supp. 3d 164, 171 (D. Me. 2018); *see also* EBIA, *Court Finds Health Plan's Denial of Surrogacy Expenses Reasonable Despite Ambiguous Plan Provision*, THOMSON REUTERS (Dec. 6, 2018), https://tax.thomsonreuters.com/blog/court-finds-health-plans-denial-of-surrogacy-expenses-reasonable-despite-ambiguous-plan-provision [https://perma.cc/6E6V-W7GZ].

239. Michael Boucai, *Is Assisted Procreation an LGBT Right?*, 2016 WIS. L. REV. 1065, 1123–24 (noting the importance of ART for LGBT family formation but questioning whether the current embrace of ART as a right glorifies biological reproduction); *see* Joslin, *supra* note 58 (manuscript at 50) (noting that "LGBTQ organizations joined the push in support of permissive surrogacy regimes" as the number of families created by surrogacy increased).

contract practices might address the role of fertility agencies in creating dynamic, responsive, and fairer routes to gestational surrogacy.[240]

V. CONCLUSION

Contractual clauses on testing and termination may be problematic, but they are not likely to disappear. Indeed, NIPT fits with the expectation that surrogates should undergo prenatal testing and with the less accepted idea that intended parents should be able to request the termination of the pregnancy for certain reasons. Statutory reform and professional advice attempt to address these issues. But this Article's research suggests that those solutions may be incomplete.

Available evidence indicates that contract terms are inconsistent with statutory requirements, not only in exceptional circumstances, but also as a matter of templates and form contracts. Having recognized that problem, one possibility would be to advocate for more detailed or emphatic statutory mandates, and perhaps that might accomplish valuable benefits. But before rushing toward a new wave of reform proposals, it is worthwhile to discern the institutional and professional dynamics of surrogacy in practice. Understanding those practical realities is indispensable for policymakers who wish to know how legal prescriptions about surrogacy contracts are translated into lived experience.

240. *See* Bridges, *supra* note 39, at 1126. "Because race privilege follows class privilege closely in this country, those same-sex couples with the money to afford a surrogacy arrangement will likely be white." *Id.* at 1144.