



# Future Choices II

An Update on the Legal, Statutory, and Policy Landscape  
of Assisted Reproductive Technologies

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Jessica Arons and Elizabeth Chen March 2013



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### COVER PHOTO

Guadalupe Benitez, right, walks with her partner Joanne Clark, left, and their son Gabriel Clark-Benitez, center, after a news conference held at the Hall of Justice in downtown San Diego Monday, Aug. 18, 2008. The California Supreme Court ruled Monday that Benitez, a lesbian, was unfairly denied a common infertility treatment by doctors at the North Coast Women's Care Medical Group based on their religious beliefs. (AP Photo/Denis Poroy)

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# Introduction and summary

In 2007 the Center for American Progress released its report “Future Choices: Assisted Reproductive Technologies and the Law,” which described a range of assisted reproductive technologies and their legal and regulatory background. The report also examined the policy implications of the largely unregulated field of reproductive technology, especially in the context of traditional feminist positions on reproductive rights. If a woman has the ultimate right to decide whether or not to bear a child when she is pregnant, for instance, does that principle hold true when she would like to become pregnant with the use of specific embryos? Is surrogacy a noble pursuit undertaken by autonomous, well-informed, and altruistic women, or is it a practice that exploits the low-income and vulnerable?

These questions have not gotten any easier to answer in the intervening years. Indeed, advances in reproductive technologies have continued to outpace the development of the laws that might govern them. At the same time, more and more people who would have been unable to procreate or become parents in past generations have been able to bring a child into their home or build a family of their choosing, including those who have historically been deemed “infertile” for social reasons such as their sexual orientation, gender identity, or unmarried status. When things do not go as planned, however, the law’s failure to prescribe clear guidelines for resolving the disputes that inevitably arise can lead to real confusion and hardship for families. And all the while, the questions keep coming.

The landscape of assisted reproductive technologies has continued to evolve since our 2007 report, and new questions have arisen as a result. Case in point: In 2010 President Barack Obama signed the Patient Protection and Affordable Care Act. Should fertility treatments be considered essential health benefits that must be required in every health plan, and what are the implications of including or excluding these services?

As assisted reproductive technologies become increasingly common and accessible, other questions demand answers: How should states define family relation-

ships? Should the government support children created after the death of a parent as it does the children of deceased parents created when that parent was alive? Should religiously affiliated employers be allowed to discriminate against employees who use assisted reproductive technologies with which the employers disagree? How do we address the rise in international surrogacy and other forms of reproductive tourism as world economies become increasingly globalized? What are the parameters for establishing citizenship for such children born abroad?

While some court opinions offer new clarity to a handful of unresolved issues, many court decisions only further muddle the landscape. We find that despite the increasing popularity of assisted reproductive technologies, the rights and responsibilities surrounding those who take part in these processes are still largely undefined.

As with the first “Future Choices,” this report examines the three primary areas in which legislatures and courts have spoken— health insurance coverage, embryo disposition, and parentage determinations—as well as additional areas where significant developments in the laws governing assisted reproductive technologies have occurred.



## Assisted reproductive technologies: A glossary

**Oocyte**—a human egg

**Gamete**—human egg and sperm

**Embryo**—a multicelled fertilized egg, up to eight weeks of development

**Fetus**—a prenatal developing human from the eighth week of gestation until birth

**Egg donor**—a woman who allows her eggs to be used in scientific research or to create a child whom she does not intend to parent, whether or not in exchange for compensation

**In vitro fertilization, or IVF**—the creation of an embryo by combining sperm and egg in a laboratory dish

**Gestational surrogate**—a woman who agrees to be impregnated with another woman's fertilized egg and give birth to a child who will be raised by others, whether or not in exchange for compensation

**Gestational mother**—a woman who carries and gives birth to a child to whom she is not genetically related but whom she intends to parent

**Gestational carrier**—a woman who carries and gives birth to a child to whom she is not genetically related; this term can refer to either a gestational surrogate or a gestational mother

**Intended parents**—people who use assisted reproduction to create a child whom they intend to parent, whether or not they have a genetic or biological relationship to that child

**Collaborative reproduction**—reproduction involving more than two biogenetic parents

# Insurance coverage and exclusions

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## Private insurance

As reflected in our 2007 report, a number of states—13—have required insurance companies to cover infertility treatments in their plans. The Appendix provides a chart with details about each state’s mandates, with a few small updates to our original “Future Choices” report. Since the report’s release, no additional states have begun requiring insurance coverage of fertility treatments. But as states begin to contemplate how they will implement different provisions of the Affordable Care Act, they must define which health benefits to deem “essential” and thus require plans to include.

Under the Affordable Care Act, each state is required to have a health care exchange from which consumers can pick a health insurance plan. In order to be included in the exchange, the insurance plan must include coverage of 10 categories of “essential health benefits.”<sup>1</sup> Congress defined those 10 categories very broadly and left it to the U.S. Department of Health and Human Services to flesh out what kinds of benefits would be included in those categories.<sup>2</sup>

In addition, states must select a “benchmark plan,” which must include benefits in each of the essential health benefits categories. All other insurance plans that wish to be included in the health care exchange must offer coverage that is substantially similar to the benefits offered by the benchmark plan. When a state fails to select a benchmark plan, federal law selects one by default.<sup>3</sup>

The Department of Health and Human Services does not explicitly include treatments for infertility among the essential health benefits categories,<sup>4</sup> but states are free to augment the required categories and mandate additional coverage. In some cases, however, the states may have to pay for that additional coverage. The Department of Health and Human Services has determined that benefits mandated by states prior to December 31, 2011, will be treated as essential health benefits, and therefore, in these cases, the states will not have to bear the cost burden of requiring

the additional coverage.<sup>5</sup> Every state that has mandated infertility coverage did so before that threshold date, so the rule would apply to all of the states.

Nevertheless, issues in the infertility context remain. In particular, there is a potential mismatch between benchmark plans and plans to which the mandates apply. There are two possible outcomes for states with mandates for coverage of infertility treatments, depending on the benchmark plans that they have selected.

- The state selects a benchmark plan that already covers infertility treatments.

In this situation, under the rule, all insurance plans in the exchange would be required to cover infertility treatments. The state would not be required to pay for the coverage; the cost, therefore, would fall on the insured individual or the insurer.<sup>6</sup>

- The state selects a benchmark plan that does not cover infertility treatments.

Under this circumstance, there would be two types of insurance plans in the exchange: plans outside of the mandate market—which would not be required to cover infertility treatments—and plans inside the mandate market—which would still be required to cover infertility treatments but at no cost to the state. This potential discrepancy is problematic because it may drive all health care consumers who desire infertility treatments to plans in the exchange that cover infertility, triggering increased costs in those particular plans.

Of the states that have mandates, some have required coverage of infertility treatments in all insurance markets, while others have limited coverage to particular markets. Still other states limit coverage to certain types of plans. The chart below shows the states where infertility insurance mandates have been enacted, the type of benefit, the markets those mandates cover within the state, and whether infertility treatments are covered by the benchmark plan.



**TABLE 1**  
**Infertility insurance mandates**  
 State breakdown of fertility treatment coverage

State	Required benefit	Market/type of plan applicability	Benchmark plan type	Issuer and plan name	Service covered
Arkansas	In vitro fertilization	Individual, small group, large group	State recommended: plan from third-largest small-group product	HMO Partners, Inc. Open Access POS, 13262 AR001	No <sup>1</sup>
Connecticut	Infertility diagnosis and treatment	Individual, group	State recommended: largest state non-Medicaid health maintenance organization, or HMO.	ConnectiCare HMO	Yes
Hawaii	In vitro fertilization	Individual, small group, large group, or HMO	State recommended: plan from largest small-group product	Hawaii Medical Service Association Preferred Provider Plan 2010	Yes
Illinois	Infertility	Group, group HMO	State recommended: plan from largest small-group product	Blue Cross and Blue Shield of Illinois BlueAdvantage PPO	Yes
Maryland	1. In vitro fertilization	1. Individual and large group	State recommended: plan from largest small-group product	CareFirst (BCBS) – HMO HSA Open Access	Yes <sup>2</sup>
	2. Infertility services	2. Small group			Yes
New Jersey	Infertility treatment	Group plans with more than 50 employees and only those providing pregnancy-related benefits	Federal default: plan from largest small-group product	Horizon HMO Access HSA Compatible	Yes
New York	Infertility coverage	Group commercial, group HMO; article 43 contracts	State recommended: plan from largest small-group product	Oxford Health Insurance, Inc. Oxford EPO	Yes
	Medical conditions leading to infertility	Group commercial, individual commercial, group HMO, article 43 contracts			
Ohio	Infertility services	All plans	Federal default: plan from largest small-group product	Community Insurance Company (Anthem BCBS) Blue 6 Blue Access PPO Medical Option D4 Rx Option G	No
Rhode Island	Infertility services	Individual	State recommended: plan from largest small-group product	Blue Cross and Blue Shield of Rhode Island Vantage Blue PPO	Yes
West Virginia	Infertility services	HMOs	Federal default: plan from largest small-group product	Highmark Blue Cross Blue Shield West Virginia Super Blue PPO Plus 2000 1000 Ded	No

Sources: The Center for Consumer Information & Insurance Oversight, Centers for Medicare & Medicaid Services, “Additional Information on Proposed State Essential Health Benefits Benchmark Plans,” available at <http://ccio.cms.gov/resources/data/ehb.html> (last accessed March 2013); U.S. Department of Health and Human Services, “Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation,” *Federal Register* 78 (37) (2013): 12834, 12869–12872; Jessica Arons, “Future Choices: Assisted Reproductive Technologies and the Law” (Washington: Center for American Progress, 2007), available at <http://www.americanprogress.org/issues/women/report/2007/12/17/3728/future-choices-assisted-reproductive-technologies-and-the-law/>.

1 The author spoke with an Arkansas Insurance Department consumer services division investigator, who stated that in the negotiations over how the state was planning on joining the federal/state partnership exchange, in vitro fertilization benefits were left out as part of the compromise. The Insurance Department is aware that the state has a mandate and also that the benchmark plan explicitly does not cover in vitro fertilization as an essential health benefit. The investigator with whom the author spoke is unsure of how that conflict will be resolved.

2 Maryland’s Health Care Reform Coordinating Council recommended that state mandates that apply in markets beyond the selected small-group product be applied globally as essential health benefits. In effect, Maryland’s Health Reform Council anticipates and is addressing the issue we identify and discuss above. Maryland Office of Health Care Reform, “Meeting: HCRCC Selects Essential Health Benefits Benchmark,” available at <http://www.healthreform.maryland.gov/2012/12/meeting-hcrcc-selects-essential-health-benefits-benchmark/> (last accessed January 2013).

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## Public insurance

While insurance coverage of fertility treatments has expanded over time, states continue to deny coverage for such treatments to recipients of public medical assistance. In addition to the states noted in the original report—Minnesota, Montana, Oklahoma, New Jersey, Ohio, Pennsylvania, and Rhode Island—Florida, Kentucky, and Texas also prohibit the use of public funds for the treatment of infertility.<sup>7</sup>

In addition, the federal government prohibits coverage of in vitro fertilization through the medical benefits package provided to veterans.<sup>8</sup> But service members who have served in Iraq and Afghanistan have survived a high number of injuries caused by improvised explosive devices that can damage reproductive tracts and preclude reproduction without the use of assisted reproductive technologies. As a result, Sen. Patty Murray (D-WA) introduced legislation in the 112th Congress that would expand fertility treatments to include in vitro fertilization for injured service members, as well as for their spouses or surrogates.<sup>9</sup> The bill passed the Senate by unanimous consent on December 13, 2012, but the House version of the bill was not brought to a vote.<sup>10</sup> The legislation will need to be reintroduced in the new Congress if it is to move forward.

# Employment discrimination

Title VII of the Civil Rights Act of 1964 prohibits discrimination in employment on the basis of sex, as well as a number of other factors.<sup>11</sup> In 1978 Congress clarified the definition of “on the basis of sex” to include a prohibition of discrimination on the basis of pregnancy through the Pregnancy Discrimination Act.<sup>12</sup> In recent years courts have been asked whether the Pregnancy Discrimination Act prevents employers from firing employees for using assisted reproductive technologies to become pregnant.

In 2008, in the case of *Hall v. Nalco*, the 7th Circuit became the first U.S. Court of Appeals to address whether the Pregnancy Discrimination Act prohibits discrimination against an employee who used in vitro fertilization. The court answered the question in the affirmative.<sup>13</sup> Because in vitro fertilization implicated the plaintiff’s childbearing capacity and because the employees who must take time off to undergo the procedure “will always be women,” the court found that firing the employee in that case was sex discrimination. The 7th Circuit’s decision has been applied by a number of district courts, but no additional appeals courts have addressed the issue.

Some plaintiffs in these cases have nevertheless had to deal with an additional legal wrinkle known as the ministerial exception, which precludes the application of antidiscrimination protections to ministers employed by religious institutions. Some religions, for example, exclude women from becoming ministers. Title VII would ordinarily prevent discrimination that denies women occupational opportunities. But recognizing that different religions should be able to choose their ministers based on their beliefs, federal courts created the exception.<sup>14</sup>

In *Hosanna-Tabor Evangelical Lutheran Church and School v. Equal Employment Opportunity Commission*,<sup>15</sup> the Supreme Court radically expanded the traditional ministerial exception. The plaintiff in the case was a teacher at a religious school, but most of her duties were secular. When she returned from disability leave, the school told her that it had hired someone to fill her position, and she was fired

when she threatened to sue. The school's actions likely would have been a violation of the Americans with Disabilities Act, but because the employee fell within the institution's internal definition of a minister, the Court applied the ministerial exception and left the plaintiff unprotected by the law.

In *Dias v. Archdiocese of Cincinnati*,<sup>16</sup> a religious school attempted to invoke the ministerial exception to defend against a case brought by a technology coordinator who was fired for using in vitro fertilization. The court decided in that case that the fired employee was not a minister because she was not Catholic and had no responsibility for religious instruction in the schools. As a result, she was permitted to sue for sex discrimination.

Two similar cases are still pending and their outcomes will depend on how lower courts apply *Hosanna-Tabor* to the facts at hand. Because so few cases have been litigated and resolved on this issue as of now, it is unclear how much latitude religiously affiliated employers will be given by the courts to use religion as an excuse to discriminate against employees who seek and obtain fertility treatments.

# Disposition of frozen embryos

As we found in our original report, no state court of last resort has permitted the use of genetic material of a person who does not wish to become a parent. And no highest state courts have considered a dispute over frozen embryos since 2007. But recently, the Superior Court of Pennsylvania—a state intermediate appellate court—did rule in favor of a woman who sought to use frozen embryos containing her ex-husband’s genetic material, over his objections.<sup>17</sup>

As explained in our initial “Future Choices” report, state courts have established a number of tests to determine the disposition of unused embryos when disputes arise. The Pennsylvania court chose to follow the Tennessee Supreme Court’s balancing test established in *Davis v. Davis*.<sup>18</sup> In that case the Tennessee court, in the absence of a contract, balanced the interests of each party in procreating or preventing procreation. Applying that test, the Pennsylvania court found in favor of the ex-wife because absent the use of the embryos she was unlikely to otherwise be able to become a biological or adoptive parent.

The court found that her interest in becoming a parent outweighed the ex-husband’s desire not to become a parent, particularly because the husband voluntarily provided the wife with sperm in order to help preserve her fertility; left blank the portion of the consent form that would have resolved the fate of the embryos in the event of divorce; never made any other written agreement prior to the commencement of the in vitro fertilization process; and was able to be involved in the child’s life if he desired. It is worth noting, however, that while carving out an exception for this particular situation, the court affirmed the general rule that the party who seeks to avoid procreation will generally prevail.

## Price caps on eggs: Ethical guidelines or price fixing?

The American Society for Reproductive Medicine recommends that women who provide eggs be compensated no more than \$5,000 per egg retrieval.<sup>19</sup> This compensation is intended to cover only the “time, inconvenience, and discomfort” associated with retrieval.<sup>20</sup> The compensation does not cover the possibility of complications or health risks that might result from the process.

These compensation guidelines have been adopted by 85 percent of clinics that offer assisted reproductive technologies as Society for Assisted Reproductive Technology member clinics. While the guidelines have long existed, egg donors have begun to argue that the price limit violates federal antitrust laws, which prohibit price fixing within industries. As a result, some women have filed a class action lawsuit against the American Society for Reproductive Medicine to lift the price limit, claiming that they should be able to be compensated according to market rates instead of the “artificially low” rates imposed by the American Society for Reproductive Medicine.<sup>21</sup>

In defending the compensation cap, the American Society for Reproductive Medicine argues that it is driven by twin notions—that women should be compensated for their time but that human life should not be devalued through the commodification of eggs.<sup>22</sup> By

constraining the market on egg donation, the organization argues that it is limiting undue inducement and exploitation while at the same time retaining the value of human life by not treating oocytes as property or commodities.<sup>23</sup>

Scholars such as Duke Law School professor Kim Krawiec argue that other forces are at work besides the American Society of Reproductive Medicine’s guidelines that operate to uphold price fixing, including the gendered notion that egg donation should not be compensated because it is inherently philanthropic, while sperm donation is transactional and should thus be compensated.<sup>24</sup>

There are, of course, additional ethical considerations that arise from compensating egg retrieval according to market rates. For clinics that do not follow the American Society of Reproductive Medicine’s guidelines, for instance, University of Pennsylvania law professor Dorothy Roberts describes a “racial supply-and-demand system” in which “black women are often paid a few thousand dollars more for their eggs than the fee typically earned by white women” because they are less likely to provide eggs, but “tall, blond, college-educated donors still fetch the highest premium.”<sup>25</sup> Even greater price disparities may emerge if the price-fixing lawsuit is successful.



# Parentage determinations

As increasing numbers of families are built through assisted reproductive technologies, questions continue to arise about the rights and responsibilities that attach to those involved. This is especially important given that a child who is the product of assisted reproduction can have as many as six individuals with parental claims. These individuals include the sperm provider, the egg provider, the person who carries the pregnancy and gives birth, up to two intended or contracting parents, and the husband of a gestational surrogate who has elected to keep the child to whom she gave birth. Problems can arise when some of these parties change their minds and wish to alter their parental status from what was originally agreed upon, as well as when the government makes a decision that contravenes the parties' original intent.

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## Disputed parental relationships

Two recent cases—both decided in state intermediate appellate courts—reflect the level of uncertainty and potential for inconsistency surrounding the determination of parental relationships after the use of assisted reproduction. One court imposed a parental relationship on a sperm donor despite clear evidence that such a relationship was never intended by any of the parties involved in creating the child, while another court denied legal recognition of an intended mother, leaving the child legally motherless.

The first case, heard before the Court of Appeals of Indiana, involved a sperm donor, a woman who was both the genetic and gestational mother, and the mother's former "Life Partner."<sup>26</sup> At the time the donor provided sperm to the mother, she was in a committed—but not legally recognized—relationship with her life partner. After a child was conceived, all of the parties involved signed a contract that stated that the mother would not seek recognition of paternity or financial support from the donor for the child that was to be born. Seven years later, the donor's sperm was used again to conceive another child for the couple, but the parties neglected to sign another contract to govern that pregnancy.

After the mother and the life partner ended their relationship, the mother sought financial assistance from the state. The state, in turn, looked to the sperm donor to provide support for the children. The court examined the contract and found that because it only contemplated the existence of a single child as a product of the donor's sperm, the donor was required to pay child support for the second child, whom it found that the contract did not cover. Because the court found that the law of contract governed the familial relationship, the donor agreement both protected the donor at the expense of the mother and first child and provided the state with a means to force the donor to support the second child.<sup>27</sup>

In the second case, all parties sought the same result—that the intended parents be recognized as the legal parents of the child. But because the New Jersey Supreme Court had previously found surrogacy to be against the public policy of the state<sup>28</sup>—and because it claimed that the state legislature had not yet spoken on this issue—instead of declaring the intended mother as the child's legal mother, the court chose to leave the child without one. The consequence of the court's action is that the child's intended mother will now be required to petition the family court to adopt the child she has already been raising.<sup>29</sup> Prior to completion of the adoption proceedings, the parents will be required to incur additional time and expense, and the child will not be entitled to claim benefits such as worker's compensation, Social Security, or life insurance, or to automatically inherit from the mother.

The outcome of this case raises two issues. First, the New Jersey law treats infertile women differently from infertile men. Infertile men are automatically recognized by statute as the father of a child of assisted reproduction when a sperm donor is used, but infertile women must petition the state for analogous recognition. This raises an important equal-protection concern—namely, whether forms of reproduction in this particular context are in fact real differences warranting different treatment of the sexes or whether they are simply excuses for stereotyping about parental fitness when a biological relationship is expected.<sup>30</sup> The stereotype at work here is that men are not expected to have a biological relationship with their genetic offspring in the fetal stage but that women should have a biological relationship because they are expected to carry the fetuses that have their genetic material.

Second, the New Jersey court's opinion was problematic because the state legislature had, in fact, spoken on the issue. The legislature had recognized the problem of leaving children born of gestational surrogates motherless, and it had addressed the matter by crafting a law to ensure that the intended mother was identified

as the child's legal mother on the child's birth certificate. New Jersey Gov. Chris Christie (R) vetoed that law in August 2012, however, claiming that there was not enough information to warrant the legislature's decision.<sup>31</sup> The court's decision was thus nonsensical in light of the legislature's clear intent.

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## Statutory efforts to increase the number of legal parents

In a landmark surrogacy case from the early 1990s, the California Supreme Court—while remaining open to the use of assisted reproductive technologies—strictly limited the number of legal parents that a child may have to two.<sup>32</sup>

In response to the California Supreme Court's limitation, Sen. Mark Leno (D-CA) proposed legislation to raise that limit. He did so in recognition of increasingly diverse family forms combined with the desire to ensure maximal private support for children.<sup>33</sup> The practical effect would be that a child could receive support from each legally recognized parent, and each parent would have the right to have a relationship with the child. In the assisted reproduction arena, it could mean that a sperm donor, egg donor, gestational surrogate, or any other party could each be recognized as the legal parents of a resulting child. Families could choose these forms of recognition to formalize commitments to the children, provide access to health insurance and citizenship, or even to provide a contingency against state intervention by the child welfare system. After passing the legislature, the law was vetoed by California Gov. Jerry Brown (D). Because California's legislative session ended, the veto override consideration expired.<sup>34</sup>

Outside of the context of assisted reproductive technologies, both Delaware and the District of Columbia have passed statutes that permit legal recognition of de facto parents, or functional parents. Those parents are established through a number of factors, including the support and consent of the child's existing parent or parents, past exercise of parental responsibility, past actions in the parental role sufficient to establish a relationship with the child, and whether the potential de facto parent lived with the child at the time of birth or adoption or for 10 of the most recent 12 months.<sup>35</sup> These de facto parents increase the number of possible legally recognized parents, but require meeting more formal requirements than the California statute, which merely requires that recognition be “in the best interests of the child.”<sup>36</sup> The Delaware statute was subsequently found to be unconstitutional by a state court,<sup>37</sup> but the District of Columbia statute continues to stand. It has not yet, however, been applied in a

reported case in the context of surrogacy, where a gestational or genetic parent sought to be recognized as a de facto parent in addition to the intended parents.

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## International surrogacy

The use of assisted reproductive technologies has become increasingly transnational. Relationships between family members, surrogates, donors, and nations have become more complex, due in part to the vast differences in regulatory schemes in different countries, which range from outright bans on the use of assisted reproductive technologies to entire permissiveness. This international patchwork of laws creates a situation in which, for example, intended parents may use their own gametes but travel to another country to hire a surrogate to gestate their fetus, or in which an intended mother might gestate the fetus herself but first cross borders to obtain an embryo.<sup>38</sup> The possible scenarios are seemingly endless.

Children born in the United States automatically gain citizenship through the 14th Amendment.<sup>39</sup> And when American citizens adopt children who were born abroad, those children receive American citizenship as soon as their adoptions are finalized.<sup>40</sup> But children created with the assistance of reproductive technologies and born abroad to intended parents who are American citizens do not have the same status.

The Immigration and Naturalization Act determines citizenship for children born outside of the United States—and whether parents can transmit citizenship to them. The Immigration and Naturalization Act only references a need for a genetic connection between a father and a child born out of wedlock,<sup>41</sup> but the U.S. Department of State has decided to infer a requirement of a genetic connection between any child born outside of the United States and its intended parents as a prerequisite for citizenship.<sup>42</sup> If intended parents use an embryo that does not contain their genetic material, then that child will not be a U.S. citizen at birth. In addition, in some countries, children born to surrogates will not acquire citizenship in that country either, leaving such children stateless.<sup>43</sup>

**TABLE 2**  
**Pathways to citizenship**

Rules governing the citizenship of a child born abroad

Born in the United States	Born outside of the United States	
Child is automatically a citizen	Adopted by citizen parents	Born of a gestational surrogate to citizen intended parents
	Citizenship when the adoption has been finalized	<b>With a genetic connection:</b> citizenship at birth
		<b>Without a genetic connection:</b> must petition for citizenship, may be stateless

Sources: United States v. Wong Kim Ark, 169 U.S. 649 (1898); U.S. Citizenship and Immigration Services, “Before Your Child Immigrates to the United States,” available at <http://www.uscis.gov/portal/site/uscis/menuitem.eb1d4c2a3e5b9ac89243c6a7543f6d1a/?vgnextoid=d72e18a1f8b73210VgnVCM100000082ca60aRCRD&vgnextchannel=d72e18a1f8b73210VgnVCM100000082ca60aRCRD> (last accessed March 2013); Immigration and Nationality Act, §§ 301, 309 (1994); Bureau of Consular Affairs, Overseas Citizen Services, “Important Information for U.S. Citizens Considering the Use of Assisted Reproductive Technology (ART) Abroad,” available at [http://travel.state.gov/law/citizenship/citizenship\\_5177.html](http://travel.state.gov/law/citizenship/citizenship_5177.html) (last accessed September 2012).

Pepperdine University law professor Kristine Knaplund argues for the use of two different presumptions of citizenship for children of U.S. citizens born abroad based on whether assisted reproductive technologies are used. In her analysis of this issue, she considers a number of ways in which parentage might be determined for such children, including the State Department’s genetic test.<sup>44</sup> Knaplund’s proposed solution offers two paths to citizenship for nongenetic children born abroad. The first path, in which the gestational mother is also the intended mother, would use the parturient test, making the presumption that the gestational mother is also the legal mother. The second path, where a gestational carrier is used, would rely instead on intent, making the intended parent the legal parent.

The State Department’s decision to require a genetic connection between intended parents and their children born abroad is an arbitrary and unnecessary barrier to citizenship for children of citizen parents. As increasing numbers of families use assisted reproductive technologies both in the United States and transnationally, the State Department should adapt its archaic rule to ensure that families are recognized as such, regardless of genetic connections. In doing so, the State Department will ensure that citizenship is conferred in a manner that ensures that all American citizens have the ability to transmit their nationality to their children.

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## Children created posthumously

Now that sperm, eggs, and embryos can be frozen and later thawed and used for procreation, there are instances when such material may be used after a genetic parent has died. Indeed, some people intentionally bank their genetic material before undergoing cancer treatments, leaving for war, or in anticipation of other potentially fatal events. Yet even when the posthumous creation of a child is contemplated, there may not be adequate protections to ensure that the child will be entitled to the financial resources that would have been available had the child been created when the parent was alive.

The Supreme Court recently weighed in on the debate over whether children created after the death of a genetic parent are entitled to Social Security death benefits from that deceased parent, though the case hardly settled the matter. The Social Security Administration interpreted its regulations to determine benefits by looking to the law of inheritance in the state where the deceased parent resided at the time of death. The Supreme Court affirmed that approach, meaning that at least 51 different laws will govern this question.<sup>45</sup>

In *Astrue v. Capato*,<sup>46</sup> Karen Capato conceived twins with sperm from her husband, Robert. The sperm had been frozen prior to his death because of fears of infertility from his cancer treatments, but Robert had been deceased for nearly a year at the time of the twins' conception. When Karen filed for survivors' insurance benefits with the government on behalf of the twins, the Social Security Administration denied her claim. At the time of his death, Robert was a resident of Florida. The agency therefore applied Florida law, which only provides benefits to children who were conceived after a parent's death if those children were provided for specifically in the deceased parent's will.<sup>47</sup>

The U.S. Court of Appeals for the 3rd Circuit disagreed with the Social Security Administration's interpretation, finding the relevant factor to be the genetic relationship between the children and the deceased, rather than state intestacy law.<sup>48</sup> But the Supreme Court ultimately followed the *Chevron*<sup>49</sup> doctrine, which provides guidelines for courts in determining when to follow an agency's interpretation of a law that it has been tasked with administering. According to the Supreme Court's prior decision in *Chevron*, if Congress has spoken on the issue and made the intent of the law clear, then both the agency and the court are required to follow Congress's intent. If the law is less clear, then the court must uphold the agency's interpretation, so long as that interpretation is reasonable. Because the Supreme Court found the



Social Security Administration's interpretation of the law to be reasonable, survivors' benefits will continue to be determined on a state-by-state basis.<sup>50</sup>

Laws throughout the states vary in their treatment of posthumously created children. The vast majority of states remain silent on the matter. In the states that do address the issue, the requirements vary among recognition of relationships and conferral of benefits. Fourteen states have passed statutes governing whether a child created by assisted reproduction after the death of a genetic parent is eligible to receive benefits from that parent, which is five more than had been passed at the time of our original report.<sup>51</sup> Two states also have case law that speaks to the issue.<sup>52</sup>

Of the 14 states with statutes, 13 require that the deceased parent has consented in writing to becoming a parent prior to the implantation of an embryo, a provision that is in the Uniform Parentage Act.<sup>53</sup> In addition, 7 of those 13 states require that the parents of the child had been married to each other.<sup>54</sup> Four states require that the child either be in utero or born within a certain period after the death of the parent, addressing the concern that there be some kind of time limit on the use of the deceased's gametes.<sup>55</sup> Three states require that the deceased parent be genetically related to the child.<sup>56</sup> And Florida's law, which governed in *Astrue v. Capato*, requires that the deceased parent provide for the anticipated child in his or her will.<sup>57</sup>

Given that the Supreme Court deferred to the agency's interpretation—which relies on state law—it is now even more imperative that states address the issue and that people who avail themselves of assisted reproductive technologies take steps to ensure that any potential children will be adequately protected.

TABLE 3

**Child created after the death of a parent**

State statutes governing children created posthumously

State	Consented in writing before death	Genetic relation	Married parents	Time limit after death of the parent	Provided for in will of deceased parent
Alabama	X		X		
California	X	X		In utero within two years	
Colorado	X		X	In utero within 36 months or born within 45 months	
Delaware	X				
Florida					X
Iowa	X	X	X	Born within two years	
Louisiana	X	X	X	Born within three years	
Massachusetts	X	X			
New Jersey		X			
New Mexico	X				
North Dakota	X				
Texas	X		X		
Utah	X		X		
Virginia	X		X		
Washington	X				
Wyoming	X				

Sources: Ala. Code § 26-17-707 (2008); Cal. Prob. Code § 249.5 (West Supp. 2011); Colo. Rev. Stat. §§15-11-120(11), 19-4-106(8) (2012); Del. Code Ann. tit. 13, § 8-707 (2003); Fla. Stat. § 742.17(4) (2008); Iowa Code § 252A.3(5)(a) (2011); La. Rev. Stat. Ann. 9:391.1 (2008); Woodward v. Commissioner, 760 N.E.2d 257 (Mass. 2002); In re Estate of Kolacy, 753 A.2d 1257 (N.J. Super. 2000); N.M. Stat. Ann. § 40-11A-707 (2009); N.D. Cent. Code § 14-20-65 (2009); Tex. Fam. Code Ann. § 160.707 (West 2008); Utah Code Ann. § 78B-15-707 (West 2008); Va. Code Ann. § 20-158 (2008); Wash. Rev. Code § 26.26.730 (2011); Wyo. Stat. Ann. § 14-2-907 (2011).

# Conclusion

As clearly demonstrated above, the terrain surrounding assisted reproductive technologies has become only more fraught and complex since we issued our original “Future Choices” report a little more than five years ago. While the task of regulating these technologies has not become any easier, it is becoming more and more evident that regulations are necessary. The use of assisted reproductive technologies is only increasing, and courts continue to struggle with how to resolve the disputes that arise in the absence of legislative and regulatory action.

Below we offer a few guiding principles that should be considered whenever lawmakers do wade into this fray:

- Policies should not discriminate against those who participate in assisted reproductive technologies based on race, ethnicity, national origin, religion, marital status, sexual orientation, class, or disability.
- Policies should protect those who use assisted reproductive technologies from employment discrimination to the greatest extent possible.
- Policies should not discriminate against children who are created with assisted reproductive technologies.
- Policies should maximize the resources available to provide financial support to a child created with assisted reproductive technologies, including public benefits that would be available had the child been created without those technologies.
- Policies should minimize the possibility that a child will be left without a legal parent or without citizenship.
- Policies should create incentives and/or penalties to ensure that parties to collaborative reproduction memorialize their intent in a written agreement prior to the use of assisted reproductive technologies.

- Policies should respect the original intent of the parties involved in collaborative reproduction, when evidence of that intent is clear and when enforcing that intent is not contrary to the best interests of the child or established public policy.

Whether one thinks assisted reproductive technologies are good or bad, the fact is that they are here to stay. And the longer we put off their regulation and oversight, the more complications that will ensue for an untold number of families. We have developed thoughtful policies in the realms of divorce, cohabiting, single parenting, multigenerational parenting, foster care, and adoption that offer consistency and help manage expectations. We must add families created with the assistance of reproductive technologies to that list.

Modern family structures may challenge our definitions of family and the rights and responsibilities we apply to various relationships, but they also add to the diversity of this nation and help people nurture the most basic human desire: to love and care for one another. Ultimately, the best policies are the ones that recognize and value all families.

## Appendix

### State mandates for infertility insurance

State	Coverage mandate		Benefit restrictions					Religious exemption	
	Mandate to cover	Mandate to offer	Age	Marriage	Own gametes	Benefit caps	Government-program exclusions	Employer	Other
Arkansas	X			X	X	X <sup>1</sup>			
California		X						X	X <sup>2</sup>
Connecticut	X		< 40 years			X <sup>3</sup>		X	
Florida							X		
Hawaii	X			X	X	X <sup>4</sup>			
Illinois	X					X <sup>5</sup>		X	X <sup>6</sup>
Kentucky								X	
Maryland	X			X	X	X <sup>7</sup>		X	
Massachusetts	X							X <sup>8</sup>	
Minnesota							X		
New Jersey	X		< 46 years <sup>9</sup>			X <sup>10</sup>	X	X <sup>11</sup>	
New York	X		21 to 44 years						
Ohio	X						X		
Oklahoma							X		
Pennsylvania							X		
Rhode Island	X		25 to 42 years <sup>12</sup>	X		X <sup>13</sup>			
Texas		X		X	X		X	X <sup>14</sup>	X <sup>15</sup>
West Virginia									

Sources: Ark. Code §§ 23-86-118, 23-85-137 (2007); Cal. Health & Safety Code § 1374.55 (2007); Conn. Gen. Stat. §§ 38a-509, 38a-536 (2007); Fla. Admin. Code R. 64F-19.007 (2008); Haw. Rev. Stat. §§ 431:10A-116.5, 432:1-604 (2007); 215 Ill. Comp. Stat. 5/356m, 125/5-3 (2007); Ky. Rev. Stat. § 311.715 (1984); Md. Ins. Code § 15-810 (2007); Md. Health-Gen. Code § 19-701 (2007); Mass. Gen. Laws ch. 175, § 47H; ch. 176A, § 8K; ch. 176B, § 4J; ch. 176G, § 4 (2007); Minn. Stat. § 256B.0625, Subd. 13(a) (2006); N.J. Stat. Ann. §§ 17-48-6x, 17-48A-7w, 17-48E-35.22, 17B:27-46.1x, 26:2J-4.23 (2007); N.Y. Ins. L. §§ 3221(k)(6), 4303(s) (2007); Ohio Rev. Code § 1751.01 (2007); 56 Okla. Stat. § 204 (2007); Pa. Stat. tit. 62, § 443.6 (2006); R.I. Gen. Laws §§ 27-18-30, 27-19-23, 27-20-20, 27-41-33 (2007); Tex. Ins. Code §§ 1366.001-007 (2007); W. Va. Code § 33-25A-2 (2007).

1 \$15,000 lifetime cap.

2 Health-plan exemption.

3 Cap of two embryo implantations per cycle.

4 Maximum benefit of one cycle of in vitro fertilization.

5 Maximum benefit of four egg retrievals for the first birth, two egg retrievals for the second birth.

6 Any entity that issues a plan or policy is exempted.

7 Cap of three in vitro fertilization cycles per live birth, lifetime cap of \$100,000.

8 Law exempts diocesan employers only.

9 A woman is considered to be infertile if she is under age 35 and has been unable to conceive for two years, or if she is older than age 35 and has been unable to conceive for one year.

10 Lifetime cap of four egg retrievals.

11 Religious employers are not required to cover specific types of procedures; notice of exclusion is required.

12 Age limit applies to women only.

13 \$100,000 lifetime cap.

14 Exempts self-insured employers only.

15 Law includes exemptions for insurers and HMOs.

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## Endnotes

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