THE PLANNED PREGNANCY PROBLEM: INCENTIVIZING UNIFORM SURROGACY LAW REFORM THROUGH TITLE X EXPANSION

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INTRODUCTION

The late twentieth century saw a unique moment in legal, social, and medical development throughout the United States.[1] As social issues pushed to the forefront of political debate, new federal programs emerged.[2] With the advent of new contraceptive technologies, including birth control pills and intrauterine devices (IUDs), and growing concerns surrounding population growth following the post-World War II baby boom, the United States government saw a benefit in promoting accessible family planning services.[3] While many Americans prospered under the United States' economic growth and new international political presence in the late twentieth century, acute wealth disparities spurred political action and ushered in the War on Poverty.[4] During this period, new social services became a pillar for providing economic relief to many families, with new access to contraception and sexual health advancements providing opportunities for family planning—including deciding whether or not to have children.[5] With government-assisted access to such healthcare, many Americans gained greater personal and financial control because of family planning.[6]

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1. S*ee* Cheryl A. Vamos, Ellen M. Daley, Kay M. Perrin, Charles S. Mahan & Eric R. Buhi, *Approaching 4 Decades of Legislation in the National Family Planning Program: An Analysis of Title X's History from 1970 to 2008*, 101 AM. J. PUB. HEALTH 2027, 2027 (2011).

2. *See id.* (explaining the government interest in establishing programs to proactively limit the need for future welfare through personal economic control, including family planning).

3. *See id.*

4. *See id.*

5. *See id.*

6. *See Title X Statutes, Regulations, and Legislative Mandates*, U.S. DEP'T OF HEALTH & HUM. SERVS. [hereinafter *Title X Statutes*], https://opa.hhs.gov/grant-programs/title-x-service-grants/title-x-statutes-regulations-and-legislative-mandates (last visited Feb. 1, 2024) (defining family planning and related services as including "natural family planning methods, infertility services, and services for adolescents; highly effective contraceptive methods; breast and cervical cancer screening and prevention services that correspond with nationally recognized standards of care; [sexually transmitted disease (STD)] and [human immunodeficiency virus (HIV)] prevention education, counseling, testing, and referral;

In 1970, under the Nixon Administration, the Title X Family Planning Program authorized the Office of Population Affairs (OPA), housed within the Department of Health and Human Services (HHS), to develop and administer grants for clinics that offered family planning assistance.[7] In subsequent decades, Title X received increased funding and expanded its programs to reflect the sexual health needs of the American public.[8] The program's reach gave many individuals control over their sexual health through accessible means.[9] Expanded services included providing contraceptive methods both to reduce unplanned pregnancy and prevent sexually transmitted infections (STIs), treatments for human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS), and screening for cancers affecting reproductive organs.[10] The success of Title X rested mainly in the broad dispensation of grants to clinics nationwide, allowing these clinics to develop services reflective of current public reproductive and sexual health needs.[11] Once a clinic received Title X funding, the clinic could broadly use those funds for almost any sexual health services with few restrictions, so long as they furthered the Title X mission of promoting accessible care.[12] The significant autonomy afforded to both the OPA in administering grants and

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adolescent abstinence counseling; and other preventive health services."). Here, Title X addresses STD prevention and contraception as elements of sexual health relating to intercourse, but STD prevention can also encourage reproductive health by diminishing potential harm to reproductive organs caused by STD exposure. Surrogacy similarly serves as a reproductive health service by allowing individuals with reproductive challenges to conceive through assisted means but is not explicitly mentioned in by Title X. *See infra* Part I.A.3. Going forward, this Comment will use the phrase sexually transmitted infections (STI) to refer to sexually transmitted diseases (STD).

7. *See* Vamos, Daley, Perrin, Mahan & Buhi, *supra* note 1 (discussing family planning assistance as a variety of services related to contraception and sexual health).

8. *See* Title X of the Public Health Service Act, 42 U.S.C. §§ 300 to 300(a)–8; Glenn A. Guarino, Annotation, *Provision of Family Planning Services under Title X of the Public Health Service Act and Implementing Regulations*, 71 A.L.R. FED. 961, 961 (1985); *see also* Vamos, Daley, Perrin, Mahan & Buhi, *supra* note 1.

9. *See* Vamos, Daley, Perrin, Mahan & Buhi, *supra* note 1.

10. *See Reproductive Health*, U.S. DEP'T OF HEALTH & HUM. SERVS., https://opa.hhs.gov/reproductive-health (last visited Feb. 1, 2024).

11. *See* Vamos, Daley, Perrin, Mahan & Buhi, *supra* note 1, at 2028; *see also Title X Service Grants*, U.S. DEP'T OF HEALTH & HUM. SERVS., https://opa.hhs.gov/grant-programs/title-x-service-grants (last visited Feb. 1, 2024).

12. *See About Title X Service Grants*, U.S. DEP'T OF HEALTH & HUM. SERVS., https://opa.hhs.gov/grant-programs/title-x-service-grants/about-title-x-service-grants (last visited Feb. 1, 2024).

the grantee clinics in their service offerings promoted program growth and increased accessibility for those who needed these services.[13]

Amid the development of contraception and family planning focuses, several medical advancements offered a new wave of reproductive technologies aimed at assisted reproduction—including artificial insemination and, eventually, in vitro fertilization (IVF).[14] These developments held the potential to assist those struggling with infertility or reproductive complications in having a biological child and led to the advent of modern surrogacy.[15] While surrogacy in some form has existed throughout history, a lack of reproductive technologies kept the practice within private family matters rather than a formal medical process.[16] However, as reproductive assistance developed, modern surrogacy practices began incorporating contractual agreements between surrogates and intended parents, often facilitated by surrogacy agencies.[17] These contracts outline expectations and compensation for surrogates following the birth of the intended child—the baby that will be carried to term by the surrogate for the intended parents.[18] Flaws emerged based on a lack of legislation and reliance on self-regulation to ensure the safety of all parties, culminating in media depiction of surrogacy as a controversial, high-risk issue.[19] The subsequent nationwide panic surrounding surrogacy ultimately led many state legislatures to pass reactionary surrogacy statutes.[20] Statutes emerged both for and against the issue, while some states remained silent,

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13. *See* Vamos, Daley, Perrin, Mahan & Buhi, *supra* note 1, at 2028.

14. *See* Brett Thomaston, Comment, *A House Divided Against Itself Cannot Stand: The Need to Federalize Surrogacy Contracts as a Result of a Fragmented State System*, 49 J. MARSHALL L. REV. 1155, 1156 (2016); *see also* Katherine Kraschel, *Going Public – The Future of ART Access Post-Dobbs*, BILL OF HEALTH (May 23, 2023), https://blog.petrieflom.law.harvard.edu/2023/05/23/going-public-the-future-of-art-access-post-dobbs/ (showing assisted reproduction and assisted reproductive technology as standard terminology for forms of medical reproductive interventions).

15. *See* Thomaston, *supra* note 14, at 1160.

16. *See* Frank J. Bewkes, *Surrogate or "Mother"? The Problem of Traditional Surrogacy*, 3 TENN. J. RACE, GENDER & SOC. JUST. 143, 144 (2014) (citing conceptual discussions of surrogacy in early texts, including the Bible, which occurred without medical intervention).

17. *See* Carol Sanger, *Developing Markets in Baby-Making: In the Matter of Baby M*, 30 HARV. J.L. & GENDER 67, 92–94 (2007).

18. *See id.*

19. *See id.* at 69 (highlighting a highly controversial case that "can easily be called the custody trial of the twentieth century . . . [where] [e]very aspect of the six-week trial . . . was covered in depth and worldwide").

20. *See* Thomaston, *supra* note 14, at 1161–66.

leaving a patchwork of inconsistent legislation across states.[21] The intricacies of surrogacy necessitate a uniform framework of informed consent of all parties in forming agreements, prioritizing health and safety for all involved throughout the process.[22]

Despite the challenges of the late twentieth century, developments into the early twenty-first century reimagined surrogacy as a safer, less controversial practice.[23] However, legislation rarely changed to reflect favorably on these new practices, and now, inconsistent surrogacy laws present a significant danger to surrogacy practices across the United States.[24] These inconsistencies leave room for exploitation in the absence of self-regulation between surrogacy agencies and individuals, creating increased risk potential.[25] Despite the parallel development of Title X and modern surrogacy—and their inherent connection to reproductive health—these facets of late twentieth century reproduction in the legal sphere never overlapped.[26] However, in a modern context, Title X can serve as an avenue for surrogacy law reform in the United States by expanding on the existing structure to provide a new wave of reproductive care access to countless Americans. The OPA should use Title X to offer conditional grants for surrogacy-focused clinics that comply with regulatory requirements in states that meet a certain surrogacy legislation standard, incentivizing the development of uniform surrogacy legislation among states.

Inconsistent surrogacy laws are detrimental to intended parents, surrogates, and intended children, creating a climate of legal uncertainty and unregulated risk for all parties.[27] Part I of this Comment discusses how the variability in state laws results in ethical, legal, and health complications, especially for interstate surrogacy contracts. Part II will analyze how the Title X Family Planning Program currently provides an infrastructure for grants related to reproductive and sexual health.[28] Part II will also consider how the statute's broad language has allowed the OPA to expand services beyond contraception, including HIV prevention,

21. *See id.*
22. *See id.* at 1156–57.
23. *See id.* at 1156.
24. *See id.* at 1161–66.
25. *See id.* at 1161–67.
26. *See id.* at 1158–59.
27. *See id.* at 1161–62.
28. *See* Title X of the Public Health Service Act, 42 U.S.C. §§ 300 to 300a–8.

specialized cancer screenings, and some basic infertility counseling.[29] Part III will propose that this expanded framework could similarly be applied to family planning for those seeking to have a child through surrogacy because fertility is already intrinsically tied to the mission of Title X in helping individuals make informed decisions in family planning.[30] Finally, this Comment will conclude that the OPA should use Title X to offer conditional grants for surrogacy-focused clinics that comply with specified regulatory requirements in states that meet a certain surrogacy legislation standard, incentivizing the development of uniform surrogacy legislation among states.

I. THE INCONSISTENT STATE OF STATE SURROGACY LAWS

A. Background

In its most basic form, surrogacy relies on an individual, the surrogate, carrying and birthing a child for someone else, the intended parent or parents, where the child is biologically related to one or more of the intended parents.[31] At its core, surrogacy seeks to allow individuals to have a child where they cannot have children themselves because of anatomical impossibility, heightened risk, or fertility challenges.[32] While the technology and practices surrounding surrogacy changed significantly in the early twenty-first century, most modern surrogacy legislation emerged during the late twentieth century amid older practices.[33]

1. Traditional Surrogacy & Early Modern Surrogacy Practices

The oldest form of surrogacy, known as traditional surrogacy, involves the surrogate carrying a child genetically related to the biological father and the surrogate, with no genetic relation to the intended mother.[34] Historically, this method needed no medical intervention, but modern

29. *See id.*

30. *See* U.S. DEP'T OF HEALTH & HUM. SERVS., PROGRAM REQUIREMENTS FOR TITLE X FUNDED FAMILY PLANNING PROJECTS 15–16 (2014) [hereinafter PROGRAM REQUIREMENTS], https://opa.hhs.gov/sites/default/files/2021-03/title-x-program-requirements-april-2014.pdf; *infra* Part III A.

31. *See* Thomaston, *supra* note 14, at 1160.

32. *See id.* at 1157, 1160; Sanger, *supra* note 17, at 72–73.

33. *See* Caitlin Conklin, Note, *Simply Inconsistent: Surrogacy Laws in the United States and the Pressing Need for Regulation*, 35 WOMEN'S RTS. L. REP. 67, 68–72 (2013) (noting early legal responses to surrogacy occurred during a period when the majority of surrogacy arrangements occurred through traditional surrogacy).

34. *See* Thomaston, *supra* note 14, at 1160–61.

reproductive technologies have allowed for traditional surrogacy through artificial insemination, effectuated by the medical implantation of the intended father's reproductive materials into the surrogate.[35] The popularity of this method arose primarily from medical limitations of the late twentieth century, which made it the only available surrogacy option for many years.[36] Under this method, where the child has no genetic relation to the intended mother, the surrogate would relinquish parental rights to the intended mother.[37] The genetic connection between the child and surrogate and the intended mother's lack of genetic connection presented distinct issues with traditional surrogacy, influencing much of the legal discourse and legislative action regarding surrogacy in this period.[38]

The modernization of surrogacy through artificial insemination in the mid-twentieth century shifted surrogacy from the purely private realm into the public sphere.[39] The subsequent visibility of medical interventions and rise in surrogacy contracts necessitated legislative action, which came far too late.[40] The culmination of a changing social landscape and rapid medical advancement reformed surrogacy faster than legal attempts at regulation could keep up, resulting in a gap in laws addressing the evolving medical technologies and techniques surrounding the practice of surrogacy.[41] In this statutory gap of the 1980s, controversy became the catalyst for a nationwide legal fallout.[42] Following the invention of artificial insemination, surrogacy expanded in the United States with minimal regulation.[43] Private surrogacy agencies took this lack of regulation as an opportunity to facilitate contractual relationships between intended parents and potential surrogates, offering assistance in the increasingly complicated practice.[44] With the rise of such agencies, surrogacy contracts rose in popularity to ensure easy custody transitions following the child's birth

35. *See* Sanger, *supra* note 17, at 78–79; *see also* Bewkes, *supra* note 16, at 144; Thomaston, *supra* note 14, at 1160.

36. *See* Thomaston, *supra* note 14, at 1160.

37. *See id.* at 1163.

38. *See* Sanger, *supra* note 17, at 69.

39. *See* Conklin, *supra* note 33.

40. *See id.*

41. *See id.* at 71–72 (citing the lack of formal surrogacy legislation during the early development of modern surrogacy).

42. *See id.*

43. *See id.* at 70–71.

44. *See id.* (explaining that agencies and clinics sought out potential donors and surrogates to pair with intended parents and orchestrated the creation of subsequent surrogacy agreements).

since surrogates maintained a genetic link to the children they carried.[45] These contracts typically outline expectations during pregnancy, compensation agreements, and custody plans.[46] Surrogacy agencies, through contracts, also coordinated compensation as the 1980s saw a shift from altruistic surrogacy, where surrogates offered their services without payment, to compensated surrogacy, with surrogates receiving monetary compensation for carrying children.[47] Over time, different contracts began incorporating compensation to cover medical expenses for the surrogate or additional payment beyond basic costs.[48]

2. Baby M & Early Legal Reactions to Surrogacy

As modern surrogacy practices began solidifying throughout the United States, the 1986 case *In re Baby M*[49] altered the landscape, garnering national press coverage and defining the American perspective on surrogacy for decades.[50] This case was about Baby M, a girl conceived through traditional surrogacy and whose surrogate mother struggled to part with her following the birth.[51] Following a prolonged period of Baby M moving between her intended parents and surrogate mother's care, Baby M's intended parents brought a case in New Jersey for custody.[52] The resulting proceedings were highly sensationalized by the media and portrayed surrogacy as a volatile practice, painting the surrogate mother as emotional and mentally unstable.[53] This case exposed the many risks of unregulated surrogacy, and fear of these risks dominated the surrogacy

45. *See id.*; Yehezkel Margalit, *In Defense of Surrogacy Agreements: A Modern Contract Law Perspective*, 20 WM. & MARY J. OF WOMEN & L. 423, 437 (2014).

46. *See* Sanger, *supra* note 17, at 80; Conklin, *supra* note 33, at 68 n.9 (citing Tara Bognar, *Essential Points of Agreement for Surrogacy Contracts*, TARA BOGNAR (July 28, 2012), https://web.archive.org/web/20160702091204/www.tarabognar.com/what-goes-into-a-surrogacy-contract). *See generally* Mark Strasser, *Parental Rights Terminations: On Surrogate Reasons and Surrogacy Policies*, 60 TENN. L. REV. 135 (1992) (explaining how some principles of contract law may be apposite in the context of surrogacy).

47. *See* Conklin, *supra* note 33, at 70–71.

48. *See id.*; Thomaston, *supra* note 14, at 1158.

49. 537 A.2d 1227 (N.J. 1988).

50. *See* Conklin, *supra* note 33, at 72 (citing *In re Baby M* as the first landmark surrogacy case where "[a]lthough every state had laws governing contractual agreements, most courts found that surrogacy contracts did not fit that category, leaving judges to base decisions on scant statutory guidance.").

51. *See* Sanger, *supra* note 17, at 68.

52. *See id.* at 68–69.

53. *See id.* at 69.

debates of many state legislatures that sought to remedy the legislative void of the preceding decades.[54] Following *In re Baby M*, several states quickly enacted legislation surrounding surrogacy, with some banning the practice altogether.[55] While some have changed their hostile surrogacy laws in the following decades, several states still ban all forms of surrogacy.[56]

3. Gestational Surrogacy & In Vitro Fertilization

In the late 1970s, the development of IVF led to the creation of gestational surrogacy.[57] Gestational surrogacy involves a surrogate carrying and birthing a child entirely genetically related to the intended parents with no genetic relation to the surrogate.[58] IVF treatment serves to develop an embryo by extracting the female and male genetic materials from the intended parents and facilitating fertilization in a laboratory environment.[59] Once created, an embryo may be artificially implanted into the uterus.[60] IVF can allow some individuals struggling with infertility to conceive, but other complications may still prevent a successful pregnancy, even with IVF intervention.[61] In a gestational surrogacy context, IVF allows for creating an embryo using the intended parent's genetic materials before implanting the embryo into the surrogate for the duration of the pregnancy.[62] Gestational surrogacy avoids some of the complications present in

54. *See* Conklin, *supra* note 33, at 70–72 (claiming that the limited legal landscape surrounding surrogacy allowed a few significant cases to define the public and legal perspective on surrogacy).

55. *See* Thomaston, *supra* note 14, at 1162–63 (stating that North Dakota, Michigan, Indiana, and the District of Colombia had distinct and persistent bans on surrogacy).

56. *See* Assemb. B. 421, 2013 Leg., 77th Sess. §§ 20, 27 (Nev. 2013) (reforming the existing Nevada surrogacy statute to reflect a more positive treatment of surrogacy with consideration of protections for surrogates and intended children); *Surrogacy Laws by State*, GIVING TREE SURROGACY & EGG DONATION, https://www.givingtreesurrogacy.com/resources/surrogacy-laws-by-state (last visited Jan. 20, 2024).

57. *See* Conklin, *supra* note 33, at 70–71.

58. *See* Thomaston, *supra* note 14, at 1161.

59. *See* Conklin, *supra* note 33, at 70–71 (citing that in vitro fertilization (IVF) would not become widely accessible until years after its invention, as researchers in the United Kingdom perfected IVF techniques in 1978, and the practice expanded to the United States in 1981 but remained cost-prohibitive).

60. *See id.* at 70; Thomaston, *supra* note 14, at 1160.

61. *See* Conklin, *supra* note 33, at 70–71; Mayo Clinic Staff, *In Vitro Fertilization (IVF)*, MAYO CLINIC, https://www.mayoclinic.org/tests-procedures/in-vitro-fertilization/about/pac-20384716 (last visited Feb. 1, 2024).

62. *See* Thomaston, *supra* note 14, at 1161.

traditional surrogacy because the surrogate mother has no genetic link to the child.[63] Despite this new medical framework and the increasingly logistical nature of assisted reproduction, surrogacy remained highly controversial in the wake of *Baby M* and subsequent legislation, resulting in minimal legal reform in the early twenty-first century.[64]

4. Modern Surrogacy & Legislative Landscape

The United States currently has a varied and inconsistent amalgamation of surrogacy laws at the state level with no federal regulation, and in that absence, a patchwork of differing laws emerged at the state level.[65] As a family law matter, surrogacy remained within state control throughout the twentieth century as formal contracts and state legislation regulating surrogacy emerged.[66] Some states have developed hostile surrogacy laws, explicitly banning some or all surrogacy practices, while others allow surrogacy in any form or have no rules regarding surrogacy.[67] This inconsistency has led to an industry of private surrogacy agencies facilitating contracts for interstate networks of intended parents and surrogates.[68] The absence of uniform surrogacy regulation has led to a lack of mental or physical health exams before surrogacy contracting and no mandated legal advocacy to promote informed consent for the surrogacy contract.[69] The current system places all responsibility on private individuals or agencies, which have repeatedly failed to self-impose necessary regulations, sometimes resulting in fatal outcomes.[70]

B. Positive Treatment of Surrogacy in State Legislation

Several states have taken a positive approach to surrogacy legislation through their initial statutes or more recent reform, allowing for the safe

63. *See* Conklin, *supra* note 33, at 73–74.

64. *See* Assemb. B. 421, 2013 Leg., 77th Sess. §§ 20, 27 (Nev. 2013) (illustrating that some states have positively reformed surrogacy laws since the initial post-*Baby M* legislative reaction).

65. *See* Conklin, *supra* note 33, at 74–86 (comparing the regulatory structures of three states: Connecticut, New Jersey, and New York).

66. *See id.* at 88–89.

67. *See* Thomaston, *supra* note 14, at 1162–66.

68. *See* Sanger, *supra* note 17, at 71, 88–89.

69. *See* Conklin, *supra* note 33, at 92–93.

70. *See* Conklin, *supra* note 33, at 93. *See generally* Sanger, *supra* note 17 (discussing features and common roles of the assisted reproduction market).

development of surrogacy practices.[71] These statutes commonly acknowledge and honor surrogacy agreements as binding contracts, making them enforceable in that state's courts if a dispute arises.[72] Among those states that honor surrogacy contracts, however, several have especially beneficial or comprehensive provisions that may provide a guideline for the potential future development of surrogacy legislation.[73]

1. California

California's surrogacy legislation highlights several critical legal avenues for surrogates and intended parents to benefit the contracting parties throughout the surrogacy process.[74] One such provision requires that those engaging in surrogacy create a surrogacy agreement before beginning the surrogacy process and that each party to the contract have an attorney to review the document and provide legal advocacy throughout the process.[75] Additionally, California's surrogacy statute permits the use of a court order obtained prior to the intended child's birth to allow for an eased transfer of custody following that birth.[76]

2. Connecticut

Connecticut's surrogacy legislation similarly includes provisions that simplify the transitional care process following the intended child's birth.[77] Based on the Connecticut statute, intended parents may obtain an order from the court before the birth to put their names directly onto the child's birth certificate, circumventing the need for a post-birth adoption.[78] By allowing for this pre-birth planning, the statute enables surrogates and intended parents to more easily transition the care of the intended child

71. *See* Thomaston, *supra* note 14, at 1165.

72. *See, e.g.*, CAL. FAM. CODE § 7962 (West 2020); CONN. GEN. STAT. § 7-48a (2022); *see also* Thomaston, *supra* note 14, at 1165.

73. *See, e.g.*, CAL. FAM. CODE § 7962; CONN. GEN. STAT. § 7-48a; Assemb. B. 421, 2013 Leg., 77th Sess. §§ 20, 27 (Nev. 2013).

74. *See* CAL. FAM. CODE § 7962(b)–(c), (i) (codifying gestational surrogacy contracts as legal and enforceable, with additional provisions aimed at safe surrogacy practices for all contracting parties).

75. *Id.* § 7962(c) (requiring that the agreement "be notarized or witnessed by an equivalent method of affirmation as required in the jurisdiction where the assisted reproduction agreement for gestational carriers is executed."); *see id.* § 7962(b)–(d).

76. *Id.* § 7962(f)(2).

77. *See* CONN. GEN. STAT. § 7-48a.

78. *See id.* § 7-48a(b).

following birth without additional legal hurdles.[79] This provision also lessens the burden on the courts by eliminating the need for urgent adoption proceedings following the child's birth.[80]

3. Nevada

Nevada's existing surrogacy statute highlights several critical elements that promote accessible and safe practices while also showing the positive impact of reform in favor of surrogacy agreements.[81] Nevada reformed their surrogacy statute in 2013 to incorporate new provisions for more favorable treatment of surrogacy arrangements, providing additional protection to those engaging in such agreements.[82] Within these provisions, several are especially unique or beneficial.[83] First, Nevada expressly permits compensation for surrogates in exchange for their services, while many states still disallow compensation, so this provision marks a critical benefit for surrogates in Nevada.[84] Additionally, Nevada's reform incorporated additional legal protections for contracting parties and inclusive language that protects intended parents of varying gender and sexual identities.[85]

C. Hostile Treatment & Legal Limbo Surrounding Surrogacy

While some states took a more favorable approach to surrogacy legislation after the *Baby M* controversy, others sought to eliminate any future issues regarding surrogacy by banning the practice altogether.[86] Some such states have since reformed their older statutes to allow for surrogacy.[87] Though many remain staunchly against surrogacy practices, several have remained silent in recent decades, leaving such matters to the

79. *See id.* § 7-48a.

80. *See id.*

81. *See* Assemb. B. 421, 2013 Leg., 77th Sess. §§ 20, 27 (Nev. 2013).

82. *See id.*; *NV AB421 | 2013 | 77th Legislature Nevada Assembly Bill 421*, LEGISCAN https://legiscan.com/NV/bill/AB421/2013 (last visited Feb. 1, 2024).

83. Assemb. B. 421, 2013 Leg., 77th Sess. §§ 20, 27.

84. *See id.* (allowing surrogates to gain financial compensation for the extensive physical labor of carrying the intended child to term and affirming the transactional nature of the surrogacy contract for all parties).

85. *See id.* §§ 4, 11, 13, 26 (providing additional protections to intended parents with non-traditional family structures who may face an elevated risk of persecution in having or adopting children based on their sexual or gender identities or marital status).

86. *See* Thomaston, *supra* note 14, at 1162–63.

87. *See id.* at 1165.

courts.[88] Among the states that still explicitly ban surrogacy, the consequences for violating the ban vary significantly.[89] One of the most common means of enforcement occurs through fines, which vary in severity depending on the party.[90] Fines for individuals remain lower than fines for surrogacy agencies in violation of the ban.[91] Comparatively, some states take a more extreme approach to deter surrogacy ban violations.[92] Michigan enforces its surrogacy ban through fines and incarceration, depending on the severity of the violation.[93] However, other states' bans render the surrogacy contract void.[94] This method may be especially challenging as it escalates any potential conflict in a surrogacy agreement to the courts if the voided contract cannot provide a solution.[95]

D. Appropriation of Positive Surrogacy Legislation for Title X Regulation

In recent decades, numerous states have passed legislation with the positive treatment of modern surrogacy practices, while others reformed existing statutes to reflect a more positive approach with new advancements decreasing the risks associated with surrogacy.[96] Several states now include critical protections that can significantly benefit those engaging with surrogacy arrangements in those states.[97] These legal benefits would have a more significant impact if applied uniformly across the United States by diminishing the need for inter-state surrogacy agreements and limiting state-specific statutory challenges to surrogacy arrangements.[98] By looking at existing positive statutes, the OPA could find appropriate, effective provisions to include in their model statutory guidelines.

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88. *See The U.S. Surrogacy Law Map*, CREATIVE FAMILY CONNECTIONS, https://www.creativefamilyconnections.com/us-surrogacy-law-map (last visited Feb. 1, 2024); *Surrogacy Laws by State*, *supra* note 56.

89. *See The U.S. Surrogacy Law Map*, *supra* note 88 (citing that the most common enforcement of the bans occurs through fines to parties found in violation of the state's surrogacy ban).

90. *See, e.g.*, 1988 Mich. Legis. Serv. 149 (West).

91. *See* Thomaston, *supra* note 14, at 1163.

92. *See id.* at 1162.

93. *See id.* at 1163.

94. *See id.* at 1162.

95. *See id.* at 1162–63.

96. *See id.* at 1165; Assemb. B. 421, 2013 Leg., 77th Sess. §§ 20, 27 (Nev. 2013).

97. *See* Thomaston, *supra* note 14, at 1165.

98. *See id.* at 1163–66 (explaining the impact of the lack of uniformity across state statutes that permit surrogacy contracts to some extent).

II. TITLE X AS AN ESTABLISHED BODY FOR REPRODUCTIVE ACCESS

A. Background

The advent of the Title X Family Planning Program in 1970 began a new era of accessible healthcare in the United States and a decades-long expansion of the program as sexual and reproductive technologies advanced into the twenty-first century.[99] In its first iteration, the program sought to provide Americans with access to sexual and reproductive healthcare services, especially contraception, regardless of their socioeconomic or insurance status.[100] The program incentivized the development of accessible clinics with services at lowered or no cost for low-income individuals who could not afford services otherwise.[101] Title X created this incentive through grants that the Secretary of HHS (the Secretary) administered with discretion where clinics met specific criteria.[102] These clinics, known as grantees, received these grants to help fund their operations and supplement the cost of administering services at a lower cost for patients in need.[103] Over time, this basic structure has grown into a more complex scheme as numerous initiatives have expanded the scope of Title X and created guidelines for assessing grantee clinics.[104] Multiple grants currently exist, including service grants for clinics and research grants to further population research.[105] These grants aim to further the OPA mission of understanding population, reproduction, and sexual health in the United States.[106] Further, as new technologies and trends surrounding reproductive and sexual healthcare emerged, Title X evaluates the public need for certain services and the efficacy of grantee clinics in meeting those needs when awarding grants.[107] These assessments are left to the discretion of the Secretary and the OPA, and they consider numerous factors.[108]

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99. *See* Vamos, Daley, Perrin, Mahan & Buhi, *supra* note 1, at 2027.

100. *See id.*

101. *See* Title X of the Public Health Service Act, 42 U.S.C. § 300–300a–8.

102. *See* PROGRAM REQUIREMENTS, *supra* note 30, at 5.

103. *See Title X Service Grants*, *supra* note 11.

104. *See* PROGRAM REQUIREMENTS, *supra* note 30, at 9.

105. *See Title X Service Grants*, *supra* note 11; ANGELA NAPILI, CONG. RSCH. SERV., IF10051, TITLE X FAMILY PLANNING PROGRAM 1 (2023).

106. *See Title X Service Grants*, *supra* note 11.

107. *See* PROGRAM REQUIREMENTS, *supra* note 30, at 9.

108. *See* 42 U.S.C. § 300a; PROGRAM REQUIREMENTS, *supra* note 30, at 9 (citing factors including "the number of patients, and, in particular, the number of low-income patients to

In the decades since its start, the Title X Family Planning Program's expanding mission and the broad authority of the Secretary and the OPA to grow Title X allowed for new focuses and initiatives for accessible care through grantee clinics.[109] Federal legislation brought about many of these initiatives by including restrictions or requirements for clinic services and expenditures.[110] The majority of such statutory expansion occurred through increased funding for Title X grants and service requirements for clinics.[111] These requirements included distributing educational materials regarding reproductive and sexual health but also extended to services that assisted with HIV and AIDS.[112] Such legislation also included the restriction on the use of Title X funds for abortions.[113] As amendments arose, they often reflected the major sexual health trends of that period, whether through education to combat teen pregnancy or screenings amid the AIDS crisis.[114] Title X should naturally continue expanding to reflection reproductive and sexual health trends in the United States during the twenty-first century, including through an emphasis on surrogacy services.

B. Broad Authority of the OPA & HHS Secretary over Title X Grants

The Family Planning Program originated during the Nixon Administration as Title X of the Public Health Service Act following rapid changes in public perception of gender equality, healthcare, and sexuality during the late twentieth century.[115] The primary purpose of Title X was

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be served; the extent to which family planning services are needed locally; the relative need of the applicant; the capacity of the applicant to make rapid and effective use of the Federal assistance; the adequacy of the applicant's facilities and staff . . . .").

109. *See Title X Statutes*, *supra* note 6 (citing the purpose of service grants as assisting "in the establishment and operation of voluntary family planning projects which provide a broad range of acceptable and effective family planning methods and related preventive health services that include natural family planning methods, infertility services, and services for adolescents" among others).

110. *See* Vamos, Daley, Perrin, Mahan & Buhi, *supra* note 1, at 2032.

111. *See id.* at 2033–34 (listing additional regulatory requirements and funding increases between 1975 and 2005 that expanded Title X's scope as different administrations targeted ongoing public health issues in sexual and reproductive health).

112. *See id.* at 2033.

113. *See* 42 U.S.C. § 300a–6 ("None of the funds appropriated under this title shall be used in programs where abortion is a method of family planning.").

114. *See* Vamos, Daley, Perrin, Mahan & Buhi, *supra* note 1, at 2033–34 (citing expansions in AIDs grants and services through Pub. L. No. 101-381 & 106-113 and in counseling for minors through Pub. L. No. 106-133, 106-554, 108-199 & 109-149).

115. *See* Vamos, Daley, Perrin, Mahan & Buhi, *supra* note 1, at 2027.

to establish nationwide programs to assist in family planning for individuals and families across the socioeconomic spectrum, especially those with a lower income, regardless of insurance status.[116] The text of the legislation granted broad authority to HHS to oversee programs related to Title X and to administer grants to further the program's goal, stating that the "Secretary is authorized to make grants . . . to State health authorities to assist in planning, establishing, maintaining, coordinating, and evaluating family planning services."[117] Title X also established the OPA within HHS to carry out the Title X mandate and oversee research.[118] The OPA became the central overseer of Title X's function and expansion over the following decades within the umbrella of HHS.[119] Title X grants the OPA and HHS the authority to create grants for programs and clinics to provide accessible contraceptive, reproductive, and sexual healthcare.[120] More specifically, Title X confers grant-making authority in the Secretary of HHS as head of both HHS and the OPA.[121] The modern text explicitly defines these services as "[i]ncluding natural family planning methods, infertility services, and services for adolescents."[122] HHS reinforced the federal importance of Title X's goals through funding to incentivize the development of more programs and clinics.[123]

Two central elements legitimize any grant created and given under Title X: the plain language of the statute and the actions of the HHS Secretary.[124] The language of Title X lays out distinct categories of grants permissible under the Title each tying into the statute's primary purpose.[125] These categories include state funds for family planning services, training in these services, population growth and family planning research, and

116. *See* 42 U.S.C. §§ 300 to 300a–7.

117. 42 U.S.C. § 300a.

118. *See* Family Planning Service and Population Research Act of 1970, Pub. L. 91–572, § 2, 84 Stat. 1504 § 3(a)–(b) ("There is established within the Department of Health, Education, and Welfare an Office of Population Affairs to be directed by a Deputy Assistant Secretary for Population Affairs under the direct supervision of the Assistant Secretary for Health and Scientific Affairs . . . . The Secretary is authorized to provide the Office of Population Affairs [with resources] . . . as may be necessary for it to carry out its duties and functions.").

119. *See, e.g.*, *id.*; 42 U.S.C. § 300a.

120. *See id.* §§ 300(a), 300a(a), 330a–1(a), 300a–3(a).

121. *See id.* § 300a.

122. PROGRAM REQUIREMENTS, *supra* note 30, at 5.

123. *See* 42 U.S.C. § 300a(a).

124. *See id.*

125. *See id.* § 300a(a) to 300a–3.

dissemination of such research to the public.[126] Clinics and state-operated facilities are incentivized to apply for these grants—even though application is voluntary and their admission is discretionary—to provide accessible care to low-income individuals.[127] The funding for these grants comes directly from appropriated OPA funds and is distributed to agency selected grantees who meet the statutory requirements.[128]

Under this system, the statute has already created the basic concept of Title X grants, and the Secretary may award them at will.[129] This award is at the Secretary's discretion with the stipulation that for clinics, "No grant may be made to a State health authority under this section unless such authority has submitted, and had approved by the Secretary, a State plan for a coordinated and comprehensive program of family planning services."[130] Therefore, Title X grants require state action through comprehensive program planning to qualify for grants.[131] Moreover, it can be argued that the Secretary could establish a new surrogacy focus for grants by promulgating the requirements and awarding qualified grantees. The creation, distribution, and discretion surrounding these grants are purely administrative.[132] Given the OPA and the Secretary's control surrounding the funding and award of these grants, there is little congressional role concerning Title X.[133] However, the funding for the OPA, which feeds these grants, comes as a portion of the HHS budget allotted by Congress each year.[134] In this way, while Congress has no role in dividing the money once given, it does have control over the total amount.[135] Given the success and growth of Title X-funded clinics and services since its enactment, Congress has no incentive to completely

126. *See id.*

127. *Title X Program Expectations*, U.S. DEP'T OF HEALTH & HUM. SERVS., https://opa.hhs.gov/grant-programs/title-x-service-grants/about-title-x-service-grants/title-x-program-expectations (last visited Feb. 1, 2024).

128. *See* 42 U.S.C. § 300(a)–a–4 (citing that the Secretary may assess applicants according to the Title X regulatory requirements and determine awards based on factors, including need for funding and local demand for services, before selecting grantees at their discretion).

129. *See id.*

130. 42 U.S.C. § 300a(a).

131. *See id.*

132. *See id.*

133. *See id.*

134. *See* Vamos, Daley, Perrin, Mahan & Buhi, *supra* note 1, at 2028–29.

135. *See id.*

defund Title X grants.[136] Thus, the issues surrounding Title X grant creation and distribution will likely remain primarily administrative.[137]

C. Expansion of Title X Services over Time

In the decades since its creation, legislative amendments have expanded and reformed Title X, providing increased funding and resources as the program's importance became apparent.[138] The program has eighty-seven grantees who received over $256 million cumulatively in 2023.[139] Historically, Title X grants have been applied to predominantly contraceptive and preventative care through clinics emphasizing accessibility.[140] The statute's broad language leaves room for interpretation in HHS's exercise of authority.[141] The statute provides that "[g]rants and contracts made under this title shall be made in accordance with such regulations as the Secretary may promulgate," and the "[a]mount of any grant under any section of this title shall be determined by the Secretary" with significant discretion.[142] Thus, this statute could be applied to a surrogacy context.[143] There is already a precedent for expansive Title X application as many prominent services at Title X-funded clinics center on STI prevention and treatment, which is more loosely related to contraception and reproduction.[144] Further, some Title X clinics already offer some fertility services, so surrogacy would not be an unnatural realm for Title X expansion.[145]

As various health trends changed throughout the late twentieth century,

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136. *See id.*

137. *See id.* at 2029.

138. *See* 42 U.S.C. § 300.

139. *See Fiscal Year 2023 Title X Service Grant Awards*, U.S. DEP'T OF HEALTH AND HUM. SERVS., https://opa.hhs.gov/grant-programs/title-x-service-grants/current-title-x-service-grantees/fy2023-title-X-service-grant-awards (last visited Feb. 1, 2024) (funding eighty-six grantee clinics nationally, including numerous Planned Parenthood locations, local family planning clinics, and regional clinics).

140. *See About Title X Service Grants*, *supra* note 12; 42 U.S.C. § 300(a)–a–4.

141. *See* 42 U.S.C. § 300(a)–a–4.

142. *Id.* § 300a–4.

143. *See id.* (providing that the Secretary holds significant authority and discretion to determine how the Title X funds shall be allocated to grantees and may consider the services offered, including infertility services, and the public need for those services—such as rising infertility rates—in determining grant awards).

144. *See Reproductive Health*, *supra* note 10 (discussing STI prevention and treatment at Title X clinics, despite such services being unrelated to contraception to prevent pregnancy).

145. *See id.*

Title X-funded clinics have adapted to provide relevant services.[146] The statute's language provides a broad definition of sexual health services, which allows grantee clinics to expand and alter their services based on the American public's sexual health needs and developing technologies.[147] Since Title X's enactment, various administrations have worked with the OPA to expand services based on the medical needs of the era.[148] They would bring legislative amendments to Title X or funding changes to facilitate such grants.[149] The HIV epidemic exemplifies one such shifting point as clinics began providing screenings, testing, and counseling for HIV and AIDS once medical advancements made such technologies available.[150] While significant social controversies surrounded the HIV epidemic, the American public's need for accessible screenings and treatments ultimately drove service expansions.[151] This effort continued into the twenty-first century as medical breakthroughs offered new preventative measures and treatment options for HIV and AIDS.[152] As these new developments were implemented, Title X-funded clinics became a gateway for accessible care regardless of insurance status or other socioeconomic factors.[153] While some contraceptive methods can effectively prevent the spread of HIV and AIDS, most of this work had little relation to contraception and centered on a broader sexual health focus.[154] This demonstrates how clinics have historically expanded services to non-contraceptive sexual health areas to meet the needs of the American public.[155]

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146. *See Title X Turns 50*, U.S. DEP'T OF HEALTH & HUM. SERVS., https://opa.hhs.gov/grant-programs/title-x-service-grants/title-x-turns-50 (last visited Feb. 1, 2024); *see also Title X Service Grants*, *supra* note 11.

147. *See Title X Statutes*, *supra* note 6; Vamos, Daley, Perrin, Mahan & Buhi, *supra* note 1, at 2028–29 (explaining that many of these expansions have gone beyond purely contraceptive focuses and serve overall sexual and reproductive health based on health trends and the needs of the American public).

148. *See* Vamos, Daley, Perrin, Mahan & Buhi, *supra* note 1, at 2034.

149. *See id.* at 2030.

150. *See id.* at 2034.

151. *See id.*

152. *See About Title X Service Grants*, *supra* note 12; Jason Potter Burda, *Prep and Our Youth: Implications in Law and Policy*, 30 COLUM. J. GENDER & L. 295, 352 (2016).

153. *See About Title X Service Grants*, *supra* note 12; Burda, *supra* note 152.

154. *See* Burda, *supra* note 152.

155. *See* Vamos, Daley, Perrin, Mahan & Buhi, *supra* note 1, at 2033–34 (listing HIV and acquired immunodeficiency syndrome (AIDS), counseling on sexual coercion, and familial counseling on teen pregnancy as areas of Title X expansion beyond contraception, which establishes a foundation for further expansion to include surrogacy as a reproductive

Some clinics already offer basic infertility services, including counseling and screenings, which demonstrates success in past inclusion of infertility in Title X as positive family planning for individuals seeking to have a child rather than prevent conception.[156] Given the broad statutory definition of sexual health services under Title X and the history of broadening clinic services to assist patients with various sexual and reproductive health matters amid changing medical needs nationwide, there is significant space for interpretation of HHS authority over Title X grants and their application to surrogacy.[157] Especially where infertility poses a legitimate national concern, the OPA has substantial authority to encourage accessible infertility treatment as a new necessity for reproductive health.[158] With the United States' substantial population growth following the post-World War II baby boom, a sudden decline in birth rates could present significant long-term population challenges.[159] While steady fluctuations in birth rates over time have occurred naturally throughout history, the trend of rapid population incline during the twentieth century and into the twenty-first century would make a sudden decline especially detrimental.[160] Declining birth rates have already appeared in numerous nations in recent decades with varied consequences.[161] Many such nations relied on countermeasures to encourage renewed birth rates and incentivize repopulation.[162] Thus, where the United

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health service).

156. *See About Title X Service Grants*, *supra* note 12.

157. *See id.*; *Title X Statutes, supra* note 6.

158. *See* PROGRAM REQUIREMENTS, *supra* note 30, at 9.

159. *See* Sanger, *supra* note 17, at 73.

160. *See id.* (discussing the economic prosperity following the "baby boom" and World War II).

161. *See, e.g.*, *Fertility in England and Wales at Lowest Recorded Level for Women in All Education Groups: Oxford Research*, UNIV. OF OXFORD NEWS (June 8, 2023), https://www.ox.ac.uk/news/2023-06-08-fertility-england-and-wales-lowest-recorded-level-women-all-education-groups-oxford (citing that "total fertility rate fell from 1.94 in 2010 to 1.55 in 2021" in the United Kingdom, with the trend appearing in other European nations too); Anthony Kuhn, *Japan's Plan to Boost Its Birthrate Raises Doubt. But One City Has Reason for Hope*, NPR (June 24, 2023), https://www.npr.org/2023/06/24/1182457365/japan-low-birthrate-akashi-success-story ("Fewer than 800,000 babies were born in Japan last year, the lowest figure since Japan began tallying births in 1899 and the seventh year of declines in a row").

162. *See, e.g.*, *Fertility in England and Wales at Lowest Recorded Level for Women in All Education Groups: Oxford Research*, UNIV. OF OXFORD (June 8, 2023), https://www.ox.ac.uk/news/2023-06-08-fertility-england-and-wales-lowest-recorded-level-women-all-education-groups-oxford; Anthony Kuhn, *Japan's Plan to Boost Its Birthrate Raises Doubt. But One City Has Reason for Hope*, NPR (June 24, 2023), https://www.npr.org/2023/06/24/1182457365/japan-low-

States may be facing similar trends, proactive measures to make infertility solutions accessible for those wanting children could mitigate future consequences of population decline.[163]

Surrogacy would fit within the general pattern of Title X expansion in recent decades, as it represents a type of fertility service that could combat an ongoing reproductive health problem.[164] Many shifts in Title X clinic services occurred as reactionary changes to address an ongoing issue in the sexual and reproductive health realm.[165] As infertility rates rise in the United States, repopulation presents a legitimate concern for the OPA, and surrogacy offers a possible solution, allowing individuals to seek alternative methods for having children where they cannot conceive traditionally.[166] Historically, very minimal limitations have been placed on the types of services that may be funded by Title X Service Grants, with the most prominent example being a prohibition on abortions.[167] In such cases, the limitations come primarily from political opposition to government funds supporting controversial treatments.[168] While surrogacy has carried substantial controversy in the past, modern practices with proper regulation would eliminate many of the risk factors associated with other methods from the late twentieth century.[169] Thus, surrogacy could constitute a natural expansion of Title X into greater infertility treatment as fertility issues become an increasing concern for many Americans.[170]

D. Application of Title X Grants to Surrogacy-Centered Clinics

In recent years, the United States has seen a steady rise in infertility rates among Americans, with the Centers for Disease Control and Prevention (CDC) categorizing infertility issues as common, especially among specific demographics.[171] As infertility rates rise and the need for non-traditional

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birthrate-akashi-success-story.

163. *See* Thomaston, *supra* note 14, at 1156.

164. *See* PROGRAM REQUIREMENTS, *supra* note 30, at 5.

165. *See* Vamos, Daley, Perrin, Mahan & Buhi, *supra* note 1.

166. *See* Thomaston, *supra* note 14, at 1156.

167. *See* Vamos, Daley, Perrin, Mahan & Buhi, *supra* note 1, at 2033.

168. *See id.*

169. *See* Thomaston, *supra* note 14, at 1161–63.

170. *See id.*

171. *See Infertility FAQ*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/reproductivehealth/infertility/index.htm (Apr. 26, 2023) ("In the United States, among married women aged 15 to 49 years with no prior births, about 1 in 5 (19%) are unable to get pregnant after one year of trying (infertility). Also, about 1 in 4

conception rises, many Americans will require additional resources and medical intervention to conceive.[172] The rise in reproductive technologies in recent decades has provided numerous options for non-traditional conception options, each case is unique, and some individuals may require fairly extreme interventions to have children.[173] Surrogacy can be a prime option when an individual or family cannot safely carry a child to term, even with other interventions, such as IVF or artificial insemination.[174] In an era of advanced technologies, surrogacy provides an avenue for individuals struggling with fertility issues who otherwise may have no option for conceiving a genetically related child.[175] As such, surrogacy sometimes acts as a viable medical intervention and treatment option for infertility.[176] However, the high cost of IVF and compensation for a surrogate, coupled with a complicated legal landscape, made this an inaccessible option for many.[177] The cost burden of childbirth remains substantial, and for those who need additional intervention to conceive, these costs increase exponentially.[178] Thus, by creating a more accessible, uniform standard surrounding surrogacy, many more Americans may be able to engage with this practice as a medical intervention for their infertility.

Increased accessibility for surrogacy would allow the American public to engage with surrogacy practices without the often cost-prohibitive barriers, especially those disproportionately impacted by infertility or with an increased need for fertility services.[179] Creating such opportunities for disproportionately impacted individuals, especially those lacking financial means to seek treatment without assistance, would align with the mission of Title X.[180] In the United States, "[i]nfertility disproportionately burdens Black, Indigenous, and people of color," and a lack of accessible infertility services can heighten this burden.[181] Further, those with non-traditional family structures—including individuals in the LGBTQ+ community—may face a greater need for interventions through assisted reproduction to

(26%) women in this group have difficulty getting pregnant or carrying a pregnancy to term (impaired fecundity).").

172. *See* Thomaston, *supra* note 14, at 1156.
173. *See id.*
174. *See id.*
175. *See id.*
176. *See id.*
177. *See id.* at 1170.
178. *See* Kraschel, *supra* note 14.
179. *See id.*
180. *See id.*
181. *See id.*

have children.[182] For individuals with a disproportionate need for infertility services and assisted reproduction, increasing access to surrogacy would serve as an affirmative and proactive form of sexual and reproductive healthcare.[183] Thus, expanding accessible surrogacy services without the typical cost burden would combat infertility and potential population concerns while also acting as a tool for individual reproductive autonomy and justice.[184]

The primary goal of Title X is its effort to expand access to sexual and reproductive healthcare for Americans regardless of their socioeconomic or insurance status, including increasing accessibility to fertility treatment.[185] Title X presents a prime solution in a time when infertility presents a legitimate and ongoing reproductive health struggle, and treatment options are limited by cost or legal complications.[186] The natural expansion of Title X over time has often involved Title X clinics incorporating services for sexual and reproductive issues that currently impact the public.[187] Where infertility is a pervasive issue, Title X may naturally expand to make treatment more accessible.[188] By expanding Title X's framework to include surrogacy as a means of combatting rising infertility rates, the OPA may apply specific considerations about surrogacy services when assessing clinics for grant awards.[189]

With absolute discretion, the OPA and the Secretary reference several key criteria when considering whether to award a grant and the amount to award.[190] Among these criteria are the need for certain services in a given area and the adequacy of a clinic to provide those services.[191] If a clinic provides highly needed services, they may be awarded more funding to continue this work than if they did not provide these services.[192] A clinic offering services to counter infertility, such as surrogacy options, may be favored in circumstances where infertility presents a legitimate reproductive

182. *See id.*

183. *See* Kimberly Mutcherson, *Reproductive Rights Without Resources or Recourse*, 47 HASTINGS CTR. REP. S12, S13 (2017).

184. *See id.* at S15; *supra* note 161 and accompanying text.

185. *See* Title X of the Public Health Service Act, 42 U.S.C. §§ 300 to 300a–8.

186. *See* Thomaston, *supra* note 14, at 1156.

187. *See id.*

188. *See Title X Service Grants*, *supra* note 11.

189. *See* PROGRAM REQUIREMENTS, *supra* note 30, at 9.

190. *See supra* note 108 and accompanying text.

191. *See* PROGRAM REQUIREMENTS, *supra* note 30, at 9.

192. *See id.* (stating that the Secretary may assess need for services by considering broad national demand and specific local needs based on the local population near a potential grantee clinic).

health concern.[193] Additionally, in assessing the adequacy of a clinic to provide such services, the OPA and the Secretary should consider necessary regulatory structures for a clinic to meet sufficiency standards.[194] In this way, the OPA could effectively create a new incentive for increased presence of surrogacy services in clinics. The OPA could acknowledge public infertility concerns by establishing regulations and allocating funding to clinics that meet regulatory requirements.[195] The OPA could further lay out detailed guidelines to articulate the clinic regulations and statutory forms necessary for a clinic's surrogacy services to be deemed a candidate for increased grant funding.[196]

III. REGULATORY RECOMMENDATIONS

A. Promulgation of Grants Targeting Surrogacy-Aligned Clinics

The orientation of surrogacy issues within the state-governed family law sphere presents a distinct challenge for any attempts at enacting uniform surrogacy law.[197] Although modern surrogacy helps individuals expand their family through non-traditional conception, it involves many complications, including mutual understanding on medical and ethical beliefs.[198] Allowing states to maintain their legislative autonomy on surrogacy issues while incentivizing reform to benefit citizens encourages state legislatures to reconsider the nature of their surrogacy legislation and adopt a positive framework centered on protecting surrogates, intended parents, and intended children.[199] This model will allow the OPA to balance the need for reform with the general state authority over family law issues.[200] The OPA will make clear a new consideration of surrogacy factors when assessing the allocation of Title X Service Grants where surrogacy services would constitute a high-priority service among grantee

193. *See id.*

194. *See id.*

195. *See infra* Part REGULATORY RECOMMENDATIONS.

196. *See id.*

197. *See* Thomaston, *supra* note 14, at 1161.

198. Modern surrogacy, while focused on helping individuals expand their family through non-traditional conception, involves many complications because intended parents and surrogates may not always align on their medical or ethical beliefs, necessitating mutual understanding. *See infra* note 231 and accompanying text.

199. *See* CAL. FAM. CODE § 7962 (West 2023) (effective Jan. 1, 2020); CONN. GEN. STAT. § 7–48a (2022); Assemb. B. 421, 2013 Leg., 77th Sess. §§ 20, 27 (Nev. 2013).

200. *See* Conklin, *supra* note 33, at 73.

clinics.[201] The OPA already explicitly considers "the extent to which family planning services are needed locally" when allocating funds.[202] The OPA and the Secretary could justify this consideration by focusing on growing infertility concerns as infertility rates have risen recently, making infertility a present trend in reproductive health concerns.[203] By explicitly marking surrogacy services as a reproductive need to combat infertility trends and potential birthrate decline, surrogacy services would fall within the scope of the OPA's explicit consideration for Title X funding.[204] By providing this framework for their consideration, the OPA would situate surrogacy as a means of treatment that would fit within the trend of Title X expansion over time.[205] The OPA also explicitly considers "the adequacy of the applicant's facilities and staff" to carry out the services they provide in assessing whether to administer a grant to such a clinic.[206] The OPA could highlight requirements for clinics providing surrogacy services, including clinic regulations and state statutory provisions.[207] The OPA's regulatory requirements for clinics offering surrogacy services and state statutes would become a legitimate safety consideration within the scope of the OPA's Title X assessment.[208] By presenting these requirements as legitimate safety steps necessary to make a clinic safe for surrogacy services, the OPA could assess clinics with surrogacy services through the lens of these requirements without necessitating any formal Title X amendment.[209]

The OPA should look to existing statutes in states with favorable treatment of surrogacy agreements to determine what factors may be most helpful to include in their guidelines. The OPA should especially look to California, Connecticut, and Nevada, which have very positive treatment of surrogacy agreements and include unique considerations in their statutes to benefit all contracting parties.[210] In looking at these states, the OPA

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201. *See* PROGRAM REQUIREMENTS, *supra* note 30, at 9.

202. *Id.*

203. *See supra* note 161 (illustrating that infertility and other social factors can contribute to declining birthrates, resulting in population decline as new generations shrink while larger generations age and leave the workforce).

204. *See* PROGRAM REQUIREMENTS, *supra* note 30, at 9.

205. *See id.*

206. *Id.*

207. *See id.*

208. *See supra* note 108 and accompanying text.

209. *See* PROGRAM REQUIREMENTS, *supra* note 30, at 9 (illustrating requirements and factors of consideration for determining grantee clinic awards, which remain discretionary without formal amendments).

210. CAL. FAM. CODE § 7962 (West 2020); CONN. GEN. STAT. § 7-48a (2022); Assemb.

should begin considering the inclusion of guidelines such as permitting gestational surrogacy—but not traditional surrogacy—and allowing compensation for surrogates.[211] These state statutes also provide examples for the OPA to use when potentially looking to include provisions that allow for pre-birth orders to put the intended parents directly onto the child's birth certificate at birth, eliminating the need for an adoption process.[212] The OPA should further consider provisions to protect equal access to surrogacy services regardless of gender, marital status, or sexual orientation, as in Nevada, though such a requirement may become controversial and delay reform in accordance with the guidelines.[213] By looking at the most positive existing surrogacy laws and compiling the most pivotal factors from those laws, the OPA could effectively create comprehensive and effective statutory guidelines for a uniform surrogacy framework.

The clinic-level requirements would ensure that each grantee complies with the necessary standards established by the OPA for safe and ethical surrogacy practices.[214] Further, the state-level framework will encourage statutory reform so that all surrogacy practices within the state comply with a uniform standard to maintain consistent surrogacy care.[215] The OPA should include provisions to give preference where a state's legislation applies to both clinics and agencies so that even surrogacy agencies with no clinic affiliation, those that would fall beyond the scope of the grant, must comply with given standards.[216] This new opportunity for additional grant funding may encourage surrogacy agencies to rebuild as clinics, establishing more holistic care, including legal and moral support beyond physical healthcare, at each step of the surrogacy process.

The proposed means of encouraging uniformity over time would allow states to reform their laws while creating an environment akin to a free market. Under this system, individuals or organizations seeking to establish surrogacy services in a state with non-compliant statutes would be

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B. 421, 2013 Leg., 77th Sess. §§ 20, 27 (Nev. 2013). *See also supra* Part I.A.

211. CAL. FAM. CODE § 7962; Assemb. B. 421, 2013 Leg., 77th Sess. §§ 20, 27. *See also supra* Part I.A.

212. *See* CAL. FAM. CODE § 7962; CONN. GEN. STAT. § 7-48a.

213. *See, e.g.*, Assemb. B. 421, 2013 Leg., 77th Sess. §§ 20, 27 (providing that prospective parents, regardless of marital status or sexual orientation, may receive equal consideration for parental rights during the surrogacy process).

214. *See* Thomaston, *supra* note 14, at 1188–89.

215. *See id.* (providing the Illinois' General Surrogacy Act as an example of a state's strong reaction to "in response to growing concern about surrogacy in an age of rapid technological progress.").

216. *See* PROGRAM REQUIREMENTS, *supra* note 30, at 9.

incentivized to contact state officials to advocate reform, potentially encouraging states with high demand to act more quickly as aspiring grantee clinics and prospective parents emphasize constituent interest. This system would also allow interested parties to establish clinics in compliant states instead of waiting for non-compliant states to undergo reform, further benefitting compliant states with new surrogate opportunities and subsequent economic growth—including increased engagement with reproductive health centers, legal resources, and other businesses throughout the surrogacy process.[217] Ultimately, while surrogacy is a familial matter, modern surrogacy carries a transactional quality where a surrogate's ability to carry a child is commodified.[218] All subsequent medical, legal, and counseling services associated with any surrogacy contract also have a monetary value, garnering potential economic benefits.[219]

Under this system, the OPA would need to consider any requirements for clinics with surrogacy services or state statutes, likely through consultation with medical professionals and counselors who have worked closely with surrogacy arrangements.[220] The requirements set out for individual clinics and those for state statutes would differ slightly in their content to complement one another and reinforce the totality of the requirements. However, they would ensure that some more nuanced medical requirements remained with private clinics rather than within the statute. In creating the grant requirements for states where grantee clinics are located, the OPA should establish several broad frameworks for states' legislation that allow for variance in wording and details of the statute while complying with the purpose of the grant's mission. Among the general guidelines, the OPA should require that the statute specify that all prospective surrogates have successfully carried at least one child to a full term to ensure that the surrogate has no history of pregnancy complications that may reoccur during the surrogacy process.[221] This provision is significant as some studies have

217. *See* Thomaston, *supra* note 14, at 1179.

218. *See id.* at 1158 (describing the development of compensation within modern surrogacy practices, shifting away from altruistic surrogacy).

219. *See id.* at 1180–81 (stating that surrogacy commodifies the surrogate's ability to carry the intended child, making surrogacy a service where intended parents' desire for children creates demand and allowing states with favorable laws to benefit from an influx of surrogacy contracts bringing those transactions into the state).

220. *See* PROGRAM REQUIREMENTS, *supra* note 30, at 9.

221. Pregnancy as a high-risk undertaking can bring about numerous medical complications, and some individuals may be pre-disposed to gestational diabetes, preeclampsia, or other complications that may remain unknown until they carry a pregnancy to term. *See* M. Simopoulou, K. Sfakianoudis, P. Tsioulou, A. Rapani, G.

shown that carrying a child through surrogacy may have heightened risks compared to traditional pregnancy.[222] Finally, to create state-specific legitimacy for the clinic requirements, the OPA should also require statutes to mandate that surrogacy agreements be arranged through clinics or agencies with resources to provide legal advocacy, counseling, and medical services or referrals throughout the surrogacy agreement.[223] Through this provision, states can reinforce the importance of these resources without mandating their use beyond grantee clinics.

B. Proposed Grantee Regulatory Clinic Requirements

The OPA should establish regulatory guidelines that a clinic with surrogacy services would need to implement to be a sufficient facility for such services and should consider whether a clinic satisfies these requirements when considering whether to administer a Title X Service Grant.[224] The requirements for clinics could most easily be broken into two categories: health-centered and advocacy-centered requirements. These requirements would work together to ensure safety for all parties to a surrogacy contract, including the surrogate, intended parents, and intended child.

The health requirements incorporate evaluations of health and wellness to address the medical factors related to a surrogacy arrangement among all parties.[225] Given this focus, clinic requirements should include comprehensive physical exams for intended parents and surrogates.[226] For surrogates, this physical exam would ensure that the surrogate is physically able to successfully carry a child to term without foreseeable complications for the surrogate or child.[227] Regardless of whether a surrogate had successfully carried a child prior, this exam would ensure that any potential

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Anifandis, A. Pantou et al., *Risks in Surrogacy Considering the Embryo: From the Preimplantation to the Gestational and Neonatal Period*, BIOMED RSCH. INT'L 1, 4–5 (2018).

222. *See id.*

223. *See* Thomaston, *supra* note 14, at 1187–89 (stating the importance of statutory language enforcing positive surrogacy practices and the benefits of safe practices for contracting parties).

224. *See* PROGRAM REQUIREMENTS, *supra* note 30, at 9.

225. *Cf.* Zoe M. Beiner, *Signed, Sealed, Delivered - Not Yours: Why the Fair Labor Standards Act Offers a Framework for Regulating Gestational Surrogacy*, 71 VAND. L. REV. 285, 312–13 (2018).

226. *See id.*

227. *See id.* (discussing that some physical exams can assess whether a prospective surrogate's basic health indicators remain within a medically typical range and that the surrogate possesses no complicating factors that may complicate a pregnancy).

changes or new complications become known before proceeding.[228] For intended parents, this exam would ensure that their genetic material is viable for the procedure and would not cause complications in the pregnancy process.[229] This requirement would undercut any potential for surrogates to contract an ailment from an intended parent through exposure to their genetic material.[230] Further, this comprehensive health screening would include genetic testing to determine potential genetic predispositions to risk factors that could carry complications during pregnancy.[231] Some genetic factors can impact how a child develops during pregnancy and many carry complications for the surrogate.[232] Prospective surrogates must be able to consider these risk factors to give informed consent to the process. Potential parents may additionally have particular desires for how to handle a pregnancy if certain complications arise related to a child's health, and these discussions should occur before the surrogacy process begins to avoid ethical conflicts between the surrogate and potential parents.[233] The clinic requirements should also establish psychological evaluations for intended parents and surrogates to ensure that all parties are mentally prepared for surrogacy; unforeseen complications, health factors, and other variables can make this an incredibly arduous process.[234] All parties must be mentally prepared to give informed consent to this process for a surrogacy arrangement to succeed.[235]

With regard to the advocacy-centered requirements, the OPA should

228. *See id.*

229. *See* Iver Peterson, *Legal Snarl Developing Around Case of a Baby Born to Surrogate Mother*, N.Y. TIMES (Feb. 7, 1983), https://www.nytimes.com/1983/02/07/us/legal-snarl-developing-around-case-of-a-baby-born-to-surrogate-mother.html.

230. *See id.*

231. *See* Elizabeth Cohen, *Surrogate Offered $10,000 to Abort Baby*, CNN HEALTH, https://www.cnn.com/2013/03/04/health/surrogacy-kelley-legal-battle/index.html (Mar. 6, 2013, 2:58 PM).

232. *See id.* (discussing one example of developmental complications in utero); *see also* Peterson, *supra* note 229 (citing an instance where both the surrogate and unborn child suffered complications from cytomegalovirus contracted from the intended father due to lack of physical testing).

233. *See* Cohen, *supra* note 231; *see also* Peterson, *supra* note 229 (citing an instance where both the surrogate and unborn child suffered complications from cytomegalovirus contracted from the intended father due to lack of physical testing).

234. *See* Tamar Lewin, *Man Accused of Killing Son Borne by a Surrogate Mother*, N.Y. TIMES (Jan. 19, 1995), https://www.nytimes.com/1995/01/19/us/man-accused-of-killing-son-borne-by-a-surrogate-mother.html.

235. *See id.*

seek to ensure that clinics prioritize the wellness of all parties to the surrogacy arrangement by maintaining an environment of informed consent throughout the process. The clinic requirements should prioritize legal advocacy and counseling resources for both parties to ensure that surrogates and potential parents understand the full scope of their legal agreement in the surrogacy contracts and establish informed consent.[236] This mutual access to advocacy would promote the disclosure of any personal, ethical, or moral inconsistencies in the legal agreement.[237] The opportunity to fully assess any health factors from the physical screenings and personal feelings surrounding the surrogacy process would allow both parties to create a balanced contract to mutual satisfaction without oversight of future decisionmaking issues.[238] One of the most significant risk factors in a surrogacy agreement arises when a lack of initial discussion and planning leads to potential exploitation or unbalanced expectations, which may carry increased emotional weight where ethical or moral dilemmas are involved.[239]

C. Proposed State Statutory Requirements

Within the principal requirements for the grant, the OPA should establish more nuanced requirements regarding the nature of surrogacy under a compliant statute. The OPA should require that the statute explicitly permit and enforce gestational surrogacy agreements and ban traditional surrogacy with no limitations regarding compensation.[240] Modern surrogacy has largely trended towards gestational surrogacy because the lack of genetic connection between the surrogate and child promotes ease of custody transitions and minimizes potential emotional connections between the surrogate and child, which could have detrimental mental health impacts upon separation.[241] The statute should provide that, in cases where intended parents do not have the viable male and female genetic material to create an embryo for implantation through IVF, a donor may be used to obtain the necessary materials for successful IVF treatment.[242] However, the statute

236. *See* CAL. FAM. CODE § 7962 (West 2020) (statute requiring contracts for parties undergoing gestational surrogacy); *supra* Part 1.A.2

237. *See supra* Part 1.A.2.

238. *See* Cohen, *supra* note 231.

239. *See* Thomaston, *supra* note 14, at 1175–78.

240. *See supra* Part III.A.

241. *See* Bewkes, *supra* note 16, at 164–66.

242. *See, e.g.*, Assemb. B. 421, 2013 Leg., 77th Sess. §§ 6, 23, 32 (Nev. 2013) (showing that individuals who need a viable sperm or egg donation to create an embryo for IVF may

should establish that the surrogate's genetic materials may not be donated to maintain genetic separation from the intended child. In doing so, the statute would eliminate any possibility of the surrogate having any genetic connection to the intended child, undermining any parental claim and reserving parental rights for the intended parents.[243]

Given the need for IVF treatment to carry out gestational surrogacy, medical interventions are integral to such surrogacy arrangements.[244] Thus, the OPA should require that statutes include that all surrogacy-related medical procedures be carried out in conjunction with an accredited hospital, clinic, or legitimate medical facility that can provide IVF services.[245] However, the current debate surrounding IVF treatment and individuals' moral or ethical stances on the issue may impact whether certain states could adhere to the presented requirements.[246] These requirements hinge on IVF remaining legal and accessible in a state that seeks to pass compliant surrogacy statutes because gestational surrogacy may only occur through IVF treatment.[247] Thus, in states banning IVF treatment, no surrogacy law could be compliant, and no clinics could be considered under the surrogacy guidelines.[248] However, clinics in such

use a separate donor to provide those materials rather than the surrogate, avoiding a genetic link between the surrogate and intended child).

243. *See, e.g.*, Sanger, *supra* note 17, at 68–69 (explaining a case in which there was an issue over parental rights in a surrogacy case in which the child was genetically related to the surrogate).

244. *See* Thomaston, *supra* note 14, at 1161.

245. This requirement would seek to ensure that all IVF treatment occurs in a facility with sufficient equipment and staff training to prevent medical complications, as IVF involves sensitive handling of genetic material and semi-invasive procedures. *See What Is Accreditation?*, JOINT COMM'N, https://www.jointcommission.org/what-we-offer/accreditation/become-accredited/what-is-accreditation/ (last visited Feb. 1, 2024) (providing the standards required for accredited hospitals).

246. Some current political debates center on whether IVF may be ethically carried out because excess embryos not implanted for pregnancy will eventually be destroyed after IVF treatment ceases, which some consider a form of abortion. Following the *Dobbs v. Jackson Women's Health Organization* decision, these arguments carry potential to make IVF increasingly inaccessible. *See* Courtney G. Joslin, *Gamete Regulation and Family Protection in a Post-Dobbs World*, BILL OF HEALTH (May 17, 2023), https://blog.petrieflom.law.harvard.edu/2023/05/17/gamete-regulation-and-family-protection-in-a-post-dobbs-world/.

247. *See id.*

248. Under a framework allowing only gestational surrogacy, not traditional surrogacy, IVF would be necessary for any such surrogacy, meaning that gestational surrogacy agreements could not exist where IVF became unavailable. *See* Thomaston, *supra* note 14, at

states could still seek funding from Title X service grants for offering other sexual and reproductive health services.[249]

The OPA should additionally lay out several clerical requirements for consideration within the surrogacy statutes based on existing statutes from states with positive treatment towards surrogacy.[250] One such requirement would mandate that all intended parties to the surrogacy contract create and agree upon a binding, comprehensive surrogacy contract prior to beginning any medical steps for the surrogacy process beyond screenings.[251] The OPA should also require that each party receive resources for obtaining legal counsel throughout the process to help create, negotiate, and review the agreements, ensuring that all parties have an equal informed consent understanding of their commitments under the contract.[252] In tandem with these agreements, the OPA should further require that statutes permit and enforce pre-birth orders that acknowledge the intended parents as the intended child's parental guardians, eliminating the need for a post-birth adoption process.[253] This would ease the transition following the birth of the child and remove some burden on the courts for adoption proceedings.[254]

CONCLUSION

The goal of this proposed system is to promote informed consent for all parties in the surrogacy process while ensuring that ample resources remain available to avoid exploitation or personal suffering. In furtherance of this mission, the proposed system relies heavily on incentivizing state reform rather than mandating it to emphasize accepted change over resisted enforcement. Thus, where state legislation may contradict the mission of the proposed grants and preclude a state from establishing grantee clinics, the OPA will have no further role in encouraging compliance.[255] In these instances, interested constituents may advocate for reform for a chance to

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1161.

249. *See Title X Service Grants*, *supra* note 11.

250. *See, e.g.*, CAL. FAM. CODE § 7962 (West 2020) (explaining California surrogacy laws); CONN. GEN. STAT. § 7–48a (2022) (Westlaw through 2023 Sess.) (providing Connecticut's laws about surrogacy). *See generally* Assemb. B. 421, 2013 Leg., 77th Sess. (Nev. 2013) (describing surrogacy requirements in Nevada).

251. *See* CAL. FAM. CODE § 7962.

252. *See id.*

253. *See* CAL. FAM. CODE § 7962; CONN. GEN. STAT. § 7–48a.

254. *See id.*

255. *See supra* notes 244–246 and accompanying text.

receive grants in such a state.[256] In using the proposed requirements acting as guidelines for grant administration, the OPA would retain the discretion to withhold grants from clinics in states that create legislation in partial compliance with the requirements or compliant statutes with additions that undermine the grant's goals in promoting consistent, safe surrogacy practices. Given the controversy surrounding surrogacy and many of the practices intrinsically tied to surrogacy, including IVF treatment, reform has been a slow process in recent decades.[257] These proposed systems would seek to expand awareness of the vitality of surrogacy to current reproductive health shifts and encourage willing states to begin the reform process with clear OPA guidance to demystify surrogacy.[258] The current presence of hostile or nonexistent surrogacy legislation presents a distinct risk to those seeking surrogacy arrangements.[259] Thus, any shift towards uniformity and increased regulation would constitute improvement in the surrogacy landscape.[260]

Within the proposed legal framework, space must remain for the nuances of delicate medical information and personal choices unique to each surrogacy agreement. Familial matters, pregnancy, parenthood, and personal beliefs each factor into the surrogacy process, and each individual involved would bring their expectations into the proposed process. Amid these variables, deeply personal choices must be considered within each surrogacy agreement.[261] However, they cannot be driven or predetermined by regulations or statutory legislation, so this proposed system cannot include guidance on those topics. This proposed system aims to establish a strong foundation for informed consent of all parties to the surrogacy process to minimize any chance of exploitation or personal ethical dilemmas. This system cannot answer every hypothetical legal question. Still, it can offer states guidance on ensuring each surrogacy agreement is comprehensively considered by all parties based on their personal expectations for the safety of all parties.

256. *See supra* note 217 and accompanying text.

257. *But see* Joslin, *supra* note 246 (arguing that the enactment of new laws is occurring too quickly and that legislators should slow down to appropriately balance all interests).

258. *See* Conklin, *supra* note 33, at 88.

259. *See supra* notes 88–89 and accompanying text.

260. *See supra* Part I.D.

261. *See supra* note 198 and accompanying text.