This proposed Model Code Governing Assisted Reproduction was drafted by the American Bar Association Family Law Section Committee on Assisted Reproductive Technology and Genetics. The draft code was initially approved by the Council in May 2006. This is the revised draft approved by the Section Council in February 2007.

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PROPOSED MODEL ACT GOVERNING ASSISTED REPRODUCTION

American Bar Association
Section of Family Law

This proposed Model Act is the work of the American Bar Association Section of Family Law's Committee on Assisted Reproductive Technology and Genetics. It has been approved by the Section Council. The sections dealing with parentage are intended, as much as possible, to be consistent with and to track the corresponding provisions of the Uniform Parentage Act of 2000, as amended in 2002.

WHEREAS, this Model Code Governing Assisted Reproduction is intended to provide suggested model legislation for the regulation of those technologies involved in the use of assisted human reproduction and

WHEREAS, the Model Code Governing Assisted Reproduction is not intended to conflict in any way with the Uniform Parentage Act, nor to limit the ability of the National Conference of Commissioners on Uniform State Laws to work in these or related subject matters in the future; therefore

BE IT RESOLVED, that the American Bar Association approves the Model Code Governing Assisted Reproduction as appropriate model legislation for consideration by the states and territories.

PREFATORY NOTE

Since the birth of the first in vitro fertilization (IVF) baby in 1978, extraordinary advances in reproductive medicine have made biological parenthood possible for people with infertility, certain other medical conditions, or for persons who risk passing on inheritable diseases or genetic abnormalities. Such advances have also been applied to extend reproductive potential by treating post-menopausal women. These advances use technology to enable individuals to have children when for personal reasons they choose not to do so by means of sexual intercourse. These advances have also been used to retrieve gametes from dead or incapacitated persons, or to manipulate differentiated cells to produce the equivalent or near-equivalent of a human embryo, capable of implantation in the uterus and gestation to term birth.

The rise of these new technologies and therapeutic modalities, including the use of third parties, to assist in creation or gestation of an embryo, has created a host of novel legal issues. The resolution of these issues has caused confusion and contradictions in the

application of a body of existing statutory and common law. It is the purpose of this Act to give assisted reproductive technology (ART) patients, participants, parents, providers, and the resulting children and their siblings clear legal rights, obligations and protections. These goals are accomplished by establishing legal standards for the use, storage, and other disposition of gametes and embryos, by addressing societal concerns about ART, such as clarifying issues of health insurance coverage for the treatment of infertility, and by establishing legal standards for informed consent, reporting, and quality assurance.

The Act provides a flexible framework that will serve as a mechanism to resolve contemporary controversies, to adapt to the need for resolution of controversies that are envisioned but which may have not yet occurred, and to guide the expansion of ways by which families are formed. That there is a need for such legislation has perhaps not been expressed any better than in an appellate decision involving a dispute about parentage:

> We join the chorus of judicial voices pleading for legislative attention to the increasing number of complex legal issues spawned by recent advances in the field of assisted reproduction. Whatever merit there may be to a fact-driven case-by-case resolution of each new issue, some over-all legislative guidelines would allow the participants to make informed choices and the courts to strive for uniformity in their decisions." In re Marriage of Buzzanca, 61 Cal.App.4th 1410, 1428-29, 72 Cal. Rptr. 280 (Cal.App. 1998).

ARTICLE 1. GENERAL PROVISIONS

SECTION 101. SHORT TITLE
This Act is entitled Model Act Governing Assisted Reproduction Technology.

SECTION 102. DEFINITIONS
1. “Assisted conception” means an attempt to achieve pregnancy either (a) with an embryo formed by means other than sexual intercourse, or (b) transfer of an embryo. Insemination of a married woman using her own husband’s sperm is assisted conception not regulated by this Act.
2. “Assisted reproduction technology” (ART) is any medical or scientific intervention provided for the purpose of achieving live birth that results from assisted conception.
3. “ART provider” means a licensed physician, group practice, clinic, or other facility that provides services for assisted reproductive technology.
4. “ART storage facility” means a licensed facility that stores reproductive material, or biological material used in assisted reproductive technology.
5. “Collaborative reproduction” means attempts by intended parent(s) to create a child through assisted conception with the involvement of participants who are not intended parents.
6. “Consultation” means an in-person meeting with a licensed mental health professional.
7. “Counseling” means consultation(s) for the purpose of exploring participation in any ART procedure.
8. “Cryopreservation” means freezing and storing tissue for use in assisted conception.
9. “Donor” means a person, not an intended parent, who provides egg, sperm, or embryo, or any component thereof, for use in assisted conception.
10. “Embryo” means a cell containing a diploid complement of chromosomes or group of such cells (not a gamete or gametes) that has the potential to develop into a live born human being if transferred into the body of a woman under conditions in which gestation may be reasonably expected to occur.
11. “Experimental procedure” means any procedure or treatment that is not generally accepted as efficacious, but is too new or too little tested so as to be considered non-efficacious, as determined by the state Department of Health at the time the procedure or treatment is recommended.
12. “Gamete” means a cell containing a haploid complement of DNA that has the potential to form an embryo when combined with another gamete. Sperm and eggs are gametes. A gamete may consist of nuclear DNA from one human being combined with the cytoplasm, including cytoplasmic DNA of another human being.
13. “Gamete provider” means a person from whom a complement of haploid DNA is derived and subsequently incorporated into the genome of an embryo.
14. “Gestational agreement” is a contract between intended parents and a gestational carrier, intended to result in a live birth.
15. “Gestational carrier” means an adult woman, not an intended parent, who enters into a gestational agreement to bear a child, whether or not she has any genetic relationship to the resulting child. Both a traditional surrogate and a gestational surrogate are gestational carriers.

16. “Infertility treatment” means any medical treatment reasonable and customary for an intended parent to achieve a live birth.
17. “Intended parent” is person, married or unmarried, who manifests an intent as provided in this Act to be legally bound as the parent of a child resulting from assisted conception.
18. “In vitro fertilization” means the formation of a human embryo outside the human body.
19. “Legal parent” is a person recognized as the parent under applicable law.
20. “Medical information” means any individually identifiable health information obtained by a health care provider in the course of medical evaluation, consultation, diagnosis, or treatment.
21. “Participant” means a person, or the spouse of a person, who provides a biological component of assisted reproduction technology, or who is an intended parent. Gestation is a biological component within the meaning of this definition.
22. “Patient” means a person using assisted reproduction technology under the direction of a provider. An intended parent is a patient.
23. “Parental rights” means those rights conferred by law on a person who has the status of a legal parent.
24. “Posthumous conception” means the transfer of an embryo or gametes with the intent to produce live birth, after a gamete provider is dead.
25. “Provider” means a person (a) licensed to administer health care, and (b) who is qualified under this Act to provide ART services, and (c) has a provider-patient relationship with a participant. Any professional corporation or corporation licensed by the State to provide health care, of which a provider is an owner or employee is also a provider.
26. “Record” means information inscribed in a tangible medium or stored in an electronic, written or other medium and which can be retrieved.
27. “Time of transfer” means the time at which a gamete or embryo is transferred into the body of a woman with the intent to produce live birth.
28. “Transfer” means the placement of an embryo or gametes into the body of a woman with the intent to achieve pregnancy and live birth.
29. “Writing” or “written” refers to an agreement, consent or other document or record inscribed in a tangible medium.

ARTICLE 2. INFORMED CONSENT

SECTION 201. INFORMED CONSENT STANDARDS

1. Informed consent requires that all of the following be provided to the patient orally and in a written authorization which meets the requirements of Section 202:

(a) A statement patient retains the option to withhold or withdraw consent at any time prior to transfer without affecting the right to future care or treatment, or risking the loss or withdrawal of any program benefits to which the patient would otherwise be entitled. A statement that the gamete donor’s right to withhold or

withdraw consent to fertilization terminates upon retrieval, subject only to the terms of any prior written agreement pursuant to Article 5.

(b) A description of the risks, consequences, and benefits of ART. Such description shall include the risk of embryo loss, including failure of implantation and thawing. The patient shall be informed that there may be foreseen or unforeseen legal consequences, and that it is advisable to seek legal counsel.

(c) Description of alternative therapies and treatments, including adoption.

(d) A statement that all existing confidentiality protections apply.

(e) A guarantee that a patient has access to all of his/her medical information, to the extent the law allows in this jurisdiction. The patient may have to pay a reasonable fee for copies of the record.

(f) Disclosure that the patient has a right to access a summary of medical and psychological information about donors and gestational carriers as described in this Act.

(g) Disclosure of any patient-identifiable information images, including information to researchers or other entities shall not occur without the consent of the patient.

(h) A statement that the intended parent(s), not the clinic or storage facility, has the right to possession and control of their embryos, subject to any prior written agreement or as provided in Section 504.

(i) The need for intended parents to agree in advance who shall acquire the right to possession and control of their embryos in the event of marriage dissolution, death of one or both of them, or subsequent disagreement over disposition, in compliance with the provisions of Section 501 of this Act.

(j) The policy of the provider regarding the number of embryos transferred and any limitation on the number of embryos transferred.

SECTION 202. RECORD AUTHORIZATION REQUIRED

1. The provider must document informed consent in a record, which must:

(a) Be in plain language;

(b) Be dated and signed by the provider and by the patient;

(c) Include the mental health counseling notice as provided in Section 302.1 of this Act;

(d) Include a written agreement clarifying parental rights if collaborative reproduction is used pursuant to Article 6 of this Act;

(e) State that disclosures have been made pursuant to this Act;

(f) Specify the length of time the consent remains valid;

(g) Advise the party signing the informed consent document of the right to receive a copy of the writing;

2. Except in an emergency, the record must be signed by both parties before informed consent is valid.

3. The record required in paragraph 1 of this Section shall become part of the medical record.

SECTION 203. DISCLOSURES

1. Disposition of frozen embryos. Prior to each retrieval or cycle, a provider must disclose to all participants in a record the following possible dispositions, together with a statement as to which are allowed under applicable law:

(a) Storage, including length of time, costs, and location; and

(b) Transfer; and

(c) Donation.

(i) To a known individual for transfer, or

(ii) To an anonymous individual for transfer, or

(iii) For research, including the recipient and intended nature of the research subject to any written agreement as provided in Section 502, or

(d) Destruction.

2. Right to transport. A provider is not required to offer all possible dispositions, but the provider must inform the patient that other providers may offer other options, and that the patient has the right to transport embryos to other providers.

3. Transfer disclosure. Before each transfer cycle, the provider must provide each intended parent with the following information in a record, where applicable:

(a) Method used to achieve fertilization, and the results of semen analysis, including, but not limited to, motility, count, and morphology;

(b) Eggs. Number of eggs retrieved; and

(c) Retrieval and transfer of fresh embryos.

(i) Number created; and

(ii) Number viable for transfer;

(iii) Number to be transferred;

(iv) Number cryopreserved;

(v) Quality of each embryo transferred; and

(vi) Quality of each embryo cryopreserved.

(d) For the transfer of cryopreserved embryos.

(i) Number of embryos thawed;

(ii) Number of embryos viable for transfer after thawing; and

(iii) Quality of embryos transferred.

(e) A statement that failure to adhere to drug administration schedules may affect the outcome of the treatment.

4. Disclosure to donors. If additional information is learned through medical or psychological evaluation or retrieval of gametes that is relevant to the donor's health, that information must be made available to the donor if the donor has made such a request. The provider must disclose to a donor that such information can be made available upon request.

5. The ART clinic must disclose at least the following regarding fertility drugs to be used:

(a) Known side-effects;

(b) Alternative drug therapies;

(c) Process of drug administration;

(d) Whether the drug is approved by the Federal Drug Administration (FDA).

6. A provider must disclose to patients other than donors, in a record, the known risks of multiple births to the intended parents, to the children and to the gestation carrier. A provider must disclose to donors the known risks of multiple retrievals.

7. A provider shall not accept from a patient or participant an embryo designated for research under Section 502 and must disclose the existence of any financial or professional relationship with any entity accepting the embryo for research.

SECTION 204. DONOR IDENTITY
1. A donor of gametes or embryos may condition donation on a reasonable assurance of anonymity, so long as non-identifying health information is provided in accordance with the requirements set forth elsewhere in this Act.
2. A donor who has given permission for release of identifying health or other information may not revoke such permission after placement or transfer of the donated gametes or embryos.

SECTION 205. COLLECTION OF GAMETES OR EMBRYOS FROM CRYOPRESERVED TISSUE, OR FROM DECEASED OR INCOMPETENT PERSONS
1. Each person and/or entity that collects gametes or embryos from cryopreserved tissue, or from deceased or incompetent persons, shall first obtain a written consent executed prior to death or incompetency by the person from whom the gametes or embryos are to be collected. In the event of an emergency where, in the opinion of the treating physician, loss of viability would occur as a result of delay, and where there is a genuine question as to the existence of a written permission, an exception is permissible.
2. If gametes or embryos are collected pursuant to paragraph 1 of this Section, transfer of gametes or of an embryo is expressly prohibited unless approved by a court of law. Absence of a writing as described in Paragraph 1 authorizing use of such gametes or embryos except in an emergency situation shall constitute a presumption of non-consent.
3. Any person or entity not acting in accordance with Paragraph 1 may be subject to civil and/or criminal liability as provided in law.

SECTION 206. LOSS OF EMBRYOS OR GAMETES DUE TO NATURAL DISASTER, ACT OF GOD OR WAR
1. A storage facility for embryos or gametes is not liable for destruction or loss of embryos due to natural disaster, act of God or war.

ARTICLE 3. MENTAL HEALTH CONSULTATION

SECTION 301. CONSULTATION AS TO MENTAL HEALTH
1. Consultation means a face-to-face meeting with a licensed mental health professional.
2. Counseling means consultation(s) for the purpose of exploring participation in any ART procedure. The offer of counseling is mandatory, but the acceptance is voluntary.

3. Qualified mental health professional is a person who:

(a) Holds a Masters or Doctorate in the field of Psychiatry, Psychology, Counseling, Social Work, Psychiatric Nursing, Marriage and Family Therapy, or state equivalent; and
(b) Is licensed in this jurisdiction to practice in the mental health field; and
(c) Where reasonably possible, has received training in, or has knowledge of reproductive physiology; the testing, diagnosis, and treatment of infertility; the psychological issues in infertility, and collaborative reproduction. If there are questions about inherited or genetic disorders, the counselor must refer to a licensed genetic counselor.

SECTION 302. EVALUATION AND COUNSELING REQUIREMENTS

1. No ART procedure which involves the transfer of donor gametes or embryos to a female intended parent, or of gametes or embryos to a gestational carrier shall be initiated or performed until:
(a) All participants made known to the ART provider have been offered additional counseling following the initial consultation, and
(b) The mental health professional prepares a written statement that:
(i) The individual has met with him or her, and
(ii) Contains a recommendation regarding that individual's appropriateness as a participant.
(c) If applicable, a prospective gestational carrier has undergone an evaluation to determine his or her suitability to participate in collaborative reproduction.
(d) Intended parents have undergone an evaluation to determine their suitability to participate in collaborative reproduction.

2. Opportunity to receive counseling. It shall be conclusively presumed that a participant has had the opportunity to receive counseling from a mental health professional pursuant to Section 301, if that individual signs a statement containing the following language:

I understand that counseling is recommended for all participants in collaborative reproduction and that counseling is a separate process from any psychological evaluation that [Provider] has required me to complete. [Provider] has given me the opportunity to meet with and receive counseling from a mental health professional with specialized knowledge of the social and psychological impact of assisted and collaborative reproduction on participants. I understand that I may choose any such mental health professional, and that I am not required to choose one recommended by this treatment facility.

3. Recommendation available to intended parents. Prior to any transfer of gametes or embryos, and prior to execution of any collaborative reproduction agreement, an intended parent shall be informed that, upon intended parent's request, the mental health professional's recommendation regarding the fitness of a participant for collaborative reproduction shall be provided by the ART provider.

4. Recommendation shall not reveal reasons. The Recommendation in Paragraph 3 of this Section shall only state the conclusion as to whether the individual is recommended as a participant, and shall not reveal the reasons behind the recommendation.

ARTICLE 4. PRIVACY AND CONFIDENTIALITY

SECTION 401. INDIVIDUALLY IDENTIFIABLE MEDICAL INFORMATION

1. All individually identifiable information obtained or created in the course of ART treatment is medical information and subject to medical record confidentiality requirements.

ARTICLE 5. EMBRYO TRANSFER AND DISPOSITION OF EMBRYOS NOT TRANSFERRED

SECTION 501. PARENTAL RIGHTS AND OBLIGATIONS UNDER EMBRYO AGREEMENTS

1. Binding written agreements, preferably executed prior to embryo creation, must be entered into by all participants as to:
    (a) Intended use and disposition of embryos; and
    (b) The use and disposition of embryos in the event of divorce, illness, or death or other change of circumstances; and
    (c) The time at which, and conditions under which, embryos will be deemed abandoned and the disposition thereof.
2. All written agreements shall include a permanent address and permanent identifier, such as the social security number, of that participant.
3. Agreements between donors and intended parents in which the participants wish to remain anonymous to one another may utilize procedures that protect confidential information through the use of intermediaries and/or attorneys.
4. Any written agreement must incorporate the following:
    (a) Intended parents must agree whether an intended parent may use the embryos in the event of divorce, illness, incapacity, or death of another intended parent; and
    (b) Clarify which intended parent may control the embryos in the event of divorce, illness, or death; and
    (c) In the event of a subsequent disagreement between intended parents, wherein one intended parent no longer wishes to use stored embryos as previously agreed, after written notice of that person’s intent to avoid conception to the other party and the clinic or storage facility, an intended parent may not transfer the embryos into the body of any woman with the intent to create a child. No agreement to the contrary will be enforceable.
    (d) In the event of a future disagreement between intended parents, when one intended parent no longer wishes to transfer stored embryos as agreed in paragraph 4(c) of this Section, that intended parent will not be the parent of a resulting child.
    (e) Following the death of an intended parent who has previously consented to posthumous use of cryopreserved embryos, the surviving intended parent may

discard, donate, or use the embryos for his/her own parenting purposes. A person born as a result of embryo transfer after the death of an intended parent or gamete provider is not the child of that gamete provider or intended parent unless the deceased person consented in a record that if assisted reproduction were to occur after death, the deceased individual would be a parent of the child.

5. No provider shall create any embryos unless the written consents referred to in 4(e) of this Section are obtained and permanently recorded.

SECTION 502. DONATION OF UNUSED EMBRYOS

Intended parents may donate their unused embryos for any of the following purposes, which choices shall be reflected in their written agreement(s):

1. Donation to another infertile patient(s), either known or anonymous. Donation to known persons may only be done for the purpose of the recipient attempting to create a child and become that child's legal parent.

2. Donation for approved research, the nature of which may be specifically set forth in the informed consent writing, and which will require the approval of an Institutional Review Board. No research will be permitted which is not within the scope of the informed consent of the written agreement. This agreement may only be modified with the consent of both gamete providers and of the intended parents. After a gamete provider has died, that person's consent endures and is irrevocable.

SECTION 503. SCREENING OF EMBRYO DONORS

Gamete and embryo donors shall be screened, prior to such donation in compliance with U.S. Food and Drug Administration's regulations, in the same manner and to the same extent as gamete donors. Permanent records of the donation shall be maintained.

SECTION 504. ABANDONMENT OF EMBRYOS AND DISPOSITION OF ABANDONED EMBRYOS

1. An embryo is deemed to be abandoned only if:

(a) At least five years have elapsed since creation of the embryo unless the participants select another time by agreement as provided in Section 501 4(c); and

(b) A diligent attempt to notify the interested participants, as well any provider(s) who contracted for storage, that the embryo is deemed to be abandoned (such attempt shall include, but not be limited to, notice by certified mail (or equivalent trackable medium) to each interested participant's permanent address or last known address, and shall require a period of not less than ninety days to elapse before any action is taken; and

(c) The interested participants have acknowledged that they have been informed of the provisions of (a) and (b) of this paragraph in a written agreement executed prior to acquisition by the storage facility.

2. Disposition of an embryo deemed to be abandoned under Paragraph 1 must be in accordance with the most recent written agreement between participants and the storage facility. If there is no written agreement, or if no written agreement can be found after a diligent search, disposition must be as ordered by a court of competent jurisdiction.

3. A storage facility in compliance with this Section is immune from all civil and criminal liability which may arise as a result of the disposition of embryos.

SECTION 505. TRANSPORTATION OF EMBRYOS
1. Transportation of embryos is the responsibility of the person or persons requesting the transfer.
2. Unless the storage facility has requested or required transport, it is immune from all civil and criminal liability incurred as a result of the transport.

ARTICLE 6. PARENTAGE

SECTION 601. SCOPE OF ARTICLE.
This article does not apply to the birth of a child conceived by sexual intercourse.

SECTION 602. PARENTAL RIGHTS IN GENERAL
1. A parent is a person who
    (a) Contemporaneously consents in a writing to assisted conception with the intent to be legally bound as a parent, OR
    (b) Is married to a patient undergoing assisted conception, which patient and spouse have executed a consent in accordance with (a), and no action for divorce has been filed at the time of embryo or gamete transfer, that person is a parent of the resulting child.
2. A person married to an intended parent who signs a consent to parentage also signed by the intended parent is a parent in accord with Paragraph 1(a) of this Section.
3. A parent under this Section is the legal equivalent of a biological parent who is also qualified as a legal parent.
4. A person who dies before embryo or gamete transfer is not a parent of the resulting child unless the deceased person consented in a written record that if assisted conception were to occur after death, the deceased individual would be a parent of the child.
5. A child resulting from assisted reproduction is issue of a legal parent.
6. Consent by an individual to assisted reproduction may be withdrawn in a written record with notice given to all interested persons, including those controlling or storing the gametes or embryos, before placement of eggs, sperm or embryos; an individual who withdraws consent under this section is not a parent of any resulting child.

SECTION 603. GAMETE OR EMBRYO DONATION
1. A donor is not a parent of the child resulting from assisted reproduction.
2. Upon execution of a written consent to assisted reproduction, the intended parent(s) shall have all rights, responsibilities, interests, and control over gametes or embryos to be used, except as limited by existing law within this jurisdiction or by other written agreement between the intended parent(s) and donor(s).
3. Intended parent(s) who execute a written agreement in accordance with 1(a) of Section 602 shall be the parent(s) of a child conceived through assisted conception.

4. Upon execution of a written consent at the time of donation of gamete(s) or embryo(s), the donor(s) relinquishes all parental rights, responsibilities, interests, and control over those gametes or embryos.

SECTION 604. GESTATIONAL AGREEMENTS

1. A prospective gestational mother, her husband if she is married, a donor or the donors, and the intended parents may enter into a written agreement providing that:

(a) the prospective gestational mother agrees to pregnancy by means of assisted reproduction;

(b) the prospective gestational mother, her husband if she is married, and the donors relinquish all rights and duties as the parents of a child conceived through assisted reproduction; and

(c) the intended parents become the parents of the child.

2. A gestational agreement is enforceable only if validated by a court of competent jurisdiction. The court shall validate a gestational agreement within thirty (30) days of the filing of the petition therefore if (a) both parties are represented and advised by separate counsel as to the terms and effect of the gestational agreement, (b) the respective attorneys have submitted to the court their affidavits attesting thereto and to the parties' express intent, together with a copy of the proposed gestational agreement, and (c) the gestational agreement and the parties are otherwise in compliance with all of the requirements of this Section 604.

3. A gestational agreement may provide for payment of reasonable compensation for the gestational mother.

4. A gestational agreement may not limit the right of the gestational mother to make decisions to safeguard her health or that of the embryos or fetus, or to terminate a pregnancy.

5. After issuance of an order under this Article, but before the prospective gestational mother becomes pregnant by means of assisted reproduction, the prospective gestational mother, her husband, or either of the intended parents may terminate the gestational agreement by giving written notice of termination to all other parties.

6. Neither a prospective gestational mother nor her husband, if any, is liable to the intended parents for terminating a gestational agreement pursuant to this section.

SECTION 605. PARENTAGE UNDER A GESTATIONAL AGREEMENT

1. Upon birth of a child to a gestational mother, the intended parents shall file notice with the court that a child has been born to the gestational mother within 300 days after assisted reproduction. Thereupon, the court shall issue an order:

(a) confirming that the intended parents are the parents of the child;

(b) if necessary, ordering that the child be surrendered to the intended parents; and

(c) directing the issuance of a birth certificate naming the intended parents as parents of the child.

2. If the parentage of a child born to a gestational mother is alleged not to be the result of assisted reproduction, the court shall order genetic testing to determine the parentage of the child.

3. If the intended parents fail to file notice required under Paragraph 1, the gestational mother or the appropriate State agency may file notice with the court that a child has been

born to the gestational mother within 300 days after assisted reproduction and the court shall order that the intended parents are the parents of the child and are financially responsible for the child.
4. Individuals who are parties to a nonvalidated gestational agreement as intended parents may be held liable for support of the resulting child, even if the agreement is otherwise unenforceable. The parentage of a child born pursuant to a nonvalidated gestational agreement shall be determined and established by a court of competent jurisdiction based exclusively upon evidence of the parties' original intent.

ARTICLE 7. POSTHUMOUS CONCEPTION

SECTION 701. POSTHUMOUS CONCEPTION NOT UNLAWFUL
Except as otherwise limited in this Act, posthumous conception is not unlawful.

SECTION 702. PARENTAL STATUS OF DECEASED INDIVIDUAL
If an individual who consented in a record to be a parent by assisted reproduction dies before placement of eggs, sperm, or embryos, the deceased individual is not a parent of the resulting child unless the deceased person consented in a record that if assisted reproduction were to occur after death, the deceased individual would be a parent of the child.

ARTICLE 8. PAYMENT FOR DONORS' TIME, EFFORT AND ECONOMIC LOSSES

SECTION 801. REIMBURSEMENT
1. A donor may receive reimbursement for economic losses resulting from the retrieval or storage of gametes or embryo, and incurred after the donor has entered into a valid written agreement to be a donor.
2. Economic losses occurring before the donor has entered into valid written agreement to be a donor may not be reimbursed.
3. Premiums paid for insurance against economic losses directly resulting from the retrieval or storage of gametes or embryos for donation may be reimbursed, even if such premiums have been paid before the donor has entered into a valid written agreement, so long as such written agreement becomes valid before the gametes of embryos are used in assisted reproduction technology in accordance with the agreement.

SECTION 802. COMPENSATION
1. The consideration, if any, paid to a gamete donor or prospective gestational mother must be reasonable.
2. Compensation may not be conditioned upon the purported quality or genome-related traits of the gametes or embryos.

3. Compensation may not be conditioned on actual genotypic or phenotypic characteristics of the donor or of the child.
4. Compensation may not be conditioned on the surrender of any resulting child for adoption.

ARTICLE 9. HEALTH INSURANCE

SECTION 901. INFERTILITY AND EXPERIMENTAL PROCEDURES

1. For the purposes of health insurance coverage, infertility means
    (a) resulting from a disease or condition that causes abnormal function of the reproductive system, the inability to:
        (i) conceive after attempts at conception by unprotected sexual intercourse have been made for at least one year; or
        (ii) sustain a pregnancy to live birth; or
    (b) The presence of another condition recognized by accepted medical standards as a cause of the inability to achieve or sustain a pregnancy to live birth; or
    (c) Aversion to coitus. Insurance coverage provided under (a) and (b) above may not be denied on the basis of this subparagraph.
2. Experimental procedure means any procedure or treatment that is not generally accepted as efficacious, but is too new or too little tested so as to be considered non-efficacious, as determined by the state Department of Health at the time the procedure or treatment is recommended:
    (a) The Department of Health may designate, from time to time, a list of ART procedures and treatments considered to be experimental.
    (b) When an experimental procedure is determined to be efficacious and no longer experimental, the Department of Health shall take appropriate action.

SECTION 902. REQUIRED NOTICE

1. Each group health benefit plan that offers assisted reproductive health services shall provide written notice to each enrollee in the plan of the specific coverage provided for those services.
2. The notice required under this Section must be prominently positioned in any literature, application, or plan description made available or distributed by the group health benefits plan to enrollees.

SECTION 903. QUALIFICATION OF PROVIDERS

A health insurer may require that any licensed physician participating in the treatment of infertility must be:
    (a) Board certified in Obstetrics and Gynecology by the American Board of Obstetrics and Gynecology and have a practice comprised of more than seventy five percent infertility cases, or

(b) Board certified in both Obstetrics and Gynecology and in Reproductive Endocrinology by the American Board of Obstetrics and Gynecology, with a practice comprised of more than thirty percent infertility cases, or
(c) Board certified and both Andrology and Urology by the American Board of Urology.

ARTICLE 10. QUALITY ASSURANCE

SECTION 1001. QUALIFICATIONS OF PROVIDERS

1. Assisted Reproduction Technology (ART) providers, ART clinics, and ART storage facilities (hereafter "program") shall assure the quality of their services by developing and complying with at least the following:

(a) Quality assurance measures:

(i) Personnel. The program shall document that senior and supervisory staff are adequately trained, including formal training in genetics. Documentation shall also include staff participation in laboratory training programs, and regular updating of staff skills and knowledge.

(ii) Equipment. The program shall develop, implement, and test regularly backup and contingency plans for cryopreservation systems, computer systems, and records.

(iii) Testing. The program shall participate in proficiency testing and on-site inspection, in compliance with the requirements for certification promulgated by the State Department of Health, if any. If genetic diagnostic services are provided, the program shall participate in the College of American Pathologists and the American College of Genetics genetic proficiency testing programs.

SECTION 1002. NATIONAL DONOR AND COLLABORATIVE REPRODUCTION REGISTRY

1. In the event that a National Donor and Collaborative Reproduction Registry (or equivalent) is created for the purpose of maintaining contact, medical, and psychosocial information about donors, gestational carriers, and children born as a result of ART, providers in this jurisdiction shall comply with the requirements of that Registry, including, but not limited to the following:

(a) Establish procedures to allow the disclosure of nonidentifying information and, when appropriate, protect the anonymity of donors and gestational carriers;
(b) Establish procedures to allow the disclosure of identifying information about participants only if mutual consent of all parties affected is obtained prior to the release of such information;
(c) Maintain medical and genetic information, and updated current health information, including change in health status, about the donor;
(d) Establish procedures to allow disclosure of nonidentifying medical and psychosocial information to the resulting child;

(e) Determine whether a resulting child is authorized to contact a program;
(f) Retain all records involving third party reproduction until the resulting child has reached the age of majority.

SECTION 1003. HEALTH INFORMATION MANAGEMENT

1. The provider shall:
   (a) Maintain a permanent address for contact by patients, resulting children, and participants;
   (b) Participate in a National Donor and Collaborative Reproduction Registry, if established as in Section 1002 of this Act, so that intended parents and donors can provide the program with address information;
   (c) Participate in a National Donor and Collaborative Reproduction Registry, if established as in Section 1002 of this Act, by collecting medical and genetic information, and updated current health information including change in health status of the donor; and
   (d) Maintain an accurate accounting of the disposition of all gametes and embryos.
2. The program shall maintain all records in compliance with State and Federal law.
3. The program shall transfer all records involving collaborative reproduction to a National Donor and Collaborative Reproduction Registry in compliance with its requirements, if established as in Section 1002 of this Act.
4. Disclosure of medical information
   (a) Medical information may be disclosed to an interested party or resulting child only if an authorization is signed pursuant to Articles 2 and 4 of this Act;
   (b) A written summary of a mental health report on a donor or gestational carrier may be disclosed to intended parents;
   (c) The program may disclose aggregate, non-identifiable data for quality assurance and reporting requirements, for the limited purpose of:
      (i) Ensuring a standard for the maintenance of records on laboratory tests and procedures performed, including safe sample disposal; and
      (ii) Maintaining written records on personnel and facilities, schedules of preventive maintenance; and
      (iii) ensuring minimum qualification standards for personnel.

SECTION 1004. PATIENT SAFETY

The program shall:
1. Conduct medical testing for sexually transmitted diseases in gamete and embryo donors, gestational carriers, and intended parents, but only if the intended parent is a gamete provider, in compliance with the U.S. Food and Drug Administration regulations and
2. Conduct medical screening of gamete and embryo donors for genetic disorders. The extent of such screening shall be in conformity with guidelines established by a selected entity that recommended procedures for, establishes guidelines for or otherwise regulates ART procedures. In the event that no such guidelines have been developed, the screening shall be in accord with accepted standards of medical practice.

3. Establish procedures for the verification of genetic identity and proper labeling of embryos and gametes, in compliance with U.S. Food and Drug Administration regulations.

ARTICLE 11. ENFORCEMENT

SECTION 1101. DAMAGES

1. The failure of a provider to comply with this ACT shall constitute unprofessional conduct and may be reported to any controlling licensing authority.
2. In addition to other remedies available at law, a patient whose ART information has been used or disclosed in violation of this Act and who has sustained economic loss, or personal or emotional injury therefrom, may recover compensatory damages, reasonable attorneys fees, and the costs of litigation.
3. Failure to account for all embryos, misuse of embryos, theft of embryos, or unauthorized disposition of embryos shall subject a provider or ART storage facility to criminal and civil penalties, including punitive damages, and reasonable legal fees to the prevailing party.

ARTICLE 12. MISCELLANEOUS PROVISIONS

SECTION 1201. LIMITATION OF MEDICAL PROFESSIONAL LIABILITY

1. Licensed providers rendering services in compliance with practice and ethical guidelines (contemporaneous to the time of alleged breach of the standard of care) or applicable state or federal regulations or statutes are presumed to have rendered care within accepted standards of care.
2. The presumption in paragraph 1 is rebuttable only upon a showing that an issue relating to a standard of care not covered in the practice and ethical guidelines or regulatory or statutory standards, as described in Paragraph 1, exists, and upon a finding that there has been a breach of the standard of care on that issue.
3. No cause of action initiated more than six years after the birth of a child from ART, or more than two years after injury resulting from ART could reasonably have been detected, whichever is greater, shall be valid.

SECTION 1202. SEVERABILITY

1. The invalidation of any part of this legislation by a court of competent jurisdiction shall not result in the invalidation of any other part.