Dear Commission member,

Thank you for your service on the Legislative Commission on Surrogacy. Hundreds of thousands of Minnesotans are dealing with infertility and gestational carrier surrogacy is one option available to them. We are keenly watching the work you are doing on behalf of our advocates and supporters in Minnesota. We appreciate the hours of work you have put into this topic.

At the September 13th Commission meeting, several misleading and false statements were made by Jennifer Lahl. Given the importance of Commission members having accurate information, this letter is to correct the record.

Assertion #1: It is unethical for young women to serve as surrogates because they lack informed consent.

Reality: All known or suspected risks are revealed to and discussed with potential gestational carriers during the Informed Consent process prior to any treatment. All gestational surrogates must complete a full physical and mental health examination prior to moving forward to assure that they are physically and mentally healthy. They must also have independent legal representation to advise them. Gestational carrier surrogates proceed only after completing this process. The fact is that gestational carrier surrogates are much better informed and much more aware of the risks of pregnancy than non-surrogate pregnancies.

Assertion #2: Outcomes are worse for gestational carrier pregnancies and the health of gestational carrier surrogates is put at risk. The CDC doesn't collect data on gestational pregnancies.

Reality: The CDC does collect data. According to a CDC review of gestational carrier pregnancy cycles from 2009-2013 (n = 14,682)[i], gestational carrier pregnancies compared to nongestational pregnancies using IVF have better implantation, clinical pregnancy, live birth and preterm delivery rates. The study notes no difference in the risk of miscarriage or multiple live births rates. Gestational surrogates had a higher birth weight than nongestational carriers for singleton deliveries.

The study notes that the better outcomes for gestational carrier pregnancies are likely due to gestational carrier surrogates being younger and healthier than nongestational IVF pregnancies. The study also points out that the American Society for Reproductive Medicine (ASRM) guidelines that recommend that gestational carriers have had at least one prior, full-term, uncomplicated pregnancy may improve the chances of pregnancy and live birth in Assisted Reproductive Technology (ART) cycles using gestational carriers.

[1] FERTILITY AND STERILITY, September 2015 Trends and outcomes of gestational surrogacy in the United States

Assertion #3: Lupron, a drug used in IVF cycles, puts women at risk. Its use in fertility treatments is dangerous because it is "off-label."

Reality: Lupron is FDA approved for use in women for precocious puberty (a condition causing early puberty in girls), endometriosis (a condition associated with pelvic pain and infertility) and uterine fibroids (benign growths of the muscle of the uterus which can cause pain and heavy menstrual bleeding). When used for these conditions, Lupron is typically given in high doses, which induces shut down of the pituitary gland for a month or more causing a "medically-induced menopause" by stopping ovarian function which helps relieve the symptoms. By contrast, the Lupron used in a fertility treatment cycle by a donor is low dose. The effects of the medications are temporary and once they are stopped, normal hormone signaling and menstrual cycles resume. Lupron is considered to be a very safe and tolerable drug and has been used successfully in fertility treatment for more than 20 years.

In fact, many FDA-approved medications in medical treatment are used off-label. Once a drug has been approved for use, a doctor may legally prescribe this medication for uses or treatment that are not on the approved labeling. Many off-label uses are considered the standard of care. Off-label does not mean unsafe or more risky. The notion that physicians are knowingly putting women at risk by using Lupron is silly. If Ms. Lahl has evidence that a physician is risking the life or health of a patient, she should file a complaint with that physician's licensure board.

Assertion #4: Payments for gestational carrier surrogates should be banned.

Reality: No state has banned payments to gestational carrier surrogates since Florida did so in 1998. Meanwhile, Arkansas and Iowa (1989), California (1993), Oregon (1997), Tennessee (2000), West Virginia and Massachusetts (2001), Texas (2003), Illinois, North Dakota and Utah (2005), Connecticut (2011), Maine (2012), Nevada, Delaware and Wisconsin (2013) and New Hampshire (2014) have passed legislation or seen court rulings supportive of surrogacy that includes payments. Legislation regulating surrogacy is pending today in Washington, D.C., Louisiana, Maryland, New Jersey and New York. We are unaware of any state which has legislation pending that would ban either gestational carrier surrogacy payments or surrogacy. The use of gestational carrier surrogacy arrangements is becoming more common and the response of states has been to propose smart legislation that offers more protections for all parties.

Thank you for the opportunity to address these misstatements, and we would be happy to answer any questions you may have.

Sincerely,

Julie Berman, Board Chair, RESOLVE: The National Infertility Association
Barb Collura, President/CEO, RESOLVE: The National Infertility Association
Owen K Davis, MD, President, American Society for Reproductive Medicine