

Paid Donation: Reconciling Altruism and Compensation in Oocyte Transfer

Saylor S. Soinski*

Abstract:

In the United States, legislation, case law, and professional guidelines have not kept pace with the rapid proliferation of oocyte transfer—commonly known as “egg donation.” As a result, private agencies have disproportionately shaped the oocyte market. Although the market structure has negative consequences for oocyte providers, prohibiting or limiting compensation will not resolve the potential for exploitation. Oocyte transfer has generally relied on altruistic rhetoric, mobilizing the language of “donation” and painting oocytes as freely given gifts. The focus on altruism is gendered, colored by expectations of ideal womanhood and motherhood, and requires oocyte providers to subordinate their own needs. This Comment proposes a federal regulatory framework that would expand existing FDA and CDC programs to affirm the multiple motivations of oocyte providers and establish uniform safeguards.

* Yale Law School, J.D. expected 2023; Brooks Institute, Emerging Scholar Fellow. The author is indebted to Professor Christine Jolls for her supervision, support, and encouragement. Many thanks as well to Chris Umanzor for his thoughtful editing and to Elle Eshleman, Mila Reed-Guevara, and Catalina Odio for their unending care and enthusiasm.

INTRODUCTION	516
I. CURRENT STATE OF OOCYTE TRANSFER	518
A. BACKGROUND.....	518
B. ACTORS SHAPING OOCYTE TRANSFER	520
1. GOVERNMENT ACTORS.....	520
2. COURTS.....	521
3. NONGOVERNMENTAL ORGANIZATIONS.....	522
4. PRIVATE ART AGENCIES	523
II. ALTRUISM AND GENDER IN THE CURRENT SYSTEM	524
A. MOTIVES FOR REGULATION.....	525
B. ALTRUISM IN OOCYTE TRANSFER.....	526
C. ALTRUISM AND GENDER.....	527
D. DANGERS OF ALTRUISTIC RHETORIC	528
E. ADVANTAGES OF ALTRUISTIC RHETORIC	530
F. ADVANTAGES OF COMPENSATION	531
III. PROPOSAL FOR FEDERAL REGULATION	532
A. ABANDONING THE ALTRUISM/COMPENSATION BINARY.....	532
B. PROVIDING FOR FEDERAL REGULATION	533
CONCLUSION	535

INTRODUCTION

In the United States, assisted reproductive technology (ART) has developed rapidly, leading to and following from new understandings of fertility, bodies, and families. The expansion of ART has also encouraged consideration of how reproductive-technology markets may protect or threaten individual liberty.¹ Oocyte transfer, in which immature ova are extracted from one person and implanted into another, is especially relevant to this theme; the implications of a free-market approach have been the focus of most legislation and litigation to date.² These implications are increasingly important as the practice becomes more prevalent. The annual number of oocyte-transfer cycles increased from 10,801 in 2000 to 18,306 in 2010.³ In 2016, the most recent year for which data was available, there were 24,300 oocyte-transfer cycles in the United States.⁴ Nonetheless, there is still little consensus on whether and how oocyte providers should be compensated.

Federal statutes on the topic are nonexistent, and compensation for oocytes is unregulated in nearly every state.⁵ There is a similar dearth of case law; the one

1 Mary Lyndon Shanley, *Collaboration and Commodification in Assisted Procreation: Reflections on an Open Market and Anonymous Donation in Human Sperm and Eggs*, 36 LAW & SOC'Y REV. 257, 258 (2002) (writing that “[t]he way in which we think about and justify [ART] engages important themes of liberal political theory,” including “the extent to which a free market may protect or undercut individual liberty”).

2 Although oocyte and sperm transfer both involve reproductive materials, their symmetry is merely superficial. Radhika Rao, *Coercion, Commercialization, and Commodification: The Ethics of Compensation for Egg Donors in Stem Cell Research*, 21 BERKELEY TECH. L.J. 1055, 1063 (2006). Oocyte transfer is much more invasive, and the potential health risks are far more serious due to hormone treatments given to providers and the surgical nature of oocyte extraction. *Id.* Further, the price of sperm and ova differs by as many as three orders of magnitude, with sperm valued between \$50 and \$100 and oocytes valued as highly as \$150,000. *Id.* Finally, oocyte transfer is distinct from sperm transfer because of the cultural implications of motherhood and the impact of gender on regulation of reproductive materials. Shanley, *supra* note 1, at 265. Due to the meaningful differences between oocyte and sperm transfer as it relates to invasiveness, risk, compensation, and cultural context, this Comment will only discuss oocyte transfer.

3 Jennifer F. Kawwass et al., *Trends and Outcomes for Donor Oocyte Cycles in the United States, 2000-2010*, 310 JAMA 2426, 2428 (2013).

4 Diane Tober et al., *Alignment Between Expectations and Experiences of Egg Donors: What Does It Mean to be Informed?*, 12 REPROD. BIOMEDICINE & SOC'Y ONLINE 1, 2 (2021).

5 See Nancy J. Kenney & Michelle L. McGowan, *Egg Donation Compensation: Ethical and Legal Challenges*, 4 MEDICOLEGAL & BIOETHICS 15, 19 (2014); Kitty L. Cone, *Eggs for Sale: The Scrambled State of Legislation in the Human Egg Market*, 35 U. ARK. LITTLE ROCK L. REV. 189, 192 (2012). There are two exceptions: Louisiana and Florida. Louisiana prohibits compensation for oocytes in no uncertain terms. LA. STAT. ANN. § 9:122 (West 2021) (“The sale of a human ovum, fertilized human ovum, or human embryo is expressly prohibited.”). In contrast, Florida permits “[o]nly reasonable compensation directly related to the donation of eggs.” FLA. STAT. ANN. § 742.14 (West 2021).

significant case addressing compensation for oocyte transfer settled out of court.⁶ While a handful of nongovernmental organizations have promulgated guidelines limiting compensation, these organizations lack any enforcement power and have been largely ignored by fertility clinics.⁷ As a result, private agencies dominate the industry, resulting in the rise of unethical practices including the recruitment of underage providers and varied compensation based on race or ethnicity.⁸

Despite the fact that oocyte providers are paid anywhere from \$1,500 to \$150,000 per cycle;⁹ the centrality of compensation in legislation and litigation; and the mixed motivations reported by oocyte providers,¹⁰ oocyte transfer is typically referred to as “egg donation.” Further, parties to oocyte transfer tend to identify altruism as the primary motivation for oocyte providers.¹¹ The prioritization of altruism demonstrates a lingering resistance to the very idea of an oocyte market in which reproductive materials are exchanged for money. This resistance is amplified by gendered stereotypes of women as selfless providers of reproductive labor.¹² Centering altruism and failing to address oocyte providers’ interest in compensation harms providers by constraining their ability to advocate for their own medical care and communicate truthfully about their motivations.¹³

In order to allow oocyte providers to disclose altruistic and financial motivations while accounting for the real risks of inappropriate compensation, this Comment proposes that the federal government implement a regulatory scheme creating consistent national standards and protections for oocyte providers. In

6 *Kamakahi v. Am. Soc’y for Reprod. Med. & Soc’y for Assisted Reprod. Tech.*, 11-cv-01781-JCS (N.D. Cal. 2015).

7 *See infra* Section I.B.3.

8 *See infra* Section I.B.4.

9 Kimberly D. Krawiec, *Sunny Samaritans and Egomaniacs: Price-Fixing in the Gamete Market*, 72 *LAW & CONTEMP. PROBS.* 59, 66 (2009).

10 Anna Curtis, *Giving ‘Til It Hurts: Egg Donation and the Costs of Altruism*, 22 *FEMINIST FORMATIONS* 80, 95 (2010).

11 Kenney & McGowan, *supra* note 5, at 18.

12 Rene Almeling, *Selling Genes, Selling Gender: Egg Agencies, Sperm Banks, and the Medical Market in Genetic Material*, 72 *AM. SOCIO. REV.* 319, 319 (2007) (reporting that results of interview and observational data from egg agencies and sperm banks show “gendered norms inspire more altruistic rhetoric in egg donation than in sperm donation, producing different regimes of bodily commodification for women and men”). Discussions of reproductive technologies necessarily complicate the distinction between sex, defined as a biological category, and gender, defined by personal identity and sociocultural roles. *Id.* at 321. While this distinction is critical to fully account for a wide range of gender identities and avoid biological essentialization, discussions of human reproduction must refer to sexed bodies and attend to biological factors. RENE ALMELING, *SEX CELLS: THE MEDICAL MARKET FOR EGGS AND SPERM* 174 (2011). This is especially the case when attempting to analyze how cultural constructions of gender influence markets for reproductive materials. While people of different genders may provide oocytes, I will focus on oocyte providers who identify as women in order to analyze the relationship between sociocultural constructions of womanhood and the female-coded body.

13 *See infra* Section II.C.

addition, consistency across states would validate families created using ART and recognize the labor of oocyte providers. The federal government already has the authority to regulate oocyte transfer under the Food and Drug Administration (FDA), and the Center for Disease Prevention and Control (CDC) collects data from all fertility clinics in the United States.¹⁴ Thus, an expansion of systems already in place would allow federal actors to enable participatory policymaking and design regulations that would maintain oocyte supply, improve the wellbeing of oocyte providers, and destigmatize compensated oocyte transfer.

This Comment argues against a system that envisions altruism and compensation as a binary, instead proposing a federal regulatory scheme that would allow parties to center altruism while reducing the potential for exploitation through social norms or compensation. Part I details the current system of oocyte transfer in the United States, unpacking the network of key participants and illuminating how a lack of meaningful regulation has allowed private actors to disproportionately shape the oocyte market. Part II argues that the current motivations for oocyte-transfer regulation are inadequate due to parties' reliance on gendered altruistic rhetoric, then explores the advantages and disadvantages of both altruistic rhetoric and compensation. Part III proposes a structure for federal regulation of the oocyte market that considers both altruism and compensation as legitimate motivations in order to promote the safety and autonomy of oocyte providers.

I. CURRENT STATE OF OOCYTE TRANSFER

As oocyte transfer becomes more prevalent, regulations, case law, and legislation have not kept pace. As a result, private agencies wield the most influence over the development and management of the oocyte market. This Part provides background information on ART and oocyte transfer, then describes the market's primary actors, their interactions with each other, and how the absence of effective regulation has allowed private groups to disproportionately influence the market.

A. Background

ART has existed in some form for millennia.¹⁵ At present, the CDC defines

14 21 C.F.R. § 1271 (2020) (establishing FDA authority over transferred oocytes); *National ART Surveillance*, CENTERS FOR DISEASE CONTROL AND PREVENTION (Mar. 12, 2021), <https://www.cdc.gov/art/nass/index.html>.

15 For example, researchers have found that Vedic populations existing between 1500 and 500 B.C.E. were familiar with artificial insemination. Radhey Shyam Sharma, Richa Saxena & Rajeev Singh, *Infertility & Assisted Reproduction: A Historical & Modern Scientific Perspective*, 148 INDIAN J. MED. RSCH. S10, S11 (2018).

ART as “all fertility treatments in which either eggs or embryos are handled.”¹⁶ Due to the medical complexity of the operation, oocyte transfer became possible relatively recently,¹⁷ and the practice is rapidly growing. From 2005 to 2016, the overall demand for transferred eggs increased by fifty percent.¹⁸ Supply has risen to meet increased demand in areas that allow for compensation, with donors being paid up to \$150,000 for a single extraction cycle.¹⁹

Due to the relative recency of oocyte-transfer technology, the long-term risks of oocyte provision are not yet known.²⁰ However, studies suggest that the medications used in preparation for oocyte provision expose providers to dangerous health risks.²¹ While there is disagreement over the extent and likelihood of these effects, potential risks include psychological problems; ovarian hyperstimulation syndrome; infertility; and breast, ovarian, and endometrial cancers.²² Though not addressed in this Comment, the absence of comprehensive information about health outcomes for providers generates important questions about informed consent and appropriate compensation.²³

The United States is an outlier as one of the only countries that permits compensation for oocyte transfer, creating an international market based in the

16 *What is Assisted Reproductive Technology?*, CENTERS FOR DISEASE CONTROL AND PREVENTION (last visited Mar. 6, 2022), <http://www.cdc.gov/art/whatis.html>. The Center for Disease Control (CDC) notes that ART does “NOT include treatments in which only sperm are handled . . . or procedures in which a woman takes medicine only to stimulate egg production.” *Id.*

17 The first pregnancy using transferred ova was reported in 1983. Michelle Sargent, *Regulating Egg Donation: A Comparative Analysis of Reproductive Technologies in the United States and United Kingdom*, 4 MICH. J. PUB. AFFS. 1, 2 (2007).

18 Tober, *supra* note 4, at 2.

19 Rao, *supra* note 2, at 1063.

20 Tober, *supra* note 4, at 2 (“[O]ne of the most striking facts about in vitro fertilization is how little is known with certainty about the long term health outcomes for women who undergo this procedure.” (quoting INST. MED. & NAT’L RSCH. COUNCIL, ASSESSING THE MEDICAL RISKS OF HUMAN OOCYTE DONATION FOR STEM CELL RESEARCH 4 (2007))).

21 Cone, *supra* note 5, at 198. While outcomes for oocyte providers are understudied, oocyte providers have shown an increased incidence of ovarian failure, reduced fertility, and cancer. *Id.*

22 *Id.* at 199-201.

23 Issues related to informed or “true” consent are outside the scope of this Comment and therefore are not closely analyzed. For an overview of the challenges of providing informed consent to prospective providers, see Naomi Cahn & Jennifer Collins, *Fully Informed Consent for Prospective Egg Donors*, 16 AMA J. ETHICS 49 (2014). See also Amanda Skillern, Marcelle Cedars & Heather Huddleston, *Egg Donor Informed Consent Tool (EDICT): Development and Validation of a New Informed Consent Tool for Oocyte Donors*, 99 FERTILITY STERILITY 1733 (2013) (designing an informed consent questionnaire for oocyte providers); Amanda A. Skillern, Marcelle I. Cedars & Heather G. Huddleston, *Oocyte Donors’ Comprehension as Assessed by EDICT (Egg Donor Informed Consent Tool)*, 101 FERTILITY & STERILITY 248 (2014) (reporting outcomes of using an informed consent questionnaire to assess oocyte providers’ comprehension of the process and risks); A.D. Gurmankin, *Risk Information Provided to Prospective Oocyte Donors in a Preliminary Phone Call*, 1 AM. J. BIOETHICS 3 (2001) (finding that a majority of surveyed oocyte transfer agencies provided “incomplete and/or inaccurate risk information” to potential providers).

United States.²⁴ Despite its global centrality, the U.S. oocyte market is essentially unregulated.²⁵ This lack of regulation has allowed unethical behaviors by institutional or individual parties to remain unchecked. For example, medical practitioners recommend that oocyte providers limit themselves to six provisions because of uncertainty about health risks.²⁶ However, some providers conceal previous provisions to remain eligible, and some agencies intentionally avoid asking about earlier provision cycles.²⁷ Further, oocyte transfer agencies are rarely operated by medical professionals despite the highly medicalized nature of the work, creating another set of bioethical concerns.²⁸

B. Actors Shaping Oocyte Transfer

There are four central actors with the capacity to meaningfully shape the oocyte market: government actors, courts, nongovernmental organizations, and private ART agencies. This Section describes the efforts and impact of each of these actors.

1. Government Actors

Statutes about oocyte transfer are limited, and politicians avoid engaging with the potentially incendiary issue.²⁹ There are no federal statutes regarding oocyte transfer, and most states do not have any legislation about compensation for oocyte

24 Robert Klitzman, *Buying and Selling Human Eggs: Infertility Providers' Ethical and Other Concerns Regarding Egg Donor Agencies*, 17 BMC MED. ETHICS 71, 72 (2016).

25 The only existing regulations are recommended guidelines that largely go unfollowed. *Infra* Section I.B.1 & Section I.B.4.

26 See, e.g., *FAQ: Common Questions for Egg Donors*, UCSF HEALTH, <https://www.ucsfhealth.org/education/faq-common-questions-for-egg-donors>.

27 Klitzman, *supra* note 24, at 78.

28 *Id.*

29 *Id.*; see also Erin Heidt-Forsythe & Heather Silber Mohamed, *The Politics of Assisted Reproduction, Explained*, WASH. POST (May 13, 2018), <https://www.washingtonpost.com/news/monkey-cage/wp/2018/05/13/on-mothers-day-here-are-5-things-to-know-about-the-politics-of-assisted-reproduction> (describing various religious groups' opposition to ART and other stigma surrounding the technology); RUTH DEECH & ANNA SMAJDOR, *FROM IVF TO IMMORTALITY: CONTROVERSY IN THE ERA OF REPRODUCTIVE TECHNOLOGY* (2007) (detailing some of the many potential controversies that may arise with expanded ART).

providers.³⁰ Currently, only Louisiana explicitly prohibits the sale of human ova.³¹ Florida is the only state to explicitly permit such sales, allowing “reasonable compensation directly related to the donation of eggs” but failing to define “reasonable compensation.”³² A potential model for future regulations, California is the only state that directly regulates fertility clinics.³³ The California Family Code includes detailed instructions for how ART agencies should manage client funds and imposes limits on agencies’ own financial interest in provision.³⁴ Additionally, the Code sets standards for assisted-reproduction agreements and procedural requirements for courts assessing such agreements.³⁵ While clearly concerned with protecting the interests of oocyte providers and recipients alike, California has stopped short of regulating compensation amounts or other elements more likely to directly influence the market.

2. Courts

Case law surrounding oocyte transfer is extremely limited, and many complications and instances of malpractice go unaddressed.³⁶ The most relevant piece of case law, *Kamakahi v. American Society for Reproductive Medicine*, arose

30 The following states do not statutorily address compensation or other requirements for oocyte transfer: Alabama, Alaska, Arizona, Arkansas, Colorado, Connecticut, Delaware, the District of Columbia, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Washington, Virginia, West Virginia, Wisconsin and Wyoming. Some state statutes banning the sale of body parts broadly contain exceptions for renewable materials such as blood or hair. However, it is not clear whether oocytes are considered renewable resources. Although their number is finite, they are so multitudinous as to function more similarly to blood than to a kidney. *See Rao, supra* note 2, at 1057. Some states currently rely on the 2002 Uniform Parentage Act (UPA) for any mention of oocyte transfer, but the UPA only covers parentage rights. These states are Alabama, ALA. CODE § 26-17-101 to 26-17-905 (2021), Delaware, DEL. CODE ANN. tit. 13, §§ 8-101 to 8-904 (West 2021), New Mexico, N.M. STAT. ANN. §§ 40-11A-701 to 903 (2018), North Dakota, N.D. CENT. CODE §§ 14-20-01 to 14-20-66 (2021), Texas, TEX. FAM. CODE ANN. §§ 160.001-763 (West 2021), Utah, UTAH CODE ANN. §§ 78B-15-101 to 78B-15-902 (West 2021), and Washington, WASH. REV. CODE ANN. §§ 26.6a.005-903 (West 2021). Other states similarly only address parentage rights, including Colorado, COLO. REV. STAT. ANN. § 19-4-16 (West 2021), New Hampshire, N.H. REV. STAT. ANN. § 168-B:6 (2021), Oklahoma, OKLA. STAT. ANN. tit. 10, § 557 (West 2021), Virginia, VA. CODE ANN. § 20-158 (West 2021), and Wyoming, WYO. STAT. ANN. §§ 14-2-401 to 14-2-408 (West 2021).

31 LA. STAT. ANN. § 9:122 (West 2021) (“The sale of a human ovum, fertilized human ovum, or human embryo is expressly prohibited.”).

32 FLA. STAT. ANN. § 742.14 (West 2021).

33 CAL. FAM. CODE §§ 7960-62 (West 2021).

34 *Id.* § 7961.

35 *Id.* § 7962.

36 Cone, *supra* note 5, at 196 n.23 (listing incidents where serious complications or malpractice that negatively affected oocyte providers did not lead to any change in the case law).

in response to guidelines set out by regulatory organizations.³⁷ The complaint, filed on behalf of a class of oocyte providers, alleged that compensation-limiting guidelines promulgated by the American Society for Reproductive Medicine (ASRM) were a “naked price-fixing” agreement.³⁸ If this were true, the guidelines would be a per se violation of the Sherman Act—a federal statute that prohibits activities that restrict commerce and competition.³⁹ This per se designation would mean the guidelines were so injurious that they should be presumed illegal without inquiry into whether actual harm occurred.⁴⁰ Because this case ultimately settled out of court, the application of antitrust law to the oocyte industry remains one of first impression.

3. Nongovernmental Organizations

Attempts at regulation have mainly come in the form of suggested guidelines proliferated by ASRM, the National Academy of Sciences (NAS), and the California Institute for Regenerative Medicine (CIRM). The NAS and CIRM guidelines categorically prohibit payments for oocyte transfer.⁴¹ ASRM guidelines formerly prohibited compensation above \$10,000 and required “justification” for payments in excess of \$5,000.⁴² Now, they do not suggest a specific price range, instead simply requiring that compensation “be fair and not used as an undue enticement that will lead prospective donors to discount risks.”⁴³ None of these recommendations carries the force of law; rather, these organizations encourage stakeholders and funding agencies to promote compliance by imposing sanctions or withholding funding.⁴⁴ Because organizations like NAS, CIRM, and ASRM cannot monitor compliance or enforce their guidelines, their attempts at regulation have been largely ineffective. Despite widespread membership in these

37 *Kamakahi v. Am. Soc’y for Reprod. Med. & Soc’y for Assisted Reprod. Tech.*, 11-cv-01781-JCS (N.D. Cal. 2015).

38 Complaint for Petitioner at 16, *Kamakahi v. Am. Soc’y for Reprod. Med. & Soc’y for Assisted Reprod. Tech.*, 11-cv-01781-JCS (N.D. Cal. 2015) (No. 3:11-cv-01781). *See also* Kimberly D. Krawiec, *Egg-Donor Price Fixing and Kamakahi v. American Society for Reproductive Medicine*, 16 *AMA J. ETHICS* 57, 58 (2014) (discussing the content of the complaint).

39 Sherman Antitrust Act, 15 U.S.C. §§ 1-38 (2018).

40 Krawiec, *supra* note 38, at 58. Considering the ineffectiveness of the regulations, it is unlikely the providers would have been able to demonstrate actual harm had occurred as a result of the guidelines.

41 Rao, *supra* note 2, at 1057.

42 Stephanie Karol, *The Market for Egg Donation*, 28 *DUKE J. ECON* 1, 2 (2016).

43 Ethics Committee of the American Society for Reproductive Medicine, *Financial Compensation of Oocyte Donors: An Ethics Committee Opinion*, 116 *FERTILITY & STERILITY* 319, 322 (2021). The ASRM guidelines also require that compensation not be conditioned on retrieval or number of oocytes retrieved, that donors not be required to pay for an interrupted cycle, and that compensation not “vary according to the number or quality of oocytes retrieved.” *Id.*

44 Rao, *supra* note 2, at 1057.

organizations, most clinic advertisements and policies do not comply with the guidelines.⁴⁵

4. Private ART Agencies

In the absence of effective statutes, case law, or professional regulations, private ART agencies have a strong influence on the landscape of the oocyte market. Although some fertility clinics are affiliated with hospitals,⁴⁶ the industry was initially comprised of standalone clinics. However, the \$25 billion industry⁴⁷ has drawn the attention of private-equity investors who buy shares from doctors who co-own fertility clinics.⁴⁸ Unsurprisingly, these investors prioritize expansion of the market with little concern for the consequences of commodification.⁴⁹ One in vitro fertilization (IVF) doctor-turned-investor expressed his desire to expand the reach of ART by saying the industry “need[s] the IVF version of the Holiday Inn.”⁵⁰

These actors are financially incentivized to advocate against meaningful guidelines or restrictions on oocyte transfer.⁵¹ One study found that a majority of

45 One study found that “81% of agency and 96% of clinic ads on Craigslist were non-compliant with ARSM guidelines,” including 85% of those agencies and clinics that were registered with the Society of Assisted Reproductive Technologies (SART), another regulatory organization. Klitzman, *supra* note 24, at 72. In 2016, almost 60% of egg donor agencies explicitly stated that they vary compensation based on donor traits in direct violation of ARSM guidelines. *Id.* Around 46% of agency websites sought donors younger than the ASRM-recommended age limit of 21. *Id.* See also Aaron D. Levine, *Self-Regulation, Compensation, and the Ethical Recruitment of Oocyte Donors*, 40 HASTINGS CTR. REV. 25, 28-33 (2010) (“[A] study examined how well sixty-six oocyte donor and surrogacy agencies that had previously signed an agreement with SART to abide by ASRM guidelines had actually complied with them. The study found that a ‘substantial number of egg donor agencies in the United States’ had not.” (citing Janelle Luk & John C. Petrozza, *Evaluation of Compliance and Range of Fees Among American Society for Reproductive Medicine-listed Egg Donor and Surrogacy Agencies*, 53(11) J. REPROD. MED. 847 (2008))).

46 See, e.g., REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY, <https://www.mountsinai.org/care/obgyn/services/reproductive-endocrinology-infertility> (last visited Dec. 31, 2021); FERTILITY CENTER, <https://www.massgeneral.org/obgyn/fertility> (last visited Dec. 31, 2021); FERTILITY CENTER, <https://www.yalemedicine.org/departments/fertility-center> (last visited Dec. 31, 2021).

47 *The Fertility Business is Booming*, ECONOMIST, <https://www.economist.com/business/2019/08/08/the-fertility-business-is-booming>. One research firm has predicted that by 2026, the global fertility industry will be worth \$41 billion. *Id.*

48 Rebecca Robbins, *Investors See Big Money in Infertility. And They’re Transforming the Industry*, STAT (Dec. 4, 2017), <https://www.statnews.com/2017/12/04/infertility-industry-investment>.

49 Private equity firms are also interested in cutting costs and monetizing patient data. *The Fertility Business is Booming*, *supra* note 47.

50 Robbins, *supra* note 48.

51 See, e.g., Rachel Strodel, *Fertility Clinics Are Being Taken Over by For-Profit Companies Selling False Hope*, NBC THINK (Mar. 1, 2020), <https://www.nbcnews.com/think/opinion/fertility->

oocyte-transfer agencies provided “incomplete and/or inaccurate” information to potential providers in violation of organizational guidelines.⁵² Further, these agencies have been found to run advertisements that do not comply with guidelines,⁵³ vary compensation based on donor traits including race and ethnicity,⁵⁴ and seek providers who are younger than the recommended minimum age of 21.⁵⁵ The director of the division of Medical Ethics at New York University’s School of Medicine described the fertility industry as “a field characterized by strong anti-regulatory sentiment because it evolved as a business, not a research enterprise.”⁵⁶ As a result, ineffective organizational guidelines and limited state statutes are the only sources of regulation available to counter the outsized influence of private ART agencies.

II. ALTRUISM AND GENDER IN THE CURRENT SYSTEM

Altruism plays a prominent role in oocyte transfer, as evidenced by the parlance of “donation.” However, existing regulations and attempts at further regulation have ignored the role of altruism, instead focusing too extensively on compensation. The failure of regulations to acknowledge and address the influence of altruistic rhetoric leaves oocyte providers unprotected from gendered social pressures that lead to unsafe behaviors, such as an unwillingness to voice medical concerns. Section II.A details the two central motives for existing regulation before arguing that these motives are inadequate to protect oocyte providers in a system whose primary virtue is altruism. Section II.B describes the prevalence of altruistic rhetoric in oocyte transfer, and Section II.C contextualizes this prevalence as it relates to gender. This Part concludes with a discussion of the harms created by an obsession with altruism (Section II.D), the benefits of altruistic rhetoric (Section II.E), and the benefits of compensation (Section II.F).

clinics-are-being-taken-over-profit-companies-selling-false-ncna145671. Some critics argue that ASRM actually intends to limit government regulation, as the ineffectiveness of their own regulations advances the business interests of their members. Michael Ollove, *States Not Eager to Regulate Fertility Industry*, PEW RSCH. (Mar. 18, 2015), <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/3/18/states-not-eager-to-regulate-fertility-industry>.

52 A.D. Gurmankin, *Risk Information Provided to Prospective Oocyte Donors in a Preliminary Phone Call*, 1 AM. J. BIOETHICS 3 (2001) (finding that a majority of surveyed oocyte transfer agencies provided “incomplete and/or inaccurate risk information” to potential providers).

53 Klitzman, *supra* note 24, at 72.

54 *Id.*

55 *Id.*

56 *Id.*

A. Motives for Regulation

Attempts at regulation have generally been driven by two motivations. The first is the fear that payment will unduly influence women to provide oocytes, and some regulatory actors believe that prohibitions on payment are necessary to ensure true consent.⁵⁷ Concerns arise when payment is either so high that it would entice women who would not otherwise choose to provide or so low that the amount would only attract those in desperate need of money.⁵⁸ The fear of exploitation is accompanied by the fear that financial incentives will encourage potential providers to lie about their medical history in order to extend their eligibility or increase their chances of being matched with a recipient.⁵⁹

The second concern that drives regulation is more philosophical: the fear that payment commodifies the components of human life in a way that is morally or ethically unsound. The ethical debate about paying women for oocytes has often hinged on whether oocytes inhabit (or ought to inhabit) a special category of objects that cannot or should not be commodified.⁶⁰ Parties fear that payment will degrade the value or meaning of something they believe should remain wholly separate from market forces.⁶¹ This concern stems from the assumption that a “gift” object, which can be exchanged but is not commodified, is fundamentally different from a “commodity.”⁶² That is, to commodify an object by trading it in the market changes something fundamental to the object itself.

Considering these motivations, it is perhaps unsurprising that regulatory standards and state statutes have focused almost entirely on compensation. However, due to the centrality of altruism, even effective restrictions or prohibitions on compensation would not sufficiently address the potential for exploitation in oocyte provision. While compensation does raise legitimate concerns, it also has advantages for providers who may be more willing to advocate for their own needs when compensated.⁶³ In addition, a fixation on providers’ altruistic motivations can place additional burdens on providers attempting to navigate a complex exchange relationship.⁶⁴ In other words, existing motives for regulation are inadequate because they overplay the risks of compensation and neglect the risks generated by a “donation” system.

57 Rao, *supra* note 2, at 1057; *see supra* note 23 (discussing consent generally).

58 Rao, *supra* note 2, at 1062.

59 Karol, *supra* note 42, at 15.

60 Kenney & McGowan, *supra* note 5, at 17.

61 Rao, *supra* note 2, at 1057.

62 For writing on the distinction between exchange goods and gifts, see generally, Jonathan Parry, *The Gift, the Indian Gift, and the 'Indian Gift'*, 21 MAN 453 (1986).

63 *See infra* Section II.F.

64 *See infra* Section II.D.

B. Altruism in Oocyte Transfer

That regulation has almost exclusively attempted to set limits on payment reflects discomfort with the idea of a compensated human ova market. Additionally, institutions involved in oocyte transfer demonstrate an aversion to considering the transfer a market exchange, even while they provide large sums of money in exchange for a discrete product.⁶⁵ Indeed, when confronted with this tension, participants in the fertility industry insist they are not in the business of purchasing eggs, instead preferring to use the term “donation.”⁶⁶ Parties to oocyte transfer thus frame the oocyte as a gift and avoid the discomfort of openly commodifying human parts.⁶⁷

Further, the focus on the oocyte as a gift indicates parties’ preference for a provider who is motivated by an internal inclination towards altruism. One physician stated that despite paying providers thousands of dollars, they “like to see some altruism.”⁶⁸ An analysis of eighty-nine oocyte-transfer agency websites found that the language used centered emotion, caring, and kindness.⁶⁹ In fact, some oocyte-transfer institutions directly contrasted altruism with an interest in compensation. One website stated, “Egg donation can be a rewarding and satisfying experience, but any woman considering the procedure primarily for financial reasons is discouraged from participating.”⁷⁰ A number of agency websites include advice or models for oocyte providers writing “donor statements.” Each includes guidance on how a provider should explain why they are participating—none of which mentions compensation. Instead, the agencies encourage women to “discuss what motherhood means to [them] . . . , if [they] know someone who has struggled with infertility, or why [they] have decided donating [their] eggs is something [they] feel *compelled* to do for others.”⁷¹

65 Karol, *supra* note 42, at 1.

66 Kenney & McGowan, *supra* note 5, at 18.

67 Karol, *supra* note 42, at 1. For more on obfuscation techniques used by parties to “disreputable” exchanges, see Gabriel Rossman, *Obfuscatory Relational Work and Disreputable Exchange*, 32 SOCIO. THEORY 43 (2014).

68 Rene Almeling, *Gender and the Value of Bodily Goods: Commodification in Egg and Sperm Donation*, 72 LAW & CONTEMP. PROBS. 37, 46 (2009). The physician considered altruism to be an indication that a provider is “less likely to have regrets down the line.” *Id.*

69 Curtis, *supra* note 10, at 87 (“Half [of the websites] made a direct pitch to recruit donors by using words like ‘altruism,’ ‘gift,’ ‘miracle,’ and ‘making dreams happen.’”).

70 *Id.* at 88.

71 *Tips for Completing Your Egg Donor Profile*, SHADY GROVE FERTILITY, <https://www.shadygrovefertility.com/become-egg-donor/completing-egg-donor-profile> (emphasis added). Another website encourages women to “go deep” and “[w]rite about how [they] feel [their] gift will have an impact on the lives of the hopeful parents,” as well as “what [they] hope to gain from the experience.” *Advice for Writing a Good Egg Donor Profile*, OVATION DONOR SRVS., <https://www.ovationeggdonor.com/egg-donors/advice-for-writing-a-good-egg-donor-profile>. One model letter states, “Every time I have injected myself with this medication, I have been very happy

C. Altruism and Gender

Framing an oocyte as an inconvertible gift even while exchanging it for money betrays the influence of gender on the work of transfer institutions and the experience of oocyte providers. Whereas compensation for sperm providers has never received much attention, compensation for oocyte providers has been hotly contested in the public sphere.⁷² The merits of compensated oocyte transfer have been questioned in the headlines of geographically and ideologically diverse newspapers,⁷³ been the subject of many personal essays,⁷⁴ and garnered charged comments from politicians.⁷⁵ While the increased costs and risks of oocyte provision as opposed to sperm provision might demand an increased response, the difference is at least partly generated by gendered assumptions about parties' investment in reproduction and their biological materials. That is, women are expected to feel an attachment to their reproductive material, whereas men are not. In an interview, a physician-researcher who ran an oocyte- and sperm-provision center explicitly stated their belief that "[men] have less attachment of their sperm than women do of their eggs."⁷⁶

knowing that you and your family are so close to having your own child." Egg Donor & Surrogacy Program, *Donor Angel Letter to Recipients*, HATCH EGG DONATION & SURROGACY (Nov. 30, 2017), <https://www.hatch.us/blog/letter-from-egg-donor-to-recipient>.

⁷² Almeling, *supra* note 68, at 45.

⁷³ E.g., Jacoba Urist, *How Much Should a Woman Be Paid for Her Eggs?*, ATLANTIC (Nov. 4, 2015), <https://www.theatlantic.com/health/archive/2015/11/how-much-should-a-woman-be-paid-for-her-eggs/414142>; Rose Eveleth, *Should Women Be Paid for Their Eggs?*, SMITHSONIAN MAG (Aug. 15, 2013), <https://www.smithsonianmag.com/smart-news/should-women-be-paid-for-their-eggs-85973>; David Tuller, *Payment Offers to Egg Donors Prompt Scrutiny*, N.Y. TIMES (May 10, 2010), <https://www.nytimes.com/2010/05/11/health/11eggs.html>; Gina Kolata, *Price of Donor Eggs Soars, Setting Off a Debate on Ethics*, N.Y. TIMES (Feb. 25, 1998), <https://www.nytimes.com/1998/02/25/us/price-of-donor-eggs-soars-setting-off-a-debate-on-ethics.html>; Jan Hoffman, *Egg Donations Meet a Need and Raise Ethical Questions*, N.Y. TIMES (Jan. 8, 1996), <https://www.nytimes.com/1996/01/08/us/egg-donations-meet-a-need-and-raise-ethical-questions.html>.

⁷⁴ E.g., Erika W. Smith, *I Donated My Eggs & This Is What It Was Like*, REFINERY29 (Feb. 11, 2020), <https://www.refinery29.com/en-us/egg-donor-stories>; Lauryn Chamberlain, *I'm an Egg Donor. Why Was It So Difficult for Me to Tell People That?*, MARIE CLAIRE (Aug. 10, 2021), <https://www.marieclaire.com/health-fitness/a37170635/egg-donor-shame>; Justine Feron, *The Eggs I Sold, the Baby I Gained*, N.Y. TIMES (Jan. 22, 2021), <https://www.nytimes.com/2021/01/22/well/family/egg-donor-complications.html>; Jamaïne Krige, *I (or 3) in a Million: My Experience as a Repeat Egg Donor*, HEALTHLINE (Oct. 28, 2020), <https://www.healthline.com/health/parenting/my-experience-as-a-repeat-egg-donor>.

⁷⁵ Cf. Michael Hiltzik, *Column: Should We Pay Women to Donate Their Eggs for Research? No, and here's why*, L.A. TIMES (July 22, 2016), <https://www.latimes.com/business/hiltzik/la-fi-hiltzik-egg-donors-20160722-snap-story.html> (reporting that California Governor Jerry Brown vetoed a bill that would have allowed women to be compensated for providing oocytes for scientific research on the basis that "[n]ot everything in life is for sale, nor should it be").

⁷⁶ Almeling, *supra* note 68, at 46 (quoting Interview by Rene Almeling with Physician-

The emphasis on altruism is distinctly gendered. Historically, when society has suggested altruism rather than money as the motivation for labor, the activity in question has generally been considered “women’s work.”⁷⁷ While some studies have noted the ways in which organizations produce and rely on altruism, they have typically disregarded the role of gender.⁷⁸ However, researchers have found that women are expected to perform more uncompensated emotional labor in their jobs. For example, a foundational 1977 study found women occupied more “nurturing” roles in U.S. corporations,⁷⁹ and professions that center empathy are still largely dominated by women.⁸⁰ Additionally, women are more likely to be perceived as motivated by altruism rather than financial compensation.⁸¹ This phenomenon is especially strong in oocyte transfer, as it is amplified by ideals of motherhood that paint women as selfless. While oocyte providers may be seen as giving the “gift of motherhood” to a recipient, sperm providers are not typically portrayed as giving the “gift of fatherhood” to intended fathers. While this framing may be comforting for oocyte providers and recipients alike, it can translate into material harms for providers.

D. Dangers of Altruistic Rhetoric

The gendered rhetoric of altruism negatively impacts providers by framing oocyte transfer as a contract that does not create mutual obligations between providers and recipients. This lack of mutuality creates a power imbalance that plays out in the rest of the provider-recipient relationship. As this Section explains, a focus on providers’ altruism puts women at risk by rendering them less likely to advocate for their own medical care and creating a stigma that burdens their ability to communicate about their motivations.⁸²

Parties’ preference for altruism can lead to the expectation that an oocyte provider will act with a lack of self-concern, reducing her voice and agency in her own medical care. Researchers have found that oocyte providers who view their

Researcher #3 (March 2006)).

⁷⁷ Curtis, *supra* note 10, at 94 (quoting Lori Andrews, *Surrogate Motherhood: The Challenge for Feminists*, in *THE ETHICS OF REPRODUCTIVE TECHNOLOGY* 205-19 (Kenneth Alpern, ed., 1992)).

⁷⁸ Almeling, *supra* note 12, at 322.

⁷⁹ *Id.* (citing ROSABETH M. KANTER, *MEN AND WOMEN OF THE CORPORATION* (1977)).

⁸⁰ See, e.g., Katherine Hekker, *Women Are the Majority in Education, Yet Still Find Themselves Overlooked for Promotions and Making Less Than Their Male Peers*, *BUS. INSIDER* (Jun. 30, 2021), <https://www.businessinsider.com/women-teachers-administrators-gender-pay-gap-public-schools-education-2021-6> (reporting that in 2018, 76% of U.S. teachers were women).

⁸¹ Almeling, *supra* note 12, at 322.

⁸² These issues arise in addition to the problematic reification of gendered stereotypes. See Curtis, *supra* note 10, at 82 (describing how gendered rhetoric relies on outdated and sexist ideologies).

contribution as a sacrificial gift are less alert for potential health risks.⁸³ In contrast, oocyte providers who are able to acknowledge financial motivations demonstrate higher expectations for their doctors and recipients.⁸⁴ Expectations of altruism also encourage women to provide oocytes more frequently, even when they did not initially plan to provide again. These later provisions occur when a provider feels a sense of loyalty or investment in the recipients' family,⁸⁵ allowing social pressures to inappropriately influence a private medical decision.

For women, altruism is seen as the most acceptable motivation for providing reproductive materials.⁸⁶ Further, the industry continues to be dominated by the idea that financial motivations, to some extent, preclude the existence of altruistic motivations.⁸⁷ This perception of mutual exclusivity conflicts with the real motivations reported by oocyte providers. A study of nine possible motivations found that altruism and compensation together were the primary motivational factors for women to become oocyte providers.⁸⁸ These findings are affirmed by qualitative research in which oocyte providers reported altruistic and financial motivations in equal measure.⁸⁹

Forcing oocyte providers to report altruism as their sole or primary motivation creates a situation in which they must hide information from their medical providers. In an interview, one oocyte provider said that her financial motivations made her "feel like a horrible person."⁹⁰ Feelings of shame and a need for secrecy burden oocyte providers as they attempt to make complex medical and ethical decisions. Women must hide any interest in financial compensation while the same work is not required of men.⁹¹ These effects also extend beyond the individual as an expression of the social discomfort that still surrounds compensation for women's labor.⁹² Stigma around compensation for oocyte transfer risks reinforcing the idea that compensation for women's labor is inappropriate or unnecessary.⁹³

83 *Id.* at 93.

84 *Id.* at 95.

85 *Id.*

86 *See* Section II.A.

87 Curtis, *supra* note 10, at 83.

88 Sherrie A. Kossoudji, *The Economics of Assisted Reproduction* 10 (IZA Bonn, Discussion Paper No. 1458, 2005).

89 Curtis, *supra* note 10, at 95 (noting that many interviewed oocyte providers were "motivated by both altruism and the desire to be financially compensated").

90 *Id.* at 82.

91 ALMELING, *supra* note 12, at 56.

92 Curtis, *supra* note 10, at 83; *see also* Gabrielle Meagher, *Is It Wrong to Pay for Housework?*, 17 *HYPATIA* 52, 52 (2002) ("Commerce seems most controversial in those activities—sex, procreation, personal care and housework—traditionally understood to be rightly undertaken by wives within matrimonial rather than market relationships.").

93 Krawiec, *supra* note 38, at 63.

E. Advantages of Altruistic Rhetoric

Despite the negative impacts of prioritizing altruism, an attempt to remove altruistic rhetoric from the discourse is neither advisable nor realistic. Discomfort with the sale of body parts for monetary gain—especially reproductive parts—is so deeply embedded in cultural norms that altruistic rhetoric is likely to persist absent a significant cultural shift in understandings of motherhood and reproductive labor.⁹⁴ Relieving some of this discomfort is not necessarily an obfuscation of reality; oocyte providers continue to report altruism as a significant motivation even when their answers are anonymous.⁹⁵ It is important for oocyte providers to be able to refer to their provision in the way that feels most truthful and comfortable.

Maintaining altruistic rhetoric also prevents what behavioral economists term “crowd-out effects.”⁹⁶ A crowd-out effect occurs when the introduction of an extrinsic incentive (in this case, money) displaces an intrinsic incentive (in this case, feelings of altruism) and leads to reduced participation.⁹⁷ For example, empirical studies have shown that individuals might be less willing to donate blood when offered payment, as the offer reduces the amount of intrinsic motivation felt by the potential donor.⁹⁸ One explanation for this effect could be that extrinsic incentives diminish “image motivation,” as someone may behave pro-socially by donating blood or providing oocytes to encourage others to think of them as kind or generous.⁹⁹ Another possible explanation is that the amount of money exchanged is viewed as a “price,” which providers see as changing something integral to the bodily product,¹⁰⁰ devaluing their contribution, or indicating something unpleasant about the task.¹⁰¹

94 *Id.* at 90. Oocyte transfer has been called “egg donation” since the first years of the technology. *See, e.g.,* Associated Press, *Clinic in Ohio Starts Egg Donor Plan*, N.Y. TIMES, July 15, 1987, at A16, <https://www.nytimes.com/1987/07/15/us/clinic-in-ohio-starts-egg-donor-plan.html>; Nadine Brozan, *Rising Use of Donated Eggs for Pregnancy Stirs Concern*, N.Y. TIMES, Jan. 18, 1988, at A1, <https://www.nytimes.com/1988/01/18/us/rising-use-of-donated-eggs-for-pregnancy-stirs-concern.html>; Frances Grandy Taylor, *Some Women Donate Their Eggs so Others Can Have Children*, HARTFORD COURANT (Feb. 13, 1996), <https://www.courant.com/news/connecticut/hc-xpm-1996-02-13-9602130038-story.html>.

95 *See supra* notes 86-93 and accompanying text.

96 Emir Kamenica, *Behavioral Economics and Psychology of Incentives*, 4 ANN. REV. ECON. 427, 444 (2012).

97 *Id.*; WILLIAM J. CONGDON ET AL., POLICY AND CHOICE: PUBLIC FINANCE THROUGH THE LENS OF BEHAVIORAL ECONOMICS 124 (2011).

98 CONGDON, *supra* note 97, at 124.

99 Uri Gneezy et al., *When and Why Incentives (Don't) Work to Modify Behavior*, J. ECON. PERSPS. 191, 201 (2011).

100 This concern parallels one of the central motives for regulation discussed in Section II.A. *See text accompanying notes 60-63.*

101 Bruno S. Frey & Reto Jegen, *Motivation Crowding Theory: A Survey of Empirical Evidence*

By prioritizing a rhetoric of altruism, parties to oocyte transfer may incidentally avoid the “crowding out” of intrinsic motivations, instead painting compensation as a means to facilitate the altruistic act or a reward for one’s generosity.¹⁰² The language of donation obscures the exchange, making it more difficult for an outside party to determine the actors’ motivations (which, based on the data, are most likely to be a mix of extrinsic and intrinsic).¹⁰³ In this way, providers retain image motivation, as they will be recognized as motivated by intrinsic generosity rather than financial incentives. Providers also avoid the implication that compensation is a “price” for a body part and the stigma associated with commodification of the body. Finally, if compensation is viewed as a technicality or a reward for an altruistic act, providers are unlikely to feel their contribution is devalued or that the task is so unpleasant as to require compensation.¹⁰⁴

F. Advantages of Compensation

Due to the invasive, personal, and potentially dangerous nature of oocyte provision, prohibiting compensation would likely reduce oocyte supply far below the demand. Further, compensation for oocyte provision is critical as the reproductive labor market simultaneously becomes more complex and more commonplace. Seeking compensation for potentially dangerous, highly valued labor should not be a subversive act. Compensating oocyte provision recognizes that a woman may act altruistically without complete self-sacrifice. While there are fears that compensation is exploitative, the current hesitancy to conceive of a “paid donation,” in which a woman holds altruistic and financial motivations in equal measure, also has negative effects for oocyte providers.¹⁰⁵ Additionally, prohibitions on compensation that reduce the supply of available oocytes could potentially encourage an unregulated black market for oocytes in which providers would likely be undercompensated and less aware of health risks.¹⁰⁶ As a result, a prohibition on monetary compensation for oocyte transfer will not remedy exploitation.

Altruism and compensation are not mutually exclusive, and in fact, the acceptance of both motivations best protects the safety and wellbeing of oocyte

7-9 (CESifo, Working Paper No. 245, 2000).

102 See also *id.* at 6 (arguing that external incentives crowd out intrinsic motivation if individuals perceive them to be controlling but “crowd in” intrinsic motivation if individuals perceive them to be supportive).

103 Oliver Schilke & Gabriel Rossman, *It’s Only Wrong If It’s Transactional*, 83 AM. SOCIO. REV. 1079, 1086 (2018).

104 Frey & Jegen, *supra* note 101, at 7-9.

105 See *supra* Section II.D.

106 Kenney & McGowan, *supra* note 5, at 18.

providers. Altruistic rhetoric has advantages for oocyte providers, as it acknowledges the more-than-commodity status of the oocyte and the sincere commitment of many providers. However, an overemphasis on altruism—especially in a highly gendered context—can harm providers by rendering them less willing to advocate for their own needs or encouraging them to undertake dangerous behaviors like repeated provision. In turn, though excessive compensation may unduly influence a potential provider, compensation allows providers to advocate for themselves and receive recognition for their labor. Parties with different motivations and varied information struggle to negotiate these exchange relationships, and they exacerbate risks and complications by acting as if altruism is the primary motivation of everyone involved. Current regulatory structures have generally stopped at attempts to limit compensation, upholding the damaging notion that acceptable oocyte transfer is driven by altruism.

III. PROPOSAL FOR FEDERAL REGULATION

An oocyte market that relies on either altruism or compensation alone will fail providers and recipients alike. Instead, the federal government should implement regulations that permit compensation for oocyte transfer, prohibit ongoing unethical practices, and set contract requirements and safety standards for oocyte provision. Safety standards should codify and expand on those touched upon in existing nongovernmental guidelines, including setting age limits and capping the number of cycles per provider. Additionally, the government could set a floor on informed consent requirements, allowing states or professional organizations to require more detailed consent. Such regulations would allow for an expanded understanding of oocyte providers' motivations that would lead to reduced stigma and improved wellbeing. This Part discusses a potential remedy in two parts: a conceptual reimagining of altruism and compensation as harmonious and the ability to implement a federal regulatory scheme under the FDA.

A. Abandoning the Altruism/Compensation Binary

Acknowledging the potential for oocyte providers to simultaneously hold altruistic and financial motivations creates new possibilities for comprehensive protection. Such recognition would expand oocyte providers' vocabulary to express their concerns and negotiate elements of their experience, as they would not have to conceal interest in compensation.¹⁰⁷ Whereas gift-giving rhetoric limits some of the commodification present in traditional market exchanges, discussion about compensation can give oocyte providers the freedom to be openly self-interested and reduce the potential for coercion. Additionally, continued

¹⁰⁷ Curtis, *supra* note 10, at 95.

compensation in tandem with recognition of the gift-like socioemotional elements of the exchange will ensure a supply of oocytes that meets demand. A system in which providers, recipients, and oocyte-transfer agencies can be transparent about their motivations is more likely to reduce exploitation of oocyte providers.

B. Providing for Federal Regulation

It is true that setting compensation too high may unduly induce individuals to become oocyte providers. Further, inappropriate compensation may specifically entice the most economically vulnerable and hence the least likely to have options for legal recourse.¹⁰⁸ Especially considering that the long-term health outcomes for oocyte providers are still unknown,¹⁰⁹ oocyte provision demands meaningful regulation.¹¹⁰ While it is possible for parties to bring cases on behalf of providers affected by the current lack of regulation, these cases have been unsuccessful in setting new standards for oocyte transfer,¹¹¹ and complex regulatory schemes should not be designed by judges.¹¹²

As the federal government and state governments alike seek to expand access to ART,¹¹³ the federal government must be the source of this regulation. The current arrangement, in which there is a limited and inconsistent collection of state statutory laws, makes it difficult for parties to predict the outcome of high-stakes

¹⁰⁸ Rao, *supra* note 2, at 1062.

¹⁰⁹ See, e.g., Milenko Martinovich, *Uncovering the Long-Term Health Outcomes for Egg Donors*, SCI. CARING (Mar. 2020), <https://scienceofcaring.ucsf.edu/research/uncovering-long-term-health-outcomes-egg-donors>.

¹¹⁰ Cf. Samantak Ghosh, *The Taking of Human Biological Products*, 102 CALIF. L. REV. 511, 528-29 (2014) (“If commodification and exploitation of the human body is a concern, there is no reason to believe that an unregulated market is a better substitute.”).

¹¹¹ See, e.g., Cone, *supra* note 5, at 196 n.23 (explaining that donors who experience serious complications are often paid to settle or struggle to win difficult medical-malpractice actions).

¹¹² See, e.g., Robert M. Howard & Jeffrey A. Segal, *A Preference for Deference? The Supreme Court and Judicial Review*, 57 POL. RSCH. Q. 131 (2004). Some judges have spoken openly about the biases they would bring to fertility litigation. Jennifer Bendery, *Republicans to Confirm Lifetime Federal Judge Opposed to Fertility Treatments*, HUFFPOST (Dec. 3, 2019), https://www.huffpost.com/entry/sarah-pitlyk-judge-fertility-treatment_n_5de69777e4b0913e6f865cb6 (reporting that the Senate confirmed a lifetime federal judge who opined that ART has “grave effects on society, including diminished respect for motherhood and the unique mother-child bond”).

¹¹³ A federal bill that would require private health insurance plans to cover infertility treatments and fertility preservation has been introduced in the House and the Senate. Access to Infertility Treatment and Care Act, H.R. 4450, 117th Cong. (as introduced in House, July 16, 2021); Access to Infertility Treatment and Care Act, S. 2960, 115th Cong. (as introduced in Senate, May 4, 2018). A similar bill focused on veterans has been introduced in the House. Veterans Infertility Treatment Act of 2021, H.R. 1957, 117th Cong. (as introduced in House, Mar. 17, 2021). For a list of 17 states with laws requiring insurance companies to cover or offer coverage for infertility treatment, see *State Laws Related to Insurance Coverage for Infertility Treatment*, NAT’L CONF. OF ST. LEGIS. (Mar. 12, 2021), <https://www.ncsl.org/research/health/insurance-coverage-for-infertility-laws.aspx>.

conflicts including parentage disagreements, misuse of oocytes, or failure to obtain informed consent.¹¹⁴ The lack of consensus may cause hesitation for parties who would otherwise engage in mutually beneficial agreements. More importantly, it threatens the legitimacy of families created using ART, both in the legal arena and the public eye. Federal regulations permitting compensation for oocyte provision would give individuals and families much-needed certainty.

While the Tenth Amendment gives states primary authority over healthcare decisions, the federal government has the authority to regulate oocyte transfer under the FDA.¹¹⁵ Transferred reproductive tissue is regulated as “human cells, tissues, and cellular and tissue-based products,”¹¹⁶ meaning that oocyte transfer clinics must register with the FDA,¹¹⁷ comply with “donor eligibility guidelines,”¹¹⁸ and undergo inspection.¹¹⁹

The federal government is best positioned to enable participatory policymaking in this area and engage with multiple stakeholders in designing a regulatory scheme. In addition to FDA regulations, the CDC currently collects data from all fertility clinics in the United States, calculating success rates for each clinic and presenting this information through the National Assisted Reproductive Technology Surveillance System.¹²⁰ As a result of the Fertility Clinic Success Rate and Certification Act of 1992, all ART programs are required to report certain data to the federal government annually.¹²¹ Further, in *Perez v. Commissioner*, the U.S. Tax Court held that payment for oocyte provision is subject to federal income tax.¹²² As a result, the federal government is already receiving information from and communicating standards to fertility clinics and oocyte providers.

Legislative actors should center oocyte providers as the stakeholders most marginalized by lack of regulation and resistance to compensation. Importantly, regulation by the FDA or CDC would affirm the idea that oocytes are fundamentally different from any other commodity and should be treated differently under the law. It is unclear what financial incentive will maximize provider wellbeing and the availability of oocytes. It is also unclear how much

114 Jody L. Madeira & Susan L. Crockin, *Legal Principles and Seminal Legal Cases in Oocyte Donation*, 110 FERTILITY STERILITY 1209, 1211 (2018).

115 21 C.F.R. § 1271 (2020).

116 *Id.* § 1271.3.

117 *Id.* § 1271.10.

118 *Id.* § 1271.1(a).

119 *Id.* § 1271.400. See also Katherine McKeen, *Cracking the Egg Donation Market*, REGUL. REV. (Oct. 13, 2021), <https://www.theregreview.org/2021/10/13/mckeen-cracking-egg-donation-market> (“In short, FDA regulates who can be an egg donor—but does not regulate how the for-profit egg donation industry treats donors.”).

120 National ART Surveillance, CTRS. FOR DISEASE CONTROL AND PREVENTION (Mar. 12, 2021), <https://www.cdc.gov/art/nass/index.html>.

121 Pub L. No. 102-493, 106 Stat. 3145 (1992).

122 *Perez v. Commissioner of Internal Revenue*, 144 T.C. 51 (2015).

altruistic rhetoric, and in what form, would accomplish the same goals. Considering the relevance of a complex system of gender norms and the inability to regulate private-agency rhetoric, framing decisions are best left to individual parties. However, by permitting compensation across the board and setting enforceable guidelines for compensation and safety, the federal government can facilitate an expansive conception of women's labor, improve the wellbeing of oocyte providers, and destigmatize compensated oocyte transfer.

CONCLUSION

Regulations, case law, and legislation have not kept pace with the rapid development and proliferation of oocyte transfer. The limited laws that do exist focus almost exclusively on prohibiting or limiting compensation. As a result, private agencies have been the actors tasked with setting standards for provider safety and compensation. Individuals must navigate this space while struggling with the perceived tension between self-interest and altruism. This tension has generally been handled by veiling providers' financial interest and privileging an image of oocytes as freely given gifts.

While inappropriate compensation can lead to exploitation of oocyte providers, banning compensation and relying on altruistic rhetoric alone does not fare much better. The focus on altruism in the oocyte market is distinctly gendered, colored by the expectation that the ideal woman (and especially the ideal mother) is generous, nurturing, and fundamentally selfless. This framing renders oocyte providers less likely to advocate for their own healthcare and medical wellbeing and forces them to hide a significant part of their motivation for provision: financial gain. Importantly, this same work is not required of their sperm-providing counterparts.

Some of the risk of exploitation can be alleviated by rejecting the notion that women are unable to be simultaneously self and other regarding. This conceptual shift could be facilitated by a federal regulatory framework that expands existing FDA and CDC relationships with fertility clinics and considers the interests of oocyte providers. Codified standardization of the oocyte market would not only protect oocyte providers, but also legitimize families created using ART, affirm the idea that oocytes are fundamentally different from other commodities, and validate women's labor as worthy of compensation.