A Call to Arms: The Department of Defense’s Egg Freezing Benefit Summons Increased Reporting Regulations

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“I don’t want this egg freezing thing to add more fuel to the fire in terms of criticisms toward women’s reproductive choices.”
-Annie, Captain in the U.S. Air Force

“Cryopreservation is just good insurance.”
-Ellen Smith, U.S. Army

INTRODUCTION

Facebook and Apple offer it.3 Some investment banks offer it.4 Some law firms offer it.5 The Department of Defense (“DOD”) now offers it.6 Oocyte cryopreservation, better known as egg freezing, is a benefit that is not only offered

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5. See Glenn Cohen, Will Your Law Firm (or Other Employer) Pay for Your Egg Freezing? Should It? (Online Abortion and Reproductive Technology Symposium), HARVARD LAW BILL OF HEALTH (April 21, 2013), http://blogs.harvard.edu/billofhealth/2013/04/21/will-your-law-firm-or-other-employer-pay-for-your-egg-freezing-should-it-online-abortion-and-reproductive-technology-symposium/ (“At least one participant at the . . . bricks-in-mortar symposium reported to me that they knew of one Am Law 100 firm that will cover egg freezing for its lawyers.”).

Oocyte cryopreservation is a scientific method of freezing cells and tissues at sub-zero temperatures to stop all biologic activity and preserve the cells and tissues for future use.8 It was originally offered as a method to preserve fertility in female cancer patients by freezing eggs that would likely be destroyed through chemotherapy.9 The use of egg freezing expanded from the cancer patient niche into a much broader market in 2012 once the American Society of Reproductive Medicine (“ASRM”), a self-regulated professional medical society,10 no longer deemed the procedure to be “experimental.”11 Two years later, Apple and Facebook jumped at the opportunity to publicly offer coverage of egg freezing in their health insurance plans to promote a female-friendly work environment.12 Simultaneously, certain investment banking companies and law firms also implemented egg freezing policies in their employer-provided health plans.13

In January of 2016, Secretary of Defense Ashton B. Carter announced that the Pentagon would begin offering egg freezing coverage to active duty troops through a pilot program.14 The DOD expanded upon the “perks arms race”15 companies like Facebook and Apple launched in Silicon Valley to recruit and maintain employees. Like private sector companies, the DOD incorporated the employer-provided egg freezing benefit (“the benefit”) to recruit and retain more females in the military.16 The DOD had one different incentive to offer egg freezing as a benefit. 15.8% of female veterans who served in Operation Enduring Freedom or Operation Iraqi Freedom reported that they had experienced infertility.17

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7. See id.
11. See Garber, supra note 9.
12. See Friedman, supra note 3.
13. See Bennett, supra note 4; Cohen, supra note 5.
14. See Schmidt, supra note 6. The Department of Defense also included a sperm freezing benefit in its initiatives for male military members. This Note will only focus on the egg freezing benefit offered for military women.
17. Infertility in Iraq and Afghanistan Veterans, U.S. DEP’T OF VETERANS AFFAIRS (July 22, 2016), http://www.publichealth.va.gov/epidemiology/studies/new-generation/infertility.asp. The report also included statistics on how 13.8% of male veterans experienced infertility. Although male infertility is an important topic, this Note will only focus on women and the egg freezing procedure.
Since only 8% of women in the general population report experiencing infertility, the DOD recognized the stark difference in risk for the fertility of military women compared to non-military women.

Operating within this unique environment, the DOD incorporated egg freezing as a benefit for military women in an initiatives program. The DOD may have intended the benefit to be an isolated decision that would not affect other companies or industries. Nevertheless, as one of the largest employers in the world, the DOD validated the private sector trend by offering the benefit to all active duty females in the military through a government program. The DOD’s acceptance and endorsement of the procedure as it increases in mainstream popularity will lead to inevitable consequences—an increased trend and growth in other employers incorporating the benefit.

As egg freezing expands in the United States, both the benefits and harms of the procedure must be evaluated by employers. Employers frame egg freezing as a benefit, but potential health and policy risks accompany the procedure. Although harms exist, the DOD’s expansion of the benefit through a government program will likely result in more companies following suit. The DOD’s promotion of the benefit calls for increased regulation in the assisted reproductive technology (“ART”) field. Women’s reproductive freedom and health may be inadequately protected because the current federal regulatory system governing egg freezing is virtually nonexistent. This Note will propose a change in current regulations by amending the reporting requirements for egg freezing. This Note will specifically propose adopting portions of the United Kingdom’s regulations to mandate fertility clinics to provide data on egg freezing. The data should be included in a separate, easily comprehensible section within the national annual reports on the success rates of fertility clinics.

Part I of this Note will provide background on the process and cost of egg freezing and how the technology has changed and is still changing. Part I will then outline how the benefit has expanded among different employers, industries, and sectors, specifically highlighting the egg freezing policies of Facebook, Apple, and the DOD. Doctors saw a steady increase in the number of cancer-free women undergoing the egg freezing procedure after ASRM’s announcement and the implementation of Facebook and Apple’s policies.

18. The general infertility population percentage has a range of up to 20%, depending on which definition of fertility is used. See id.


21. See Garber, supra note 9.
This Note will emphasize the first government application of the procedure in a health plan in response to creative private sector benefits.

Part II will delve into a summary of the benefits, potential health harms, and policy risks of implementing the egg freezing benefit for women who decide to undergo the procedure. The importance of examining the benefits and harms of the procedure grows because the government’s approval of the benefit could result in a wider acceptance of egg freezing as an advantage for women. The benefit has empowered women take control of their “biological fertility clock.”

On the other hand, the procedure may still cause potential physical and emotional health risks. There is currently a lack of data to confirm the procedure is completely safe. Furthermore, the benefit has been negatively portrayed as a policy that will only encourage women to delay motherhood to work longer and harder for their employers in the present.

Acknowledging the harms and policy risks of the benefit, Part III will then evaluate the protections in place for women when the benefit continues to inevitably expand. Part III will analyze the current regulatory framework surrounding the ART field. The ART field is known as the “Wild West,” due to its lack of direct regulation. In 1992, Congress passed the Fertility Clinic Success Rate and Certification Act (“FCSCA”), the only federal ART law in the United States. Egg freezing is a very small segment within a sprawling, disordered ART regulatory framework and had not been directly regulated under the FCSCA until 2015. Egg freezing is also governed by a piecemeal legal scheme within the ART framework that includes aspects related to tort law, contract law, family law, inheritance law, and state regulations. Part III will evaluate the issues related to the current federal ART regulatory scheme and how these problems will continue to affect egg freezing and the fertility clinics that offer the procedure.

Part IV will then propose solutions to the current regulatory problems surrounding ART and egg freezing. The DOD’s benefit calls for a regulatory

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23. See infra Part II.B for discussion on physical and emotional harms of egg freezing.
24. See Practice Committees, supra note 8, at 41–42.
25. A large portion of women who freeze their eggs are single. These women encounter the same situation that all single women face in the workplace. See Jacoby, infra note 99 and accompanying text; Trina Jones, Single and Childfree! Reassessing Parental and Marital Status Discrimination, 46 ARIZ. ST. L.J. 1253, 1266 (2014) (citing several articles and stories referencing how single workers often have more pressure to work and travel longer and harder in comparison to their married-with-kids counter-parts).
30. See id. at 1585–86.
31. See Daar, supra note 26, at 260.
solution in the United States to inform potential consumers about the procedure. By understanding the United Kingdom’s approach to reporting on egg freezing, changes can be made to regulatory reporting requirements in the United States that will further the policy goals of the FCSCA—informing the public and protecting women and their future children. Finally, this Note will conclude with general remarks.

I. BACKGROUND

In the United States, there is no governmental body that regulates ART or egg freezing. The ASRM is a self-regulatory professional medical society that guides industry practices and procedures for reproductive medicine, including egg freezing. Egg freezing was originally created for young female patients undergoing chemotherapy. In 2008, the ASRM labeled the egg freezing procedure as “experimental.” It then lifted the “experimental” label in 2012. ASRM qualified the lifting of its label with a warning of a lack of “data on safety, efficacy, cost-effectiveness, and emotional risks” associated with egg freezing. ASRM also warned against the widespread use of egg freezing because it may “give women false hope and encourage women to delay childbearing.”

Unsurprisingly, even with the qualification, lifting the “experimental” label led to a surge in cancer-free women electing to freeze their eggs. The egg freezing procedure is a relatively new technology that is still evolving. This section will discuss the background of the procedure and provide detail on the specific benefit plans currently in place.

A. The Egg Freezing Procedure

The egg freezing process begins with a patient undergoing a hormone self-injection method similar to the in vitro fertilization (“IVF”) process. The patient

32. See Michele Goodwin, Assisted Reproductive Technology and the Double Bind: The Illusory Choice of Motherhood, 9 J. GENDER RACE & JUST. 1, 54 n.195 (2005) (“FCSCA serves as the primary legislative response to assisted reproductive technology; Congress has been otherwise virtually silent on the issue.”).
33. See Vera, supra note 10.
36. See Bennett, supra note 4.
37. See Practice Committees, supra note 8, at 41.
38. Id.
39. See Laura Donnelly, Number of Women Freezing Their Eggs Triples in Just Five Years, TELEGRAPH (Mar. 23, 2016, 1:00 PM), http://www.telegraph.co.uk/news/2016/03/23/number-of-women-freezing-their-eggs-triples-in-just-five-years/ (detailing how the ASRM press release likely played a substantial role in the increase in popularity of egg freezing since it publicized, for the first time, promising statistics about the recent success of vitrification); see also Paller, supra note 29, at 1585.
40. During the IVF process, a woman will first use an ovulation predictor kit to determine when she is ovulating. Once the doctor detects ovulation, the woman will be instructed to take certain fertility drugs by mouth. The first official day of the treatment cycle is the day the woman gets her
must also submit to a series of demanding blood tests and ultrasounds conducted over a period of several weeks. The hormone injections hyperstimulate a patient’s ovaries to produce more eggs, since a female’s natural cycle only releases one egg per month. An exceptional number of eggs produced in response to the hormones and stimulation process would be about six eggs, depending on the woman’s age. When the woman’s eggs reach the appropriate size and number after the hormonal stimulation, a reproductive endocrinologist will use a needle to perform a transvaginal oocyte retrieval to extract the eggs from the woman’s ovaries while she is sedated. The oocyte retrieval is classified as an invasive surgical procedure.

Following retrieval, the eggs are then immediately frozen using either the slow-freeze method or a flash-freeze method called vitrification. The slow-freeze method was the original option for patients undergoing the egg freezing procedure. Although this method works to freeze sperm and embryos, it is less successful for eggs. Since eggs contain more water compared to sperm or embryos, the slow-freeze method produces many ice crystals during cryopreservation, which frequently results in damaged and unusable eggs when thawed.

period. The doctor will then perform blood work and a transvaginal ultrasound. If these tests turn out normal, the woman will begin injecting ovarian stimulation drugs. After learning how to self-inject the drugs at a clinic, a woman will typically inject herself anywhere from one to four shots a day in the stomach area. At a certain point, a woman’s eggs will mature, which will signal that they can be retrieved. See generally Rachel Gurevich, What to Expect Along the Path to Conceiving With IVF, VERYWELL (Oct. 6, 2016), https://www.verywell.com/understanding-ivf-treatment-step-by-step-1960200. 41. Pamela Mahoney Tsigdinos, The Sobering Facts About Egg Freezing That Nobody’s Talking About, WIRED (Oct. 24, 2014, 3:55 PM), https://www.wired.com/2014/10/egg-freezing-risks/.

42.  Id.
43.  Id.
44.  Once a woman is ready for the procedure, she is given anesthesia. Using ultrasound guidance, the doctor inserts a needle through the vaginal wall and into the ovarian follicle. Outside the body, the other end of the needle attaches to a special suction device. After entering the follicle, the doctor gently applies suction to pull out follicular fluid containing eggs. Several follicles are targeted during one session. See generally Transvaginal Oocyte Retrieval, U.S. FERTILITY NETWORK, http://usfertilitynetwork.com/services/in-vitro-fertilization/transvaginal-oocyte-retrieval/ (last visited May 3, 2017).


46.  See Tsigdinos, supra note 41.
49.  Id.
50.  Id.
Vitrification is a modern flash-freeze method, which is so called because during the process the eggs transition to a vitreous, or “glass-like,” state. The retrieved eggs are placed in liquid nitrogen, which is potentially toxic to the egg and requires special care during the procedure. The liquid nitrogen solution instantaneously freezes the egg with minimal ice crystals. The egg is then held in a tiny straw and stored in a freezer until thawed.

Months or years after the eggs of a patient have been frozen, a woman may decide to use her eggs to become pregnant. The woman will then have to undergo the IVF process which involves her frozen eggs being thawed, fertilized, and transferred to her uterus as embryos. In the IVF process, a woman must again self-inject hormones and undergo blood tests and ultrasounds. A 2016 ASRM study found that the chances of having at least one baby from eight frozen eggs through IVF was 41% in women who were younger than thirty-five when they froze their eggs. The percentage decreases to 20% in women who were thirty-five or older when they froze their eggs.

Although IVF after egg freezing is an option, another study released in January of 2017 found that few women who freeze their eggs actually use them. Of the 100 women surveyed in the study who had elected to freeze their eggs for non-medical reasons between 1999 and 2014, only 6% of the women had used their frozen eggs at the time of the survey. Only 3% had given birth using the frozen eggs. The average age of the women was thirty-seven years old at the time they froze their eggs and forty years old at the time they completed the survey.


52. Id.

53. Id.

54. Id.


56. See Gurevich, supra note 40.

57. Rachael Rettner, Most Women Who Freeze Their Eggs Never End Up Using Them, HUFFINGTON POST (Jan. 23, 2017, 12:42 PM), http://www.huffingtonpost.com/entry/most-women-who-freeze-their-eggs-never-end-up-using-them_us_5886384de4b0e3a7356a7db5 (noting the study was conducted on women in Australia).

58. Id.

59. It is important to note that many women in the new study had only recently frozen their eggs—nearly half the women said they had frozen their eggs within the last two years, and this may, in part, explain why so few women reported using their eggs. The data is limited because only so many years have passed since the procedure was deemed non-experimental. See id.


61. Id.

62. The survey results do not necessarily demonstrate a “low usage rate of frozen eggs.” It is quite possible many of the women surveyed simply have not reached the point of unfreezing their eggs.
“When asked why they had [not] yet used their frozen eggs, most of the women said that they did [not] want to be a single parent, or that they wanted to try to conceive naturally.”

Women who accept the possible risks associated with egg freezing and undergo the procedure are actively choosing against thawing their frozen eggs to conceive naturally. The low usage rate of the frozen eggs emphasizes how women perceive the procedure as an immediate fertility insurance benefit. At the same time, these women may fail to recognize that they are giving up the opportunity to conceive naturally without ever having undergone a medical fertility procedure. Additionally, the focus on the immediate insurance benefit of egg freezing overshadows the future risk of lower success rates for viable births with frozen eggs and potential health risks of the procedure.

Given the low success rates of egg freezing and low usage rate of frozen eggs, the decision to undergo the process is not easy, especially considering the cost. The egg freezing procedure typically costs between $9,000 and $20,000 per cycle. The total costs fall within such a wide range because each woman experiences a varied level of risk and success rate associated with producing more eggs. Women are likely required to undergo “several cycles to have the suggested number of eggs frozen to optimize the chance of success.” Additional costs include $2,000 to $4,000 per cycle for hormone injection drugs and $500 or more per year for storage fees. The cost estimate for egg freezing does not include the cost of IVF, which is required when a woman decides to use her frozen eggs. The cost of IVF ranges from $8,000 to $15,000 per cycle, with the national average costing around $12,400. Altogether, the process of freezing eggs, storing, and implanting the eggs through IVF has been estimated to cost more than $40,000.

There is no requirement that health insurance covers the high cost of egg freezing. Only a limited number of insurance plans in certain states cover the

yet. See id.

63. See Rettner, supra note 57.

64. The cost of egg freezing creates a large financial disparity that could discriminatorily affect different classes of women, which has been discussed in prior scholarship. The new government implementation of egg freezing could further affect class discrimination among women potentially undergoing the procedure, but this Note will not analyze this issue. See June Carbone & Naomi Cahn, The Gender/Class Divide: Reproduction, Privilege, and the Workplace, 8 FIU L. REV. 287, 296 (2013) (“[E]gg freezing [can] perpetuat[e] non-supportive workplaces for middle class women. The lure of egg freezing for some women and its utter irrelevance for others is based on the economic realities of the workplace for men and women, along with cultural expectations surrounding men, women, marriage, and childbearing.”).


66. Galst, supra note 45.

67. See, e.g., Mohapatra, supra note 65 at 386.


69. Mohapatra, supra note 65, at 387.

70. “America”s Health Insurance Plans hasn”t surveyed insurers specifically about egg-freezing coverage, says Susan Pisano, a spokesperson for the trade group. However, she said her understanding
high cost of IVF. Therefore, the egg freezing benefit is a creative solution for companies to recruit and retain female employees by covering the costs of one possible ART procedure for women in the workplace.

B. Current Employee Benefit Plans

Facebook and Apple were the first companies in Silicon Valley to offer payment for employees to freeze their eggs for non-medical reasons. Facebook’s policy began in October 2014 under the company’s surrogacy benefit. Facebook’s benefit covers costs up to $20,000 and would also cover employees’ spouses. Apple’s policy began in January of 2015 under the company’s fertility benefit. Similarly, Apple’s benefit covers costs up to $20,000 and employees’ spouses.

After conducting an interview with Rachel Lo, a former Engineering Program Manager on Hardware Product Design at Apple, she believed Apple’s fertility benefit only covered egg freezing and did not cover IVF. Rachel did not believe there were any other conditional requirements for employees to use Apple’s fertility benefit, but she was also not aware of anyone who had taken advantage of the benefit during the time she was at the company from 2014 to 2016.
The egg freezing benefit may have seemed like just another weapon in the “perks arm race” of Silicon Valley, but the benefit did not stop with Facebook and Apple. In December of 2015, Secretary of Defense Ashton B. Carter announced that the new year would bring an end to restrictions on women in the U.S. military serving in combat positions. The move opened as many as 220,000 jobs previously unavailable to female soldiers.

With the expansion of jobs to females in the military, Carter shortly followed with another announcement in January of 2016. The Pentagon would begin offering egg freezing coverage to active duty troops through a $150 million pilot program. When announcing the benefit, Carter emphasized that “for women who are midgrade officers and enlisted personnel, [the] benefit [would] demonstrate that [the DOD] understand[s] the demands upon them and want[s] to help them balance commitments to force and family.” Carter further stressed: “We are not Google. We are not Wal-Mart. We’re war fighters, [. . .] But that doesn’t mean we should not be challenging ourselves just like the private sector. To modernize our workplace and workforce, to retain and attract the top talent we need, so that our force can remain the best for future generations.”

The benefit would be part of a series of measures incorporated into the DOD’s Force of the Future Initiative, instituted with the main incentive to recruit and maintain female employees. The specific egg freezing benefit would “be offered to any service member who request[ed] it[,] as well as troops anticipating a deployment.” ‘The two-year pilot program [would] cover the cost of freezing

79. See Farr, supra note 15.
81. Prior to the end of 2015, women were precluded in some areas of the military, such as Army Rangers and Green Berets, Navy SEALs, Marine Corps infantry, and Air Force para-jumpers. Women were also precluded from driving tanks, firing mortars, operating machine gunnery, firing support reconnaissance, and leading infantry soldiers into combat. With Carter’s announcement, these positions and activities opened to women. See id.
83. See Schmidt, supra note 6.
85. See U.S. DEP’T OF DEF., Fact Sheet: Building the Second Link to the Force of the Future Strengthening Comprehensive Family Benefits, (2015) available at http://www.al.mil/Portals/1/documents/Fact_Sheet_Tranche_2_FOTF_FINAL.pdf (last visited May 3, 2017). The Force of the Future Initiative also included other family-friendly workplace benefits: increased maternity leave from six to twelve weeks; increased paternity leave from ten to fourteen days; extended day-care hours; expanded adoption leave; and lactation rooms to be installed at more than 3,600 bases.
86. See Kime, supra note 82.
eggs through Tricare[,]” the military’s civilian health benefits program.87 Tricare does not cover IVF or artificial insemination, which would be an added cost for military women who decide to use their frozen eggs.88 Once the two-year “test program is complete, the DOD will assess its impact, including cost and recruiting and retention benefits[.]”89 With this information, the DOD will decide whether to “renew the program or [to] allow service members to pay out[-]of[-]pocket for continued storage” of their eggs.90

When deciding which benefits to add to the initiative, the DOD mainly referenced workplace data and studies from the private sector.91 Carter even referenced Sheryl Sandberg in his announcement.92 The DOD also took several surveys of women working in different areas of the military.93 The surveys indicated the egg freezing benefit was a common interest among military women.94 The direct comparison with private sector benefits and use of similar data show the DOD is acknowledging the private sector is moving in the right direction. By offering similar benefits, like egg freezing, the DOD is affirming private employers’ actions.

By incorporating the benefit in a government program, there will be future consequences. The DOD’s affirmation of the benefit expands egg freezing outside the private technology sector into the health plan of one of the largest employers in the world. Before more companies begin to follow in the DOD’s footsteps, employers must analyze the harms and risks of the procedure in addition to the benefits.

II. EGG FREEZING POLICY OVERVIEW

As the popularity of egg freezing increases among women, private companies and government entities that begin to implement the benefit must analyze the advantages and disadvantages of the procedure. This section will summarize the benefits of egg freezing in the daily lives of women, as well as in the workplace. This section will then highlight the physical and emotional harms women who freeze their eggs may experience and examine the specific harms that could result in the workplace if an egg freezing policy is implemented.

A. Benefits of Egg Freezing

Egg freezing has steadfastly gained momentum in the market. The technology provides several benefits for women, including reproductive flexibility and workplace balance in the present and potentially in the future.

87. Id.
88. Id.
89. Id.
90. Id.
91. See C-SPAN Broadcast, supra note 16.
92. Id.
93. Id.
94. Id.
In 2004, Extend Fertility was the first U.S. company that expanded egg freezing beyond a method to preserve reproductive potential.95 Extend Fertility began advertising egg freezing as a lifestyle choice.96 The company emphasized how the technology would extend a woman’s average fertility window,97 acting as a form of insurance.98 By potentially expanding her fertility window, a woman can literally buy more time within her personal life and career—whether it is to become financially secure and stable enough to raise children or to find the perfect partner.

For example, a woman who has found a partner and is steadily gaining success in her career may be a “Clock-Watcher.”99 She still may not have decided whether she wants children in her life. The woman may be paralyzed by indecision of how a child will affect her current life and career.100 At the same time, the woman recognizes that her fertility window will expire at a certain point.101 Her biological clock may continue to tick and function to “shift her psychological motivations and actual behaviors to facilitate utilizing remaining fertility.”102 Consequently, a woman could decide to freeze her eggs.

On the other hand, a woman may still be looking for a partner or have recently undergone a breakup and feels the societal pressure to freeze her eggs to “check the box.”103 The women undergoing the procedure for this reason are steadily increasing in percentage.104 By making an active reproductive decision to freeze her eggs, a woman feels empowered.105 Based on a recent study, a majority of women share their egg freezing decision with friends and family.106 By sharing her actions, a woman who takes control of her fertility and freezes her eggs may

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96. Id.
97. Id.
98. See Ludden, The Biological Clock, supra note 22.
100. Freezing eggs while in a committed relationship is less common: “[L]ess than five percent [of women freezing their eggs] are . . . engaged, married, or in very committed relationships.”
101. Id.
102. Id.
feel less cultural pressure to have children early and more relaxed about the future. These emotional benefits for a woman who decides to freeze her eggs may eclipse the low potential success rates of a live birth from the procedure.

Employers have capitalized on this sense of empowerment by offering to pay for the cost of egg freezing through health insurance to recruit and maintain female employees. Facebook and Apple not only implemented the benefit to promote reproductive choice but also claimed the benefit would help equalize women in the workplace. The egg freezing benefit would finally allow women to have it all—a career, marriage, and a family—at whatever time women wanted.

The DOD further validated the advantages of egg freezing by incorporating the benefit into a government program. Although women surveyed in the military were supportive of the egg freezing benefit, there are still risks and harms to all women who undergo the procedure. These risks and harms must be evaluated in conjunction with the benefits before an employer implements an egg freezing policy.

B. Physical and Emotional Harms of Egg Freezing

Although egg freezing has some advantages for women, it also poses considerable risks to a woman’s physical and mental health. Since the ASRM only recently lifted the “experimental” label on egg freezing in 2012 with qualifications, there is a lack of long-term data on fertility success rates and health information tracking women who inject hormones and undergo egg retrieval. Since the women who originally undertook the procedure were cancer patients, the data is even sparser when evaluating the risks for women who are healthy and decide to freeze their eggs for non-medical reasons.

First, there are few studies that have been conducted that consider the long-term effects and consequences on a woman’s physical health after freezing her eggs. A woman who decides to freeze her eggs will potentially have to undergo hormone injections for ovarian stimulation twice—once to retrieve the eggs and once to use the thawed eggs for IVF. A major risk of injecting hormones to increase the stimulation of egg production in the ovaries is the development of Ovarian Hyperstimulation Syndrome ("OHSS"), which in extreme cases can be life-threatening. Approximately one-quarter of women who undergo ovarian stimulation will exhibit OHSS, with symptoms that may range from mild nausea

107. Id.
108. See Bennett, supra note 4.
109. Anne-Marie Slaughter, Why Women Still Can’t Have It All, THE ATLANTIC (June 13, 2012, 10:15 AM), https://www.theatlantic.com/magazine/archive/2012/07/why-women-still-cant-have-it-all/309920/ ("I recommend establishing yourself in your career first but still trying to have kids before you are 35—or else freeze your eggs . . .").
110. See Garber, supra note 9.
111. See Tsigdinos, supra note 41.
112. Id.
113. See Practice Committees, supra note 8, at 40.
to blood clots and kidney failure. There have also been studies that ovarian stimulation may increase the risk of ovarian cancer, especially for borderline ovarian tumors. Patients choosing to undergo egg freezing, an invasive surgical procedure, also face the general risks and symptoms involved when having surgery.

From beginning to end, the physical harms accompanying egg freezing are immense. The risks include developing OHSS after retrieving and implanting the eggs, as well as developing other general symptoms from undergoing two invasive surgical procedures while sedated.

Second, the lack of information on egg freezing could create a false hope for women who expect to become pregnant later in life. The benefit could undermine the employer targeted efforts to create a family-friendly work environment. The longer a woman waits to freeze her eggs, the less likely the eggs will result in a live birth. For example, a twenty-five year old woman has about a 12.4% chance of two frozen eggs leading to a live birth. The percentage decreases to 5.4% for a woman who is thirty-eight years old and 4.1% for a woman who is forty-two years old. A recent meta-analysis showed that to have a roughly comparable live birth success rate using fresh eggs, a woman must thaw six viable eggs frozen at the age of twenty-five. Considering the average age of non-medical egg freezing customers in the U.S. is around thirty-seven years old, these statistics become more disheartening.

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116. See F.E. Van Leewuen et al., Risk of Borderline and Invasive Ovarian Tumours after Ovarian Stimulation for In Vitro Fertilization in a Large Dutch Cohort, 26 HUM. REPROD. 3456, 3456 (2011).


118. See id.; Mayo Clinic Staff, supra note 114.

119. See Carbone & Cahn, supra note 64, at 300.


121. Id.

122. The success rate of six viable, thawed eggs of women who froze their eggs at the age of twenty-five is 31.3%. See Vanessa Gruben, Freezing as Freedom? A Regulatory Approach to Elective Egg Freezing and Women’s Reproductive Autonomy, 54 ALBERTA L. REV. 753, 756 (2017) (discussing egg freezing regulation in Ontario, Canada and how it should be amended to protect more women undergoing the procedure).


In a 2016 study published by Shady Grove, the nation’s largest fertility center, of 1,283 thawed eggs, only fifty-one resulted in viable pregnancies. Although freezing more eggs at a woman’s reproductive age may increase the likelihood of success, the costs of freezing and storing more eggs over a longer period of time make this option financially impossible for some women. As a result, the extensive advertising of egg freezing benefits could instill a false hope that creates an emotional toll on a woman’s mental health when reconciling expectations and actual results after undergoing a physically demanding medical procedure.

C. Workplace Harms of Egg Freezing

Women and employers must scrutinize the effects of egg freezing even more carefully within the workplace context. Initially, the egg freezing benefit appears to be exactly that—a benefit. Nevertheless, that benefit may ultimately result in adverse effects within the workplace.

The egg freezing policy could pressure women to delay motherhood. The pressure could create a perverse incentive for employers to keep women working. A woman who wants to appear more favorably to her superiors may decide to freeze her eggs to show her dedication to her job. Her actions may disadvantage other women who still decide to become pregnant mid-career while the egg freezing policy is available in the workplace. The employer may be more accommodating to a woman if she freezes her eggs, because the woman may work longer, without disruption, for the employer in the future. In comparison, the employer may be less accommodating to a woman while she is pregnant and likely to go on maternity leave.


126. The medical definition of a woman’s reproductive age are the years of life between menarche and menopause. The WHO defines this age range from 15 to 44 years old, with the adult reproductive age being 20 to 59 years old. Women’s Health, WORLD HEALTH ORGANIZATION (Sept. 2013), http://www.who.int/mediacentre/factsheets/fs334/en/ (last visited May 3, 2017).

127. See Carbone & Cahn, supra note 64, at 289.


After a longer period of time, the women may both experience consequential effects—the woman who decided to freeze her eggs may receive more promotions at a faster rate compared to the woman who decided to become pregnant.

The Pregnancy Discrimination Act (“PDA”) states that employers must treat pregnant women “[t]he same for all employment related purposes . . . as other persons not so affected but similar in their ability to work.”130 In *Young v. United Parcel Service*, the Supreme Court held that the employer had accommodated non-pregnant workers while failing to accommodate pregnant workers, which posed a significant burden on the pregnant workers.131 Women who are affected by the egg freezing benefit could likely pursue a similar claim if the right factual situation arises.132 Women may also pursue a disparate impact claim, if in the long term, a pattern develops for employers who offer the benefit: women who freeze their eggs advance further and quicker compared to women who become pregnant.133 There is currently a lack of detailed studies and statistics available to support a successful legal suit.134 As time passes, more detailed studies, data, and statistics will be compiled, especially if more employers begin providing the benefit.135

The DOD’s initiative to implement egg freezing in the first government employer application of the benefit signals a larger acceptance of the procedure as an expansion of women’s reproductive choice.136 Consequently, more employers may begin offering the egg freezing benefit. Acknowledging the harms and policy risks of the benefit, this Note evaluates the regulatory protections in place for women and solutions to current regulatory problems as the benefit continues to grow.

132. *See* Mattson, *supra* note 129, at 27–28 (providing an example where an employer may be willing to accommodate a woman’s egg freezing schedule adjustments but unwilling to accommodate a woman experiencing severe morning sickness due to pregnancy).
133. Disparate impact occurs when an employer utilizes a “neutral” test, rule, policy, or selection criterion that impacts adversely on a protected group. *See* LABOR AND EMPLOYMENT LAW, Ch. 51, § 51.06 (2017).
134. “If interpreted as tacit encouragement to pursue cryopreservation, or as a warning that child-rearing could jeopardize opportunities for advancement, the policy would expose these companies to risk for alleged discrimination [. . .] Though disparate impact claims are generally more difficult to argue, requiring statistics, data and number crunching to substantiate claims, the news from Facebook and Apple also comes at a time of [. . .] heightened scrutiny around pregnancy-related discrimination.” Christina L. Lewis, *Retaining Talent With Cryopreservation Benefit Is Risky*, HINCKLEY ALLEN (Nov. 5, 2014), http://www.hinckleyallen.com/publications/retaining-talent-with-cryopreservation-benefit-is-risky/.
135. *See e.g.*, Donnelly, *supra* note 39; HUMAN FERTILISATION & EMBRYOLOGY AUTHORITY, FERTILITY TREATMENT 2014 TRENDS AND FIGURES 29 (2016), available at http://www.hfea.gov.uk/docs/HFEA_Fertility_treatment_Trends_and_figures_2014.pdf (last visited May 3, 2017) (“Since 2001, fewer than [sixty] babies have been born to patients storing and thawing their own eggs. This is a low number considering the attention egg freezing receives, but this is a new, emerging treatment area which we will continue to monitor.”) [hereinafter 2014 HFEA Report].
III. THE EGG FREEZING REGULATORY FRAMEWORK

In the United States, there is currently a lack of uniform regulation governing egg freezing. This section will begin with a hypothetical scenario facing a female military member who decides to take advantage of the DOD’s new benefit. This is followed by a summary of the current regulatory framework and the specific problems surrounding ART and egg freezing requirements in the United States.

A. Ellen’s Dilemma

Ellen Smith, an active member of the U.S. army, has decided to take advantage of the new DOD egg freezing benefit. She does not know exactly where to begin. She does not even know where egg freezing is offered near her. Tricare, the military’s health insurance provider, can probably offer Ellen a list of fertility clinics where the benefit is covered. Ellen will likely obtain more information about the success rates of live births after freezing her eggs from the clinics she visits. Ellen may eventually have the success rate statistics for each clinic covered by Tricare, but she also wants to know what other information is publicly available. How will Ellen know the fertility clinics Tricare covers have the highest success rates? How can Ellen compare the clinics’ statistics to the national standards? What are the national standards for egg freezing success rates?

If Ellen were undergoing IVF, she could answer these questions. IVF national reports provide the percentage of live births for fresh embryos and frozen embryos categorized by the age of the woman. The report begins with a table summarizing all the fertility clinic data collected in the United States. The report then breaks down the statistics by each fertility clinic based on location in the United States. Each fertility clinic’s percentage of live birth success rates are detailed in a separate table within the national report.

These national reports lack similar transparency for egg freezing. There is limited data on egg freezing success rates compiled in one location or within one report. There is also a disarray of information about which fertility clinics offer

137. See Miller, supra note 2 (providing more detail about Ellen’s role in the military and story).
138. “[T]he lack of transparency [for egg freezing] contrasts sharply with that for in vitro fertilization, for which the results of all cycles must be reported to the US Centers for Disease Control and Prevention in Atlanta, Georgia, either directly or through the Society for Assisted Reproductive Technology (SART), a sister organization to the ASRM. ‘We don’t have the same transparency for egg freezing,’ says Widra, chair of the SART practice committee.” See Alison Motluk, Growth of Egg Freezing Blurs “Experimental” Label, NATURE (Aug. 23, 2011), http://www.nature.com/news/2011/110823/full/476382a.html.
140. Id. at 21.
141. Id. 23–514.
142. Id.
143. See Motluk, supra note 138.
144. See id.
egg freezing and the success rates of each fertility clinic. The lack of information about egg freezing creates information asymmetry for consumers and potential patients like Ellen. Without the national standards to compare, Ellen will lack the knowledge to make an informed decision about whether and where she should undergo her egg freezing procedure.

B. The Current Regulatory Framework for ART and Egg Freezing

There is currently no uniform and coherent regulatory framework specifically governing egg freezing in the United States. Instead, egg freezing falls underneath the umbrella of ART. There is limited federal regulation of ART in the United States, which has resulted in the industry being labeled “The Wild West.” The most recognized and significant federal ART law in the United States is the FCSCA.

When passing the FCSCA, the Senate Committee on Labor and Human Resources concentrated on how “[m]edical advancements in the field of assisted reproductive technologies have significantly improved the likelihood of overcoming some infertility problems.” After several well-publicized instances where fertility doctors “misrepresented professional credentials, engaged in questionable advertising, and misused reproductive technology,” the act was pushed through Congress.

The FCSCA does not regulate reproductive technologies. It merely encourages the Centers for Disease Control (“CDC”) to collect data on the success of reproductive technologies in the United States. The CDC, under the Department of Health and Human Services, has served as the federal government’s primary arm for data collection on ART, clinics, and birthrates since 1992. The CDC collaborates with the Society for Assisted Reproductive Technology (SART) and the ASRM to annually measure the success of ART procedures.

Both SART and ASRM are self-regulated entities. SART was formed in 1987 as an affiliated society in response to the rapid development of ART technology in the United States and around the world. In conjunction with the CDC’s
reporting, SART also publishes success rates of SART clinic members on a voluntary basis within a national summary report.\textsuperscript{157}

ASRM, a non-profit organization, is composed of physicians, technicians, nurses, researchers, and other professionals.\textsuperscript{158} These individuals conduct research, publish reports, sponsor educational outreach programs, and draft policy guidelines.\textsuperscript{159} ASRM collaborates with the CDC and SART by endorsing or disapproving various reproductive technologies and setting corresponding guidelines.\textsuperscript{160} ASRM’s policies and guidelines are entirely voluntary.\textsuperscript{161}

Besides the FCSCA’s legislative response to ART, Congress has been practically silent on the issue.\textsuperscript{162} As a result, the United States has consistently been in “catch-up mode,” rather than in “shaping mode” regarding ART laws compared to many other countries around the world.\textsuperscript{163} The slow movement in change and lack of uniformity within the regulations is exemplified in the egg freezing procedure. The original definition of ART within the FCSCA only included procedures involving both the egg and sperm.\textsuperscript{164} Thus, egg freezing was initially not regulated under the FCSCA. Egg freezing was instead governed by a piecemeal legal scheme that combined “precedent set by frozen embryo disputes (that addresses disposition), statutes related to family law and inheritance (that define parentage), and basic contract law principles (which govern clinic-patient disputes and provide gap-fillers in the absence of other applicable legal terms).”\textsuperscript{165}

The legal scheme surrounding egg freezing will change slightly in the future, because the definition of ART within the FCSCA was amended in 2015 to include egg freezing.\textsuperscript{166} Fertility clinics that offer egg freezing will now have to provide
of egg freezing will still encompass the same issues that have plagued the FCSCA’s limited effect on ART.

C. Problems with the Current Regulatory Framework of ART

The current regulatory framework surrounding ART has two main issues. First, there is a lack of national standards that create a threshold of quality that fertility programs must meet to operate. The lack of uniformity and specificity in the regulations for ART influence how the CDC and SART report on fertility clinic success rates.

The FCSCA provides a regulatory framework for ART in the United States, but it is general and lacks real power. The FCSCA created a framework that only requires voluntary submission to guidelines and encouraged reporting of success rates. Among fertility clinics, the “gate-keeping methods” used to screen potential clients vary widely. Furthermore, there is no uniform standard or menu of services. Clinics vary as to the “techniques offered, the quality of treatment, size of staff, resources for women, and costs.” For example, one clinic may offer a variety of different fertility treatments from IVF to egg freezing. Another fertility network may connect patients with specialized doctors to perform the specific treatment the patient is seeking.

The lack of uniformity and complexity is compounded by the CDC and SART, which create national summary reports. The reports do not show the success rates for each individual program or treatment, but rather tally and summarize the data from different fertility clinics into one public report. Additionally, the CDC statistics and SART statistics likely differ because certain clinics may not be SART members, but still report to the CDC. The CDC report includes clinic specific success rates, but the SART report combines all clinics into one national summary. Because the summarized information is calculated based on cycles, the national reports are typically released two years behind, given the time needed to determine pregnancies conceived. Finally, both the CDC and

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167. See Mohapatra, supra note 65, at 393.
170. See Goodwin, supra note 32, at 44–45.
172. Id.
SART reports mainly focus on ART involving embryos, and the clinics within the reports are not given rankings by the CDC or SART. Therefore, the complexity of the data can result in patients misinterpreting and inappropriately comparing one clinic to another.

Second, there is a lack of serious financial or other sanctions for the ART programs that do not report success rates. The FCSCA uses the CDC to collect data related to ART, but the reporting of the data is completely voluntary. Moreover, the CDC is not a regulatory body and does not have the authority to sanction non-reporters. If a fertility clinic decides not to report success rates to the CDC, then there is no monetary penalty. Instead, noncompliant clinics are placed on a list of non-reporters published by the CDC in an appendix within the annual report. The current report assumes consumers will fully inform themselves about non-reporters. The nearly nonexistent punishment for non-reporters could potentially endanger consumers that would not be deterred from seeking services, especially within locations with limited ART options.

Ultimately, both issues within the current ART regulatory framework will have a direct impact on how egg freezing will be regulated in the future after its recent incorporation into the FCSCA ART definition.

IV. SOLUTION: EGG FREEZING REGULATION

The incorporation of the egg freezing benefit by the DOD in a government program calls for a solution to the current regulatory problems surrounding the ART field. This section will emphasize why an increase in regulations for egg freezing is needed now and will propose a regulatory solution to require reporting on egg freezing in the United States following a similar approach to the United Kingdom’s.

A. Increased Regulations for Egg Freezing Is Needed Now

Although there are many broad issues surrounding the current regulatory framework of ART, this Note argues for specific changes in the regulatory reporting requirements relating to egg freezing. Broad federal regulation of ART

176. Categories within the CDC national report include “Fresh Embryos from Nondonor Eggs,” “Frozen Embryos from Nondonor Eggs,” and “Donor Eggs.” Categories within the SART national report include “Outcome Per Egg Retrieval Cycle,” “Subsequent Outcome (Frozen Cycles),” and “Final Live Birth Per New Patient,” all of which combine data for fresh and frozen eggs and embryos. See id.


178. In 2000, the society developed guidelines and standards to which its members are expected, but not forced, to comply. In 1991, the director of the CDC reported that 90% of clinics were voluntarily reporting their conception success rates. Without an independent audit mechanism, the accuracy of this statement cannot be verified. See Hecht, supra note 161, at 253.

179. See Adamson, supra note 178, at 731.

180. See Mohapatra, supra note 65, at 393.

181. Id; 2014 CDC Report, supra note 139, at 574–76.

182. Id.
could improve outcomes for both women and their future children, but national regulations have historically been difficult to effectuate because the topic of fertility and women’s health is so polarizing. Nevertheless, ART regulation cannot be disregarded because there is a fear of failure in bringing provocative reproductive women’s policy issues to the table.

Egg freezing is a particularly good area within ART to begin. The increasing popularity and percentage of women undergoing the procedure clearly shows a need for more refinement and reform within the regulations. With the DOD’s recent decision to include egg freezing as an employee benefit for military women, the regulations surrounding egg freezing must be addressed now. The DOD’s initiative is the first government implementation of the egg freezing benefit, broadening the potential patient pool undergoing the procedure. What was formerly only an option within the Silicon Valley private sector has now become an option for employees of one of the largest employers in the world. The DOD set a precedent for more employers to follow. Increasing access to the benefit will lead to more women potentially facing the risks of the procedure. These women must be better informed when deciding whether to capitalize on the benefit or not.

Furthermore, the first clinic to only offer egg freezing, called Extend Fertility, opened in Manhattan in 2016. Dr. Joshua U. Klein opened his egg-freezing-only clinic in direct response to seeing uncomfortable millennials seeking to freeze their eggs sitting in fertility waiting rooms next to women who were older and struggling with infertility. He also found that removing the egg freezing process from the fertility clinic’s diagnostic services cut the price of the procedure down to just $5,000 for a starter egg freezing package. With Dr. Klein setting the precedent, more egg-freezing-only centers will likely open in the future.

The recent implementation of the benefit by the DOD, establishment of egg-freezing-only clinics, and general increase in women undergoing the procedure merit further review of policies that will specifically regulate egg freezing.

184. Catherine A. Clements, What About the Children? A Call for Regulation of Assisted Reproductive Technology, 84 Ind. L. J. 331, 338 (2009) (recognizing Clements argues for regulation of ART to improve outcomes for both prospective mothers and their future children using a different rationale in comparison to this Note).
185. See Daar, Federalizing Embryo Transfers, supra note 26, at 260.
186. See Schmidt, supra note 6.
187. See McCarthy, supra note 19 and accompanying text.
188. Id.
190. Id.
191. Id.
B. Suggested Change in Reporting Requirements for Egg Freezing

The FCSCA should be amended to include language adopting mandatory reporting requirements for egg freezing.\(^{192}\) The process of changing the language in the statute to institute mandatory reporting requirements would be simple.\(^{193}\) The current statute uses voluntary language to describe the reporting requirements for clinics.\(^{194}\) The legal responsibilities of fertility clinics should be clear and concrete, even in a field that is evolving rapidly with new technologies. Therefore, the language of the statute should be amended to require mandatory reporting of fertility clinic data for all procedures offered that meet the definition of ART under the FCSCA.

The current law provides that “each assisted reproductive technology (as defined in section 7) program shall annually report to the Secretary through the Centers for Disease Control.”\(^{195}\) The amendment could be effectuated by changing the word “shall” to “must.” The new mandatory language under the FCSCA would require fertility clinics that offer egg freezing to report data to the CDC. The mandatory reporting requirement would enable the second step to the regulatory reporting solution.

The federal regulation should also require reporting to be outlined in an easily understandable format to the public. The change should be effectuated directly by the CDC and SART, which create the annual national success rate reports. The current CDC and SART annual reports are not formatted to show direct figures regarding egg freezing success rates for clinics. The current reports either focus on frozen embryos or combine the total data for frozen embryos and frozen eggs.\(^{196}\) The combined data makes the information difficult for readers to parse out and understand.\(^{197}\) Furthermore, there is no specific information on each fertility clinic’s success rates for egg freezing.\(^{198}\)

With the amendment in reporting requirements, the new report would provide data on the success rates of women who freeze their eggs for personal, non-medical reasons. Incorporating a mandatory egg freezing reporting requirement can help guarantee information will be available for future patients. The CDC, SART, and ASRM have a responsibility to provide enough information to patients.\(^{199}\) The current state of reporting requirements fails to provide patients with sufficient knowledge to make informed decisions about fertility care.\(^{200}\) With the new requirements, Ellen may no longer have a dilemma.\(^{201}\)


\(^{193}\) Id.

\(^{194}\) Id.


\(^{197}\) See Daar, *Regulating Reproductive Technologies*, supra note 168, at 643.

\(^{198}\) Id.

\(^{199}\) See Hecht, supra note 161, at 253.


\(^{201}\) See supra Part III.A for background on Ellen’s dilemma.
The United States has a direct comparison of how it should go about requiring the reported data on egg freezing through the United Kingdom’s example. The United Kingdom is one of the more advanced countries in the world for creating structure and authority surrounding ART regulations. In 1990, the Human Fertilisation and Embryology Authority (“HFEA”) was enacted in the United Kingdom, which established an independent statutory licensing authority that regulates treatment using eggs, sperm, and embryos. The HFEA uniquely requires research on fertilization and embryos to complement treatment services for infertility. The development of new reproductive technologies comes about through the process of change in medicine which involves both research and patient care. The HFEA emphasizes that all dimensions of the process must be present for the result to be human and humane. Therefore, the HFEA requires frequent updates and reporting on forthcoming technologies as a way to inform the providers, as well as protect the patients and consumers of the services.

The HFEA Fertility Treatment 2014 Trends and Figures report exemplifies this philosophy by publishing the first set of figures on the emerging area of egg freezing and thawing within a separate section of their annual report. The report provides statistics on how many patients are storing their eggs, why women are freezing their eggs, how many patients are thawing their eggs, how many clinics perform this treatment, how long the eggs are frozen for, and the live birth rates of the eggs that are thawed. The most updated trends and figures in this report establish that there has been a substantial increase in the number of patients freezing their eggs. Of these patients who froze their eggs since 2001,
fewer than sixty babies have been born. Although this data is strictly from United Kingdom clinics, the trends and patterns provide meaningful insight about the procedure for patients in the United States.

The United Kingdom has laid a foundation for separate reporting on the egg freezing procedure, a growing area of ART. This Note does not petition for a complete transplant of United Kingdom ART regulation into the United States’ framework. Instead, the CDC and SART should mandatorily report on egg freezing following a similar approach to the United Kingdom’s. Egg freezing is now in its commercial infancy. Because egg freezing involves women who may be giving up their opportunity to have a child without medical intervention, it is particularly important that women are aware of how many successful births a clinic has had with frozen eggs. Details, such as the age of the women when they froze their eggs, how long the eggs were frozen, and the age of the women into which the eggs were implanted, could help female consumers compare clinics. Regulation enforcing this specific approach to reporting emphasizes how important it is for clinics to track this information over several years to uncover trends and analyze the procedure. Furthermore, requiring egg freezing information to be formatted in a comparable manner to the United Kingdom’s report will provide important decision-making information to future consumers.

The DOD’s new egg freezing policy creates an impetus for the United States to change its regulations to mandate similar reporting of egg freezing to the United Kingdom. Given the increased coverage and potential for women to undergo the egg freezing procedure, women should be fully informed of all the risks they may face. If mandatory reporting of egg freezing in a separate section of annual reports is required, then consumers can more easily obtain necessary information. Implementing the new reporting requirements on egg freezing will provide a stepping stone as ART develops and increased future regulations are needed.

CONCLUSION

The DOD’s recent expansion of the employer-provided egg freezing benefit into the government, which had previously only been a well-known part of Facebook and Apple’s health insurance coverage, calls for increased regulation in the ART field. Employers are incorporating the egg freezing benefit into health care plans because egg freezing may offer women more reproductive choices. By providing the benefit, employers hope to recruit and retain more women throughout their careers. There are many potential emotional, physical, and workplace harms to women if the egg freezing benefit is offered. Employers must consider and acknowledge these risks before implementing the benefit into their health insurance plans.

216. Id.
217. See Tsigdinos, supra note 41.
218. See Mohapatra, supra note 65, at 393.
219. Id.
220. Id.
221. Id.
As the popularity of egg freezing increases, more employers may follow the DOD’s precedent and begin providing the egg freezing benefit. The current state of regulations for egg freezing is disordered and incomplete. By expanding the FCSCA definition of ART to include egg freezing, egg freezing reporting now falls under federal regulation. The United Kingdom has begun to separately report egg freezing figures through their independent ART regulatory body. The federal reporting requirements in the United States should be amended to require reporting similar to the United Kingdom’s approach. The CDC and SART should report separate figures and trends regarding egg freezing treatment offered by fertility clinics. These changes would better inform potential consumers of the risks of the procedure and protect future women and their children.