

**MEDICINE AND SOCIETY: PEER-REVIEWED ARTICLE**

**Should Uterus Transplantation for Transwomen and Transmen Be Subsidized?**

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**Abstract**

Success in uterus transplantation (UTx) among ciswomen suggests that transwomen and some transmen will also likely have interest in this intervention. It does not seem likely, however, that all parties interested in UTx will have the same standing when it comes to federal subsidies or insurance coverage benefits. This analysis describes the comparative moral strength of claims for financial support for UTx that different parties might make.

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**Costs of Uterus Transplantation**

Gestation of a child following uterus transplantation (UTx) in cisgender women with absolute uterine infertility factor has proved successful in the United States.<sup>1</sup> Given the success of UTx that relies on both living and deceased donors, interest in the procedure is likely to extend beyond cisgender women.<sup>2</sup> Among those likely to be interested in UTx are transwomen who want to gestate their own children, transwomen who want uterus transplants to consolidate their identities but not to gestate children, some transmen who want to gestate their own children, and cisgender men wanting to gestate children of their own. Transwomen and cisgender men will not have been born with a uterus, and transmen might have had female-typical bodies in the past but lacked a uterus for reasons of disease or disorder. Here, we understand transgender people to be those who meet American Psychiatric Association or World Health Organization standards for gender dysphoria or gender incongruence respectively.<sup>3,4</sup>

In one possible economic arrangement, all parties wanting UTx for any reason would rely entirely on their own resources or philanthropy to pay all costs. However, because the costs are significant, it is likely that all parties interested in UTx will look to both private insurance and government providers for help covering costs. The Swedish researchers involved in the initial successful uterus transplants resulting in live births estimate the average cost per successful gestation to be €74 564—including in vitro fertilization (IVF) and medical care (€55 400) and paid sick leave (€19 164).<sup>5</sup> In the United States, the costs of UTx have been estimated to run between \$100 000 and \$300 000, and these

costs are typically paid by institutions themselves or through research grants supporting clinical trials.<sup>6</sup> A few institutions offer UTx to cisgender women paying out of pocket, although these women's insurance might cover some of their expenses that would ordinarily be paid by health insurers for pregnancy and childbearing.

No reliable estimates exist on how many transwomen, transmen, or cismen might be candidates for or want UTx, and even a rough estimate of what the individual cost might be for such people can only be speculative, especially since no UTx has been reported in such parties. However, the overall total financial cost of UTx for these parties would likely be smaller than the overall total cost for cisgender women because of the comparatively smaller number of transpeople and the even smaller subset likely to be interested in this intervention. In this analysis, we consider the comparative moral strength of transwomen's and transmen's claims for financial support.

### **Ethical Considerations**

Any system for subsidizing health care costs involves a mix of ethical and civic considerations. Ethical considerations typically focus on the importance of health as a good unlike any other. Health is good in itself, and it also serves as a means of access to other goods that confer meaning and value in life. Many governments offer some support for health care costs to ensure equity among their citizenry, but political opinion is divided over the rationale for and the extent of government responsibility to pay for health care. For their part, employers offering health insurance may understand insurance as a competitive tool in the marketplace—as a way to attract and retain the employees they want. Certain ethical considerations are of course taken into account by both government and private providers to ensure, among other things, that like cases are treated alike.

The strength of claims for subsidy of UTx will vary according to ethical rationales for covering costs in the first place. One might claim, for example, that UTx is important as a matter of health in restoring a compromised capacity that is the cause of pain and suffering.<sup>7</sup> Or one might claim that UTx is important as a matter of access to a good that is fundamental to social status equality. Some subsidies by private and government payers rely not on health, properly speaking, but on notions of well-being, and one might claim that UTx is essential to well-being.<sup>8</sup> Or one might claim that, as a transplant procedure, UTx ought to be eligible for the subsidy that governments provide for other transplantations.<sup>9</sup> When it comes to private insurance, one might argue that coverage for UTx is contractually implied in private insurance policies to the extent that these policies provide fertility coverage—as happens, for example, in states that require health insurers doing business in their state to provide a certain degree of subsidy for IVF.<sup>10</sup> In general, IVF and other interventions in fertility medicine are not subsidized by government or private insurers in the United States. With this background in place, let us review the various parties who might come forward with a claim for subsidy for UTx.

*Transwomen who want to gestate children.* Even though there has been no uterus transplant to date in transwomen that we know of, some clinicians have maintained that there are no absolute barriers in anatomy, hormones, and obstetric considerations that would rule out the possibility of successful UTx in transwomen.<sup>11</sup> Transwomen wanting to gestate children can plausibly justify subsidy of UTx on a number of grounds, as mentioned above. Transwomen lack a trait (the ability to bear children) that may cause them to experience psychological dissonance in a way that undermines their health and well-being. The lack of a uterus also closes off the prospect of gestating a child in a way

that is available to women as a class. It follows that lack of a uterus is an obstacle to full participation in the social goods attached to women's identity.

Such women might also note that because some insurance coverage is available in the United States for IVF, it is inconsistent that only some kinds of infertility treatment are subsidized. Moreover, just because no pregnancy has been achieved by UTx in a transwoman, some commentators have argued that the government has some responsibility to support research on methods to achieve that goal on the grounds that government has a responsibility to help secure equity in the social goods important to human well-being.<sup>8,12</sup> However, the counterargument might be raised that other options for having children are available, such as through adoption, thereby limiting government responsibility for that kind of research. Nevertheless, transwomen might point to values of gestation that cannot be offset by adoption and to obstacles that sexual and gender minorities sometimes face in adoption.<sup>13</sup>

*Transwomen who want to consolidate identity.* Some—but not all—of this rationale also applies to transwomen who want UTx not to have a child but to consolidate their identity. They may experience dissonance at not having a uterus but, in this case, UTx is not sought to remedy lack of access to the goods of gestation and childbearing. This interest in UTx might be judged to be less important than other kinds of medical interventions wanted by transwomen. For example, some transwomen seek subsidies for facial feminization because they exhibit a “masculine” face in an otherwise “feminine” presentation of self.<sup>14</sup> Their masculine-typical appearance can elicit harm, threats of harm, and social discrimination. Facial feminization can significantly diminish that adversity. Genital modification can also be important in helping people secure relationships consistent with their gender.

In contrast, UTx offers no comparable outward benefit, which is not to say that it is of no value, only that it might be evaluated as less important than other health care interests, especially if the risks of the intervention are not offset by a sufficiently important gain. It is also an open question whether carrying out UTx for one person's identity consolidation would close off the option for another person to secure UTx in order to have a child, in which case questions of justice would necessarily be involved, involving competing claims on limited resources. Moreover, UTx as currently practiced involves only temporary placement, whereas a uterus might be wanted indefinitely, thus exposing the individual to much longer-term risks of immunosuppression. Third-party payers might, again, reasonably judge a transient medical intervention less important and riskier than others, especially since for private insurers and governments alike resources will be limited.

*Transmen who want to gestate children after gender-affirming surgery.* Transmen start life with female-typical bodies but modify their bodies to align with male-typical traits to varying degrees. Some transmen have children prior to any body modifications that interfere with gestation. Others do not and have their uterus removed to conform their bodies to a certain gender ideal. Some transmen have transitioned in gender but retained their uterus and gestated children. This precedent triggered interest in UTx among transmen, especially if they did not retain their uterus or store gametes prior to their transition.<sup>15</sup> Transmen's justifications for subsidies will differ from those of transwomen in that transmen cannot claim that they lack a capacity characteristic of men that compromises their health or that compromises status equality with other men. Unless one wants to argue that all people have a fundamental interest in gestating, it is

not clear that men lack a capacity they ought to expect as a matter of reproductive justice.

Moreover, other means of having children are available to them, no less than to other adults facing infertility of one kind or another. One might make the case for some transmen, however, that their fertility was compromised by failure on the part of clinicians and institutions to incorporate the prospect of retaining a uterus until such time as they decided definitively not to gestate children. As a matter of restorative justice, some transmen might have a stronger case for subsidies than others. This claim would be undercut, of course, by informed consent processes that advised about this option.

### Conclusions

As UTx is clinically safe and effective in principle,<sup>16</sup> we might expect transwomen and some transmen to join with ciswomen in seeking subsidies for the procedure from government and private payers. In the United States, private insurers are free to offer coverage largely (but not entirely) as they choose. Some may be expected to resist coverage should UTx become possible for transwomen and transmen, especially employers that use their closely held businesses to express religious views.<sup>17</sup> By contrast, some employers offering health insurance may not want to discriminate against any actual or potential employees and thus may extend coverage of UTx to those parties. Federal and state providers of health insurance are also ultimately free to decide what medical interventions they wish to cover and for what reasons (whether for “health” in a limited sense or “well-being” in a more expansive sense). At present, some states require private insurers doing business in their jurisdiction to pay for certain IVF services, but most do not.<sup>18</sup> For its part, the federal government does not subsidize fertility treatment except under very limited circumstances.<sup>19</sup>

Certain moral considerations apply in the provision of health care by both private insurers and the state since the purpose and importance of health care services vary. We have offered scenarios involving stronger and weaker moral grounds for subsidy of UTx. Morally stronger claims for coverage point to the significance of UTx for protecting health, comparable coverage for **other fertility services**, and securing a gender-characteristic capacity as a matter of equity and access. Morally weaker cases involve claims grounded in personal interests unrelated to having children or achieving other kinds of status equality and involve relatively greater risk than benefit.

Even if we were to accept that some transpeople are morally entitled to subsidies for UTx, not all will be subsidized. Third-party payers are entitled to offer coverage in light of certain factors, especially medical criteria such as general health, age, and life expectancy. Not all transpeople will be positioned to benefit from UTx; some will simply not be healthy enough to undergo UTx, and, regardless of the reason they want UTx, third-party payers could justifiably decline reimbursement. Other parties will have stronger claims to UTx subsidies for reasons related to health and well-being—benefits that justify the risks. Bayefsky and Berkman have set out criteria for the allocation of uteruses from dead donors, including the prospect of success, medical eligibility, and age, among others.<sup>20</sup> Bruno and Arora have suggested further criteria, such as lower priority for parties who have already given birth.<sup>21</sup>

We suggest that governments and private insurers rely on similar kinds of **guidelines** to set out exclusion criteria for UTx, such that even when payers cover the costs for some,

they would retain the moral right to exclude coverage of UTx for other parties. Even if there are limits on subsidies, the case could be made that no moral obstacle stands in the way of justifying subsidies for UTx for some transwomen and transmen, just as there seems to be no fully persuasive argument against gestating a child via UTx.

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