Reverse Transplant Tourism

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I. Introduction

In this article, we analyze a novel form of kidney transplantation. The new approach involves cross-border kidney-paired donation, which we label “Reverse Transplant Tourism,” or “RTT.” Though RTT is currently still a hypothetical – to date, no RTT swaps have been performed – we argue that such a program, if properly structured, is both legal and ethical, and is a natural next step in the development of kidney exchange.

Kidney exchanges, in which patients with willing but incompatible living kidney donors exchange their donor’s kidneys, have become common in the United States. RTT takes this approach a step further, by redefining incompatibility to include not only immunological barriers, but also a more prevalent incompatibility when transplantation is considered worldwide—the barrier of poverty. In the United States, there are many patients with kidney failure (end-stage renal disease, or “ESRD”) who have insurance to pay for a transplant, but whose donor has the wrong blood type or HLA antigens and thus is not immunologically compatible. In contrast, there are many poor patients outside of the United States with willing compatible living donors, who are not able to afford the immunosuppression necessary to sustain a renal transplant.¹ In both these cases, the patients have barriers that prevent the transplant from moving forward.

RTT, if properly structured, can provide an opportunity for impoverished foreign patients to overcome their financial barrier and for American recipients to overcome immunological barriers through an international exchange of kidneys. Moreover, RTT reverses some of the more pernicious effects of typical transplant tourism, in which a (comparatively wealthy) individual with ESRD travels abroad,

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¹ The international pair could also be both immunologically incompatible and financially destitute, thus explicitly fitting within the plain language of the Norwood exception. Practically, however, a much greater impact will be achieved through the inclusion of biologically compatible, but destitute pairs. Thus throughout this paper we assume that the international pair is biologically compatible and specifically analyze the legally more complex, but medically more practical, possibility of RTT with biologically compatible international pairs.
normally to a comparatively poor country, to purchase organs for transplantation. These black market transactions have been widely condemned as a commercialization of organ transplantation that results in a net outflow of organs from the developing world to the developed (with accompanying cash flows in the opposite direction) under conditions that guarantee no protections for either donor or recipient.  

RTT, in contrast, leverages the donative intent and reciprocity of friends and family inherent in the kidney paired donation model to avoid the “organ deficit” of traditional transplant tourism – under RTT, organ flows out of each country are matched with inflows. RTT also extends the benefits of the US transplant system to impoverished nations, allowing patients who could never afford a kidney transplant to obtain one. The “reverse” in Reverse Transplant Tourism thus carries a double meaning, one geographic and the other figurative.

Imperative to developing a proper structure for RTT will be to partner with countries that have enough infrastructure available to their citizens to ensure that ongoing transplant-specific medical care is available and local conditions are not hazardous to an immunosuppressed patient, so that the kidney transplant for the impoverished patient is not lost from preventable causes. Other safeguards could include patient screening protocols, standards and procedures to ensure organ quality, and firewalls between the non-profit funder and participating transplant centers and, eventually, between the nonprofit and any insurance and pharmaceutical companies that may provide funding.

Part II introduces the concept of Kidney Paired Donation (“KPD”) and an increasingly common variant, Altruistically Unbalanced Kidney Paired Donation (“AUKPD”), arguing that RTT is less ethically controversial in some respects than AUKPD, because neither RTT pair could successfully transplant in the absence of a swap. Part III details our RTT proposal, illustrating the mechanics and expenses of the exchange. Part IV analyzes RTT’s permissibility under NOTA, concluding that RTT does not involve “valuable consideration” as contemplated by the statute. Part V considers the policy considerations that might motivate the ban against the exchange of valuable consideration for transplantable organs, concluding that RTT does not threaten any of these policy concerns and, in fact, improves on the status quo with respect to some concerns. Part VI discusses the numerous benefits of RTT,

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4 See infra Part VII (discussing these and other safeguards).
both to the individual patient participants and to the health care system more generally. Part VII discusses sustainability and safeguards, while Part VIII concludes.

II. AN INTRODUCTION TO KPD

In this section, we introduce KPD, as practiced domestically in the United States, and the relevant laws governing it. This discussion will help set the stage for the RTT proposal we detail in section III, below.

A. Conventional KPD

Estimates suggest that roughly 6000 ESRD patients on the waiting list have a willing, but incompatible, living donor.\(^5\) KPD arose as a means to permit these patients whose donor has the wrong blood type or HLA antigens to nonetheless receive a kidney transplant, due to the willingness of their incompatible donor to donate.

To illustrate, suppose that Amanda wants to donate a kidney to Bob, but is unable to do so, either because their blood types do not match or because there is some other incompatibility. Another pair, Carlos and Diana, faces the same problem. However, Carlos is compatible with Bob and Amanda is compatible with Diana. By “swapping,” as illustrated in Figure 1, KPD enables two transplants, providing both Bob and Diana with a compatible kidney.\(^6\) Though KPD began with these types of two-pair exchanges, more recently longer exchanges and chains of transplants have come to dominate.\(^7\)

KPD has experienced rapid growth in recent years due to advancements in kidney matching algorithms and the ability to ship organs from living donors.\(^8\) Yet, barriers remain. Specifically, blood type O donors are disadvantaged in a KPD system. If one considers a pool limited to blood type incompatible pairs, there will be no blood type O donors. This is because, as the universal donor, most O-type donors are able to donate to their intended recipient, unless the intended recipient has antibodies


directed against the donor’s kidney. Thus, blood type O donors are enrolled into KPD pools only when the recipient has donor-specific antibodies that prevent the intended donor from being compatible. As a result, O-type recipients, who can only receive from O-type donors, are less likely to find suitable donors through KPD, given the shortage of O-donor pairs in the pool. This is a troubling fact, given that O blood type candidates comprise more than half of the waiting list and have longer median waiting times than any other blood group. As a result, some KPD programs now include biologically compatible donors in KPD, sometimes referred to as “altruistically unbalanced” KPD (hereafter, AUKPD).

Figure 1

B. AUKPD And The Case For RTT

While the inclusion of compatible pairs in KPD is not without controversy, many KPD programs now include compatible pairs, due to the utilitarian benefits of such

9 Jeremy M. Blumberg, Kidney Paired Donation: Advancements And Future Directions, 16 Current Opinion in Organ Transplantation 380, 380-81 (2011)
inclusion, particularly the increased number of O blood type donors that will be added to the KPD pool.\textsuperscript{11} For example, one study found that the inclusion of compatible pairs in a national KPD registry could more than double the probability that donor/recipient pairs find a compatible KPD match, from 37.4\% to 75.4\%.\textsuperscript{12} Moreover, there are several potential benefits to individual compatible pairs from participation in KPD. For example, it may be possible to improve the recipient’s outcome by “trading up” for a younger organ, a more appropriately sized organ, or for a better immunological match.\textsuperscript{13} In addition, some compatible pairs may choose to participate in KPD solely for altruistic reasons, which some researchers consider a psychological benefit in favor of compatible pair inclusion in KPD and others consider an ethical problem that weighs against such inclusion.\textsuperscript{14}

It is worth noting that RTT fares well against these ethical concerns. Some commenters, such as Ross, object to the inclusion of compatible pairs in KPD because of the “altruistically unbalanced” nature of the exchange – the incompatible pair receives something of great value (a compatible organ), while the compatible pair enters a complex exchange unnecessarily and without sufficient countervailing benefit.\textsuperscript{15} Though others dispute that contention,\textsuperscript{16} the concern is clearly not present in the case of RTT. Rather than presenting a potentially unbalanced exchange, both RTT pairs are made better off. One pair, though biologically compatible, would be unable to engage in the transplant due to financial constraints. The other, biologically incompatible pair, would be unable to transplant due to incompatibility. KPD provides great benefit to both pairs, permitting two transplants to occur that otherwise would not. With respect to ethical concerns regarding altruistic balance, therefore, RTT is less problematic than existing compatible-incompatible KPD programs. Of course, RTT raises other legal and ethical concerns not posed by domestic AUKPD. As discussed in Parts IV and V, however, these concerns are surmountable and can be adequately addressed through a variety of safeguards.

C. The Legal Status Of AUKPD And RTT Implications

\textsuperscript{12} Gentry SE, et.al., Expanding kidney paired donation through participation by compatible pairs. Am J Transplant 2007; 7:2361–2370.
\textsuperscript{13} Blumberg, at 382-83.
\textsuperscript{14} Compare, e.g. LS Ross and ES Woodle, Ethical Issues in Increasing Living Kidney Donations by Expanding Kidney Paired Exchange Programs, 69(8) Transplantation 1539 (2000) (criticizing altruistically unbalanced kidney paired exchange as ethically problematic) with Ratner, supra note __ at 108 (defending AUKPD).
\textsuperscript{15} See David Steinberg, Compatible-Incompatible Live Donor Kidney Exchanges, Transplantation • Volume 91, Number 3, February 15, 2011, p. 257.
\textsuperscript{16} \textit{Id.}
The National Organ Transplant Act (NOTA) prohibits the knowing acquisition, receipt, or transfer of “any human organ for valuable consideration for use in human transplantation if the transfer affects interstate commerce.”\(^\text{17}\) NOTA does not define the term valuable consideration and, as detailed in Part IV, the act’s legislative history provides almost no guidance regarding the meaning of the term beyond the obvious legislative concerns of “buying,” “selling,” and “commerce” in human organs.\(^\text{18}\) In the Charlie W. Norwood Living Organ Donation Act (“Norwood”), however, Congress provided some guidance on what is \textit{not} valuable consideration.\(^\text{19}\) Specifically, Norwood provided that NOTA’s ban against valuable consideration did not apply to KPD among biologically incompatible pairs.\(^\text{20}\)

This raises two important points relevant to the RTT discussion. First, Norwood provides a non-exclusive exemption from the definition of valuable consideration. There is no suggestion that Congress intended its failure to specifically exempt any activity to be read as a condemnation of that activity. In fact, just the opposite is true. Norwood’s legislative history suggests that the ban on “valuable consideration” remains the touchstone for determining legality under NOTA. Indeed, during Congressional deliberations on Norwood many members of Congress emphasized that the statute was unnecessary, as it should be obvious that KPD did not involve “valuable consideration” as contemplated by NOTA.\(^\text{21}\)

The prevalence of AUKPD further supports this interpretation. Though only biologically incompatible pairs are specifically exempted by Norwood, as already noted, AUKPD is becoming increasingly common and – though not entirely free from controversy – is largely accepted by the medical community. Our research has uncovered no suggestion in either the legal or medical literature that the practice is illegal under NOTA. The foregoing is relevant to a legal analysis of RTT – the text of NOTA and Norwood and the legislative history of both provisions suggest that RTT is prohibited only if it involves the transfer of a human organ in exchange for valuable consideration. We address the legality of RTT under NOTA’s prohibition against valuable consideration in detail in Part IV, below.

III. AN RTT PROPOSAL

To illustrate the mechanics of our RTT proposal, recall the previously-discussed donor-recipient pairs of Amanda-Bob and Carlos-Diana. Let us imagine now, however, that Carlos and Diana, rather than facing biological incompatibility, face a

\(^{17}\) National Organ Transplant Act §274e.


\(^{19}\) Public Law 110–144 110th Congress, 42 USC 201 (2007).

\(^{20}\) \textit{Id.}

\(^{21}\) See infra notes 48-57 and accompanying text (providing examples).
different problem: they are poor and live in a country where poverty is a barrier to transplantation. For a specific example, assume that Carlos and Diana live in Mexico. The Mexican health care system pays for the basic medical costs of transplantation, such as the nephrectomy, transplant, and the in- and outpatient costs associated with the surgery. Importantly, however, the most basic form of public health insurance in Mexico does not pay for the outpatient immunosuppressive drugs necessary to prevent Diana’s body from rejecting Carlos’s kidney, which cost at least several thousand dollars per year and which Diana must take for the rest of her life. Unless Diana has sufficient personal wealth to pay for this ongoing long-term care, therefore, transplantation is unfeasible.

As illustrated in Figure 2, RTT can help both Bob and Diana, allowing each to receive a kidney that they otherwise could not – in Bob’s case because of his biological incompatibility with Amanda, and in Diana’s case because of her lack of access to adequate long-term immunosuppression. Under RTT, the domestic pair (Amanda and Bob) would both remain in the United States, while Carlos, the international donor, would travel to the United States for transplantation, and Diana, the international recipient, would remain in her home country (in Diana’s case, Mexico). The expenses of the swap will be paid by a combination of three parties: the Mexican government; Bob’s insurance provider; and a nonprofit organization established for the purpose of paying for excess medically necessary expenses associated with RTT swaps. Note that the swap is designed to ensure that neither the US-based insurance provider nor the Mexican government pay more than would be required for a transplant directly from Amanda to Bob or from Carlos to Diana, respectively. In fact, as will be discussed in more detail in Part V, RTT could eventually reduce the long-term costs of ESRD to both the US and Mexican governments and to US insurance providers.

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22 We will hereafter refer to Amanda and Bob as the domestic donor and domestic recipient, respectively, and as the domestic pair, collectively. We will refer to Carlos and Diana as the international donor and international recipient, respectively, and the international pair, collectively.
A. The Amanda-Diana Transplant

Let us first analyze the expenses associated with the transplant from Amanda to Diana, which will involve removing Amanda’s kidney in the United States and shipping it to Mexico for transplantation into Diana, as illustrated by Figure 3. Table 1 details the relevant parties to the swap and their accompanying expenses.

For the Amanda-Diana portion of the swap, Amanda will remain in the United States and her nephrectomy will be performed there. Her kidney will then be shipped to Mexico. The costs of Amanda’s nephrectomy and any other associated medical costs will be borne in part by the Mexican government according to what they would normally pay for a living donor’s kidney to be removed in Mexico. Not surprisingly, the cost of such surgery is higher in the United States – a cost that the Mexican government is unwilling to pay. This remainder, therefore, will be paid by a non-profit organization, as will the costs of shipping the kidney internationally.

As already noted, the Mexican government pays for some, but not all, of the expenses associated with transplants performed in Mexico. Because Diana is transplanted in Mexico, the cost of subsequent care is paid for by the Mexican government, supplemented with support from a nonprofit organization. Diana’s
outpatient immunosuppressive drugs and transportation to and from the transplant clinic or hospital will be provided by the nonprofit organization. The Mexican government will pay Diana’s outpatient clinic visit and inpatient admission expenses.

**Figure 3**
### Table 1

<table>
<thead>
<tr>
<th></th>
<th>Amanda Domestic Donor</th>
<th>Bob Domestic Recipient</th>
<th>Carlos International Donor</th>
<th>Diana International Recipient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
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<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Costs paid by</td>
<td></td>
<td></td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Mexican govern</td>
<td></td>
<td>Nephrectomy and other associated medical costs, up to normal amounts required for a transplant performed in Mexico.</td>
<td>All costs of transplanttion, immunosuppressive drugs (up to three years if Medicare primary)</td>
<td>All medical costs (nephrectomy, domestic kidney shipping, if any)</td>
</tr>
<tr>
<td>by Bob's insurance or Medicare</td>
<td>NA</td>
<td>All travel, food, and lodging costs</td>
<td>Outpatient clinic visit, all inpatient admission expenses, cost of subsequent care</td>
<td></td>
</tr>
<tr>
<td>Costs paid by non-profit organization</td>
<td>Kidney shipping and medical costs in excess of normal expenses for nephrectomy in Mexico</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

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### B. The Carlos-Bob Transplant

The Carlos-Bob transplant is illustrated by Figure 4. Carlos, as the international donor, will have to travel to the United States for a nephrectomy, as the Organ Procurement and Transplantation Network (OPTN) specifies that US transplant centers may only transplant living donor kidneys that have been removed at an OPTN-approved living donor nephrectomy site — there are no sites approved outside of the United States.²³ All of Carlos’s medical costs (for example, the

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²³ The Organ Procurement and Transplantation Network (OPTN) specifies that live kidney donation is only permissible when the transplanted kidney is removed at an OPTN member transplant facility. U.S. DEPT OF HEALTH AND HUMAN SERVS., ORGAN PROCUREMENT & TRANSPLANTATION NETWORK, POLICIES: LIVING
nephrectomy and domestic kidney shipping, if required) will be borne by Bob’s insurance provider.24 Carlos’s travel, food, and lodging costs would be paid by the nonprofit organization. Bob’s transplant will occur in the United States and all of his costs will be borne by his insurance provider.


24 The term “insurance provider” includes both commercial insurance providers and Medicare, as applicable.
IV. RTT Under NOTA

The legal status of RTT under NOTA is best understood by analyzing NOTA’s applicability to each component of the RTT swap. The RTT medical expense payments by U.S. insurance providers and the Mexican government are—by design—simply the normal reimbursements for transplantation by each of these entities and are legally unproblematic. This section thus analyzes those expenses covered by the nonprofit entity. Specifically, and as detailed in Table 1, those expenses include: (1) Amanda’s kidney shipping and medical costs in excess of normal expenses for nephrectomy in Mexico; (2) all of Carlos’s travel, food, and lodging costs; (3) Diana’s outpatient immunosuppressive drugs (up to 10 years); and (4) Diana’s transportation to and from the transplant clinic or hospital.

A. Diana’s Drugs And Transportation

As previously discussed, NOTA prohibits the knowing acquisition, receipt, or transfer of “any human organ for valuable consideration for use in human transplantation if the transfer affects interstate commerce.”25 Though the term “valuable consideration” is left undefined, NOTA specifically excludes certain payments from the definition:

The term ‘valuable consideration’ does not include the reasonable payments associated with the removal, transportation, implantation, processing, preservation, quality control, and storage of a human organ or the expenses of travel, housing, and lost wages incurred by the donor of a human organ in connection with the donation of the organ.26

Items one and two of the RTT reimbursements discussed above and categorized in Table 1 are exempt from NOTA’s definition of valuable consideration, provided they are reasonable in amount, under the plain language of the statute. Items three and four, however—the payments for Diana’s outpatient immunosuppressive drugs and Diana’s transportation to and from the transplant clinic or hospital—are not explicitly addressed by NOTA. These payments may appear, at first glance, an odd possibility for inclusion under the definition of “valuable consideration.” After all, Diana is an organ recipient, not an organ donor. And though Carlos gives up his kidney, he receives no direct compensation in return. It is thus tempting to conclude that NOTA has no bearing on these reimbursements.

Such a conclusion would be premature. A court could infer that, when Carlos agrees to donate his kidney through RTT so that Diana can receive the immunosuppression and medical transport necessary to complete her transplant, Carlos has received valuable consideration in exchange for his kidney. The transaction, in the eyes of

25 National Organ Transplant Act §274e.
26 NOTA Sec. 274e (c)(2)
the law, could be equivalent to Carlos exchanging his kidney for cash, then using that money to purchase the immunosuppressive drugs and transport for Diana.\textsuperscript{27} Accordingly, we assume that these reimbursements must pass muster under NOTA. That determination requires an analysis of NOTA’s legislative history as well as the possible policy rationales behind the statute, an analysis we undertake in Parts IV B-C and V.

We do not wish to make too much of the kidney for cash which is then used to purchase drugs and transport analogy, however. Traditional KPD, AUKPD, NEAD chains, and RTT are each examples of a donor who agrees to transfer his kidney only in exchange for something of value.\textsuperscript{28} In the case of KPD, AUKPD, and NEAD chains the value received is a compatible kidney for a friend or family member. In the case of RTT, the value received is medically necessary immunosuppression, transportation to and from the transplant clinic or hospital, and a compatible kidney transplant. Yet, Congress has explicitly exempted KPD from NOTA’s prohibition against the exchange of valuable consideration for transplantable organs (though, as discussed in part IV.C., many members of the Norwood Congress argued that an explicit exemption was unnecessary). And AUKPD and NEAD chains are increasingly common, despite the lack of an explicit Congressional exemption. The common assumption (and one that we share) appears to be that AUKPD and NEAD chains are legally permissible because of their similarity to KPD, the underlying federal concerns that prompt the ban against valuable consideration, and the original donative intent of each participant – each donor would give altruistically to her friend or family member, if only she could do so.\textsuperscript{29} RTT shares these characteristics.

B. NOTA’s Text and Legislative History

Although NOTA is today most often discussed in connection with the prohibition on valuable consideration, it is important to remember that such a ban was not the central purpose of the statute. In fact, original drafts of NOTA addressed only the development of a national organ procurement and distribution system.\textsuperscript{30} The

\textsuperscript{27} C.f. Choi, Gulati, and Posner, THIS VOLUME (discussing “altruism exchanges” and their status under NOTA).
\textsuperscript{28} A NEAD (nonsimultaneous, extended, altruistic donor) chain is similar to a kidney swap. However, in a NEAD chain an altruistic donor gives a kidney to a patient, initiating a chain of transplants among a series of incompatible donor-patient pairs. The addition of the altruistic donor at the front of the chain frees the constraint of simultaneity and reciprocity, allowing longer chains with more transplants. See Rees, et. al, supra note 7 (discussing NEAD chains in more detail).
\textsuperscript{29} Healy & Krawiec, supra note 18 (arguing that NEAD chains can be squared with both the language and legislative history of NOTA, despite the exchange of something of great value).
\textsuperscript{30} Sally Satel and Joshua C. Morrison, SYMPOSIUM ARTICLE (discussing the origination of NOTA’s ban on valuable compensation).
prohibition on compensated organ donation was added later, in response to a *Washington Post* article about the plans of H. Barry Jacobs, a Virginia physician whose medical license previously had been revoked for Medicare fraud, to establish a for-profit organ brokerage.31

Perhaps because of this late addition to the statute in response to a specific concern, neither NOTA’s text nor the legislative history provide meaningful insight into the meaning of the term “valuable consideration.” Looking first at the language of the statute, most analyses of the term “valuable consideration” – including an influential Department of Justice memo on the topic – conclude that the phrase has no clear meaning.32 Although the term “consideration,” with origins in the common law of contract, has a fairly well-established meaning that clearly encompasses a variety of non-monetary bargains, the significance, if any, of the additional word “valuable” is much less clear.33 The phrase is rarely defined and the meaning, to the extent one is discernable, appears to have varied across time, place, and setting.34 Though some sources treat the two terms as synonymous, other sources (including cases, statutes, and secondary sources) suggest that the word “valuable” denotes a financial or pecuniary gain.35

31 Id.
33 Id.
34 Id.
35 Id. See also, Prewit v. Wilson, 103 U.S. 22, 24 (1881) (“[m]arriage is to be ranked among the valuable considerations, yet it is distinguishable from most of these in not being reducible to a value which can be expressed in dollars and cents.”). Contemporaneous state laws also define “valuable consideration” as involving financial gain. See, e.g., Cal. Penal Code § 367f(a) (2005) (prohibiting the transfer of any human organ for valuable consideration, then defining valuable consideration as “financial gain or advantage.”) Id. § 367f(c)(2).

Choi, Gulati, and Posner assume that “valuable consideration” has the same meaning as “consideration” under contract law, but conclude that certain altruistically-motivated exchanges, including NEAD chains, operate under a legal fiction that treats certain exchanges for value, when undertaken for altruistic purposes, as gifts. Choi et. al. this volume. Though we believe the better interpretation is that such exchanges do not involve valuable consideration as contemplated by NOTA, RTT nonetheless passes muster as such a legal fiction. Though Choi et. al. conclude that NOTA should be amended to explicitly permit their proposed altruistic exchanges, RTT differs from these proposals in that it contemplates only the provision of those goods or services medically necessary to complete the transplant, thus making it similar to NEAD chains, AUKPD, and the explicit exemptions for expenses incident to the transplant contained in NOTA. See infra notes and accompanying text (discussing this in more detail).
Other elements of NOTA and its legislative history reinforce the notion that Congress certainly meant to prohibit the commercial, for-profit, buying and selling of human organs for transplantation. The extent to which it intended to reach other exchanges in which the donor receives some benefit, however, is far from clear. For example, the title of section 301 “Prohibition of Organ Purchases,” suggests a congressional concern with the buying and selling of organs for profit, as do statements in the accompanying Senate and House conference reports. During House hearings on NOTA, the most commonly discussed issues were the need to address the organ shortage through a combination of national coordination and federal financial support and the controversial provision for Medicare coverage of outpatient immunosuppressive drugs. Several House members did mention the §301 prohibition against valuable consideration in exchange for human organs, sometimes with a specific allusion to the Jacobs venture, but without elaborating on the meaning of the term “valuable consideration” beyond commercial buying and selling. For example, California Representative Henry A. Waxman stated:

In recent months, proposals have been made to encourage otherwise healthy individuals to sell one of their kidneys in exchange for payments ranging from $6,000 to $50,000. If these commercial ventures were allowed to proceed, I believe our efforts to promote voluntary organ donations would collapse, and health risks to transplant patients would greatly increase.

Other House member statements, while condemning organ buying and selling, were similarly uninformative. Even the most specific references to the §301 ban tend

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37 See generally, Hearing Before the Subcommittee on Health of the Committee on Ways and Means, House of Representatives, Ninety-Eighth Congress, Second Session on H.R. 4080, To Amend The Public Health Service Act To Authorize Financial Assistance For Organ Procurement Organizations, And For Other Purposes (Feb. 9, 1984).

38 Id. At 26 (Statement of Hon. Henry A. Waxman, A Representative In Congress From The State Of California, And Chairman, Subcommittee On Health And The Environment, Committee On Energy And Commerce). (emphasis added)

39 Id. At 30 (Statement of Hon. Edward R. Madigan, A Representative In Congress From The State Of Illinois) (“I wholeheartedly agree that the buying of human organs should be made illegal”); Id. At 34 (Statement of Hon. W. Henson Moore, A Representative in Congress from the State of Louisiana) (“I also agree with the comment that Mr. Waxman made in his testimony that we ought to prohibit the sale of organs.”)
to address the meaning and scope of terms other than “valuable consideration.” The most detailed discussions of §301 terminology, for example, address clarifications or expansions of the definition of “reasonable expenses” and arguments to exclude blood, blood products, and other items from the definition of “organ.”

In the Senate, the Committee On Labor And Human Resources held hearings on organ transplantation in 1983, after NOTA had been introduced in both the House and Senate. As in the House, the Jacobs proposal was referenced by several Senate members, accompanied by condemnations of organ buying and selling. As in the House, there was also some discussion of the term “reasonable expenses.” For example, witnesses expressed concern that “reasonable expenses” must include out of pocket expenses associated with organ donation, such as travel, lost wages, and the like, lest the statute operate as a deterrent to organ donation, rather than an encouragement. But, as in the House, a careful reading of the Senate history of NOTA suggests that Congress paid little, if any, attention to the possible meanings of and ambiguities in the phrase “valuable consideration.”

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40 Id. At 34, Response of Rep. Al Gore (noting that “we are changing the bill to change the definition of ‘valuable consideration,’ so that it does not include the reasonable costs associated with removal, processing, preservation, quality control procedures, storage, and transportation.”) and at 36 (noting that “we are going to specifically exclude corneas” from the definition of “organ”); Id. At 130, Statement Of Robert E. Stevnson, Ph.D., American Association Of Tissue Banks (noting that while the current draft excludes “the reasonable costs associated with removal, storage and transportation’ the bill fails to consider the reasonable costs of quality control, processing, and preservation which are equally essential to high quality organ and tissue transplantation.”); Id. At 116, Statement Of The American Medical Association, Presented By James E. Davis, M.D. (urging the exclusion of blood and blood products from the ban on organ sales); Id. At 170, Statement Of Mary Jane O’Neill, Executive Director, The Eye-Bank For Sight Restoration, Inc., New York, N.Y., (urging the inclusion of “processing, preservation and quality control procedures among the reasonable costs not included in the term ‘valuable consideration.’”);  

41 Hearing Before The Committee On Labor And Human Resources United States Senate Ninety-Eighth Congress First Session On Examination Of The Problems Involved In Obtaining Organs For Transplant Surgery October 20, 1983.  

42 Id. At 131, 135, Statement of Senator Metzenbaum (referencing “a Virginia physician’s” organ brokerage proposal); Id. At 13 Statement of Senator Dan Quayle (referencing “the Washington Post article about the Virginia physician who has written the FDA seeking a license to import organs” and condemning such methods).  

43 See, e.g., Id. At 250, Statement of Carol G. Bluemle (“to send or threaten to send donors to prison for receiving reimbursement for out-of-pocket expenses would decrease the total pool of available kidneys”).
In sum, a vast academic literature addresses valuable consideration under NOTA. Concerns about running afoul of the provision have halted state programs, such as Pennsylvania’s planned pilot program to reimburse funeral expenses, and have caused uncertainty about the validity of specific practices, such as kidney swaps. Commenters debate the meaning of the term and what Congress must have intended with this ambiguous language. But our analysis suggests the limits of attempts to divine NOTA’s intended scope from the statute’s legislative history. Congress provided almost no guidance on the meaning of the term beyond the obvious (and immediately salient) threat of buying, selling, and for-profit commerce in human organs and failed to outline the extent to which NOTA reaches other exchanges in which the donor receives some value.

C. From NOTA To Norwood

Between the passage of NOTA, in 1984, and the Norwood Act, in 2007, Congress had several occasions to clarify, expand, or otherwise alter the ban against valuable consideration in exchange for human organs and failed to do so. For example, bills were introduced or considered that would have allowed tax credits, honorific awards, and the provision of insurance policies as incentives for organ donation. None of these bills passed, however, and NOTA’s original language banning valuable consideration remained unchanged. While these failed Congressional efforts thus did nothing to clarify or alter the meaning of the term “valuable consideration” as used in NOTA, we reference the debates surrounding these potential changes in Part V, where we analyze the possible federal concerns underlying NOTA.

In 2007, however, Congress explicitly revisited the term “valuable consideration,” when passing the Norwood Act. Prior to 2007, some Organ Procurement Organizations had implemented KPD programs. Due to an interpretation by the Department of Health and Human Services that KPD may violate NOTA, however,

44 Jed Adam Gross, E Pluribus UNOS: The National Organ Transplant Act and Its Post-Operative Complications, 8 Yale J. of Health Policy, Law, & Ethics 145, 148 (2013) (finding that the vast majority of articles on NOTA address the section 301 ban against valuable consideration.)
45 Cite for Penn program; see infra notes __ and accompanying text (discussing the uncertainty surrounding kidney swaps).
46 See, e.g. R.S. Gaston, et. al, Limiting Financial Disincentives in Live Organ Donation: A Rational Solution to the Kidney Shortage, 6 AM. J. OF TRANSPLANTATION 2548 (2006) (proposing a compensation scheme for organ donors and defending its legality under NOTA), MORE
47 Satel, et. al, supra note __ ( detailing these bills and the surrounding debates); Erin D. Williams, et al, Living Organ Donation and Valuable Consideration, Congressional Research Service 3 (2010) (detailing bills designed to incentivize organ donation).
many hospitals were reluctant to perform paired donations, for fear of violating NOTA.\footnote{153 Cong. Rec. H 2192 (March 6, 2007) (Statement of Rep. Dingell); id. (statement of Rep. Gingrey).
}

In the course of enacting the Norwood Act, many Congressional members made claims regarding the intent of the NOTA-enacting Congress with respect to the phrase “valuable consideration,” reiterating the enacting Congress’s refrain that the statute was intended to prohibit the buying and selling of transplantable organs. We reference that discussion here, not to suggest that these remarks have any direct bearing on the term’s meaning – most legal scholars conclude that they do not.\footnote{Many commentators and jurists contend that subsequent legislative history of this sort should have no relevance in statutory interpretation and black letter statements of the law typically emphasize subsequent legislative history’s inferior role in statutory interpretation, even among those willing to accord some weight to legislative history. See, e.g., Richard A. Posner, Statutory Interpretation – In the Classroom and in The Courtroom, 50 U. Chi. L. Rev. 800, 809-10 (1983) (arguing that courts should ignore subsequent legislative history); Consumer Product Safety Comm’n v. GTE Sylvania, 447 U.S. 102, 118 n.13 (1980) (“isolated statements by individual Members of Congress or its committees, all made after enactment of the statute under consideration, cannot substitute for a clear expression of legislative intent at the time of enactment”).}

But subsequent legislative history may, nonetheless, be relevant to courts as a means to determine the probability of being overruled through subsequent legislative action and in assessing current societal norms.\footnote{See, e.g., Daniel A. Farber & Phillip P. Frickey, Legislative Intent and Public Choice, 74 Va. L. Rev. 423, 467-68 (1988); Lee Epstein & Jack Knight, Mapping Out the Strategic Terrain: The Informational Role of Amici Curiae, in Supreme Court Decisionmaking at 226 (arguing that the probability of legislative override is relevant to courts and that they glean information about this probability from many sources, including the current positions of legislators). In addition, recent empirical work documents some citations to subsequent legislative history, suggesting at least some relevance. Epstein & Staudt – which paper?}

In any event, together with the material in Part V, this history may help elucidate the possible public policy rationales underlying NOTA and we include it for that purpose.

For example, Representative Inslee stated on the house floor when introducing the Norwood bill that “I believe it is imperative that we make it clear that there is no intent by Congress to bar this procedure. It is my hope that the Senate will act quickly on this. Simply put, we want this legislation to save lives immediately.”\footnote{153 Cong. Rec. H 2192 (March 6, 2007) (Statement of Rep. Inslee) (emphasis added).}

Similarly, Representative Dingell insisted that “the [valuable consideration] clause was intended to outlaw the buying or selling of transplantable human organs.”\footnote{Id. (Statement of Rep. Dingell).}
Representative Linder: “The valuable consideration clause has a noble purpose, which is to keep people from buying and selling human organs. . . . Let me be clear: paired-organ donation does not constitute the buying or selling of organs.”

Some House members made reference to the fact that the Norwood Act would “clarify” that NOTA’s ban on valuable consideration did not prohibit KPD, suggesting that the statute was never intended to ban such behavior. Charlie Norwood himself was even more explicit in a statement read into the record (he had died just a month earlier from lung cancer that spread to his liver, despite a successful lung transplant):

For years, people missed or were delayed in an opportunity to have a life-saving kidney transplant simply because a member of the executive branch couldn’t grasp the true intent of the National Organ Transplant Act’s valuable consideration clause. The valuable consideration clause was meant to outlaw the buying and selling of organs, which everyone agrees is proper . . .

Now, I’m just an old country dentist, but isn’t this just common sense? I want to give to someone, but I’m not compatible, but I can give to another patient. Their willing, yet also incompatible, friend can give to my loved one. As a result, two people live; two more slots are opened on the list for even more transplants to take place. Common sense, Mr. Speaker.

However, instead of every single transplant center undertaking this commonsense approach, some folks were denied the chance to be cross-matched and, instead, their loved one suffered and even died while awaiting a transplant.

The Senate record expresses similar sentiments. For example, said Senator Levin when introducing the Norwood legislation in the Senate:

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53 Id. (Statement of Rep. Linder).
54 Id. (Statement of Rep. Barton) (“The legislation before us today clarifies the ability to perform paired transplantations through the National Organ Transplant Act, or NOTA. This legislation clarifies that paired donations are not considered a valuable consideration.”); Id. (Statement of Rep. Gingrey) (“H.R. 710 would clarify in statute that that this type of paired living kidney donation would be allowed under Federal law.”)
This legislation is necessary because the National Organ Transplant Act, NOTA, which contains a prohibition intended by Congress to preclude purchasing organs, is unintentionally impeding the facilitation of matching incompatible pairs, as just described. ... That section has been interpreted by a number of transplant centers to prohibit such donations. ...

Congress surely never intended that the living donation arrangements that permit paired donation be impaired by NOTA. Our bill simply makes that clear.57

In sum, Norwood’s legislative history provides no suggestion that RTT involves valuable consideration. In fact, just the opposite is true. Though the dominant view among scholars and jurists is that subsequent legislative history is, if not wholly irrelevant in determining a statute’s meaning, at least of secondary importance as compared to the original text and contemporaneous legislative history, many scholars have argued that subsequent legislative history is, nonetheless, relevant to courts. This is not so much because courts use such history to determine what the enacting Congress meant, but because courts have a natural aversion to being overridden and are often interpreting vague language by reference to contemporary social norms and standards. Under that metric, the case for the legality of RTT is strong.

V. Policy Rationales

Even if Congress did not clearly specify the intended scope of NOTA’s prohibition against valuable consideration in exchange for human organs, commentators have asserted a variety of public policy concerns that justify the ban. In so doing, they implicitly provide some context by which to judge the statute’s potential scope. We analyze those in this section, demonstrating that RTT does not run afoul of any of these public policy concerns. In fact, RTT actually minimizes some of those concerns better than existing transplant policy.

When considering the extent to which RTT withstands standard objections to inducements, it is important to remember one important difference between RTT and other inducement schemes that might qualify as valuable consideration under NOTA: RTT does not provide an inducement to donate an organ. Rather, RTT provides an inducement for someone who has already decided to donate an organ to a friend or family member, but is unable to do so, to donate that same organ to someone else. Once this is recognized, it becomes clear how and why RTT does not run afoul of standard objections to inducements to donate.

To illustrate, recall that Carlos wants to donate his kidney to Diana. However, because Carlos and Diana are poor and the Mexican public health care system does not provide immunosuppression to transplant patients, Carlos’s donation to Diana would be pointless – in the absence of immunosuppression her body would reject the kidney and the transplant would fail. Thus, Carlos is not a person previously uninterested or ambivalent about organ donation who was induced to donate through the lure of compensation. Rather, RTT merely ensures that Carlos’s prior decision to donate results in a successful transplant to Diana, while at the same time helping an immunologically incompatible American pair through a kidney swap.

A. Slippery Slopes

One possible objection to RTT relates not to RTT itself, but to its possible effect on the validity of future proposals to increase the organ supply. If the exchange of a kidney for a kidney plus immunosuppression and medically necessary transport is valid under NOTA, then what is to prevent the exchange of a kidney for a kidney plus college tuition for a donor’s child? Or a beachfront condominium?

This fear, though understandable, is unwarranted. RTT passes muster under NOTA due to a combination of three unusual characteristics of the exchange: (1) Carlos’s prior donative intent, (2) Carlos’s altruistic motivation, and (3) the benefit received in the swap – Diana’s immunosuppression and transport – is medically necessary for and intrinsically tied to the transplant. First, and as already discussed, Carlos is not induced to donate a kidney through the promise of immunosuppression for Diana. Carlos comes to the exchange with a prior commitment and willingness to donate his kidney, which is merely facilitated by the RTT exchange. Second, Carlos’s motivation for the exchange is altruistic – he wants to benefit Diana, rather than himself. These two factors distinguish RTT from other common proposals to increase the organ supply through inducements, such as financial incentives that accrue directly to the donor.

Finally, the benefit in question – Diana’s immunosuppression and clinic travel--is incidental to and medically necessary for the transplant to proceed. In this sense, RTT is more like current exchange practices, such as KPD, AUKPD, and NEAD chains, along with NOTA’s explicit exclusions for reasonable payments to donors incidental to the transplant, such as travel, housing, and lost wages.\(^{58}\) This characteristic distinguishes RTT from other inducement proposals that rely on altruism, such as the altruism exchanges proposed by Choi, Gulati, and Posner in this volume, which the authors conclude would likely require an amendment to NOTA.\(^{59}\)

B. Equality of Access

\(^{58}\) See supra notes __ and accompanying text (discussing these exclusions).

\(^{59}\) Choi et. al. THIS VOLUME.
Many objections to the exchange of valuable consideration for organs rest on concerns about unequal access. Some worry, for example, that in a system that permits valuable consideration, only the rich will have access to organs. Access concerns are evident in Congressional deliberations on organ donation and appear to animate at least some objections to the exchange of valuable considerations for transplantable organs. While others dispute the contention that inducements to donate would necessarily disadvantage the poor, arguing that access issues are easily addressed through a variety of mechanisms, we need not engage that debate here because RTT easily withstands this objection. RTT is specifically designed to provide transplant access to the poor, by providing them with necessary immunosuppression that they could not otherwise afford. In terms of access, therefore, RTT improves upon the status quo.

C. Coercion and Exploitation

One concern frequently expressed with transplant tourism (or, indeed, inducements to the poor more generally) relates to coercion and exploitation, and this concern is evident in some of the legislative history regarding organ donation. Coercion normally implies a concern that poor sellers will be forced into selling their organs because they have no reasonable alternative. Exploitation generally envisions a bad bargain for or unfair advantage over the weaker party to the transaction, in this case the poor Mexican pair of Carlos and Diana.

Dealing with exploitation first, it is difficult to see how RTT could be considered exploitative of Carlos and Diana. Neither Diana nor Carlos receive a bad bargain in the transaction relative to either the other pair (Amanda and Bob) or to their respective outcomes in the absence of an RTT swap. In the absence of a swap, Carlos could donate his kidney, but Diana’s body would reject the kidney for lack of immunosuppression and the transplant would fail. With the RTT swap, Diana receives the immunosuppression she needs for the transplant to succeed. In both cases, Carlos is left with only one kidney. But with RTT, Diana has the chance of a successful transplant, which is a better state of affairs for both Carlos and Diana.

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60 Gerald Dworkin, Markets & Morals: The Case For Organ Sales in Morality, Harm, and The Law 157-58 (Westview 1984). See also, quotes from legislative history (expressing concerns that financial incentives to donate would advantage the wealthy)
61 Brittany: Add excerpts from legislative history here
62 See, e.g. Beard & Leitzel, THIS VOLUME.
63 Excerpts from legislative history.
64 See I. Glenn Cohen, THIS VOLUME. Glenn Cohen provides more formal definitions of various strands of the coercion, exploitation, and justified paternalism concerns, with illustrative examples. Id.
Similarly, RTT does not appear to coerce Carlos. This is not a case, such as those often invoked as arguments against inducements to donate, in which a poor person sells her organ in order to provide food or shelter for her family or to escape bonded labor.\textsuperscript{65} Although one could debate whether these examples are, in fact, coercive, we need not do so here. Rather, we emphasize again that Carlos had already decided to donate his kidney and was thwarted in that decision by his poverty and Diana’s lack of access to immunosuppression – the initial decision was not motivated by the RTT scheme, but only facilitated by it.

To the extent that any lingering concerns regarding the informed or voluntary nature of the Carlos-Diana choice remain, they are addressable through the same types of safeguards currently employed in the US to ensure informed consent and voluntariness among organ donors. In fact, meeting these safeguards would be a prerequisite for any RTT program.

\textbf{D. Commodification}

Also sometimes labeled corruption or alienation, this objection (more accurately, a collection of objections) to inducements relate to the purported degrading effect of market exchange on certain items or activities.\textsuperscript{66} In the case of inducements for organs, the specific objection is normally that allowing valuable consideration in exchange for organs degrades and dehumanizes humanity, by treating the human body and its parts as mere commodities to be bought and sold.\textsuperscript{67}

It can be hard to refute an objection as inchoate as commodification, but RTT does not seem to implicate the concerns most critics have in mind with this objection. Carlos does not “sell” his organ or value it like cash or its equivalents. Rather Carlos trades one like good – a healthy kidney – in exchange for another healthy kidney. Diana does also receive immunosuppression thanks to the RTT exchange, but it is not obvious that this corrupts the exchange, the parties to it, or human beings more generally.

In any event, the primary potential critic that concerns us here are courts interpreting NOTA and Congress, should it decide to override those interpretations. Though Congressional members have, at times, expressed concerns that fall within the commodification family, these concerns arose in the context of condemnations of monetary payments in exchange for human organs.\textsuperscript{68} The text of the statute, legislative history, and animating policy goals discussed throughout this Article all

\begin{itemize}
  \item \textsuperscript{65} See Cohen, supra note ___ (providing these and other examples).
  \item \textsuperscript{66} See, e.g., Dworkin, supra note at 159 (referring to commodification as “a large class of arguments” that are “diverse in character.”); ELIZABETH ANDERSON, VALUE IN ETHICS AND ECONOMICS xii-xiii (1993) (discussing commodification).
  \item \textsuperscript{67} Peggy Radin, CONTESTED COMMODITIES at 125-26 (discussing organ markets and commodification).
  \item \textsuperscript{68} Quote re: car parts from legislative history.
\end{itemize}
suggest that RTT would not be derailed by the courts or congress because of commodification concerns. Instead, RTT is most similar to KPD, which Congress has already explicitly approved, and AUKPD and NEAD chains, which, while never explicitly permitted by Congress, currently enjoy widespread acceptance.

VI. RTT Benefits

A. Cost Savings To The US Healthcare System

RTT will save money for the US healthcare system and insurance providers. Using data from 2010 and assuming that the average US paired donation recipient would remain on the deceased donor kidney transplant waitlist undergoing hemodialysis for a minimum of five years before receiving a transplant, the Centers for Medicare and Medicaid Services (CMS) will save $273,235 per transplant as compared with dialysis, and commercial insurance providers stand to save more than this amount for pre-emptive transplants.\(^\text{70}\)

Innovation in healthcare currently focuses on improving the quality of care while reducing the cost. There is perhaps no single disease entity in which this purpose is more easily achieved than for patients with End Stage Renal Disease (ESRD). Simply put, ESRD is most commonly treated by dialysis, but this form of treatment is much less effective, and ultimately much more costly, than kidney transplantation. According to the United States Renal Data Services (USRDS) 2012 Annual report, one year of hemodialysis cost the Centers for Medicare and Medicaid Services (CMS) $87,561 in 2010 (the last year data is available), whereas one year of kidney transplantation cost CMS $32,914.\(^\text{71}\) Over five years, transplanting a single ESRD patient rather than having them remain on dialysis saves CMS $274,235. If these patients are transplanted preemptively before starting dialysis, there is a net benefit to the commercial payer of $250 000–400 000 for cost avoidance during the 33 months Medicare is the secondary payer.\(^\text{72}\)

\(^{69}\) Quotes from NOTA legislative history
\(^{70}\) See 2012 USRDS report, Chapter 11 of the 2012 report: http://www.usrds.org/atlas.aspx. These calculations are based on page 332 (page 4 of chapter 11), where the report states: "Per person per year Medicare ESRD costs rose just 1.4 and 1.7 percent for hemodialysis and peritoneal dialysis in 2010, to $87,561 and $66,751, while transplant costs fell 1.1 percent, to $32,914. » Figures 11.4–7; see page 445 for analytical methods."
B. Better Health Outcomes

In addition to the cost savings, the average patient who receives a deceased donor kidney transplant lives 10 years longer than had they remained on dialysis.\(^73\) Further, living donor kidney transplants function on average for 16.5 years, while deceased donor kidneys last only 8.5 years.\(^74\) Thus, increasing the number of patients transplanted via living donor chains and simultaneous exchanges reduces the number of patients on dialysis, leads to better health, better healthcare, lower costs, and a better chance of receiving a deceased donor organ for those remaining on the waiting list.

C. Additional Financial Benefits

In addition to savings for health insurance payers and better health outcomes for patients, additional financial benefits will accrue from reverse transplant tourism in the United States. Pharmaceutical companies that sell immunosuppressive drugs required for the lifetime of patients undergoing renal transplantation make a profit with every patient transplanted. The average annual cost of immunosuppressive agents in the US is $15-20,000.\(^75\) Given a reasonable profit margin from these drugs, the pharmaceutical companies that provide these immunosuppressive drugs stand to make a substantial profit for every American patient transplanted. Likewise, American transplant centers who perform renal transplants will profit from performing a larger volume of transplants. Thus, reverse transplant tourism produces value for every entity involved: the American and international patients receive transplants they would not otherwise have received; the American and international donors both receive the desired transplant for their loved one; US health insurance payers save a substantial amount of money for every patient transplanted as compared with the cost of remaining on dialysis; US pharmaceutical providers profit from selling a larger volume of immunosuppressive agents to US patients; US transplant providers profit from performing a larger volume of kidney transplants.

VII. Sustainability And Safeguards

Reverse Transplant Tourism will only become sustainable if it is not based on philanthropy. However, philanthropy will be required to pilot this concept and demonstrate its value to those who stand to financially benefit. Given that dialysis is expensive and transplantation is relatively less expensive, health insurance


providers stand to save a substantial amount of money for each person who is transplanted instead of remaining on dialysis. Commercial payers are likely to save in excess of $300,000 for a patient preemptively transplanted prior to starting dialysis. As the cost of a renal transplant is approximately $100,000 in the first year and then an annual cost every year thereafter for immunosuppressive medications (in Mexico the cost of immunosuppressive medications is about $8,000 per month), the proposal discussed in this article would cost about $100,000 for ten years of immunosuppressive medications and the costs associated with the international patient costs related to travel to and from their Mexican transplant healthcare provider. It seems a reasonable investment on the part of a commercial insurance carrier to make a donation to a non-profit that supported reverse transplant tourism so that on an annual basis this process could become sustainable. In order for a commercial insurance company to donate money to a non-profit involved in reverse transplant tourism, the algorithm matching international patients with American patients would have to be transparent and clearly demonstrate that financial contributions did not influence the allocation of kidneys. There could be no implication that a specific insurance company could purchase a kidney for a specific patient. However, the program will not be sustainable on philanthropy alone, so there will need to be a mechanism to allow insurance payers to see the value of their donation, while not directly linking donated dollars to a specific reverse transplant tourism event.

Commercial payers are not the only commercial organizations that could benefit from reverse transplant tourism. As the pharmaceutical companies that provide transplant immunosuppressive agents stand to profit from additional sales, it would also be in the pharmaceutical industries best interest to donate to a reverse transplant tourism non-profit to both help transplant more patients, and in the process, increase the companies’ revenue from selling kidney transplant medications. As for the commercial insurance payers, there could be no implication that a specific pharmaceutical company could purchase a kidney in exchange for a specific patient or program where that pharmaceutical’s companies drugs were more likely to be used.

Finally it is not only commercial insurance payers and the pharmaceutical industry that stand to benefit financially from a robust reverse transplant tourism program. CMS as an entity saves $273,235 per transplant as compared with dialysis over five years. Thus, CMS could legitimately use part of this savings to support reverse transplant tourism as a means of both reducing the overall cost of ESRD for American taxpayers and improving the quality of healthcare provided. As noted in section V.E., innovation in American Healthcare is being driven by the desire to decrease cost while improving the quality of healthcare provided. As renal transplantation as opposed to remaining on dialysis is one of the best examples of this type of innovation, reverse transplant tourism is an example of the type of innovation that CMS is trying to promote. While it seems hard to imagine that the US

76 Irwin, supra note 72.
The government should invest $100,000 to help transplant a poor international patient when there are so many poor people in the United States lacking adequate healthcare, it is clear that such an investment in a reverse transplant tourism event would actually still save US taxpayers $173,235 and provide better healthcare to one American who would otherwise have remained on dialysis. While CMS support of such a non-profit could not be directly linked to the transplantation of Medicare patients, support from the US government will be critical to the program’s success. To this end, there will need to be a mechanism to allow CMS to see the value of their investment, without the allocation of a specific reverse transplant tourism event being influenced by the funding provided to the non-profit overseeing reverse transplant tourism.

VIII. Conclusion

The benefits of RTT for the individuals involved and the US healthcare system are many and suggest that any lingering uncertainties about the validity of RTT should be resolved in the proposal’s favor. Instead of non-US kidney donors being offered money through a black market middleman in exchange for one of their kidneys, RTT would provide a legal and ethical exchange of living donor kidneys through kidney-paired donation. In this way, the donors will not receive money for their kidneys, but rather will receive a transplant for someone they love.

[more to come]