

Inconceivable - Deducting the Costs of Fertility Treatment

Katherine T. Pratt

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Katherine T. Pratt, *Inconceivable - Deducting the Costs of Fertility Treatment*, 89 Cornell L. Rev. 1121 (2004)
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INCONCEIVABLE? DEDUCTING THE COSTS OF FERTILITY TREATMENT

Katherine T. Pratt†

This Article considers whether infertile taxpayers can deduct their fertility treatment costs as medical expenses under Internal Revenue Code § 213 and whether they should be able to deduct them. Internal Revenue Code § 213 defines medical expenses as “amounts paid—for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body.” This definition is interpreted by reference to a baseline of normal biological functioning, which includes reproductive functioning. Most people conceive and bear children without having to incur expenses for fertility treatment. Expenses incurred to approximate the baseline of normal reproductive health are deductible, even if the taxpayer winds up better off, with a child, after the fertility treatment. The medical profession recognizes that infertility is a disease or condition. Infertility is a loss, just as a broken leg is a loss. Fertility treatment costs are thus medical expenses under § 213. In addition, given the existence of the medical expense deduction, taxpayers should be able to deduct the cost of fertility treatments, including IVF, egg donor, and surrogate procedures, under either an “ability-to-pay” or consequentialist normative approach. Reproduction is extremely important to most people. In addition, allowing taxpayers to deduct the costs of fertility treatment will encourage infertile taxpayers to elect the most effective treatment option and reduce the rate of risky multifetal pregnancies. This Article concludes that fertility treatment costs are deductible as medical expenses under current law and should be deductible as medical expenses.

INTRODUCTION	1123
1. THE EXPERIENCE OF INFERTILITY	1126
A. The Extreme Emotional Distress Caused by Infertility	1126
B. The Medical Treatment of Infertility	1130
C. The Cost of Medical Treatment for Infertility	1135

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II.	THE TAX TREATMENT OF FERTILITY TREATMENT COSTS UNDER CURRENT LAW	1137
A.	The Tax Treatment of Medical Expenses	1137
B.	The Characterization of Fertility Treatment Expenses as Medical Expenses	1139
1.	<i>The Definition of Medical Expenses</i>	1139
2.	<i>Application to Fertility Treatment Expenses</i>	1144
a.	<i>Fertility Treatment Expenses in General</i>	1144
b.	<i>The Expenses of Donor and Surrogate Procedures</i>	1156
III.	SHOULD FERTILITY TREATMENT COSTS BE TREATED AS MEDICAL OR NONMEDICAL EXPENSES?	1162
A.	The Normative Starting Point	1162
B.	Fertility Treatment Costs and Ability to Pay	1164
C.	The Incentive Effects of Allowing a Deduction for Fertility Treatment Costs	1173
1.	<i>The Positive Consequences of Fertility Treatment</i>	1174
a.	<i>The Benefits of Fertility Treatment to the Parents and Child</i>	1174
b.	<i>Adoption as an Alternative to Fertility Treatment</i>	1176
2.	<i>The Negative Consequences of Fertility Treatment</i>	1181
a.	<i>The Medical and Psychological Risks of Fertility Treatment</i>	1181
i.	<i>The Medical Risks to the Woman Whose Ovaries are Being Stimulated</i>	1182
(A)	The Risk of Hyperstimulation	1182
(B)	The Uncertainty Regarding the Increased Risk of Ovarian Cancer	1182
ii.	<i>The Medical Risks of Multifetal Pregnancies to the Children Gestated and the Gestating Woman</i>	1185
(A)	The Medical Risks of Multifetal Pregnancies	1185
(B)	The Development of New Protocols to Reduce the Risk of Multifetal Pregnancies	1187
iii.	<i>Other Risks to the Child or Children Gestated</i>	1189
(A)	Other Medical Risks	1189
(B)	Potential Psychological Risks	1191
b.	<i>The Judgments About Fertility Treatment that May Be Affected by Heuristics and Biases</i>	1192
i.	<i>The Potential for Overestimating the Chances of Success</i>	1192

ii.	<i>The Potential for Underestimating the Risks of Multifetal Pregnancies</i>	1195
3.	<i>The Implications for the Tax Characterization of Fertility Treatment Costs</i>	1196
a.	<i>Medical Care that Cures or Treats Infertility</i>	1196
b.	<i>Ovarian Stimulation With IUI or IVF</i>	1197
c.	<i>Donor and Surrogate Procedures</i>	1198
CONCLUSION	1199

*Something to live for came to the place,
Something to die for maybe,
Something to give even sorrow a grace,
And yet it was only a baby.¹*

INTRODUCTION

Each year, more than a million Americans receive medical treatment for infertility.² This Article addresses one of the financial aspects of fertility treatment, specifically the taxation of fertility treatment costs. Most medical insurance policies do not cover fertility treatment.³ As a result, infertile patients bear the costs of fertility treatment themselves. Infertile patients may, however, be able to recoup some of these expenses by deducting their fertility treatment

¹ Harriett Prescott Spofford, *Only*, in THE HOME BOOK OF QUOTATIONS 122 (Burton Stevenson ed., 1949); see also DEBRA BRIDWELL, THE ACHE FOR A CHILD 22 (1994) (quoting Spofford's poem, *Only*). Poetry is included in this Article to convey the intensity of the emotions surrounding infertility and childbearing. "Poetry is the art of letting the primordial word resound through the common word." THE RAG AND BONE SHOP OF THE HEART: POEMS FOR MEN 182 (Robert Bly et al. eds., 1992) (quoting Gerhart Hauptmann).

² See RESOLVE, NAT'L INFERTILITY ASS'N, RESOLVING INFERTILITY: UNDERSTANDING THE OPTIONS AND CHOOSING SOLUTIONS WHEN YOU WANT TO HAVE A BABY 3 (1999) [hereinafter RESOLVING INFERTILITY]. The American Society of Reproductive Medicine (ASRM) indicates that infertility affects about ten percent of the reproductive-age population in the United States (about 6.1 million people). See Am. Soc'y for Reprod. Med., *Frequently Asked Questions About Infertility*, at <http://www.asrm.org/Patients/faqs.html> (last visited Mar. 5, 2004) [hereinafter ASRM, *Infertility Q&A*].

³ See Thomas D. Flanigan, Note, *Assisted Reproductive Technologies and Insurance Under the Americans with Disabilities Act of 1990*, 38 BRANDEIS L.J. 777, 777 (2000) (noting that ninety-three percent of health insurance plans exclude coverage for fertility treatments); see also RESOLVING INFERTILITY, *supra* note 2, at 296 (quoting insurance policy language that inferentially excludes fertility treatment from coverage). On the other hand, some specific diseases that can cause infertility, such as endometriosis, require treatment even if the patient is not trying to have a child, so insurance policies often cover this type of treatment. A small number of states have enacted statutes that require insurance coverage of high-tech fertility treatments, such as in vitro fertilization. The website of RESOLVE, a non-profit organization that addresses infertility issues, describes the scope of mandated insurance coverage in such states. See RESOLVE, *Insurance Coverage, State laws*, at <http://www.resolve.org/main/national/advocacy/insurance> (last visited Mar. 5, 2004).

costs as medical expenses or having their fertility treatment expenses reimbursed through a medical flexible spending account.⁴

Although many fertility patients assume that all of their fertility treatment costs are medical expenses, for tax purposes,⁵ the classification of some fertility treatment costs as medical expenses is controversial.⁶ No reported cases address this issue.⁷ The Internal Revenue Service (IRS) has issued conflicting rulings on the deductibility of fertility treatment costs. In 1957, the IRS ruled that the costs of artificial insemination were not deductible medical expenses.⁸ More recently, however, the IRS ruled that egg donor expenses were deductible medical expenses.⁹

Tax commentators disagree about the deductibility of fertility treatment costs. During an exchange among tax professors on a law professor listserv, Professor Joseph Dodge argued that fertility treatment costs are not medical expenses because fertility treatment is a "lifestyle choice," not health care: "[R]eproduction is a bodily function, but it is one the exercise of which is purely optional—a lifestyle choice."¹⁰ Although a similar argument could be made about sexual

⁴ I.R.C. §§ 105, 213 (2000). The § 213 medical expense deduction and the § 105(b) medical flexible spending account reimbursement exclusion provide for the tax treatment of certain "medical care," as defined in § 213(d)(1). This Article considers whether fertility treatment costs are deductible under § 213, or excludable under §105, as medical expenses, and whether they should be deductible or excludable. Section 213(a) of the Internal Revenue Code provides: "There shall be allowed as a deduction the expenses paid during the taxable year, not compensated for by insurance or otherwise, for medical care of the taxpayer, his spouse, or a dependent . . . to the extent that such expenses exceed 7.5 percent of adjusted gross income." *Id.* § 213(a). Section 105(b) provides that an employee-taxpayer's gross income does not include employer reimbursements for "expenses incurred by him for the medical care . . . of the taxpayer, his spouse, and his dependents." *Id.* § 105(b). References to § 213 deductibility in this Article apply equally to § 105 reimbursability.

⁵ See, e.g., Kristin Davis, *The Agonizing Price of Infertility*, KIPLINGER'S PERS. FIN. MAG., May 1996, at 50, 53 (describing the tax reporting positions patients have taken with respect to fertility treatment costs).

⁶ See, e.g., James Edward Maule, *Federal Tax Consequences of Surrogate Motherhood*, 60 TAXES 656, 661-64 (1982); see also *id.* at 663 ("In light of the treatment accorded other devices and procedures designed to mitigate the effects of a disease or bodily malfunction, a medical expense deduction should be allowed for the cost of resorting to a surrogate motherhood arrangement."). But see Mark Reid & Daphne Main, *Tax Issues Surrounding Assisted Reproduction Expenses*, TAXES, May 2000, at 28-29 (concluding that infertile taxpayers cannot take a medical expense deduction for surrogacy costs).

⁷ The IRS challenged a taxpayer's deduction of surrogacy costs in a case it litigated, but the case settled and there was no reported decision. See *Sedgwick v. Commissioner*, No. 10133-94, 94 PTT 13-53 (T.C. filed June 7, 1994) (LEXSTAT) (noting that the IRS determined that surrogacy expenses are not medical expenses).

⁸ See Priv. Ltr. Rul. 5707244900A (July 24, 1957) (denying a medical expense deduction for the costs of artificial insemination).

⁹ See Priv. Ltr. Rul. 200318017 (Jan. 9, 2003) (ruling that egg donor expenses and related costs are medical care expenses within § 213).

¹⁰ Posting of Professor Joseph Dodge, Florida State University College of Law, jdodge@law.fsu.edu, to Taxprof@Listserv.uc.edu (Apr. 20, 2000) (copy on file with au-

functioning, Professor Dodge argued that the cost of Viagra is distinguishable from the cost of fertility treatment and the cost of Viagra may qualify for the medical expense deduction.¹¹ Professor Calvin Johnson took the position that the costs of both fertility treatment and Viagra should not be deductible as medical expenses because reproductive and sexual dysfunction do not involve the sort of catastrophic losses that justify a medical expense deduction.¹² Professor Jim Maule argued that fertility treatment costs should be deductible as medical expenses if the costs of Viagra are deductible as medical expenses.¹³

This Article considers whether the costs of fertility treatment are deductible under current federal tax law and whether they should be deductible. In dealing with these questions, this Article discusses similarities between the costs of treatment for reproductive and sexual dysfunction, and the costs of medical care that permits reproductive choice.

thor). Taxprof is a closed Internet discussion group for tax law professors at AALS-accredited law schools.

¹¹ See *id.*

Viagra does pose an interesting issue, namely whether outlays to overcome the effects of aging should be viewed as repairs. . . . The "repair" idea . . . presupposes a baseline or norm. Outlays to "improve" one's body probably shouldn't count as medical expenses, at least in principle. . . . In the case of Viagra, "ED" apparently does not effect geezers exclusively. So it might be a "repair" for some, an "improvement" for some, and in the gray zone for many.

Id.

¹² E-mail from Professor Calvin H. Johnson, University of Texas at Austin, School of Law, chjohnson@mail.law.utexas.edu, to Professor Katherine T. Pratt, Loyola Law School (Oct. 3, 2003) (on file with author) (reproducing Posting of Professor Calvin H. Johnson, to Taxprof@Listserv.uc.edu (Apr. 20, 2000)).

The only legitimate reason for allowing a tax deduction is that the taxpayer has lost the money and is poorer. The intellectual case for giving deductions to subsidize good people or good things is essentially trivial. Giving out real money is a far better idea, primarily because everyone knows it is real money when they talk about it, and they distribute the money more sanely. The only rationale for a medical deduction is that medical expenses are not consumption but inherent losses. You are no better off spending \$10,000 for a broken leg because the combination of break and expense leave you not improved. They took cosmetic surgery out of [§] 213 because it did not fit the core idea.

It is difficult to see how a childless couple has a loss by acquiring a child by high tech means that wipes out the benefit of the expense. Children are not losses or deductions. . . . Children are God's gift to parents and they leave you way ahead, even after counting every dime of the cost. High technology reproduction hits me as obviously distinct from expenses to cure disease or breaks. Children are neither a broken leg nor a disease.

Id.

¹³ Posting of Professor James Edward Maule, Villanova University School of Law, maule@law.villanova.edu, to Taxprof@Listserv.uc.edu (Apr. 20, 2000). Professor Maule took the position that fertility treatment for uterine dysfunction is the analogue of Viagra treatment for erectile dysfunction because both fertility treatment and Viagra mitigate the effects of reproductive disease. Thus, he argued that surrogacy costs should be deductible if the costs of Viagra are deductible. *Id.*

Part I examines the experience of infertility, including the emotional distress caused by infertility, the medical treatment of infertility, and the financial burdens of fertility treatment. Part II considers the tax treatment of fertility treatment costs under current law, first for medical care that does not involve donors or surrogates, then for the additional costs of procedures involving donors and surrogates. Part III explores whether fertility treatment costs should be treated as medical expenses or as nonmedical expenses, given the existence of a medical expense deduction. In order to resolve this normative question, this Article considers: (1) whether fertility treatment costs should be deductible in order to take into account taxpayers' ability to pay;¹⁴ and (2) whether various types of fertility treatment costs should be deductible under a consequentialist normative approach.¹⁵ The Article concludes that fertility treatment expenses, like the costs of medical care that facilitates reproductive choice and the costs of treating sexual dysfunction, should be treated as medical expenses because of the vital importance of reproductive and sexual functioning to most people.

I

THE EXPERIENCE OF INFERTILITY

A. The Extreme Emotional Distress Caused by Infertility

Most people want to have children at some point in their lives.¹⁶ This does not mean that every person should want to have children. In addition, people who want to have children want to be able to decide when to have their children. Reproductive choice is highly personal. The point here is that the desire to have children is pervasive, although not universal.

The vast majority of couples can conceive and bear children without fertility treatment, so fertility treatment merely returns infertile taxpayers to where they would have been absent the medical infertility. Professor Calvin Johnson argues that the medical expense deduction applies to losses incurred to try to return the taxpayer to a baseline of health; bearing a child makes the taxpayer better off, so fertility treatment does not fit the rationale for the medical expense deduction.¹⁷ In his view, "[c]hildren are neither a broken leg nor a

¹⁴ See discussion *infra* Part III.B.

¹⁵ See discussion *infra* Part III.C.

¹⁶ See Lewis J. Lord et al., *Desperately Seeking Baby: Ten Million Americans Are Struggling to Have Children*, U.S. NEWS & WORLD REP., Oct. 5, 1987, at 58, 59 (noting that "[o]nly [two] percent of married women actually prefer to be childless").

¹⁷ See E-mail from Professor Calvin H. Johnson, University of Texas at Austin, School of Law, chjohnson@mail.law.utexas.edu, to Professor Katherine T. Pratt, Loyola Law School (Oct. 3, 2003) (on file with author) (reproducing Posting of Professor Calvin H. Johnson, to Taxprof@Listserv.uc.edu (Apr. 20, 2000)).

disease.”¹⁸ It is not the child that is the loss, however; the infertility is the loss. The goal of the medical treatment is to restore the infertile taxpayers to the normal state of being able to bear a child if they want one.

Infertility is a loss, just as a broken leg is a loss, and the following discussion explores the effects of that loss. People usually assume that they will not have any trouble having children when they want to have them. The reality of infertility comes as a shock. As one infertile patient observed, “[f]inding out that you are infertile can feel like suddenly discovering a limb is paralyzed.”¹⁹

Long-term treatment of infertility exacts a heavy toll, both emotionally and financially.²⁰ Infertility often has a devastating emotional

¹⁸ *Id.*

¹⁹ See BRIDWELL, *supra* note 1, at 93.

What if for instance, a woman on her way out the door in the morning, reached out to pick up a glass of orange juice and found her arm wouldn't move. Imagine her shock. She thinks, *That's strange, maybe I just need to think about what I'm doing.* She concentrates and tries again. Nothing happens. She's confused because she's never had any reason to doubt that her arm would work. The cold fear of something dreadfully wrong settles on her. She sees a doctor and goes through years of test and treatments. All the doctor can tell her is that she might never regain the use of her arm, but there is always the chance that it might spontaneously heal sometime in the future if she keeps trying to use it.

Each time she thinks of using her arm, a small persistent hope rises in her—maybe this time it will work. But each time it fails her hopes are crushed. Meanwhile, she looks no different to the outside world. People are confused when she stops coming to the volleyball games or won't shake hands.

When she finally ventures to tell some friends about her disability, she hears a lack of understanding: “well at least you have your other arm,” or “at least it's not life-threatening.” . . . She will have to go through a myriad of feelings on her own as she sorts through and realigns herself to her new reality without the use of her arm. Before she adjusts, the shock and fear will probably turn into questioning, anger, feelings of vulnerability, and deep sadness. . . .

With an infertile person, the part of his or her body that would make a baby or hold a baby until it can be born is that part that is disabled. To varying degrees, we go through this same type of grief and reassessment process as we adjust to the reality that part of our body is not working and what that means to our self-image and life plans.

Id. at 93–94.

²⁰ See SUSAN LEWIS COOPER & ELLEN SARASOHN GLAZER, CHOOSING ASSISTED REPRODUCTION: SOCIAL, EMOTIONAL, & ETHICAL CONSIDERATIONS 17 (1998).

[I]nfertility involves multiple losses. From the first moment that an individual or couple realizes that they are having difficulty conceiving or carrying a child, they are confronted with loss. [They suffer the] loss of self-esteem, loss of body integrity, loss of privacy, loss of sexual pleasure, loss of time, loss of money, [and] loss of comfort in friendships and family relationships. . . .

Id. The authors also note that infertility and its treatment can imperil the infertile patient's marriage, relationships with others, and career. *Id.*

Another author compares the stresses of being infertile to the stresses of having a chronic illness. See BRIDWELL, *supra* note 1, at 129. These include the stresses associated

effect, especially on women.²¹ In numerous psychological studies, researchers have found that infertile women frequently suffer from severe depression.²² In a famous study, researchers discovered that infertile women's scores on the Beck Depression Inventory (BDI) (a test used to measure the severity of depression) were comparable to the scores of patients with *terminal* diseases like cancer.²³

Infertility causes grief in men as well, but men sometimes feel constrained in their expression of grief.²⁴ One grieving man stated:

I'll always love the ones we lost. Every time we had a miscarriage, I thought it would be easier if somebody would just take [my] arm or leg so I could have a child. . . .

with "dealing with the schedule of doctor's appointments and medication, operations and uncomfortable medical procedures, the side effects of drugs, the emotional energy spent in working through fears and grief, and needing to adjust to a different reality than [the intended parents] had planned." *Id.*

²¹ COOPER & GLAZER, *supra* note 20, at 18–19.

The observation that women and men experience infertility in different ways is something that has long been known by infertile couples and their caregivers. This phenomenon has been studied by several researchers. Women have been found to experience significantly more psychological distress than do their partners, especially in the areas of depression, anxiety, cognitive disturbance and hostility. Researchers suggest that these findings can best be explained by differences in expectations about motherhood and fatherhood.

. . . .

. . . For many [women], the threatened loss of pregnancy and childbirth represents an immense loss. They report having looked forward for many years to growing a baby inside them—to feeling its movement within their womb and experiencing its birth during labor and delivery. Some find the thought that they might never have this experience unfathomable: it fills them with profound sadness. Thus, for some women pregnancy feels like an essential life event, one that cannot be missed.

Id. Most of the psychological literature on the experience of infertility focuses on women's experiences of infertility.

²² See, e.g., Alice D. Domar et al., *The Prevalence and Predictability of Depression in Infertile Women*, 58 FERTILITY & STERILITY 1158, 1161–62 (1992) (noting that the researchers were not surprised to find that the "infertile women had higher depression scores than control women"); Anna Hjelmstedt et al., *Gender Differences in Psychological Reactions to Infertility Among Couples Seeking IVF- and ICSI-Treatment*, 78 ACTA OBSTETRICIA ET GYNECOLOGICA SCANDINAVICA 42, 44–46 (1999) (noting the different psychological impact infertility has on women and men); Michelle P. Lukse & Nicholas A. Vacc, *Grief, Depression, and Coping in Women Undergoing Infertility Treatment*, 93 OBSTETRICS & GYNECOLOGY 245, 249 (1999) (finding that infertile women "experienced measurable levels of grief and depression").

²³ See Domar, *supra* note 22, at 1161–62 (reporting BDI scores for women suffering from infertility). One patient describes the depth of her despair: "What surprised me about the grief was the way it kept blindsiding me when I least expected it. A day . . . would start with no great emotional load, but a word or a song would set me off, and . . . I couldn't control my sobbing—not crying—uncontrollable sobbing." BRIDWELL, *supra* note 1, at 95.

²⁴ See BRIDWELL, *supra* note 1, at 146 (societal roles permit women to express their grief openly, but pressure men to appear strong even when they experience grief).

. . . The sadness hit so deep [I] couldn't sleep. It was blacker than black. When you're that low, there's not much anybody can do or say.²⁵

Many infertile patients report that infertility has been "the most upsetting experience of their lives."²⁶ Infertile patients repeatedly experience a cycle of hope for a child and loss of their hoped for child.²⁷ The hoped-for child exists on an emotional level even if the child is never physically conceived.²⁸ The feelings of loss experienced by infertile patients are real and recurrent, even though most people find them difficult to comprehend.²⁹ The failure of others to understand the anguish of infertile patients adds to patients' feelings of isolation.³⁰

Infertility deprives would-be parents of an "experience that is central to . . . identity and meaning in life."³¹ As Lori Andrews and Lisa Douglass have noted, "[t]he lengths to which [infertile patients] will go to conceive a child attest to the intensity of the pain of infertility."³²

²⁵ *Id.* (alterations in original).

²⁶ Ellen W. Freeman et al., *Psychological Evaluation and Support in a Program of In Vitro Fertilization and Embryo Transfer*, 43 FERTILITY & STERILITY 48, 50 (1985) (noting that fifty percent of women and fifteen percent of men being treated for infertility described the experience with this language).

²⁷ BRIDWELL, *supra* note 1, at 94-95 ("Those unable to conceive a child do not experience a clean grief because the loss happens over an extended period of time as a monthly cycle of hope and grief.").

²⁸ The following poem captures the experience of a hoped-for child:

How can I say good-bye,
When we've not yet said hello?
My "Imagined Child"—will you ever come to be?
From early years the future was guaranteed—now
I wonder, "Will this dream be realized?"
Carefree and assured, we started our lives together;
Tentative and unsure, will we forever fear the future?
The pathway to you is uncertain,
The questions unanswerable.
As the journey continues, filled with evaluation of
uncharted territory, my vision of you remains constant.
My peace is found in knowing that while I may not
hold you in my arms, I will always hold you in my heart.

D. Rausch, *Uncharted Territory*, reprinted in JOHN C. JARRETT II & DEIDRA T. RAUSCH, *THE FERTILITY GUIDE: A COUPLES HANDBOOK FOR WHEN YOU WANT TO HAVE A BABY (MORE THAN ANYTHING ELSE)* iii (1998).

²⁹ BRIDWELL, *supra* note 1, at 128-29.

³⁰ See JOAN LIEBMAN-SMITH, ET. AL., *THE UNOFFICIAL GUIDE TO OVERCOMING INFERTILITY* 273-77 (discussing the embarrassment and stigma many infertile patients feel in deciding whether to tell others of their infertility); RESOLVING INFERTILITY, *supra* note 2, at 220 ("[S]elf-imposed secrecy that tends to surround infertility is a major contributor to stress [and] [c]oming out in the open about your infertility can mean opening yourself to comments and criticisms from those who do not understand what you are experiencing.").

³¹ See JOHN A. ROBERTSON, *CHILDREN OF CHOICE: FREEDOM AND THE NEW REPRODUCTIVE TECHNOLOGIES* 24 (1994).

³² Lori B. Andrews & Lisa Douglass, *Alternative Reproduction*, 65 S. CAL. L. REV. 623, 629 (1991).

The following poem captures the elemental despair infertile patients experience:

Oh, many's the time in the evening
 When the light has fled o'er the sea,
 That I dream alone in the gloaming
 Of the joys that are not for me;
 And oft in my sorrowful bosom
 Swells up the mother-love flame,
 And I clasp with my arms that are trembling
 My child that never came. . . .

. . . .
 The hours swim on the midnight,
 The moon looks over the hill,
 And the u-lu-lu of the night owl
 Sinks mournfully and shrill;
 The solitude aches with rapture,
 And my heart with the mother-love flame
 As I sing alone in the gloaming
 To the child that never came.³³

B. The Medical Treatment of Infertility

Infertility is "a disease or condition affecting the reproductive system that interferes with the ability of a man or woman to achieve a pregnancy or of a woman to carry a pregnancy to live birth."³⁴ There are many causes of infertility. Male factors and female factors each account for about a third of infertility cases.³⁵ Infertility is attributable to a combination of male and female factors in about ten percent of infertility cases.³⁶ In about twenty percent of infertility cases, the infertility is "unexplained," i.e., it cannot be diagnosed.³⁷

Male factors include: (1) disorders related to impaired sperm production, maturation, or transfer, including varicocele (testicular varicose veins);³⁸ (2) blocked or absent vas deferens (the tube that connects the testes and the urethra); and (3) absent or retrograde ejaculation.³⁹ These problems can be caused by a variety of factors, including: hormonal imbalances; genetic disorders; environmental

³³ Ella Rhoads Higginson, *The Childless Mother's Lullaby*, in *A BOOK OF LULLABIES* 383 (Elva S. Smith ed., 1925).

³⁴ RESOLVING INFERTILITY, *supra* note 2, at 5. According to the American Society of Reproductive Medicine, infertility is "a disease of the reproductive system that impairs one of the body's most basic functions." ASRM, *Infertility Q&A*, *supra* note 2.

³⁵ See ASRM, *Infertility Q&A*, *supra* note 2.

³⁶ *Id.*

³⁷ *Id.*

³⁸ Ten to fifteen percent of men may have varicocele and forty to fifty percent of men treated for infertility have varicocele. See RESOLVING INFERTILITY, *supra* note 2, at 165.

³⁹ See BRIAN KEARNEY, *HIGH-TECH CONCEPTION: A COMPREHENSIVE HANDBOOK FOR CONSUMERS* 14-15 (1998).

factors; anatomical defects; sexually transmitted diseases; spinal cord injuries; and bladder, prostate gland, or testicular cancer or surgery.⁴⁰

Female factors include ovulation disorders, blocked fallopian tubes, cervical disorders, endometriosis, and uterine disorders.⁴¹ These female factors can be caused by a variety of conditions, such as: hormonal imbalances; autoimmune reactions; genetic disorders; anatomical defects (including those caused by in utero exposure to DES taken by the patient's mother⁴²); pelvic inflammatory disease, venereal disease, and other types of infection; scar tissue; fibroid tumors; and cancer.⁴³

Fertility rates decline for women in their thirties and dramatically decline for women in their forties.⁴⁴ The progressive decline in a woman's fertility is due to a combination of several factors, including increased rates of ovarian dysfunction,⁴⁵ uterine dysfunction,⁴⁶ and chromosomal abnormalities in their eggs.⁴⁷ While women can still conceive and bear children during perimenopause (the series of gradual hormonal changes that precede menopause), they are less fertile at this point in their lives.⁴⁸

⁴⁰ *Id.* at 14–15; see also Herman Kattlove & Roger J. Winn, *Ongoing Care of Patients After Primary Treatment for Their Cancer*, CA (AM. CANCER SOC'Y), May 1, 2003, at 172 (noting that infertility is a complication of testicular cancer treatment).

⁴¹ *Id.* at 11–14.

⁴² During the mid-1900s, some pregnant women took a prescription drug called diethylstilbestrol (DES). See RESOLVING INFERTILITY, *supra* note 2, at 136. Women who, as fetuses, were exposed to DES can develop various types of reproductive disorders that cause infertility, including cervical disorders, uterine disorders, tubal disorders, irregular menstrual cycles, and endometriosis. See *id.* at 137–38. In utero exposure to DES also increases a woman's risk of miscarriage and premature delivery. See *id.* at 138.

⁴³ See KEARNEY, *supra* note 39, at 11–14; Resolving Infertility, *supra* note 2, at 89–101, 121–45; see also Anita Hamilton, *Eggs on Ice: A Woman's Fertility Often Peaks Before She's Ready to Have Babies. Does Banking Her Eggs Make Sense?*, TIME, July 1, 2002, at 54 (noting that cancer treatment causes infertility).

⁴⁴ See JARRETT & RAUSCH, *supra* note 28, at 37–38.

⁴⁵ See KEARNEY, *supra* note 39, at 11 (noting that certain ovulation disorders are more common in older women); RESOLVING INFERTILITY, *supra* note 2, at 149 (same).

⁴⁶ See RESOLVING INFERTILITY, *supra* note 2, at 149 (noting that rates of certain uterine disorders increase as a woman ages).

⁴⁷ See KEARNEY, *supra* note 39, at 293 (noting that embryos of older women have a higher risk of chromosomal abnormalities); RESOLVING INFERTILITY, *supra* note 2, at 149 (same).

⁴⁸ See RESOLVING INFERTILITY, *supra* note 2, at 14. A higher percentage of older women are having children, despite the fact that a woman's fertility declines with age. *Id.* at 11, 14. Since 1981, the birthrate for 40 to 44-year-old women has increased seventy-four percent. *Id.* at 14. About sixty-nine percent of the in vitro fertilization (IVF) cycles in 2001 were performed on women between the ages of 30 and 39. See CTRS. FOR DISEASE CONTROL & PREVENTION, ET AL., 2001 ASSISTED REPRODUCTIVE TECHNOLOGY SUCCESS RATES 21 (2003), available at <http://www.cdc.gov/reproductivehealth/ART01/PDF/ART2001.pdf> [hereinafter 2001 CDC REPORT]. Although some female factors are related to age, other female factors are not related to age and can occur in younger women. See COOPER & GLAZER, *supra* note 20, at 196–97 (describing various causes of premature ovarian failure in young

Medical treatment of infertility is progressive. The physician begins fertility treatment by taking the patient couple's⁴⁹ medical history and by conducting physical and pelvic examinations.⁵⁰ If, based on this preliminary information, the source of the infertility cannot be determined, the doctor selects from a number of other tests and procedures.⁵¹

Doctors frequently ask infertile female patients to generate ovulation records (based on their temperature and on ovulation indicator tests)⁵² and order blood tests to determine whether the woman's hormones are within normal ranges at various times during her cycle.⁵³ Transvaginal ultrasound often is used to monitor the woman's ovulatory cycle.⁵⁴ Doctors also frequently order an X-ray of the fallopian tubes and uterus to check for blockage of the patient's fallopian tubes and abnormalities in the uterus.⁵⁵ If the doctor suspects that the infertility is caused by certain problems, such as endometriosis or fibroid tumors, the doctor may perform a laparoscopy, which is a diagnostic, outpatient surgical procedure. The doctor may also perform a postcoital test to determine whether the woman's cervical mucus is normal or abnormal and whether any of the man's sperm are alive and moving.⁵⁶

The workup for male patients begins with the man submitting a semen sample to determine whether each of the following is normal or abnormal: (1) the total volume of semen; (2) the sperm count; (3) sperm motility and velocity; (4) morphology (maturity, shape, and size of the sperm or the sperm head); (5) liquefaction and viscosity of the

women); *see also supra* notes 44–47 (describing fertility problems that are more likely to occur in older women).

⁴⁹ Infertile patients may be in a traditional or nontraditional relationship. Most infertile patients are heterosexual married men and women. Some patients are unmarried couples, either heterosexual or same-sex, and some patients are individuals who plan to be single parents. For consistency and unless otherwise noted, this Article will use nomenclature that fits the typical case. Professor Lisa Ikemoto criticizes the common assumption that the fertility patient is heterosexual and married, and considers the implications of this assumption for nontraditional patients, including single parents and gay and lesbian couples. Lisa C. Ikemoto, *The In/Fertile, the Too Fertile, and the Dysfertile*, 47 HASTINGS L.J. 1007, 1027–33, 1053–57 (1996).

⁵⁰ *See* RESOLVING INFERTILITY, *supra* note 2, at 66–69.

⁵¹ *Id.* at 68–69.

⁵² *See id.* at 70–72.

⁵³ *See id.* at 90–91. The hormones commonly tested include FSH, LH, estrogen (in the form of estradiol), prolactin, progesterone, thyroid-stimulating hormone (TSH), and androgens (including the male hormones testosterone and dehydroepiandrosterone sulfate). *Id.*

⁵⁴ *See id.* at 74.

⁵⁵ *See id.* at 75–77. This diagnostic X-ray is called a hysterosalpingogram (HSG). *Id.* at 75.

⁵⁶ *See id.* at 75.

semen; (6) white blood cell count; and (7) seminal fructose levels.⁵⁷ Semen is also tested for: (1) infections, such as chlamydia; (2) sperm antibodies; and (3) the ability of the sperm to penetrate an egg.⁵⁸ Male patients also submit blood samples so that the laboratory can determine whether the man's hormone levels are normal or abnormal.⁵⁹ In more severe cases, doctors may perform a testicular biopsy to evaluate sperm production.⁶⁰

This infertility workup usually enables the doctor to identify and treat specific causes of infertility. For example, endometriosis may be treated with surgery, hormonal treatment, or a combination of the two.⁶¹ Clomiphene citrate, a moderately priced pill, which is taken orally, is often prescribed for certain types of ovulation and uterine disorders.⁶² Doctors may also treat these ovulation and uterine disorders, as well as other types of disorders, with various injectable prescription drugs that stimulate the ovaries.⁶³ A doctor stimulating a woman's ovaries monitors the cycle with blood tests and transvaginal ultrasounds in order to determine the number of developing follicles and the correct medication dosage, and to detect any side effects of the medications.⁶⁴ Doctors also treat certain male factors with surgery or hormonal medication. For example, varicocele, a common male factor, can be surgically repaired.⁶⁵ Doctors also use intrauterine insemination (IUI) for some female factors and some male factors.⁶⁶

The vast majority of infertile patients receive conventional drug and surgical treatment.⁶⁷ If these treatments are not successful, how-

⁵⁷ *Id.* at 81–85.

⁵⁸ *Id.* at 85–86.

⁵⁹ *See id.* at 86–87.

⁶⁰ *See id.* at 86.

⁶¹ *Id.* at 125.

⁶² *Id.* at 103–04. Clomiphene citrate is sold under the brand name Clomid or Serophene. Clomiphene citrate is typically administered for five consecutive days during a woman's cycle. *Id.* The daily dose is one to four 50-milligram pills and the cost is around \$10 per pill. *Id.*

⁶³ *Id.* at 105–10.

⁶⁴ The most serious immediate side effect of ovarian stimulation is Ovarian Hyperstimulation Syndrome (OHSS), which occurs in one to five percent of medicated cycles. *Id.* at 114. Ovarian Hyperstimulation Syndrome is a condition in which the ovarian stimulation causes an abnormal amount of fluid to accumulate in the abdominal cavity. *Id.* The "fluid accumulation can cause pressure on surrounding organs, including the lungs and heart. Breathing difficulties, dehydration, and severe nausea can result; occasionally, hospitalization may be required." *Id.*

⁶⁵ *Id.* at 166–67. Surgical repair of varicocele dramatically improves sperm counts, sperm motility, and fertility. *See id.* at 168.

⁶⁶ *Id.* at 145–46, 171. In an IUI, the man's sperm is processed to concentrate the highest quality sperm, and then the physician transfers the sperm into the woman's uterus at the time of ovulation, using a catheter through the cervix. *Id.* at 145–46.

⁶⁷ The ASRM estimates that eighty-five to ninety percent of infertile patients are treated with conventional drug and surgical treatments. *See ASRM, Infertility Q&A, supra* note 2.

ever, patients sometimes resort to assisted reproductive technologies (also known as high-tech fertility treatments), including in vitro fertilization (IVF) and procedures that involve third parties, such as sperm donors, egg donors, and surrogates. In IVF procedures, the doctor stimulates the ovaries of the intended mother and extracts her eggs when they are mature.⁶⁸ The eggs are then fertilized with the intended father's sperm in a test tube and several days later the resulting embryos are implanted in the intended mother's uterus.⁶⁹

If the cause of the infertility is a sperm disorder (such as low sperm count, poor sperm motility, or abnormal sperm morphology), a relatively new technique called Intracytoplasmic Sperm Injection (ICSI) may be used in conjunction with IVF. In an ICSI procedure, an embryologist injects a single sperm into each egg.⁷⁰ ICSI dramatically improves fertilization rates,⁷¹ and doctors have hailed it as a revolutionary treatment for sperm disorders.⁷²

Some couples can only have a child with the help of a sperm donor, egg donor, or surrogate. Couples requiring sperm donation typically use the sperm of an anonymous donor from a sperm bank.⁷³ The cost of sperm donation is minimal because it is easy for the donor to provide the sperm sample.⁷⁴

If the intended mother cannot produce healthy eggs, the couple can arrange for an egg donor to provide them with eggs. An egg donor procedure is similar to an IVF procedure, except that the doctor stimulates the egg donor's ovaries instead of the intended mother's ovaries, and then extracts the donor's eggs when they are mature. The eggs are fertilized with the sperm of the intended father or a donor, and the resulting embryos are then implanted in the intended

⁶⁸ See *RESOLVING INFERTILITY*, *supra* note 2, at 176–80.

⁶⁹ See *id.* at 180–82.

⁷⁰ See *KEARNEY*, *supra* note 39, at 115, 117–18. The first successful ICSI procedure occurred in 1992. It is now a common procedure. *Id.* at 115–16.

⁷¹ See *id.* at 118–20 (reporting that ninety percent of eggs injected using ICSI survive intact and seventy percent of those injected eggs reach normal fertilization).

⁷² See *id.* at 115; *RESOLVING INFERTILITY*, *supra* note 2, at 186. One fertility specialist, Dr. Sherman J. Silber, opined: “The development of ICSI has completely revised the way we look at male-factor infertility. There may soon be virtually no form of male infertility [other than complete absence of the testes] that is not amenable to treatment.” *KEARNEY*, *supra* note 39, at 115.

⁷³ See *COOPER & GLAZER*, *supra* note 20, at 175 (noting that couples rarely use a known sperm donor).

⁷⁴ The cost of sperm donation is incidental compared to the cost of egg donation or surrogacy. *BRIDWELL*, *supra* note 1, at 198, 209 (comparing average sperm donation cost of \$30 and average egg donor cost in 1993 of around \$1,500). Thus, this Article will limit discussion of third-party costs to egg donor and surrogacy fees.

mother's uterus.⁷⁵ Couples enlisting the assistance of an egg donor may know the donor or may find the donor through an agency.⁷⁶

If the intended mother can produce eggs but cannot gestate the child, the intended parents can arrange for a surrogate to gestate the child. After the intended mother's ovaries are stimulated, the eggs are extracted and fertilized and the resulting embryos are implanted in the uterus of a surrogate who carries and bears the child.⁷⁷ If the intended mother cannot produce healthy eggs or carry the child, the intended parents can either arrange for a donor to give them eggs, which are fertilized and then implanted into the uterus of a surrogate who carries and bears the child, or for a surrogate to both provide the eggs and gestate the child.⁷⁸

C. The Cost of Medical Treatment for Infertility

The cost of fertility treatment ranges from moderately priced treatments to very expensive treatments. The cost of clomiphene citrate for one month of treatment is usually between \$40 and \$200.⁷⁹ An IUI procedure usually costs a "few hundred dollars."⁸⁰ Surgery to open blocked fallopian tubes costs \$10,000 to \$15,000.⁸¹ The costs of injectable ovarian stimulation drugs for one cycle of treatment can total up to \$5,000.⁸² Surgery to repair varicocele typically costs \$5,000 to \$8,000.⁸³

Assisted reproductive technologies are among the very expensive types of treatment.⁸⁴ The average price for a single IVF procedure is

⁷⁵ See RESOLVING INFERTILITY, *supra* note 2, at 273.

⁷⁶ Intended parents often use known egg donors, but rarely use known sperm donors. COOPER & GLAZER, *supra* note 20, at 211. About twenty percent of egg donors are known by the intended parents. See RESOLVING INFERTILITY, *supra* note 2, at 277.

⁷⁷ See RESOLVING INFERTILITY, *supra* note 2, at 280.

⁷⁸ See COOPER & GLAZER, *supra* note 20, at 251. Surrogates are typically paid a fee, which varies and can range from \$10,000 to \$25,000, with additional amounts paid for carrying multiple fetuses. See, e.g., Liz Doup, *The New Extended Family*, S. FLA. SUN-SENTINEL, Apr. 6, 2003, at 1E (noting that the typical surrogate fee is about \$18,000); Brian M. Schleiter, *The Business of Babies*, THE CAPITAL (Annapolis, MD), Aug. 6, 2001, at A1 (reporting that surrogate fee can be up to \$25,000); Janet Zimmerman, *Path to Parenthood: An Inland Woman Steps in as a Surrogate to Help Other Couples Have Children*, PRESS ENTERPRISE (CA), June 23, 2002, at E1 (noting that surrogates are paid about \$20,000).

⁷⁹ Patients take one to four pills a day for five days and the cost for one pill is around \$10. See RESOLVING INFERTILITY, *supra* note 2, at 103-04.

⁸⁰ See Davis, *supra* note 5, at 51.

⁸¹ See Vickie Chachere, *'Test Tube' Babies Began 20 Years Ago*, TAMPA TRIB., July 25, 1998, at 1.

⁸² See LIEBMANN-SMITH ET AL., *supra* note 30, at 320.

⁸³ See Chachere, *supra* note 81.

⁸⁴ Assisted reproductive technology expenses include: (1) the costs of various prescription drugs, including the drugs used to stimulate the ovaries of the intended mother or egg donor; (2) the costs of medical supervision of the stimulation, including the costs of ultrasound monitoring of the developing eggs; and (3) the hospital, lab, and doctor fees

around \$10,000, and infertile patients often undergo numerous procedures.⁸⁵ ICSI adds about \$2,500 to the cost of a single IVF cycle.⁸⁶ In egg donor and surrogate procedures, the intended parents incur additional expenses, the largest of which is the fee paid to the egg donor or surrogate.⁸⁷ An egg donor's fee is typically in the \$3,000 to \$5,000 range, but a small number of egg donors receive a higher fee.⁸⁸ The fee for surrogates also varies, but is usually in the \$10,000 to \$25,000 range.⁸⁹

Insurance does not usually cover fertility treatments per se,⁹⁰ but may cover the treatment of certain disorders that can cause infertility.⁹¹ Fertility patients therefore must pay for most of their fertility treatment.

Patients spend vast sums of money to increase their chances of conceiving and bearing a child, even though two in five are not able to do so.⁹² This willingness to pay large amounts for fertility treatment creates intense financial pressure for infertile patients. Patients

for the egg extraction and implantation. See LIEBMANN-SMITH ET AL., *supra* note 30, at 319–20 (discussing these expenses).

⁸⁵ See RESOLVING INFERTILITY, *supra* note 2, at 303; see also Davis, *supra* note 5, at 51 (reporting that “[i]t isn’t unusual for [infertile] couples to spend \$30,000 or more in their quest for a child”).

⁸⁶ See Chachere, *supra* note 81.

⁸⁷ These expenses include the fees paid to: (1) the agency that represents the donor or surrogate; (2) legal counsel to represent the donor or surrogate; (3) a psychologist to evaluate and counsel the donor or surrogate; and (4) the donor or surrogate. See LIEBMANN-SMITH ET AL., *supra* note 30, at 320; see also Doup, *supra* note 78, at 1E (noting that expenses for a surrogacy procedure included the surrogate’s fee, the fee paid to the agency representing the surrogate, and the surrogate’s legal and medical fees).

⁸⁸ Donors have been offered fees as high as \$100,000. See, e.g., Marilee Enge, *Ad Seeks Donor Eggs for \$100,000, Possible New High*, CHI. TRIB., Feb. 10, 2000, § 1, at 3 (describing a full-page advertisement in a college newspaper offering egg donors \$100,000); Kenneth R. Weiss, *Eggs Buy a College Education*, L.A. TIMES, May 27, 2001, at A1 (displaying photographs of advertisements offering up to \$100,000 to potential donors). Very few donors are paid such high fees. *Id.* at A30–31.

⁸⁹ See, e.g., Erica Noonan, *Breathing Life into Hopes for a Family: Rare Lung Disease Won’t Derail Goal*, BOSTON GLOBE, Apr. 13, 2003, at NW1 (noting that costs of surrogacy procedure to overcome infertility can exceed \$40,000); Schleter, *supra* note 78, at A1 (noting that surrogate fee is usually between \$10,000 and \$25,000); Zimmerman, *supra* note 78, at E1 (noting that surrogates are paid about \$20,000).

⁹⁰ Peter J. Neumann, *Should Health Insurance Cover IVF? Issues and Options*, 22 J. HEALTH POL. POL’Y & L. 1215, 1217–18 (1997) (noting that health insurance rarely covers IVF).

⁹¹ See LIEBMANN-SMITH ET AL., *supra* note 30, at 331.

⁹² See Neumann, *supra* note 90, at 1223. Neumann cites studies in which survey respondents indicated that they would pay large sums to increase their chances of having a child. *Id.* For example, Neumann cites a U.K. study in which survey respondents indicated that they “were willing to pay 29 percent of their after-tax income for a 50 percent chance of having a child, and willing to risk a 20 percent chance of death in order to have a child.” *Id.* at 1224 (citation omitted).

often defer as many nonmedical expenses as possible in order to finance their fertility treatment.⁹³

In addition, patients may rely heavily on less expensive treatments, such as IUI after ovulation induction with clomiphene, even though these treatments are not effective for certain types of infertility problems.⁹⁴ Patients also sometimes proceed with whatever type of care is covered by their insurance, even if, compared to IVF, that care is more invasive and less effective in dealing with their particular infertility problem.⁹⁵ For example, where insurance covers tubal surgeries, but not IVF, a woman with blocked fallopian tubes may have several tubal surgeries to attempt to repair her tubes, instead of bypassing the tubes with IVF.

II

THE TAX TREATMENT OF FERTILITY TREATMENT COSTS UNDER CURRENT LAW

Taxpayers may be able to recoup some of their fertility treatment costs under the tax code. The following sections consider whether some or all fertility treatment costs are deductible as medical expenses under current law.

A. The Tax Treatment of Medical Expenses

Internal Revenue Code (IRC) § 262 provides that taxpayers generally may not deduct personal expenses.⁹⁶ Section 213 provides, however, that taxpayers can deduct their expenses for medical care (i.e., medical care of the taxpayer, his or her spouse, or a dependent) to the extent that those expenses exceed 7.5 percent of the taxpayer's adjusted gross income (AGI).⁹⁷ For example, assume that a taxpayer

⁹³ See *RESOLVING INFERTILITY*, *supra* note 2, at 305.

⁹⁴ See *id.* at 304 (“The least expensive alternatives may turn out to be the least effective. . . . [I]f they do not [work], the costs can quickly add up to equal or exceed what you would have paid for more expensive, although more effective, treatment.”); Davis, *supra* note 5, at 54 (“[Multiple] cycles of IUI with blocked fallopian tubes . . . [are] a waste.”).

⁹⁵ See *RESOLVING INFERTILITY*, *supra* note 2, at 304–05.

⁹⁶ See I.R.C. § 262(a) (2000) (“Except as otherwise expressly provided . . . no deduction shall be allowed for personal, living, or family expenses.”).

⁹⁷ See I.R.C. § 213(a). Taxpayers with large medical expenses may be subject to the Alternative Minimum Tax (AMT). Taxpayers compute their tax liability both under the regular income tax and the AMT, and then pay whichever tax liability is higher. See I.R.C. § 55(a). The base of the AMT, “alternative minimum taxable income” (AMTI), is broader than the base under the regular income tax. See I.R.C. §§ 55(b)(2), 56–58. The AMT tax rate for individuals is twenty-six percent on the first \$175,000 of the “taxable excess” and twenty-eight percent on the “taxable excess” exceeding \$175,000. See I.R.C. §§ 55(b)(1)(A)(i)–(ii). The “taxable excess” is AMTI less an exemption amount (\$45,000 for married couples filing jointly and \$33,750 for single filers, with the exemption amount being phased out at higher AMTIs). See I.R.C. § 55(b)(1)(A)(ii), (b)(2), (d)(1), & (d)(3) (amended 2001). For purposes of the regular income tax, medical expenses can be de-

in the thirty-five percent tax rate bracket has \$100,000 of AGI and \$17,500 of medical expenses. The taxpayer can deduct \$10,000 of the medical expenses because the \$17,500 of medical expenses exceed \$7,500 (7.5 percent of the \$100,000 of AGI) by \$10,000. This deduction reduces the taxpayer's taxable income by \$10,000, which saves the taxpayer \$3,500 in taxes.

Medical expenses for which the taxpayer has been reimbursed do not qualify for the § 213 deduction.⁹⁸ Taxpayers who participate in employer-sponsored medical flexible spending accounts are reimbursed for their medical expenses, which are expenses attributable to "medical care," as defined in § 213.⁹⁹ The reimbursements from medical flexible spending accounts are funded by pre-tax deductions from the participants' income, so participation in the medical flexible spending account allows the participants to pay medical expenses out of pre-tax dollars.¹⁰⁰ For example, assume that a taxpayer in the thirty-five percent tax rate bracket participates in her employer's medical flexible spending account. The taxpayer's annual contributions to the account are capped at \$5,000. The employer periodically withholds funds from the taxpayer's paycheck in order to fund the \$5,000 amount in the taxpayer's flexible spending account. After the taxpayer pays \$5,000 of medical expenses, she is reimbursed that amount out of the account. The \$5,000 of pay withheld and contributed to the flexible spending account is not taxed, which saves the taxpayer \$1,750 (35 percent of the \$5,000 of pay excluded from income).

ducted only to the extent they exceed 7.5% of the taxpayer's Adjusted Gross Income (AGI). See I.R.C. § 213(a). For purposes of the AMT, however, medical expenses can be deducted only to the extent they exceed ten percent of the taxpayer's AGI. See I.R.C. § 56(b)(1)(B) (2000). See I.R.C. § 56(b)(1)(B).

Klaassen v. Commissioner, No. 98-9035, 1999 WL 197172, at *1 (10th Cir. 1999), illustrates the effect of subjecting taxpayers with medical expenses to the AMT. In *Klaassen*, taxpayers with AGI of \$83,056.42 and a medical expense deduction of \$4,767 were subject to the AMT. See *id.* The taxpayers, a husband and wife, had ten dependents and claimed twelve personal exemptions on their tax return. See *id.* They also had total medical expenses of \$10,996. Of that amount, they deducted \$4,767 (\$10,996 medical expenses less \$6,229, which is 7.5% of \$83,056 of AGI). Under the regular income tax, they owed \$5,111. *Id.* Under the AMT, they owed an additional \$1,085, in part because their medical expense deduction, for purposes of the AMT, was only \$2,690 (\$10,996 medical expenses less \$8,306, which is ten percent of \$83,056 of AGI). *Id.*

⁹⁸ See I.R.C. § 213(a).

⁹⁹ I.R.C. §§ 105(b), 125. The 7.5% floor of § 213 does not apply to these reimbursements.

¹⁰⁰ See Maureen B. Cavanaugh, *On the Road to Incoherence: Congress, Economics, and Taxes*, 49 UCLA L. Rev. 685, 706 (2002) (noting that flexible spending accounts permit taxpayers to pay medical expenses with pretax earnings).

B. The Characterization of Fertility Treatment Expenses as Medical Expenses

The characterization of some fertility treatment expenses as § 213 medical expenses is unsettled. There are no reported cases that squarely address this issue. IRS administrative pronouncements have reached conclusions that are seemingly inconsistent, but the most recent of these pronouncements indicate that, at least for the time being, fertility treatment expenses other than surrogacy expenses are deductible as medical expenses. In 1957, the IRS ruled that the costs of IUI are not medical expenses.¹⁰¹ In 2002, however, the IRS stated, in a publication for taxpayers, that the costs of fertility treatment, including IVF, are medical expenses.¹⁰² Even more recently, the IRS issued a private letter ruling in which it concluded that the fee paid to an egg donor, and the related costs of arranging for the egg donation, are medical expenses under § 213.¹⁰³

On the other hand, the IRS, with the approval of its national office, has taken the position in litigation that the costs of surrogacy are not medical expenses.¹⁰⁴ In addition, although the recent administrative pronouncements indicate the current IRS position on fertility treatment costs other than surrogacy costs, the IRS is not bound to follow the position it has taken in private letter rulings¹⁰⁵ or in taxpayer publications.¹⁰⁶

1. *The Definition of Medical Expenses*

Section 213 provides that medical expenses include costs incurred for “the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of

¹⁰¹ See Priv. Ltr. Rul. 5707244900A (July 24, 1957) (ruling that a taxpayer could not deduct as a medical expense the amount paid for artificial insemination).

¹⁰² See INTERNAL REVENUE SERV., DEP'T OF TREASURY, NO. 502, MEDICAL AND DENTAL EXPENSES 6 (2002), available at <http://www.irs.gov/pub/irs-pdf/p502.pdf> (last visited Mar. 7, 2004) [hereinafter IRS PUBLICATION 502] (advising taxpayers that they may deduct the cost of fertility enhancements “such as *in vitro* fertilization (including temporary storage of eggs or sperm)”).

¹⁰³ See Priv. Ltr. Rul. 200318017 (Jan. 9, 2003) (ruling that egg donor expenses and related costs are § 213 medical expenses).

¹⁰⁴ See *Sedgwick v. Commissioner*, No. 10133-94, 94 PTT 13-53 (T.C. June 7, 1994) (LEXSTAT).

¹⁰⁵ Private letter rulings may not be used or cited as precedent. See I.R.C. § 6110(k)(3). The IRS sometimes considers such rulings internally, however, to determine its position on an issue. See MICHAEL I. SALTZMAN, *IRS PRACTICE AND PROCEDURE* ¶ 3.03[3][c], at 3-30, 3-32 (2d ed. 1991).

¹⁰⁶ See, e.g., *Adler v. Commissioner*, 330 F.2d 91, 93 (9th Cir. 1964) (language in a taxpayer publication does not estop the government from making a contrary argument at a later date); SALTZMAN, *supra* note 105, ¶ 3.04[8] (stating that taxpayer publications “perform a useful and laudable function,” but “they may not be relied on by taxpayers in planning future transactions”).

the body.”¹⁰⁷ The first prong of this two-part definition is potentially underinclusive; if read literally and narrowly, it might fail to characterize as medical expenses the costs of medically treating injuries, conditions, and defects. The Department of the Treasury (Treasury Department) has resolved some of this underinclusiveness problem by broadly interpreting the term “disease” to cover conditions (including those caused by personal injury), impairments, and disorders.¹⁰⁸

The potential underinclusiveness of the first prong of the definition is, to some extent, offset by the broader language in the second, or “structure or function,” prong of the definition. This second prong correctly characterizes as medical expenses the costs of medical treatment of a patient’s injuries, conditions, impairments, or disorders. The problem with the “structure or function” prong of the medical expense definition is that it is overinclusive. For example, read literally, the second prong would characterize even the costs of cosmetic surgery as medical expenses.¹⁰⁹ Consistent with this interpretation of § 213, the IRS ruled that the costs of cosmetic surgery were medical expenses under the “structure or function” prong of the definition.¹¹⁰ Although the IRS was no doubt unhappy about allowing taxpayers to deduct the costs of cosmetic surgery as medical expenses, such costs were within the broad second prong of the statutory definition. In 1990, Congress addressed this problem by amending § 213 to specifically exclude “cosmetic surgery or other similar procedures” from the definition of medical expenses.¹¹¹

Medicine and drugs also affect the structure or function of the body, so medicine and drug costs seem to be within the definition of medical expenses. Congress, however, specifically provided in § 213

¹⁰⁷ I.R.C. § 213(d)(1)(A). Treasury Regulation § 1.213-1(e) tracks this statutory language. Treas. Reg. § 1.213-1(e) (2003).

¹⁰⁸ See Treas. Reg. § 1.213-1(e)(1)(v)(a). The Regulation states:

[T]he cost of medical care includes the cost of attending a special school for a mentally or physically handicapped individual, if his *condition* is such that the resources of the institution for alleviating such mental or physical handicap are a principal reason for his presence there. . . . Thus, the cost of medical care includes the cost of attending a special school designed to compensate for or overcome a physical handicap. . . .

Id. (emphasis added).

¹⁰⁹ Law professors who teach the basic income tax class sometimes provide students with other extreme *reductio ad absurdum* examples of the overinclusiveness of the second prong of the medical expense definition. One such example is the cost of a spa day, complete with a manicure, pedicure, and haircut, each of which affects the “structure” of the body, but seems to be a clear consumption expense.

¹¹⁰ See Rev. Rul. 76-332, 1976-2 C.B. 81, 82 (ruling that fees paid for a face-lift operation qualified as medical expenses under § 213); Gen. Couns. Mem. 36,515 (Dec. II, 1975) (concluding that the cost of cosmetic surgery is a medical expense under § 213 because the surgery alters the structure of the body).

¹¹¹ See I.R.C. § 213(d)(9)(A).

that medicine and drug costs are medical expenses only if the drugs are prescription drugs.¹¹²

The Treasury Department has also excluded from the definition of medical expenses any expenses incurred for the general well being of the taxpayer.¹¹³ Treasury Regulation § 1.213 provides that the medical expense deduction is for “expenses incurred primarily for the prevention or alleviation of a physical or mental defect or illness,” and that “an expenditure which is merely beneficial to the general health of an individual, such as an expenditure for a vacation, is not [deductible].”¹¹⁴ For example, the cost of a gym membership is not a medical expense, despite the fact that exercise will improve the taxpayer’s health.¹¹⁵ The cost of a weight loss program for an obese taxpayer is a medical expense, however, because doctors recognize that obesity is a disease or condition.¹¹⁶

Much of the case law under § 213 involves taxpayers trying to deduct as a medical expense the cost of an item, such as a pool or a vacation, which is usually purchased for nonmedical personal reasons.¹¹⁷ The idea is that taxpayers should not be able to convert a nondeductible personal consumption expense into a deductible medical expense by arguing that their medical condition required them to buy the recreational personal items. In distinguishing between nondeductible personal expenses and deductible medical expenses, courts look for a direct and proximate relation between the expense and the medical care.¹¹⁸ In doing so, courts consider various factors. For example, in *Havey v. Commissioner*, the court stated:

In determining allowability, many factors must be considered. Consideration should be accorded the motive or purpose of the taxpayer, but such factor is not alone determinative . . . [A]lso[,] it is important to inquire as to the origin of the expense. Was it incurred at the direction or suggestion of a physician; did the treatment bear directly on the physical condition in question; did the treatment bear such a direct or proximate therapeutic relation to

¹¹² See *id.* § 213(b).

¹¹³ See Treas. Reg. § 1.213-1(e)(1)(ii) (2003).

¹¹⁴ *Id.*

¹¹⁵ See Rev. Rul. 79-151, 1979-1 C.B. 116 (ruling that the cost of a weight reduction program to improve the taxpayer’s health, but not prescribed for the specific purpose of curing a disease, is not a § 213 medical expense).

¹¹⁶ See Rev. Rul. 2002-19, 2002-1 C.B. 778.

¹¹⁷ See, e.g., *Evanoff v. Commissioner*, 44 T.C.M. (CCH) 1394, 1396 (1982) (denying a medical expense deduction for the costs of installing an in-ground pool at the taxpayers’ home because there were community pools nearby).

¹¹⁸ See *Havey v. Commissioner*, 12 T.C. 409 (1949). The taxpayer’s doctor recommended that she go to the seashore in the summer and to Arizona in the winter as treatment for her heart disease. Despite this recommendation, the court held that the taxpayer could not deduct the cost of vacations in New Jersey and Arizona because the medical benefit of the vacations was incidental. *Id.* at 409-10, 413.

the bodily condition as to justify a reasonable belief the same would be efficacious; was the treatment so proximate in time to the onset or the recurrence of the disease or condition as to make one the true occasion of the other, thus eliminating expense incurred for general, as contrasted with some specific, physical improvement?¹¹⁹

Section 213 cases and rulings also indicate that fees paid to non-medical providers are deductible as medical expenses only if the services provided are necessary to treat the taxpayer's medical condition. These cases and rulings involve expenses incurred for items that are not recreational, but may nonetheless be characterized as either personal or medical. For example, in *Gerstacker v. Commissioner*,¹²⁰ the court held that the taxpayers could take a § 213 deduction for legal fees paid to establish a guardianship for Mrs. Gerstacker, so that she could be committed to a mental institution and receive the medical care her doctors prescribed.¹²¹ On the other hand, the court, in *Levine v. Commissioner*,¹²² denied the taxpayers a medical expense deduction for fees paid to a lawyer who helped their mentally ill son with activities such as filling prescriptions, paying bills, buying clothes, hiring a housekeeper, and finding a job.¹²³

Where the taxpayers' expenses are for treatment that is medical in nature (including fees for doctors' services, hospital charges, fees for diagnostic tests, surgical fees, or prescription drugs), it is very difficult for the IRS to argue that the expenses are not medical expenses. The assumption is that most medical treatment originates out of medical necessity, rather than pure personal consumption motives.¹²⁴ The problem with this assumption is that the "structure" part of the "structure or function" prong of the medical expense definition is overinclusive; it characterizes medical services that are undertaken for nonmedical reasons as medical expenses. This is what prompted the 1990 cosmetic surgery amendment to § 213 mentioned above.¹²⁵

It is interesting to note the specific language Congress used in the 1990 cosmetic surgery amendment. Section 213(d)(9) provides that: "The term 'medical care' does not include cosmetic surgery or other

¹¹⁹ *Id.* at 412.

¹²⁰ 414 F.2d 448 (6th Cir. 1969).

¹²¹ *See id.* at 453. The IRS later ruled that it would follow the Sixth Circuit's decision in *Gerstacker*, 414 F.2d 448. *See* Rev. Rul. 71-281, 1971-2 C.B. 166.

¹²² 695 F.2d 57 (2d Cir. 1982).

¹²³ *See id.* at 58, 61 (holding that such fees "lack 'the proximate relationship to the illness . . . required for deductibility,'" *id.* at 61 (quoting *Gerstacker*, 414 F.2d at 453)).

¹²⁴ *See* Mark G. Kelman, *Personal Deductions Revisited: Why They Fit Poorly in an "Ideal" Income Tax and Why They Fit Worse in a Far from Ideal World*, 31 STAN. L. REV. 831, 865 (1979). Professor Kelman has challenged this assumption, pointing out the income elasticity and price elasticity of medical care. *See id.* at 866-68.

¹²⁵ *See* Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 11342(a), 104 Stat. 1388-471 (1990).

similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease.”¹²⁶ Cosmetic surgery is defined as “any procedure which is directed at improving the patient’s appearance and does not meaningfully promote the proper function of the body.”¹²⁷

Congress thus narrowed the second part of the medical expense definition by limiting it in a way that is consistent with the broader interpretation of the first prong of the definition. In other words, the real baseline for characterization of medical expenses is whether the expense helps the patient resume or approximate normal biological functioning. This baseline of *normal biological functioning* is implicit in § 213. For example, Treasury Regulation § 1.213-1 provides: “[T]he cost of medical care includes the cost of attending a special school designed to compensate for or overcome a physical handicap, in order to qualify the individual for future *normal* education or for *normal* living, such as a school for the teaching of braille or lip reading.”¹²⁸

The § 213 regulations, revenue rulings, and case law also indicate that the cost of a *substitute* for a taxpayer’s diseased or impaired body part is a medical expense. In Revenue Ruling 68-452, the taxpayer received a kidney transplant and paid the travel, surgical, and hospital expenses of a kidney donor.¹²⁹ The IRS ruled that the taxpayer could deduct the expenses attributable to the donor, but paid by the taxpayer, under § 213.¹³⁰ The costs of the kidney donor were medical expenses of the taxpayer-patient under either prong of the medical expense definition: the transplant was a “treatment” for the taxpayer-patient’s kidney disease and it was for the purpose of affecting the “structure or function” of the taxpayer-patient’s body—even though some of the medical care was given to a third-party donor.¹³¹

The cost of a substitute for the taxpayer’s diseased or impaired body part can qualify as a medical expense under the first prong of the definition, even though it would not qualify under the second prong. This is particularly true for the cost of care that “mitigates” or “ameliorates” the taxpayer’s disease, condition, or impairment. For

¹²⁶ I.R.C. § 213(d)(9)(A) (2000).

¹²⁷ I.R.C. § 213(d)(9)(B). In 1996, the IRS ruled that the cost of laser vision correction surgery is a medical expense, despite the fact that it improves the taxpayer’s appearance, because it promotes the proper function of the taxpayer’s eyes. *See* Priv. Ltr. Rul. 9625049 (Mar. 27, 1996).

¹²⁸ Treas. Reg. § 1.213-1(e)(1)(v)(a) (2003) (emphasis added).

¹²⁹ *See* Rev. Rul. 68-452, 1968-2 C.B. 111.

¹³⁰ *Id.*

¹³¹ *See id.* at 112 (stating that the surgical and hospital care expenses of the donor were “for the ‘medical care’ of the [donee-taxpayer] and that the donor’s transportation costs were “primarily for and essential to medical care of [the donee-taxpayer]”).

example, the § 213 regulations specifically provide that taxpayers can take a medical expense deduction for the cost of a seeing eye dog.¹³² In Revenue Ruling 64-173, the IRS ruled that the taxpayers could deduct the amounts paid to a blind student's guide at school.¹³³ The tax court has also held that taxpayers could deduct the amounts paid to a person who took class notes for their deaf child.¹³⁴

Although these various substitutes for normal functioning do not affect the structure or function of the taxpayer's body, the costs of these substitutes still qualify as medical expenses because the items in question mitigate a disease, condition, or impairment under the first prong of the definition. In all of these examples, the payments are made to nonmedical providers, but the expenses are incurred for care. These examples are thus distinguishable from cases such as *Gerstacker* because in those cases the payments made to nonmedical providers were not for the care of the patient; instead, the expenses were for services that were ancillary to the care of the patient.

2. *Application to Fertility Treatment Expenses*

a. *Fertility Treatment Expenses in General*

The costs of fertility treatments that do not involve a donor or a surrogate are medical expenses under either prong of the § 213(d)(1)(A) definition. The purpose of non-third-party fertility treatment is to enable the female patient to become pregnant and give birth to a child. Thus, the treatment costs are incurred "for the purpose of affecting any structure or function of the [taxpayer's] body."¹³⁵ Fertility treatment costs also qualify as medical expenses under the first prong of § 213(d)(1)(A) because the medical profession recognizes that infertility is a disease or condition,¹³⁶ and fertility treatment costs are incurred for the diagnosis, cure, mitigation, or treatment of that disease or condition.¹³⁷ The costs of the initial physician and laboratory workup are incurred to diagnose the specific cause of the infertility.¹³⁸ Some fertility treatments, such as the surgical repair of blocked fallopian tubes, endometriosis, or varicocele,

¹³² See Treas. Reg. § 1.213-1(e)(1)(iii). It is irrelevant whether the blindness was caused by disease or injury, or was congenital. *Id.*

¹³³ See Rev. Rul. 64-173, 1964-1 C.B. 121.

¹³⁴ See *Estate of Baer v. Commissioner*, 26 T.C.M. (CCH) 170, 173 (1967) (holding that "the amount paid to the 'notetaker' was for the primary purpose of alleviating [the] physical defect of deafness and, therefore, is deductible as a medical expense").

¹³⁵ I.R.C. § 213(d)(1)(A) (2000).

¹³⁶ The American Society of Reproductive Medicine, a nonprofit organization of scientists, doctors, nurses, and other health professionals, characterizes infertility as a "disease of the reproductive system." See ASRM, *Infertility Q&A*, *supra* note 2.

¹³⁷ See discussion *supra* Parts I.B-C.

¹³⁸ See *supra* Part I.C.

cure or treat the disease or condition of infertility.¹³⁹ Other conventional treatments and assisted reproductive technologies mitigate rather than cure the disease or condition.¹⁴⁰

In spite of the fact that fertility treatment expenses seem to fit the medical expense definition, it is possible to argue that fertility treatment expenses are nonetheless nondeductible under § 213, because the decision to bear children is a personal *consumption* decision, not a *medical* decision. For purposes of defining the scope of the business expense deduction,¹⁴¹ the tax law has consistently treated child rearing as a form of personal consumption. For example, in *Smith v. Commissioner*, the taxpayers, Mr. and Mrs. Smith, paid for child care so that they could both work outside of the home.¹⁴² They argued that their child care costs should be deductible as a business expense.¹⁴³ The court disallowed the business expense deduction, stating, “[w]e are not prepared to say that the care of children, like similar aspects of family and household life, is other than a personal concern.”¹⁴⁴

The IRS could analogize to these business expense deduction cases and argue that fertility treatment costs are personal consumption expenses, not deductible medical expenses. There are two different ways in which the IRS could make this argument. First, the IRS could argue that fertility treatment is within the cosmetic surgery exception, because fertility treatment is a lifestyle choice and is thus similar to cosmetic surgery. Recall that § 213(d)(9)(A) provides that “the term ‘medical care’ does not include cosmetic surgery or other *similar* procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease.”¹⁴⁵ Section 213(d)(9)(B) defines cosmetic surgery as

¹³⁹ See *supra* Part I.B.

¹⁴⁰ See *supra* notes 61–78 and accompanying text.

¹⁴¹ Taxpayers are allowed to deduct their ordinary and necessary business expenses under I.R.C. § 162 (2000).

¹⁴² See 40 B.T.A. 1038, 1038–39 (1939) (“The wife’s services as custodian of the home and protector of its children are ordinarily rendered without monetary compensation. There results no taxable income from the performance of this service and the correlative expenditure is personal and not susceptible of deduction.”).

¹⁴³ See *id.* at 1039.

¹⁴⁴ *Id.* Professor Douglas Kahn summarizes the tax law’s treatment of child care costs in this way:

While the expense of caring for children may be a necessary cost of freeing the parent from the home so that he can earn income, it also is an expense arising out of personal, family obligations. The cost of child care is analogous to commuting expenses which are not deductible even though a taxpayer is not able to earn gross income unless he travels from his residence to his place of work.

DOUGLAS A. KAHN, FEDERAL INCOME TAX: A STUDENT’S GUIDE TO THE INTERNAL REVENUE CODE §10.2000, at 434 (4th ed. 1999).

¹⁴⁵ I.R.C. § 213(d)(9)(A) (2000) (emphasis added).

“any procedure which is directed at improving the patient’s appearance and does not meaningfully promote the proper function of the body.”¹⁴⁶

The scope of § 213(d)(9), however, is too narrow for this argument to succeed. “Similar” in the context of § 213(d)(9) means procedures other than cosmetic surgery that improve the patient’s appearance, but do not promote functioning,¹⁴⁷ such as liposuction and hair transplants. The legislative history of the amendment to § 213 specifically states:

[U]nder the provision, procedures such as hair removal, electrolysis, hair transplants, [liposuction], and face lift operations generally are not deductible. In contrast, expenses for procedures that are medically necessary to promote the proper function of the body and only incidentally affect the patient’s appearance or expenses for treatment of a disfiguring condition arising from a congenital abnormality, personal injury or trauma, or disease (such as reconstructive surgery following removal of a malignancy) continue to be deductible under present-law rules.¹⁴⁸

The cosmetic surgery amendment was drafted to create an exception for the cost of medical procedures that affect the structure and appearance of the body, but not the functioning of the body. In other words, Congress drafted the amendment to limit the “structure or function” prong of the medical expense definition, but not the first prong of the definition. Under this approach, the cost of breast augmentation, for example, cannot qualify as a medical expense because: (1) the cost is not incurred because of a disease or a medical condition, and thus is not within the first prong of the definition; and (2) the cost is not incurred for a procedure that affects the functioning of the body, and thus is not within the second prong of the definition.¹⁴⁹

On the other hand, the costs of cosmetic surgery procedures that either affect the functioning of the body or mitigate the affects of a disease or medical condition are deductible as medical expenses.¹⁵⁰ Similarly, fertility treatment expenses, other than the costs of surrogacy, could be characterized as medical expenses both under the “structure or function” prong and under the first prong because fertil-

¹⁴⁶ *Id.* at § 213(d)(9)(B).

¹⁴⁷ *Id.* at § 213(d)(9).

¹⁴⁸ 136 CONG. REC. S30,485 (daily ed. Oct. 18, 1990).

¹⁴⁹ *See* I.R.C. § 213(d)(1)(A), (d)(9)(A), (B).

¹⁵⁰ *See id.* § 213(d)(9)(A) (stating that the cost of cosmetic surgery that is “necessary to ameliorate a deformity arising from, or directly related to a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease” is a medical expense).

ity treatment costs are incurred for the diagnosis, cure, mitigation, or treatment of the disease or medical condition of infertility.¹⁵¹

Second, and more generally, the IRS could argue that giving birth to a child is “merely beneficial to the general health of the [taxpayer],” and therefore fertility treatment expenses are not deductible as medical expenses.¹⁵² This argument is consistent with Professor Johnson’s view that a person can lead a “normal” life without ever having children, and thus the choice of whether to bear children is a consumption decision, not a medical decision.¹⁵³ If this argument were persuasive, however, it would apply with equal force to other medical expenses that relate to reproductive choice, such as the costs of contraceptives, abortions, vasectomies, and sterilization procedures. The argument could also apply to the cost of medical care for sexual conditions or dysfunction, such as the cost of Viagra, because a person can also lead a “normal” life without being sexually active.

Some insurance companies have taken the position that the decision to bear or not bear children is a “lifestyle choice” and have declined to cover fertility treatment and contraceptives for that reason.¹⁵⁴ The majority of insurance plans cover abortion, vasectomy,

¹⁵¹ One could argue that fertility treatment is analogous to cosmetic surgery because fertility treatment is not a life or death matter for the infertile patient. Cosmetic surgery is the only type of medical expense specifically excluded from § 213, however. The congressional failure to exclude fertility treatment along with cosmetic surgery in the 1990 amendment may have been deliberate. As the old maxim of statutory construction goes, *expressio unius, exclusio alterius* (meaning that one can infer from the specific inclusion of one item, that the omission of other specific items was intentional). See, e.g., GAIL LEVIN RICHMOND, FEDERAL TAX RESEARCH: GUIDE TO MATERIALS & TECHNIQUES 40 (5th ed. 1997) (citing *Becker v. United States*, 451 U.S. 1306, 1309 (1981), *vacated on other grounds*, 452 U.S. 935 (1981)); see also *Barnhart v. Peabody Coal Co.*, 537 U.S. 149, 168 (2003) (“[T]he canon . . . does not apply to every statutory listing or grouping; it has force only when the items expressed are members of an ‘associated group or series,’ justifying the inference that items not mentioned were excluded by deliberate choice, not inadvertence.” (quoting *United States v. Vonn*, 535 U.S. 55, 65 (2002))).

¹⁵² Treasury Regulation § 1.213-1 provides that “an expenditure which is merely beneficial to the general health of an individual, such as an expenditure for a vacation, is not [deductible].” Treas. Reg. § 1.213-1(e)(1)(ii) (2003).

¹⁵³ See E-mail from Professor Calvin H. Johnson, University of Texas at Austin, School of Law, chjohnson@mail.law.utexas.edu, to Professor Katherine T. Pratt, Loyola Law School (Oct. 3, 2003) (on file with author) (reproducing Posting of Professor Calvin H. Johnson, to Taxprof@Listserv.uc.edu (Apr. 20, 2000)).

¹⁵⁴ See Lisa A. Hayden, *Gender Discrimination Within the Reproductive Health Care System: Viagra v. Birth Control*, 13 J.L. & HEALTH 171, 183 (1998–99) (quoting an insurance industry spokesperson who characterized contraceptives as a “lifestyle drug;” “[c]onsequently, only fifteen percent of indemnity insurance plans offer coverage of the five most common contraceptive methods”); Marie McCullough, *Infertile Couples Get New Ammo*, CHARLSTON GAZETTE, July 9, 2000, at 5B. Few plans cover contraceptives and even fewer plans cover fertility treatment, such as IVF. See Bob Rosenblatt, *Viagra Spurs New Questions About HMO Drug Coverage*, L.A. TIMES, June 8, 1998, at S8 (comparing insurance coverage of Viagra, contraceptives, and fertility treatment).

and tubal ligation, however.¹⁵⁵ Insurance companies and employers who purchase insurance for their employees take into account the cost of treatments when they determine which treatments will be covered by their plans. Given their need to ration care, it is not surprising that many insurance companies have not wanted to cover expensive treatments such as IVF, or widely used, inexpensive treatments such as contraceptives. Many insurers cover the costs of Viagra, however.¹⁵⁶ According to an insurance industry spokesperson, insurance companies treat Viagra differently than contraceptives because, “there is a clear distinction between Viagra, which has been approved as a cure for a medical dysfunction, and contraception, which [is] a ‘lifestyle drug.’”¹⁵⁷

If the IRS adopted this “lifestyle” approach, the cost of medical care that furthers reproductive choice would not be deductible under section 213 where the medical care does not repair or treat a disease or a condition. In other words, the cost of contraceptives, vasectomies, and tubal ligations would not be deductible. Viagra and IVF, however, both ameliorate a disease or condition; the costs of fertility treatment for reproductive dysfunction would thus be deductible if the costs of Viagra to treat sexual dysfunction were deductible. (Viagra and IVF both simulate normal functioning by temporarily bypassing, but not curing, the underlying medical problem.¹⁵⁸)

Consider whether the IRS could successfully argue the line of cases in which taxpayers have tried to convert nondeductible personal consumption expenses into deductible medical expenses.¹⁵⁹ The

¹⁵⁵ See Rosenblatt, *supra* note 154, at S8.

¹⁵⁶ See Paul Rauber, *It's a Man's World: Is Male Potency More Important Than Preventing Pregnancy?*, SIERRA, Sept.–Oct.1998, at 20 (criticizing the willingness of insurers to cover Viagra but not contraceptives, and noting that only fifteen percent of non-HMO plans cover the five most common forms of reversible contraceptives).

¹⁵⁷ Debra Baker, *Viagra Spawns Birth Control Issue*, A.B.A. J., Aug. 1998, at 36, 36 (quoting Richard Coorsh, spokesperson for the Health Insurance Association of America). Similarly, Professor Dodge argued that fertility treatment costs are not deductible as medical expenses because fertility treatment constitutes a lifestyle choice, not medical treatment. See Dodge, *supra* note 10 (“I suppose reproduction is a bodily function, but it is one the exercise of which is purely optional.”). Professor Dodge also expressed the view that the cost of Viagra could be deductible as a medical expense only in some cases. Professor Dodge argues that expenditures incurred to “repair” a physical defect are deductible, but expenditures incurred to “improve” physical performance beyond a baseline of normal functioning are not deductible. See *id.* In his view, expenditures for treatment that merely counteracts the effects of aging are not deductible, but he notes that erectile dysfunction is, in some cases, not age related. *Id.*

¹⁵⁸ Erectile dysfunction has a variety of causes including diabetes, prostate disorders, and heart problems. See generally John Simons, *Taking on Viagra*, FORTUNE, June 9, 2003, at 102, 108 (discussing some of the common causes of erectile dysfunction). Viagra does not cure these disorders; instead it creates a temporary erection by blocking a specific enzyme in the penis. *Id.* at 110. For a summary of how IVF works to bypass the underlying medical problem of infertility, see *supra* notes 68–69 and accompanying text.

¹⁵⁹ See *supra* notes 117–19 and accompanying text.

types of expenses involved in these cases, such as the cost of a pool, a vacation, golf, a gym membership, or a trip to a spa, are typically incurred for a consumption motive by people who are healthy. Although the item in question may provide incidental health benefits, the cost of the item is not a medical expense. In some cases, however, the taxpayer can argue that the recreational expenses were incurred primarily for medical reasons.

In many cases in which the taxpayer tries to deduct recreational expenses as medical expenses, the taxpayer fails to establish the factors required to support a medical expense deduction.¹⁶⁰ In contrast, a court applying the factors from these cases to fertility treatment expenses would likely conclude that: (1) the taxpayer's motive is to diagnose, treat, or ameliorate the medical disease or condition of infertility; (2) the fertility treatment is undertaken at the direction or suggestion of a physician; (3) the diagnosis, treatment, or amelioration bears a direct relationship to the infertility and justifies a reasonable belief that the care will be efficacious; and (4) the care is proximate in time to the onset or recurrence of the infertility.¹⁶¹

Said another way, healthy individuals purchase pools, vacations, and golf primarily for fun, and only incidentally for health benefits. Conversely, healthy individuals do not undergo IVF, egg donor, and surrogacy procedures for fun. In this respect, fertility treatment presents a clearer case for deduction than Viagra, because many men who do not suffer from erectile dysfunction use Viagra "recreationally."¹⁶² If a doctor told an infertile patient to take a vacation in Hawaii to improve his or her chances of conceiving, the costs of such a vacation could be characterized as personal and nondeductible under this line of cases, but the costs of medical procedures to ameliorate infertility cannot be characterized as personal and nondeductible under this line of cases.¹⁶³

¹⁶⁰ See *Havey v. Commissioner*, 12 T.C. 409, 412 (1949); *supra* notes 115–17 and accompanying text.

¹⁶¹ *Id.*

¹⁶² See Christine Gorman, *Viagra Turns 5*, TIME, Jan. 20, 2003, at 146.

One trend that has started to worry public-health officials . . . is the growing recreational use of Viagra in some settings. . . . Viagra, often in combination with illegal drugs like ecstasy, enables patrons of sex clubs to have sex with more partners, which increases their risk of contracting sexually transmitted diseases (STDs) like syphilis and AIDS. "One out of three sexually active gay men at our STD clinics has used Viagra in the past year," says Dr. Jeffrey Klausner, director of STD Prevention and Control Services in San Francisco. The same was true for 1 of 14 heterosexual men at the clinics.

Id.

¹⁶³ During an e-mail exchange on the Taxprof list serve, Professor Joseph Dodge argued: "I suppose reproduction is a bodily function, but it [is] one the exercise of which is purely optional—a lifestyle choice. Sexual activity is also a bodily function, but nobody would seriously claim that sexual devices, toys, and fees for sexual services should be deductible." E-mail submission from Professor Joseph Dodge, Florida State University College

The IRS has taken seemingly inconsistent positions on the characterization of the costs of various types of reproductive medical care as deductible medical expenses. The § 213 regulations specifically provide that “amounts paid for operations or treatments affecting any portion of the body, *including obstetrical expenses*. . . , are deemed to be for the purpose of affecting any structure or function of the body. . . .”¹⁶⁴ Thus, medical obstetrical care of a woman who is already pregnant is medical care under § 213.

The IRS has, over the years, changed its position on the deductibility of the costs of medical care that permits reproductive choice. As noted earlier, the IRS ruled in 1957 that taxpayers could *not* deduct the cost of an artificial insemination as a medical expense, since the expense was “not incurred primarily for prevention or alleviation of a physical or mental defect or illness.”¹⁶⁵ In other words, the IRS, in 1957, did not regard infertility as a defect or illness. The reasoning of this ruling, however, may lead to a different conclusion today because the medical profession now recognizes infertility as a disease or medical condition. In the early 1970s, following *Roe v. Wade*,¹⁶⁶ the IRS issued a series of revenue rulings in which it ruled that the costs of contraceptives, abortions, and vasectomies all qualify as § 213 medical expenses.¹⁶⁷ Also, as noted earlier, the IRS recently revised the taxpayer publication on medical expenses to include “fertility enhancement” on the list of items that are deductible as medical expenses.¹⁶⁸ The publication states that § 213 medical expenses include “the cost of . . . procedures to overcome your inability to have children,” specifically including IVF.¹⁶⁹

For purposes of characterizing costs as deductible medical expenses, the appropriate baseline in § 213 is *normal biological function-*

of Law, to Taxprof@Listserv.uc.edu (Apr. 20, 2000) (copy on file with author). Expenditures for sexual devices, toys, and sexual services are not deductible because such items are the analogue of the trip to Hawaii, meaning that healthy individuals typically purchase such items for fun, not for medical reasons. These expenditures are thus distinguishable from expenditures for medical fertility treatment under § 213.

¹⁶⁴ Treas. Reg. § 1.213-1(e)(1)(ii) (2003). The Treasury Department promulgated this Regulation in 1957, before fertility treatment was common, so the term “obstetrical expenses” does not necessarily include fertility treatment expenses. T.D. 6279, 1957-2 C.B. 190.

¹⁶⁵ Priv. Ltr. Rul. 5707244900A (July 24, 1957).

¹⁶⁶ 410 U.S. 113 (1973).

¹⁶⁷ See, e.g., Rev. Rul. 73-200, 1973-1 C.B. 140 (ruling that the cost of birth control pills is a medical expense under § 213); Rev. Rul. 73-201, 1973-1 C.B. 140 (ruling that the cost of a legal vasectomy or abortion is a medical expense under § 213).

¹⁶⁸ IRS PUBLICATION 502, *supra* note 102, at 6.

¹⁶⁹ *Id.* The publication also states that “[s]urgery, including an operation to reverse prior surgery that prevents you from having children,” is medical care for purposes of § 213. *Id.*

ing,¹⁷⁰ and the § 213(d)(1)(A) definition must be interpreted in light of this benchmark. Recall that the costs of cosmetic surgery were thought to qualify as medical expenses, prior to the amendment of § 213, under the “structure or function” prong of the definition.¹⁷¹ For purposes of § 213, however, medical care that affects a structure of the body should only be treated as medical care if it helps to restore or approximate normal biological functioning. For example, the cost of a prosthetic leg is a medical expense because the prosthetic limb affects both the structure and function of the body.

Although cosmetic surgery affects the structure of the body, it is not generally medical care for purposes of § 213 because it does not usually affect normal biological functioning. The change in the structure of the body merely affects appearance. Where cosmetic surgery is necessary to restore or approximate normal functioning, it is medical care. Medically necessary cosmetic surgery includes surgery to repair congenital abnormalities, injuries, and disfigurements from disease. Consistent with this language, a breast augmentation procedure is not medical care, for purposes of § 213, but a breast reconstruction surgery following surgical removal of breast cancer is medical care.¹⁷² The standard is not whether the patient would die or appear disabled without treatment; rather, it is whether the treatment is necessary to restore or approximate normal biological functioning.¹⁷³

Reproduction is part of normal biological functioning. Both disability law and constitutional law recognize that reproduction is not only a normal biological function, but is a *major* or *fundamental* life activity. For example, the Supreme Court held, in *Bragdon v. Abbott*, that reproduction is a “major life activity” for purposes of applying the Americans with Disabilities Act of 1990 (ADA).¹⁷⁴ A person is dis-

¹⁷⁰ For example, Treasury Regulation § 1.213-1 provides: “[T]he cost of medical care includes the cost of attending a special school designed to compensate for or overcome a physical handicap, in order to qualify the individual for future *normal* education or for *normal* living, such as a school for the teaching of braille or lip reading.” Treas. Reg. § 1.213-1(e)(1)(v)(a) (2003) (emphasis added).

¹⁷¹ See *supra* note 110 and accompanying text.

¹⁷² See *supra* notes 149–50 and accompanying text.

¹⁷³ Breast reconstruction surgery affects the structure of the body, but it also helps to repair a disfigurement that is caused by disease. In addition, it helps the patient restore some of the bodily integrity lost in the cancer surgery, and may permit the patient to resume normal sexual functioning. In contrast, regular cosmetic surgeries do not similarly affect the functioning of the body.

¹⁷⁴ 524 U.S. 624, 638 (1998) (“We have little difficulty concluding that [reproduction is a major life activity].”). The respondent in the case, who was HIV positive, needed a cavity filled by the petitioner dentist. See *id.* at 624. After disclosing her HIV status, the dentist informed her that he would fill the cavity only in the hospital, which meant that the respondent would have to pay an extra hospital fee for the procedure. *Id.* The respondent sued the dentist, alleging a violation of the ADA, which prohibits discrimination “on the basis of disability in the . . . enjoyment of the . . . services . . . of any place of public accommodation by any person who . . . operates [such] a place.” *Id.* (quoting 42 U.S.C.

abled under the ADA if he or she has "a physical or mental impairment that substantially limits one or more [of his or her] major life activities."¹⁷⁵ The ADA does not define the operative terms in this definition, so courts have had to interpret the terms.¹⁷⁶

Under the ADA, courts have interpreted the term "major life activity" by comparing the activity in question to an illustrative list of "major life activities" in a Rehabilitation Act regulation.¹⁷⁷ The list includes activities "such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working."¹⁷⁸ Some courts have defined "major life activity" narrowly to require that the activity in question meet three requirements: (1) microfrequency, (2) macrofrequency, and (3) universality.¹⁷⁹ Other

§ 12182(a) (2000). The District Court granted summary judgment for the respondent. *See* *Abbot v. Bragdon*, 912 F. Supp. 580 (D. Me. 1995). The First Circuit affirmed. *See* *Abbot v. Bragdon*, 107 F.3d 934 (1st Cir. 1997). The Supreme Court agreed with the Court of Appeals that the respondent's HIV infection was a "disability" for purposes of §12102(2)(A) of the ADA, which defines a disability as "a physical . . . impairment that substantially limits one or more of [an individual's] major life activities," but vacated and remanded for a determination as to whether or not an exemption to the ADA applied in this case. *See* *Bragdon*, 524 U.S. at 655.

¹⁷⁵ 42 U.S.C. §12102(2)(A) (2000).

¹⁷⁶ *Bragdon*, 524 U.S. at 631-32. Regulations promulgated by the Department of Health and Human Services (DHHS) defined "physical or mental impairment" as "any physiological disorder or condition . . . affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive[;] digestive[;] genito-urinary; hemic and lymphatic; skin; and endocrine." 45 C.F.R. § 84.3(j)(2)(i) (1997). Courts have defined the term "physical or mental impairment" for purposes of the ADA by looking to the definition of that term in other regulations, including the DHHS regulation quoted above. For further discussion of this portion of the ADA test for disability, see Sarah Lynn Oquist, Note, *Reproduction Constitutes a "Major Life Activity" Under the ADA: Implications of the Supreme Court's Decision in Bragdon v. Abbott*, 32 CREIGHTON L. REV. 1357, 1382-83 (1999).

¹⁷⁷ *See, e.g., Bragdon*, 524 U.S. at 631-32, 638 (stating that courts must construe the ADA in a manner that is consistent with the Rehabilitation Act regulations).

¹⁷⁸ 28 C.F.R. § 41.31(b)(2) (2003); 45 C.F.R. § 84.3(j)(2)(ii) (1997).

¹⁷⁹ *See, e.g., Krauel v. Iowa Methodist Med. Ctr.*, 915 F. Supp. 102, 106-08 (S.D. Iowa 1995) (concluding that reproduction is not a "major life activity" because it is an activity that is engaged in only infrequently); *Zatarain v. WDSU-Television, Inc.*, 881 F. Supp. 240, 243 (E.D. La. 1995) (concluding that reproduction is not a "major life activity" because it is not an activity one engages in "throughout the day, every day").

Microfrequency characterizes an activity in which an individual engages in numerous times throughout a day or continuously for a substantial portion of the day. Macrofrequency characterizes an activity in which an individual engages in almost every day, if not every day. Universality characterizes an activity in which almost all individuals engage in, unless an individual has a "disability." The ADA's list of major life activities includes "caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working." All individuals—unless disabled—participate in the listed major life activities throughout the day, every day.

Oquist, *supra* note 176, at 1413; *see infra* notes 271-73 and accompanying text.

Courts have interpreted the "substantial limitation" requirement of the major life activity definition, to mean: "(i) [u]nable to perform a major life activity that the average person in the general population can perform; or (ii) [s]ignificantly restricted as to the

courts, including the United States Supreme Court, have interpreted the term more broadly to include any activity of “comparative importance.”¹⁸⁰

Justice Kennedy’s opinion in *Bragdon v. Abbott* states, “reproduction falls well within the phrase ‘major life activity.’ Reproduction and the sexual dynamics surrounding it are central to the life process itself.”¹⁸¹ Although the petitioner argued that, for purposes of the ADA, “major life activity” means activities that have a “public, economic, or daily character,”¹⁸² a majority of the Court disagreed, on the theory that “reproduction could not be regarded as any less important than working and learning,” activities which are listed as major life activities in the Rehabilitation Act.¹⁸³

condition, manner or duration under which an individual can perform a particular major life activity as compared to . . . the average person in the general population [performing that major life activity].” See, e.g., *Whitfield v. Pathmark Stores, Inc.*, 39 F. Supp. 2d 434, 437 (D. Del. 1999). This definition is derived from Equal Employment Opportunity Commission (EEOC) regulations. See 29 C.F.R. § 1630.2(j)(i)–(ii).

¹⁸⁰ *Bragdon*, 524 U.S. at 638 (“As the Court of Appeals held, ‘[t]he plain meaning of the word “major” denotes comparative importance’ and ‘suggest[s] that the touchstone for determining an activity’s inclusion under the statutory rubric is its significance,’” (quoting *Abbot v. Bragdon*, 107 F.3d 934, 939 (1st Cir. 1997)). For criticism of this broader definition of “major life activity,” see, for example, Oquist, *supra* note 176, at 1412–15 (arguing that the Supreme Court should have adopted the narrower three-part test used in *Krauel*, 915 F. Supp. 102).

¹⁸¹ *Bragdon*, 524 U.S. at 638.

¹⁸² *Id.*

¹⁸³ *Id.* at 639. Justice Kennedy noted:

[T]he ADA must be construed to be consistent with regulations issued to implement the Rehabilitation Act. . . . Rather than enunciating a general principle for determining what is and is not a major life activity, the Rehabilitation Act regulations instead provide a representative list. . . . [T]he list is illustrative, not exhaustive.

These regulations are contrary to petitioner’s attempt to limit the meaning of the term “major” to public activities. The inclusion of activities such as caring for one’s self and performing manual tasks belies the suggestion that a task must have a public or economic character in order to be a major life activity for purposes of the ADA. On the contrary, the Rehabilitation Act regulations support the inclusion of reproduction as a major life activity, since reproduction could not be regarded as any less important than working and learning.

Id. at 638–39 (citations omitted).

Chief Justice Rehnquist took the position that, for purposes of the ADA, “major” should be interpreted to mean “greater in quantity, number, or extent,” rather than of “comparative importance.” *Id.* at 660 (Rehnquist, C.J., concurring in part and dissenting in part).

No one can deny that reproductive decisions are important in a person’s life. But so are decisions as to who to marry, where to live, and how to earn one’s living. Fundamental importance of this sort is not the common thread linking the statute’s listed activities. The common thread is rather that the activities are repetitively performed and essential in the day-to-day existence of a normally functioning individual. They are thus quite different from the series of activities leading to the birth of a child.

Id.

Constitutional law cases have also treated reproduction as fundamentally important. For example, in *Skinner v. Oklahoma*, the Supreme Court struck down a forced sterilization statute.¹⁸⁴ Justice Douglas noted: "We are dealing here with legislation which involves one of the basic civil rights of man. Marriage and procreation are fundamental to the very existence and survival of the race."¹⁸⁵

Case law thus establishes that reproduction is a normal biological function, and the baseline for deductibility under §213 is normal biological functioning. In the context of reproductive functioning, "normal" functioning does not necessarily mean "natural" functioning. Instead, normal in this context means a state of the body (pregnant or not pregnant) that the patient can choose and achieve with medical assistance. In other words, the § 213 definition of "medical care" includes medical intervention that facilitates reproductive choice. Reproductive medical care sometimes facilitates pregnancy, by treating or bypassing a diseased or impaired reproductive system and allowing an infertile patient to achieve the "normal" state of pregnancy that a fertile patient can achieve without any medical intervention. In other cases, reproductive medical care prevents or ends pregnancy.

Since the early 1970s, the IRS has consistently taken the position that the costs of medical treatment to *prevent* pregnancy are deductible under § 213.¹⁸⁶ Similarly, the costs of medical treatment to *facilitate* pregnancy are also deductible. In fact, the argument for deductibility of fertility treatment expenses is arguably stronger; unlike medical means of birth control, fertility treatment diagnoses, treats, or mitigates an existing disease or condition.¹⁸⁷ In other words, fertility treatment is more like the example of Viagra being used to treat sexual dysfunction.¹⁸⁸

It is irrelevant that some people who choose not to have children (or who choose not to be sexually active) can lead happy, "normal" lives. A person who wants to have children (or to be sexually active) and cannot, because of a biological limitation, is not leading a normal

Justice O'Connor concluded that reproduction is not a "major life activity" for purposes of the ADA because it is not an activity in which all persons engage. *Id.* at 664-65 (O'Connor, J., concurring in part and dissenting in part).

In my view, the act of giving birth to a child, while a very important part of the lives of many women, is not generally the same as the representative major life activities of all persons—"caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working"—listed in regulations relevant to the Americans with Disabilities Act of 1990.

Id.

¹⁸⁴ 316 U.S. 535, 543 (1942).

¹⁸⁵ *Id.* at 541.

¹⁸⁶ See *supra* note 167 and accompanying text.

¹⁸⁷ See *supra* notes 49-78 and accompanying text.

¹⁸⁸ See *supra* note 158 and accompanying text.

life. A person's body should permit the person to choose whether to bear children: what a person does with that choice is irrelevant. If a person's body does not permit the person to choose whether to bear children and that person seeks medical care to overcome the disease or condition of infertility, the cost of that medical care is deductible under § 213.

With a § 213 benchmark of normal functioning, the tax law might distinguish between fertility treatment costs of premenopausal women and postmenopausal women.¹⁸⁹ If a younger woman cannot have children without an IVF procedure because her fallopian tubes are blocked, the IVF procedure enables the woman to approximate normal functioning. If a fifty-year-old woman cannot have children without an IVF procedure (and perhaps an egg donor) because of her age, it might appear that the fertility treatment enables the woman to approximate *supernormal* functioning. On the other hand, the activity, child bearing, is part of normal functioning.

As noted above, normal reproductive functioning incorporates reproductive choice.¹⁹⁰ Childbearing by a postmenopausal woman is not *natural*—meaning that it requires medical intervention in all cases—but that is true of all medical care designed to counter the natural effects of aging, and it is true of all forms of medical care that prevent or end pregnancy. Medical treatment of other disorders related to aging, such as osteoporosis, heart disease, and dementia, constitute medical care despite the fact that these disorders are “natural” in older people. In addition, prescription hormone replacement therapy for postmenopausal women is treated as medical care.¹⁹¹ Said another way, “[i]t is certainly ‘unnatural’ for [postmenopausal] women to give birth, [but] virtually every medical intervention is ‘unnatural’ to some degree.”¹⁹² The only difference between the medical treatment of infertility of postmenopausal women and the medical treatment of other disorders related to aging is that the other disorders entail loss of day-to-day functioning, but nothing in § 213 makes deductibility turn on such a distinction.

¹⁸⁹ Fertility of women declines with age, but more and more older women are having children. See *RESOLVING INFERTILITY*, *supra* note 2, at 11, 14. The birthrate for forty to forty-four-year-old women has increased seventy-four percent since 1981. See *supra* note 48 and accompanying text.

¹⁹⁰ This argument is consistent with the position of the IRS that contraceptives, abortion, vasectomy, and sterilization expenses are all medical expenses. See *supra* note 167 and accompanying text (discussing revenue rulings in which the IRS concluded that these expenses are medical expenses).

¹⁹¹ See I.R.C. § 213(b), (d)(3) (2000).

¹⁹² KEARNEY, *supra* note 39, at 162.

b. *The Expenses of Donor and Surrogate Procedures*

Fertility procedures involving donors and surrogates raise additional characterization issues. In a donor procedure, the issue is whether the additional costs of using the donor (e.g., the donor's fee, the broker's fee, the fee for the donor's attorney, the cost of insurance, and the costs of medical care of the donor) are characterized as medical expenses under § 213. In a surrogate procedure, there are two issues: (1) are any of the costs of the procedure characterized as medical expenses under § 213; and (2) if so, are the additional costs of using the surrogate (e.g., the surrogate's fee, the fee for the surrogate's attorney, the cost of insurance for the surrogate, and the costs of medical care for the surrogate) characterized as medical expenses?

The goal of a donor procedure is to enable the female taxpayer to conceive and bear a child. The procedure changes the structure of the taxpayer's body and is undertaken to ameliorate the taxpayer's infertility. The costs of the donor procedure,¹⁹³ including the costs of care for the taxpayer and the donor, and the related costs, are thus medical expenses under either prong of the § 213 definition.¹⁹⁴ The IRS has, at least for now, conceded this issue and allowed a medical expense deduction for the costs of an egg donor procedure.¹⁹⁵ Nevertheless, in the unusual case in which the taxpayer pays a super-model egg donor or super-brainy egg donor an exorbitant donor fee, the IRS could challenge the medical expense deduction for the donor's fee on the theory that the extra amount paid to the donor for her beauty or brains is analogous to cosmetic surgery expenses.¹⁹⁶

¹⁹³ See *supra* notes 87–89 and accompanying text.

¹⁹⁴ See *supra* note 107 and accompanying text.

¹⁹⁵ Priv. Ltr. Rul. 200318017 (Jan. 9, 2003) (“The unreimbursed expenses for the egg donor fee, the agency fee, the donor’s medical and psychological testing, the insurance for post-procedure donor assistance, and the legal fees . . . are medical care expenses that are deductible under § 213.”).

¹⁹⁶ Patients who are trying to find a particular type of egg donor are typically looking for a proxy for themselves. Most couples try to find an egg donor who physically and psychologically resembles the intended mother or father. See COOPER & GLAZER, *supra* note 20, at 238.

Most recipient couples are very grateful to be able to receive donated ova and they try to have few expectations or requirements of a donor. Nonetheless, like parents through sperm donation, they hope that the donor will bear some physical (and ideally psychological) resemblance to them. Although many will tell the child the truth about his or her origins, they prefer a child that “fits in,” because similarities will make it less likely that strangers will be asking bothersome and intrusive questions.

As with sperm donation, concerns about the donor extend beyond physical appearances. Aware of the significance of genetics, couples hope that the donor will resemble them in other ways as well. Although most seek personality and intellectual similarities, some couples focus on ethnic or religious connections.

Surrogate procedures differ from nonsurrogate procedures because the goal in a surrogate procedure is to have the surrogate, not the taxpayer, get pregnant and bear a child. If the female taxpayer can produce eggs, some of the medical treatment affects the structure or function of her body, but the costs of implanting the embryo in the surrogate's uterus and the additional costs of a surrogate are not incurred for the purpose of affecting the structure or function of the taxpayer's body. If the female taxpayer cannot produce eggs, either an egg donor or the surrogate is stimulated to produce eggs, and the resulting embryos are implanted in the surrogate's uterus. Under these circumstances, none of the treatment affects the structure or function of the female taxpayer's body.¹⁹⁷

It is irrelevant that some or all of the surrogacy expenses do not qualify under the second prong of the medical expenses definition, if the expenses qualify under the first prong of the definition. The characterization of these expenses under the first prong of the § 213 definition turns on whether the medical profession regards infertility as a disease or condition.¹⁹⁸

As discussed earlier, the § 213 regulations, revenue rulings, and case law indicate that the cost of a *substitute* for a taxpayer's diseased or defective body part is a medical expense.¹⁹⁹ The IRS ruled, for example, that a taxpayer who needed a kidney transplant could deduct the kidney donor's surgical, hospital, and travel costs as § 213 medical expenses.²⁰⁰ Whether payments for a "substitute" uterus or for "substitute" eggs or sperm are analogous to the sanctioned substitutes depends on whether reproduction is part of normal functioning.²⁰¹ Because courts are likely to conclude that reproductive

Ironically, the husband and wife who placed one of the most notorious "top dollar" egg donor advertisements, which specified that the donor be at least 5'10", were for a 5'11" woman and her 6'5" husband. See Weiss, *supra* note 88. Darlene Pinkerton, the egg donor broker who placed this advertisement, stated: "They want a tall child. . . . People are not trying to create a super-athlete or super-intelligent being. They are trying to match themselves." *Id.* (internal quotation marks omitted). Families selecting a sperm donor also typically try to find a donor who physically resembles the intended father. See COOPER & GLAZER, *supra* note 20, at 190. While some patients try to have a child with more desirable traits than the patient has, those cases are the exception, not the rule. See Meghan Daum, *Baby Gift*, HARPER'S BAZAAR, Apr. 1, 2000, at 222 (noting that, although more infertile couples are having children with donated eggs, such couples rarely seek out exceptionally beautiful or intelligent donors); Weiss, *supra* note 88.

¹⁹⁷ Where the surrogate supplies the eggs and carries the child, the procedure is sometimes an artificial insemination procedure. COOPER & GLAZER, *supra* note 20, at 280. An artificial insemination procedure is less costly than an IVF procedure. See *supra* note 80 and accompanying text.

¹⁹⁸ See *supra* Part II.B.2.a.

¹⁹⁹ See *supra* notes 129–31 and accompanying text.

²⁰⁰ See *supra* notes 129–31 and accompanying text.

²⁰¹ See *supra* notes 170–73 and accompanying text.

functioning is part of normal functioning,²⁰² they are also likely to conclude that donor eggs and sperm, or a donor uterus, are sanctioned substitutes as well.

[I]f one has the freedom to procreate, then by extension one should also have the freedom to choose how procreation will occur. This argument appears to have merit when one considers that infertile couples have the same desires to have and to raise children of their own as do fertile couples. Infertile couples should not be forced to give up their fundamental right to procreate when available medical technology and social agreements can allow them to enjoy the same rights as couples who are fertile.²⁰³

This “substitute for normal functioning” argument would support a medical expense deduction for the additional costs of a donor procedure,²⁰⁴ and a deduction for all of the costs of a surrogate procedure.²⁰⁵

The IRS could try to distinguish the kidney donor ruling on the grounds that,²⁰⁶ in the case of a donor or surrogate procedure, some of the extra treatment costs are paid to nonmedical parties, such as the donor or surrogate and the lawyer and broker for the donor or surrogate.²⁰⁷ The payment to the egg donor or surrogate is payment

²⁰² See *supra* notes 174–85 and accompanying text.

²⁰³ Laura A. Brill, *When Will the Law Catch Up with Technology?* Jaycee B. v. Superior Court of Orange County: *An Urgent Cry for Legislation on Gestational Surrogacy*, 39 CATH. LAW. 241, 252–53 (1999) (footnotes and citations omitted).

²⁰⁴ More specifically, this “substitute for normal functioning” argument would support a deduction for the typical additional costs of a donor procedure, but it would not support the deduction of extra amounts expended to create a “designer baby.” This would not be an issue in most cases, however, because parents enlisting the assistance of an egg donor are usually trying to match themselves. Weiss, *supra* note 88. This raises a difficult issue. While the parents are trying to approximate *their* normal functioning, one could argue that normal functioning produces a child, not a child with specific attributes, even if the infertile mother has those attributes. In addition, it would be very difficult and awkward to determine what is required as a “substitute for normal functioning” on a case-by-case basis. Thus, a bright-line rule, in the form of a cap on the amount of the deductible donor fee, is probably advisable from an administrative perspective.

²⁰⁵ These third-party costs are analogous to the extra costs paid for a kidney donor by the donee (i.e., the donor’s plane fare, surgical and medical expenses). See Rev. Rul. 68-452, 1968-2 C.B. 111 (ruling that the costs of a kidney donor are deductible by the donee as medical expenses). Although a kidney transplant is lifesaving medical care, and fertility treatment is not lifesaving treatment, there is nothing in § 213 that distinguishes between lifesaving treatment and treatment or mitigation of non-life-threatening diseases and conditions.

²⁰⁶ See *id.* (describing the IRS’s position with respect to a donee-taxpayer’s deduction of a donor’s expenses).

²⁰⁷ The intended parents may have to pay fees to the donor or surrogate, the agency that represents the donor or surrogate, and the lawyer who represents the donor or surrogate. See *supra* note 87. These additional amounts are paid to nonmedical personnel. The intended parents may also have to pay an insurance carrier for supplemental medical insurance for the donor or surrogate and a psychologist for evaluating the donor or surrogate. These fees are paid to medical providers, so they are less problematic under § 213

for a substitute for the taxpayer's diseased or impaired body part, so it is deductible, just as the costs of seeing eye dogs, human guides, and note takers are deductible.²⁰⁸ In these cases, the payment to the non-medical provider is for care that mitigates the taxpayer's disease or condition.²⁰⁹

These expenses are distinguishable from payments to nonmedical providers for services that are ancillary to care, rather than for actual care. In the context of fertility treatment, the ancillary expenses paid to nonmedical providers would include the fees paid to the lawyer for the donor or surrogate and the fees paid to the broker or agency that represents the donor or surrogate. In order to determine whether these fees are medical expenses, it is necessary to determine whether the fees are for services that are necessary to treat the taxpayer's medical condition.²¹⁰ In *Gerstacker v. Commissioner*²¹¹ and *Levine v. Commissioner*,²¹² the courts struggled to determine whether the fees in question were necessary for the taxpayer's medical treatment or were the sort of ordinary personal living expenses that are undertaken without regard to medical problems. This standard would usually be satisfied with respect to the payments to nonmedical providers in donor and surrogacy procedures because infertile patients do not usually resort to such procedures unless they are the only way for the patients to overcome their infertility.²¹³

One potential problem with the "substitute for normal functioning" argument is that it might go too far. The logical extension of this argument might seem to permit adoptive parents to deduct adoption expenses where the reason for adoption is the medical infertility of the parents. Congress recently enacted I.R.C. § 23, which provides an adoption credit for expenses incurred by parents adopting a child.²¹⁴ Intended parents who arrange for a surrogate to carry their child, and then adopt the child, cannot claim the § 23 credit.²¹⁵ The enactment

than the fees paid to the nonmedical providers. The issue remains, however, whether these fees paid to medical providers are medical expenses of the taxpayer. They are if they are incurred to treat or ameliorate the taxpayer's medical infertility.

²⁰⁸ See *supra* notes 132–34 and accompanying text.

²⁰⁹ In the kidney donor ruling, Revenue Ruling 68-452, 1968-2 C.B. 111, the taxpayer who needed the kidney transplant did not pay the prospective kidney donor for the kidney.

²¹⁰ See *supra* notes 120–23 and accompanying text.

²¹¹ 414 F.2d 448 (6th Cir. 1969), *rev'g* 49 T.C. 522 (1968). In Revenue Ruling 71-281, 1971-2 C.B. 165, the IRS ruled that it would follow the appellate court decision in *Gerstacker*, 414 F.2d 448.

²¹² 695 F.2d 57, 61 (2d Cir. 1982), *aff'g* 42 T.C.M. (CCH) 763 (1981).

²¹³ Cf. *supra* note 67 and accompanying text (noting that eighty-five to ninety percent of fertility patients are treated with conventional drug and surgical treatments).

²¹⁴ See I.R.C. § 23 (2000) (amended 2001).

²¹⁵ See I.R.C. § 23(d) defines the term "qualified adoption expenses" as "reasonable and necessary adoption fees, court costs, attorney fees, and other expenses . . . which are

of § 23 might at first seem inconsistent with the broadest definition of medical expenses under § 213, but donor and surrogate procedures can be distinguished from adoption procedures for purposes of § 213. In both donor and surrogate procedures, the intended parents initiate a medical procedure to bear their own child. In adoptions that do not involve surrogacy, the adoptive parents do not initiate a medical procedure to bear their own child; instead they initiate a nonmedical process that enables them to adopt a child conceived by the child's biological parents. Adoption expenses are not, therefore, medical expenses under § 213, even if the adoption results from the medical infertility of the adoptive parents.

The legislative history of § 23, which supports this interpretation, indicates that members of Congress specifically excluded surrogacy expenses from the scope of § 23 precisely because they assumed that those surrogacy expenses would be deductible under § 213 as medical expenses:

The question of fairness is raised when we compare the treatment of adoption costs to those expenses related to the conception, delivery, and birth of a child—or high technology medical expenses for in-vitro conception, etc. *Parents could in most cases itemize and deduct the latter costs as medical expenses.* No similar relief is currently available for adoptive families.²¹⁶

In *Sedgwick v. Commissioner*, however, the IRS challenged a taxpayer's medical expense deduction for fertility treatment expenses involving a surrogate.²¹⁷ Jeanne and Walter Sedgwick had gone through six years of unsuccessful fertility treatment.²¹⁸ After their doctors concluded that Jeanne could not physically carry a child to term, the Sedgwicks arranged for a surrogate to carry their genetic child.²¹⁹ The IRS took the position that the costs of the surrogate procedure were not deductible medical expenses. Counsel for the IRS argued:

[S]urrogacy is an elective procedure. Having a child through a surrogate mother is not a diagnosis, cure, mitigation, treatment, or pre-

not incurred in violation of State or Federal law or in carrying out any surrogate parenting arrangement."

²¹⁶ 140 CONG. REC. S6,604 (daily ed. June 8, 1994) (statement of Senator Riegle) (supporting the adoption credit bill).

²¹⁷ *Sedgwick v. Commissioner*, No. 10133-94, 94 PTT 13-53 (T.C. filed June 7, 1994) (LEXSTAT). Judge Jacobs noted that the case was one of first impression. He asked the lawyer from the IRS Office of District Counsel if she had consulted the IRS National Office about whether to proceed in the case. After she responded yes, Judge Jacobs said: "That's okay. I was praying they would say no." Judge Jacobs' remark prompted laughter in the courtroom. Case Transcript at 22-23, *Sedgwick v. Commissioner*, No. 10133-94, 94 PTT 13-53 (T.C. filed June 7, 1994).

²¹⁸ Case Transcript at 9-10, *Sedgwick v. Commissioner*, No. 10133-94, 94 PTT 13-53 (T.C. filed June 7, 1994).

²¹⁹ *Id.* at 12, 50.

vention of disease, or for the purpose of [affecting] any structure or function of the petitioner wife.

Although it may have improved the petitioner's general mental health, that's not sufficient for allowing a deduction.²²⁰

In other words, the IRS argued that the surrogacy expenses did not qualify under the first prong of the medical expense definition, because infertility is not a disease, and did not qualify under the second prong of the definition, because the treatment affected the structure or function of the surrogate's body, not the taxpayer's body.²²¹

On the witness stand, Jeanne Sedgwick described the eight difficult years of medical treatment she and her husband experienced.²²² During her testimony, Mrs. Sedgwick cried as she recounted the wrenching course of her medical treatment,²²³ which included numerous surgeries to diagnose and treat reproductive disease, two ectopic pregnancies that resulted from tubal disease, two unsuccessful IVF procedures, and counseling to treat the severe psychological distress Mrs. Sedgwick experienced.²²⁴ Mrs. Sedgwick then explained that her doctors had eventually given her the medical advice that she should try a surrogate.²²⁵ After her testimony and a conference in the judge's chambers, the IRS settled the case in favor of the taxpayers.²²⁶

The facts in the *Sedgwick* case illustrate the progression of the medical treatment of infertility.²²⁷ Infertile patients endure years of medical treatment precisely because their bodies are unable biologically to do something that healthy bodies do naturally. The medical treatment of infertility simply allows patients to achieve or approximate normal biological functioning. Fertility treatment costs are thus § 213 medical expenses under current law.

²²⁰ *Id.* at 25. The IRS also argued that the expenses of surrogacy cannot be characterized as medical expenses of the fetus, because cases have held that a fetus becomes a dependent for tax purposes only after it is born. *See id.* at 26. The Sedgwick's first attempt to have a child through a surrogate failed (the surrogate miscarried), but later, the Sedgwicks had a child with the help of another surrogate. *Id.* at 5-6 (noting also that only the costs of the first surrogate procedure were at issue in the case).

²²¹ *See supra* note 104 and accompanying text.

²²² Case Transcript at 28-50, *Sedgwick v. Commissioner*, No. 10133-94, 94 PTT 13-53 (T.C. filed June 7, 1994).

²²³ *See id.* at 40-42 ("I cry all the time about this." (quoting Mrs. Sedgwick)).

²²⁴ *See id.*

²²⁵ *See id.* at 39, 41-42, 48-49.

²²⁶ There was no reported decision in the case, but there is a stipulated decision, which stated, "there is no deficiency due from . . . the petitioners." *Sedgwick v. Commissioner*, No.10133-94 (T.C. Nov. 20, 1995). Counsel for the IRS settled the *Sedgwick* case instead of waiting for the judge to rule in the taxpayer's favor. There is no indication that the IRS has changed its position on the deductibility of surrogacy costs in the years since the case was settled.

²²⁷ *See supra* Part I.B.

III

SHOULD FERTILITY TREATMENT COSTS BE TREATED AS
MEDICAL OR NONMEDICAL EXPENSES?

A. The Normative Starting Point

Our starting point in this normative discussion is a tax code with a § 213 medical expense deduction. It is not a world in which we have a credit for medical expenses; nor is it a world in which we have universal health coverage with explicit rationing of health care resources.²²⁸ Instead, the federal government provides a partial patchwork of direct medical subsidies²²⁹ and the § 213 medical expense deduction.²³⁰ Given this normative starting point, should fertility treatment costs be characterized as medical expenses or nonmedical expenses under § 213?

To resolve this issue, two questions must be considered. First, should fertility treatment costs be deductible in order to take into account taxpayers' ability to pay?²³¹ Second, would a deduction

²²⁸ It is possible to defend either of these worlds on various normative grounds. *See, e.g.*, NORMAN DANIELS, *JUST HEALTH CARE* 36–39 (1985) (making a Rawlsian argument for universal health coverage); W. John Thomas, *The Oregon Medicaid Proposal: Ethical Paralysis, Tragic Democracy, and the Fate of a Utilitarian Health Care Program*, 72 *OR. L. REV.* 47, 115–21 (1993) (applying a Utilitarian ethic to the Oregon Medicaid program after the state legislature decided to cover more poor Oregonians and to explicitly ration medical care).

If Congress repealed § 213 and adopted universal health care with explicit rationing to provide a basic package of health care to the forty-two million Americans who are uninsured, the author would readily concede that fertility treatments would probably not be covered, along with many other types of medical treatments, such as Viagra treatment for erectile dysfunction. If Congress instead converted § 213 into a credit with a dollar cap, the author would concede that fertility patients would not receive a tax benefit for part of their treatment costs.

²²⁹ These direct expenditure health care programs include Medicaid and Medicare. Medicaid is a federal program that provides grants to state health care plans for the poor. *See* 42 U.S.C. § 1396 (2000). For an overview of Medicaid, *see* Thomas, *supra* note 228, at 79–91. Medicare is a federal medical insurance program for the elderly and the disabled. *See* 42 U.S.C. § 1395–1395hhh (2000).

²³⁰ In addition to the § 213 deduction, § 105(b) of the tax code permits taxpayers to exclude employer reimbursements from medical flexible spending accounts. *See* I.R.C. § 105(b). The § 105(b) exclusion turns on whether the medical expense is within the § 213 definition of medical expenses. Arguments that apply to § 213 also apply to the § 105(b) exclusion. *Id.* For simplicity, this Part refers only to the § 213 deduction, unless otherwise indicated.

²³¹ This normative question dominates the theoretical literature on the medical expense deduction. Considering the relationship between the expense and the ideal income tax base is the traditional approach to tax policy questions. Under this internal coherence approach to tax policy questions, “arguments are first and foremost arguments of tax law, and their normative criteria—the criteria of coherency, consistency, and clarity—are, in a sense, intrinsic to the law.” Mark P. Gergen, *The Common Knowledge of Tax Abuse*, 54 *SMU L. REV.* 131, 143–44 (2001).

This traditional normative approach to tax policy typically incorporates the “horizontal equity” and “vertical equity” norms, both of which are controversial. *Cf.* Paul R. McDaniell & James R. Repetti, *Horizontal and Vertical Equity: The Musgrave/Kaplow Exchange*, 1 *FLA. TAX REV.* 607 (1993) (arguing against formulaic use of the horizontal and vertical equity

for fertility treatment costs create improper incentives for taxpayers?²³²

norms). The term “vertical equity” refers to the proposition that we should apply an appropriate pattern of differentiating between those who are unequally situated. *Id.* at 607. The term “horizontal equity” is used for the proposition that equals should be treated alike. *Id.* Economic income is generally regarded as the measure of equality and inequality. See RICHARD A. MUSGRAVE, *THE THEORY OF PUBLIC FINANCE* 165 (1959).

The vertical equity norm is typically applied by considering whether persons pay tax according to their ability to pay: Money is assumed to have declining marginal utility, so a progressive income tax is thought to represent the most appropriate pattern for differentiating between taxpayers with different amounts of income. See *id.* at 90–115; McDaniel & Repetti, *supra*, at 611. However, some commentators have argued that the concept of vertical equity has meaning only if it is infused with a specific theory of distributive justice. *Id.*

Many tax policymakers and economists consider the horizontal equity norm the most widely applicable equity norm. See, e.g., MUSGRAVE, *supra*, at 160 (“Perhaps the most widely accepted principle of equity in taxation is that people in equal positions should be treated equally.”); C. EUGENE STEUERLE & JON M. BAKIJA, *RETOOLING SOCIAL SECURITY FOR THE 21ST CENTURY: RIGHT & WRONG APPROACHES TO REFORM 20–21* (1994) (“One beauty of the horizontal equity principle is its lack of conflict with other principles You and I may disagree on how progressive we would like government to be, but we can still agree that, whatever the level of progressivity, two persons in equal circumstances should be treated equally under the law.”).

There is disagreement, however, about whether the horizontal equity norm should be considered an independent equity norm. Some commentators, including Professors Kaplow, Griffith, McDaniel, and Repetti, have argued that the horizontal equity norm should not be considered an independent norm because: (i) The horizontal equity norm is subsumed within the vertical equity norm because any appropriate pattern of differentiating between unequals must treat equals equally; (ii) it is difficult to determine whether two persons are situated exactly equally; and (iii) the horizontal equity norm gives no guidance if the situations of two persons vary at all. See, e.g., Thomas D. Griffith, *Should “Tax Norms” Be Abandoned? Rethinking Tax Policy Analysis and the Taxation of Personal Injury Recoveries*, 1993 WIS. L. REV. 1115, 1155–59 (1993); Kaplow, *supra*, at 143, 147; Louis Kaplow, *A Note on Horizontal Equity*, 1 FLA. TAX REV. 191 (1992); McDaniel & Repetti, *supra*, at 613.

²³² This normative question takes into account the particular consequences of allowing a medical expense deduction for fertility treatment costs. Although the traditional normative approach to tax policy questions dominates, some influential commentators, including Professors Bankman, Kaplow, Griffith, and Weisbach advocate a consequentialist approach to normative questions in tax policy. See, e.g., Joseph Bankman, *The Business Purpose Doctrine and the Sociology of Tax*, 54 SMU L. REV. 149, 154–56 (2001). Professor Bankman explains this approach:

Those who adopt the welfarist/efficiency approach seek to determine the effects of a particular tax provision or proposal on efficiency or welfare. Those who adopt an internal coherency approach are skeptical of the claim that we know enough about how the economy interacts with the tax law to make that calculation. To that extent, they challenge a positive assumption that underlies the welfarist/efficiency approach. Many are skeptical as well about the normative assumption that underlies the welfarist/efficiency approach: that efficiency or welfare is all that matters. Consider, for example, the belief that “likes should be treated alike” which serves as the basis for the concept of “horizontal equity.” This belief seems generally consistent with values of internal coherency. My guess is that it and its instantiation in a system of horizontal equity is one of the desiderata of a tax system that is built on internal coherency. Thus, like treatment of likes is a value in itself. Followers of the efficiency/welfare approach regard “likes should be treated alike” as an empty tautology, and horizontal equity as of no independent value in setting tax policy.

Id. at 156 (footnote omitted).

B. Fertility Treatment Costs and Ability to Pay

Most of the influential writing on the medical expense deduction, including the work of Professors Surrey, Andrews, and Kelman, considers the relationship between the medical expense deduction and the ideal income tax base.²³³ This literature addresses the question of whether medical expenses in general are part of the ideal income tax base.²³⁴ As such, it does not really address the specific question posed here, which is whether fertility treatment expenses should be deductible. Considering ability to pay may, however, help us determine what types of expenses should and should not be deductible, given the existence of the § 213 deduction.

Professor Surrey's influential tax expenditure model distinguishes between tax provisions that are part of the "normal tax structure" and those that are "special preferences."²³⁵ The "normal tax structure" is based on Haig-Simons income,²³⁶ but takes into account deviations from Haig-Simons that are thought to be part of the "generally accepted structure" of the tax code (such as the realization requirement, which results in the deferral of income from the appreciation of property).²³⁷ Special preferences, also known as tax expenditures, are deviations from the normal tax structure that are "designed to favor a particular industry, activity, or class of persons."²³⁸ Surrey characterized the medical expense deduction as a tax

The influential articles on the medical expense deduction written by Professors Kaplow and Griffith adopt a consequentialist approach. See Thomas D. Griffith, *Theories of Personal Deductions in the Income Tax*, 40 HASTINGS L.J. 343 (1989) [hereinafter Griffith, *Theories of Personal Deductions*]; Louis Kaplow, *The Income Tax as Insurance: The Casualty Loss and Medical Expense Deductions and the Exclusion of Medical Insurance Premiums*, 79 CAL. L. REV. 1485 (1991) [hereinafter Kaplow, *Income Tax as Insurance*].

²³³ See STANLEY S. SURREY & PAUL R. MCDANIEL, TAX EXPENDITURES 79, 205-06 (1985) (stating that the medical expense deduction "constitutes a national health insurance program for well-to-do homeowners," *id.* at 79); William D. Andrews, *Personal Deductions in an Ideal Income Tax*, 86 HARV. L. REV. 309, 314 (1972); see also Kelman, *supra* note 124, at 858-79 (criticizing the medical expense deduction of personal-consumption elements as an indefensible tax expenditure).

²³⁴ See *supra* note 233.

²³⁵ SURREY & MCDANIEL, *supra* note 233, at 1-30 (defining the tax expenditure concept). For a critique of Surrey's tax expenditure approach, see Griffith, *Theories of Personal Deductions*, *supra* note 232, at 345-66.

²³⁶ Haig-Simons income is the sum of (1) the taxpayer's consumption during the taxable period, plus (or minus) (2) the taxpayer's change in wealth during the taxable period. Robert Murray Haig, *The Concept of Income—Economic and Legal Aspects*, in THE FEDERAL INCOME TAX (Robert M. Haig ed., 1921), reprinted in AM. ECON. ASS'N, READINGS IN THE ECONOMICS OF TAXATION 54, 55, 75N76 (Richard A. Musgrave & Carl S. Shoup eds., 1959); HENRY C. SIMONS, PERSONAL INCOME TAXATION: THE DEFINITION OF INCOME AS A PROBLEM OF FISCAL POLICY 50 (1938).

²³⁷ SURREY & MCDANIEL, *supra* note 233, at 4.

²³⁸ *Id.* at 3.

expenditure.²³⁹ In other words, he thought that medical expenses were properly includable in the income tax base.

Professor Andrews, on the other hand, argued that medical expenses should be excluded from the tax base, for reasons intrinsic to the tax system.²⁴⁰ Although Andrews acknowledged that amounts spent on medical care could be construed as consumption,²⁴¹ he took the position that the ideal income tax base should reflect “material well-being,” not just consumption.²⁴² He argued that medical expenses should be excluded from the income tax base because, “[a]s between two people with otherwise similar patterns of personal consumption and accumulation, a greater utilization of medical services by one is not likely to reflect any greater material well-being or taxable capacity, but rather only greater medical need.”²⁴³ He also noted that, “differences in health affect relative . . . well-being,” but concluded that it would be impractical to try to include good health in the tax base.²⁴⁴

Professor Andrews also considered the distributional implications of the medical expense deduction.²⁴⁵ He illustrated the equity issues raised by the § 213 deduction with the following hypothetical:²⁴⁶ Taxpayer A has \$120,000 of income before paying his medical bills and \$20,000 of medical expenses. Taxpayer B has \$100,000 of income and no current medical expenses. Taxpayer C has \$10,000 of income and the same medical condition that taxpayer A has, but C cannot afford treatment. Andrews asked whether A’s \$20,000 of medical expenses should be excluded from the income tax base.²⁴⁷

²³⁹ *Id.* at 79. Professor Surrey observed that tax expenditures are a form of government spending. *See id.* at 99. He noted that tax expenditures represent “upside-down” subsidies because the value of a tax deduction increases as the taxpayer’s income and marginal tax rate increase. *See id.* at 103. He argued that Congress should eliminate many tax expenditures or replace them with direct expenditure provisions. *Id.* at 116–17.

²⁴⁰ *See Andrews, supra* note 233, at 309–13.

²⁴¹ *See id.* at 314. Andrews agreed with earlier ideal income tax theorists, such as Simons, that the tax code should not have source-based distinctions. *See id.* at 316–17 n.12, 375–76.

²⁴² *See id.* at 335.

²⁴³ *Id.* at 314. Andrews argued that medical expenses are different from other expenses: “What distinguishes medical expenses from other personal expenses at bottom is a sense that large differences in their magnitude between people in otherwise similar circumstances are apt to reflect differences in need rather than choices among gratifications.” *Id.* at 336.

²⁴⁴ *Id.* at 335.

²⁴⁵ *Id.* at 338 (“[T]he ability to afford medical care if needed . . . is roughly a function of wealth or income and . . . it will be distributed among persons generally in relation to their income.”).

²⁴⁶ *See id.* The hypothetical is based on Andrews’ hypothetical, but dollar amounts have been added for clarity.

²⁴⁷ *Cf. id.* (implicitly raising this question).

Andrews considered both vertical equity and horizontal equity in answering the question.²⁴⁸ He acknowledged that richer taxpayers can buy more medical care and better medical care, so A is better off than C.²⁴⁹ He defended the medical expense deduction, nonetheless, on the ground that the “horizontal equity” comparison between A and B is more important than the “vertical equity” comparison between A and C:

[T]he exclusion of medical services from taxable income is justified because it will tend to ameliorate the effect of differences in utilization of medical services attributable to differences in health and need for medical services. The amelioration of differences among people attributable to differences in general income level, on the other hand, is primarily a matter of rate structure rather than elaboration of the tax base.²⁵⁰

Andrews acknowledged that some medical expenditures include “a considerable component of voluntary personal gratification,”²⁵¹ but thought it was “reasonable to act upon the proposition that disease or injury is a burden, not a boon, and that large differences in utilization of medical services go less than all the way toward offsetting differences in health need.”²⁵² He acknowledged that the medical expense deduction would, of course, present line-drawing difficulties, giving as an example the treatment of cosmetic surgery, which he admitted is similar to the nonmedical purchase of cosmetics, but he argued that “such borderline difficulties are inevitable whatever general policies [the tax system chooses] to pursue.”²⁵³

Professor Mark Kelman challenged Andrews’s conclusions and argued against the § 213 deduction.²⁵⁴ In Kelman’s view, there should be no medical expense deduction because (1) taxpayers’ use of their income is irrelevant, and (2) personal deductions undermine progressivity.²⁵⁵ Kelman criticized Andrews’s approach to the medical ex-

²⁴⁸ *Id.* at 337–41.

²⁴⁹ *See id.* at 338.

²⁵⁰ *Id.* at 339. Even if large fertility treatment expenses are more often incurred by taxpayers with relatively higher income, the income tax rate structure can be altered to address such distributional issues.

²⁵¹ *Id.* at 337.

²⁵² *Id.*

²⁵³ *Id.*

²⁵⁴ *See generally* Kelman, *supra* note 124, at 834 (“[W]hile *some* deductions for medical care might be supportable, Professor Andrews’ argument, which allows deduction for *all* actual expenditures on what is conventionally deemed medical care[,] . . . is ultimately unpersuasive.”). Kelman took the position that the tax system has two goals: first, to allocate tax burdens in a way that reflects individual earnings capacity; and second, to tax individuals only on market transactions. *See id.* at 880, 882 (stating that “earnings capacity best measures ability to pay” and that “net receipts best measure earnings capacity,” *id.* at 882).

²⁵⁵ *See id.* at 835, 880–83.

pense deduction on various grounds. First, Kelman argued that good health is no different from other psychic pleasures, yet Andrews singled it out for special treatment.²⁵⁶ If taxpayers A and B engage in a risky behavior, such as smoking, what happens if A quits smoking and does not get sick, but B keeps smoking and gets sick?²⁵⁷ If the tax code does not tax gains from risky behavior, but allows B a deduction for medical care, B is better off than A.²⁵⁸ Second, Kelman challenged Andrews's assumption that all medical expenditures are price-inelastic and income-inelastic.²⁵⁹ He argued that spending on emergency life-saving measures, like treatment of arterial bleeding, is consistent with Andrews's assumption,²⁶⁰ but points out that "such cases are, to say the least, atypical."²⁶¹ Most medical expenditures are both price-elastic²⁶² and income-elastic.²⁶³

Third, Kelman argued that medical expenditures often include payments for nonmedical benefits, such as a private hospital room, but § 213 does not require taxpayers to segregate the payments for the nonmedical expenses.²⁶⁴ He noted that the tax code could address the problem of mixed-motive expenses by creating a system of standard medical deductions for various disorders, like the system used for worker's compensation claims.²⁶⁵ In Kelman's view, the tax law should not permit full deductibility of mixed-motive medical expenditures, even if the medical care: (1) is the "but-for" cause of the expenditure; (2) provides a sufficient motive for incurring the medical expense; or (3) is the dominant motive for incurring the medical expense.²⁶⁶ He also argued that trying to apportion mixed-motive expenses and permitting the taxpayer to deduct only the medical portion of the expenditure is not administrable, and thus is an unprincipled compromise between full deductibility and full inclusion in the tax base.²⁶⁷

²⁵⁶ See *id.* at 869.

²⁵⁷ See *id.*

²⁵⁸ *Id.*

²⁵⁹ *Id.* at 865–66.

²⁶⁰ See *id.*

²⁶¹ *Id.* at 866.

²⁶² *Id.* at 868.

²⁶³ *Id.* at 866. Kelman notes that richer taxpayers: buy more expensive, high-tech medical care (assuming that it is "better" than less expensive care); consume more discretionary medical care like psychotherapy; and buy more amenities, such as a private hospital room. *Id.*

²⁶⁴ See *id.* at 864–65.

²⁶⁵ See *id.* at 876. Kelman considered other methods of dealing with mixed-motive expenses, but found them all lacking. See *id.* at 872–79.

²⁶⁶ See *id.* at 877.

²⁶⁷ See *id.* at 878–79 ("As long as medical care expenditures include personal consumption elements, the [§] 213 scheme will not be rationally defensible." *Id.* at 879).

The scope of § 213 under current law is consistent with Professor Andrews's normative position that a medical expenditure should be excluded from the base unless it constitutes an extreme "borderline" expenditure, such as cosmetic surgery.²⁶⁸ Why should medical expenditures be subtracted from the base when other things that also affect well being are not subtracted from the base? In part, because of the elemental importance of health and the catastrophic nature of medical expenses that exceed the 7.5 percent floor. As Professor Gostin has observed:

Health is basic to all human endeavor. . . . First, health is necessary for the pursuit of livelihood. . . .

Second, a certain level of health is a necessary condition for the exercise of fundamental rights and privileges. . . .

Third, health is of overriding importance in achieving personal satisfaction, happiness, and better personal relationships. . . . [H]ealth is one of the more important aspects of personhood. A person's self dignity, self-identification, and status in society are often connected with that person's vitality and ability to function. . . .

When illness or disease are preventable, or when pain and disability can be alleviated, the government's failure to act is conspicuous.²⁶⁹

Assuming that the § 213 deduction continues to be part of the tax code, the current definition of the term "medical care" could be altered to address some of Kelman's concerns about the § 213 deduction. Medical care falls on a continuum, with emergency, life-saving treatment on one end, and cosmetic surgery on the other end. The tax system could draw the line between the two broad categories of "voluntary" and "involuntary" medical care at various places on the continuum of care.

Instead of considering the taxpayer's motives or trying to apportion between the medical and nonmedical elements of the expense, the tax system could distinguish between different types of medical care based on whether or not the care is important enough to be regarded as involuntary. Under such a system, the cost of medical care that is classified as involuntary would continue to be deductible, but

²⁶⁸ For example, Congress has specifically excluded cosmetic surgery from the definition of medical care, but has not excluded from the definition other forms of medical treatment that include a nonmedical element, such as laser eye surgery that corrects vision and eliminates the need for glasses. *See supra* note 127; *see also* Rev. Rul. 2003-57, 2003-22 I.R.B. 959 (ruling that the cost of laser vision correction surgery is a medical expense under § 213). As noted earlier, in the area of reproductive medical care, the IRS has ruled that vasectomies, tubal ligations, prescription contraceptives, and abortions are medical care for purposes of § 213. *See supra* note 167 and accompanying text.

²⁶⁹ Lawrence O. Gostin, *Securing Health or Just Health Care? The Effect of the Health Care System on the Health of America*, 39 ST. LOUIS U. L.J. 7, 13 (1994) (footnotes omitted).

the cost of medical care that is classified as voluntary would not be deductible. It might seem incongruous to treat medical care that facilitates reproductive *choice* as *involuntary*, but the tax system might place such care on the involuntary side of the line if it is a type of care that is very important to most taxpayers.

The § 213 test could be the tax analogue of the “major life activity” part of the ADA disability test.²⁷⁰ Recall that the broad interpretation of the term “major life activity” is an activity “of comparative importance.”²⁷¹ The narrow interpretation of the term “major life activity” is an activity that satisfies the three requirements of microfrequency, macrofrequency, and universality.²⁷² If the tax system defined medical care under § 213 by reference to this latter narrow test, the term medical care would include only care that relates to an activity that is engaged in *all day, every day, by everyone*.²⁷³

Under this narrow definition, § 213 would not cover medical care for sexual dysfunction, including Viagra, or reproductive medical care, including fertility treatment, abortion, vasectomy, or oral contraceptives. The argument in support of this position is that a person can lead a perfectly “normal” life without engaging in these activities.

The problem with defining medical care so narrowly is that sexual and reproductive functioning, while not engaged in all day, every day, by everyone, is extremely important to most people. The test under § 213 should not be whether an activity is one in which all people engage; rather, the test should be whether a person’s reproductive system can function normally, such that the person can exercise sexual and reproductive choice. What a person decides to do with their normally functioning body is irrelevant. A person who wants very much to engage in sex or reproduction, but cannot because of a disease, condition, or abnormality, can hardly be said to be leading a perfectly “normal” life just because some people decide not to engage in sexual activity or reproduction.

This approach to drawing the § 213 line is consistent with the broader definition of “major life activity” adopted by the Supreme Court in *Bragdon*.²⁷⁴ The Court concluded that reproduction was a major life activity because reproduction is “central to the life process itself.”²⁷⁵ Under this approach to § 213, medical care would continue

²⁷⁰ See *supra* notes 174–75 (discussing judicial interpretations of the ADA disability test).

²⁷¹ See *supra* note 180 and accompanying text.

²⁷² See *supra* note 179 and accompanying text.

²⁷³ See *supra* note 179.

²⁷⁴ See *Bragdon v. Abbott*, 524 U.S. 624, 638 (1997).

²⁷⁵ *Id.*

to be broadly defined and would include reproductive medical care.²⁷⁶

In numerous health law cases, courts have had to define the terms "illness," "disease," and "medical necessity," in order to determine the scope of medical insurance coverage. Some of these cases relate to medical care for various types of sexual and reproductive dysfunction. These cases may be relevant for purposes of considering whether, for tax purposes, such medical care should be treated as voluntary or involuntary.

These cases indicate that courts seem to appreciate the importance of sex and reproduction more than insurers.²⁷⁷ In part, this is due to the fact that insurers have narrowed the scope of insurance coverage to contain growing health care costs. Traditionally, insurers deferred to doctors' medical judgment and covered medical care that was ordered by doctors.²⁷⁸ When expensive new high-tech treatments began driving up the cost of health care dramatically, however, insurance companies changed their practices.²⁷⁹ Beginning in the mid-1970s, following the 1965 enactment of Medicare and Medicaid, our national health policy objectives shifted from a policy of expanding health care coverage to a policy of cost containment.²⁸⁰ Private insurers attempted to control skyrocketing health care costs by stating in their contracts that coverage is limited to treatment: (1) of a "disease" or "illness,"²⁸¹ (2) that is a "medical necessity,"²⁸² and (3) that is not "experimental" or "investigat[ive]."²⁸³ Medicare and Medicaid also

²⁷⁶ Narrowing the § 213 definition of medical care is a form of rationing medical care. Americans (and their representatives in Congress) do not favor explicit health care rationing. In fact, they generally recoil at the notion of such rationing. Given the fact that Congress has not enacted a directly subsidized universal health care plan, it is possible that the broad scope of § 213 is a result of Congress's and the IRS's inability or unwillingness to make the difficult calls about rationing medical care in the tax code. As a deduction with broad scope, the § 213 deduction resembles an insurance policy with liberal coverage. The only types of medical care specifically excluded are cosmetic surgery and similar treatments.

²⁷⁷ See Hazel Glenn Beh, *Sex, Sexual Pleasure, and Reproduction: Health Insurers Don't Want You to Do Those Nasty Things*, 13 WIS. WOMEN'S L.J. 119, 158-59 (1998).

²⁷⁸ See Mark A. Hall & Gerard F. Anderson, *Health Insurers' Assessment of Medical Necessity*, 140 U. PA. L. REV. 1637, 1644-45 (1992).

²⁷⁹ See *id.* at 1644-51.

²⁸⁰ *Id.* at 1663.

²⁸¹ For example, the insurance contract in *Egert v. Connecticut General Life Insurance Co.* specified that coverage was limited to the treatment of "illness." See 900 F.2d 1032, 1033 (7th Cir. 1990).

²⁸² See Hall & Anderson, *supra* note 278, at 1645-46. In some cases, courts have deferred to the insurer's definition of medical necessity. See, e.g., *Dowden v. Blue Cross & Blue Shield of Tex., Inc.*, 126 F.3d 641, 644 (5th Cir. 1997) (concluding that the insurance plan granted Blue Cross "the exclusive and conclusive authority to determine coverage and benefits, and to interpret provisions of the plan, including whether treatment is medically necessary" (internal quotation marks omitted)).

²⁸³ Hall & Anderson, *supra* note 278, at 1647.

exclude from coverage services that are not medically necessary.²⁸⁴ Insurers use these definitions to support their denials of coverage.

Courts have defined the terms "illness," "disease," and "medical necessity," in cases involving sexual and reproductive dysfunction. In *Egert v. Connecticut General Life Insurance Co.*, the court held that infertility was an "illness" and that IVF was "medically necessary" treatment for infertility, so the patient was entitled to reimbursement for the costs of IVF.²⁸⁵ Several courts have also held that sex reassignment surgery for treatment of a transsexual with gender identity disorder is a medical necessity.²⁸⁶ Shortly after the FDA approved Viagra, the federal agency that administers the Medicaid program²⁸⁷ took the position that Viagra is a medically necessary treatment for erectile dysfunction and mandated that state Medicaid programs cover the drug.²⁸⁸

²⁸⁴ The federal Medicare statute excludes from coverage medical services that are not "reasonable and necessary for the treatment or prevention of illness." 42 U.S.C. § 1395y(a)(1)(A), (B) (2000). Medicaid also limits coverage to medically necessary treatment. See 42 C.F.R. § 440.230(d) (2003).

²⁸⁵ 900 F.2d 1032, 1037-39. In a similar case, the Iowa Supreme Court held that infertility was an illness, since "the natural function of the reproductive organs is to procreate." See *Witcraft v. Sundstrand Health & Disability Group Benefit Plan*, 420 N.W.2d 785, 788 (Iowa 1988). The Oklahoma Court of Appeals, however, held that IVF "was not a medically necessary service because it was elective and was not required to cure or preserve [the plaintiff's] health." *Kinzie v. Physician's Liab. Ins. Co.*, 750 P.2d 1140, 1141 (Okla. Ct. App. 1987). The result in *Kinzie* has been criticized on the ground that many types of covered treatments ameliorate, but do not cure, illness or disease. See, e.g., Lisa M. Kerr, Note, *Can Money Buy Happiness? An Examination of the Coverage of Infertility Services Under HMO Contracts*, 49 CASE W. RES. L. REV. 599, 609, 628 (1999).

²⁸⁶ See, e.g., *Pinneke v. Preisser*, 623 F.2d 546, 550 (8th Cir. 1980).

²⁸⁷ The administrative agency, formerly known as the Health Care Financing Administration, is now called the Center for Medicare and Medicaid Services. See <http://www.hcfa.gov/error.asp?404>; <http://www.hcfa.gov/newsitecms.asp> (last visited Mar. 11, 2004).

²⁸⁸ See David F. Chavkin, *Medicaid and Viagra: Restoring Potency to an Old Program?*, 11 HEALTH MATRIX 189, 207-08 (2001) (describing the circumstances under which the Health Care Financing Administration issued a letter to the states mandating coverage of Viagra). The National Governors' Association, the American Public Welfare Association, and the National Association of State Medicaid Directors all opposed the Viagra mandate on the ground that it constituted an unfunded mandate that would cost the states \$100 million per year. *Id.* at 208-11. These groups were concerned that covering Viagra would divert badly needed funds away from maternal and childcare, HIV care, and care of the disabled. See Carole L. Stewart, Comment, *Mandated Medicaid Coverage of Viagra: Raising the Issues of Questionable Priorities, the Need for a Definition of Medical Necessity, and the Politics of Poverty*, 44 LOY. L. REV. 611, 626 (1998) (noting that ninety percent of Medicaid beneficiaries are women and children). Many states eventually covered Viagra, but others refused to do so. See Chavkin, *supra*, at 231-38. According to Professor Chavkin, "[s]tate claims of dire financial consequences and 'unfunded mandates' have proven to be grossly exaggerated and [s]tates have been able to comply with federal law without threatening their financial health." *Id.* at 231.

Some insurance companies have taken the position that Viagra is a "medical necessity,"²⁸⁹ but fertility treatment involves a "lifestyle choice" and is not a "medical necessity."²⁹⁰ Perhaps the difference in insurance coverage of Viagra and fertility treatments is due in part to gendered views of the importance of reproduction and sex. For years, women have lived with the reality that contraceptives and fertility treatment are not generally covered by insurance.²⁹¹ Conversely, within two months after Viagra was introduced, a group of men filed a class action suit against their insurer, which had limited the number of Viagra pills it would cover each month. The men argued that they had been denied treatment for a "vital human function."²⁹²

If medical care is understood to fall on a continuum, with emergency, life-saving treatment on one end and cosmetic surgery on the other end, reasonable people could disagree about where on the continuum fertility treatment falls, but could probably reach consensus about its relative importance. The vast majority of people probably think that both sex and reproduction are vitally important, although there may be gendered views about whether sex or reproduction is more important.

Unfortunately, this ability-to-pay approach does not provide a clear normative foundation for determining where to draw the line on the medical care continuum. Professor Griffith has argued that the normative underpinnings of both the Andrews and Kelman approaches to the medical expense deduction are incoherent.²⁹³ In addition, Professor Weisbach has argued that tax policy makers should adopt a consequentialist approach to line drawing questions in the tax law.²⁹⁴ The following section considers this consequentialist approach.

²⁸⁹ See Hayden, *supra* note 154, at 183 (noting that "insurance companies offer prescriptive coverage of Viagra, classifying it as a 'medically necessary' drug to treat male impotence" (citation omitted)).

²⁹⁰ McCullough, *supra* note 154.

²⁹¹ See Sylvia A. Law, *Sex Discrimination and Insurance for Contraception*, 73 WASH. L. REV. 363, 363 (1998). Only recently has coverage of both contraceptives and fertility treatment been mandated in some states. See Chavkin, *supra* note 288, at 231-38; Hayden, *supra* note 154, at 189.

²⁹² See Hayden, *supra* note 154, at 180.

²⁹³ See Griffith, *Theories of Personal Deductions*, *supra* note 232, at 370, 385. Professor Griffith notes that sometimes Andrews seems to be adopting an egalitarian ethic and other times he seems to be adopting a utilitarian ethic. See *id.* at 370.

²⁹⁴ David A. Weisbach, *An Efficiency Analysis of Line Drawing in the Tax Law*, 29 J. LEGAL STUD. 71, 74 (2000); David A. Weisbach, *Line Drawing, Doctrine, and Efficiency in the Tax Law*, 84 CORNELL L. REV. 1627, 1649-51 (1999) [hereinafter Weisbach, *Line Drawing*].

C. The Incentive Effects of Allowing a Deduction for Fertility Treatment Costs

In order to determine whether these costs should be deductible under a consequentialist normative approach,²⁹⁵ it is necessary to consider the *ex ante* incentive effects of characterizing fertility treatment costs as medical expenses or nonmedical expenses.²⁹⁶ Allowing the medical expense deduction for the costs of fertility treatment would encourage fertility treatment by reducing the cost of such treatment for the taxpayer; not allowing the deduction would discourage fertility treatment by increasing the cost of such treatment. If the tax system allowed the deduction for certain fertility treatments, but not others, it would discourage use of the tax-disfavored treatments and encourage use of the tax-favored treatments.

The tax system should perhaps *encourage* all fertility treatments, or certain types of fertility treatments, *if*: (1) fertility treatments are underutilized, given the extreme importance of reproduction, but general lack of insurance coverage; (2) infertile patients choose to undergo treatment that is covered by insurance, instead of pursuing less expensive, less painful, or less invasive procedures that are not covered by insurance; (3) the success rates for certain forms of fertility treatment are dramatically higher than the success rates for other forms of fertility treatment; and (4) the attendant risks of multifetal pregnancies are lower for certain forms of fertility treatment than for other forms of treatment.

The tax system should perhaps *discourage* all fertility treatments, or certain types of fertility treatment, *if*: (1) ovarian stimulation poses significant health risks to the woman whose ovaries are being stimulated; (2) ovarian stimulation increases the rate of multifetal pregnancies, which poses health risks both to the woman bearing the children and to the children she bears; (3) the fertility treatment

²⁹⁵ Consequentialist theories of distributive justice may be either entitlement theories or welfarist theories. See Joseph Bankman & Thomas Griffith, *Social Welfare and the Rate Structure: A New Look at Progressive Taxation*, 75 CAL. L. REV. 1905, 1915 (1987). Entitlement theories focus on a person's right to keep what she owns. See, e.g., ROBERT NOZICK, ANARCHY, STATE, AND UTOPIA 150–53 (1974). Welfarist theories instead focus on the welfare of some or all members of society. See Bankman & Griffith, *supra*, at 1915. The two most prominent welfarist theories are utilitarianism and the Rawlsian leximin. See *id.* at 1915–16. Utilitarianism seeks to maximize the aggregate welfare of a society; the leximin seeks to maximize the welfare of the least well off persons in society. See *id.* at 1916.

²⁹⁶ See Kaplow, *Income Tax as Insurance*, *supra* note 232, at 1489–90, 1506. Again, the normative starting point assumes a tax system with a § 213 deduction and a patchwork of direct medical subsidies. See *supra* notes 228–30. The question discussed in this Article is how, given that assumption, the tax system should characterize fertility treatment costs.

Also, since § 213 is a deduction, not a credit, it is, in effect, like an insurance co-pay, because the tax savings from the medical expense deduction equal the product of the dollar amount of the deduction multiplied by the taxpayer's marginal tax rate.

poses other health risks or psychological risks to the children conceived; (4) infertile patients overestimate the success rates for fertility treatment or underestimate the health risks of multifetal pregnancies; or (5) adoption is a better alternative. This Article considers both the negative and positive consequences of various fertility treatments below.

1. *The Positive Consequences of Fertility Treatment*

a. *The Benefits of Fertility Treatment to the Parents and Child*

Fertility treatment dramatically improves the welfare of the intended parents. Infertile patients suffer extreme emotional distress, as this Article discussed in an earlier section.²⁹⁷ That distress stands in stark contrast to the happiness of those who want to have children and are able to have them.

Ten thousand parks where dear run,
Ten thousand roses in the sun,
Ten thousand pearls beneath the sea,
My baby more precious is to me.²⁹⁸

Infertile patients prefer to have a genetic, gestational, and nurturing connection to their child. If their physiology prevents them from having all three, however, they are often quite happy to have the nurturing connection and whichever of the other two connections is physiologically possible. In other words, they are often quite happy to have a child with the assistance of a third-party sperm donor, egg donor, or surrogate.²⁹⁹

The financial sacrifices that infertile patients make to pay for fertility treatment provide an indication of how important fertility treatment is to these patients.³⁰⁰ As noted earlier, numerous studies have demonstrated that infertile patients are prepared to pay dearly to in-

²⁹⁷ See *supra* Part I.A.

²⁹⁸ *Mother's Song*, in A BOOK OF NURSERY SONGS AND RHYMES 18–20 (S. Baring-Gould ed., 1895), at <http://www.poemfinder.com/poem-print.cfm?CFID=478086&CFTOKEN=42873018&id=199570> (last visited May 22, 2001) (copy on file with author). Many other poems also describe the joy of parenting.

I would not trade one day with you
To wear the purple robes of power,
Nor drop your hand from mine to do
Some great deed in a selfish hour.
For you have brought me joy serene
And made my soul supremely glad.
In life rewarded I have been;
'Twas all worth while to be your dad.

EDGAR A. GUEST, *To The Boy*, in THE PATH TO HOME 156–57 (1919).

²⁹⁹ See *supra* notes 73–78 and accompanying text.

³⁰⁰ See *supra* Part I.C.

crease their chances of conceiving and bearing a child.³⁰¹ For example, survey respondents in a United Kingdom study “were willing to pay [twenty-nine] percent of their after-tax income for a [fifty] percent chance of having a child, and willing to risk a [twenty] percent chance of death in order to have a child.”³⁰²

Studies such as the United Kingdom study demonstrate the paramount importance of fertility treatment to infertile patients³⁰³ and suggest that the demand for fertility treatment is relatively inelastic.³⁰⁴ Professor Weisbach has argued that tax policy makers should draw lines in the tax law in a manner that minimizes deadweight losses.³⁰⁵ If fertility treatment is uninsured and nondeductible, patients will be encouraged to either: (1) opt for less effective medical treatment that insurance does cover;³⁰⁶ or (2) opt for very aggressive fertility treatment that increases the risk of a multifetal pregnancy.³⁰⁷ Thus, disallowing the deduction would likely increase deadweight losses and be inefficient.

Fertility treatment also improves the welfare of the children who would not have been born but for such treatment. The magnitude of this effect on the consequentialist conclusion depends on the specific consequentialist approach employed.³⁰⁸ For example, Peter Neumann, a public health expert, has computed the cost of IVF per life-year-gained for a child conceived with IVF and compared that cost to the cost per life-year-gained of other common medical treatments.³⁰⁹ Neumann assumed that an IVF cycle costs \$8,000 and has a twelve percent chance of success, and that a child conceived with IVF would

³⁰¹ See Neumann, *supra* note 90, at 1223–25 (summarizing results of studies exploring how much couples were willing to pay for IVF).

³⁰² *Id.* at 1223–24 (citation omitted).

³⁰³ Neumann, *supra* note 90, at 1225.

³⁰⁴ As Weisbach notes: “[T]he size of the deadweight loss from a tax on an item is related to the elasticity of demand [for] the item. The greater the elasticity, the more the demand changes for a change in price, and consequently the greater the economic distortion.” Weisbach, *Line Drawing*, *supra* note 294, at 1656.

³⁰⁵ *Id.* Weisbach argues that we should draw lines in the tax law to maximize efficiency, and notes that “[a]n efficient tax is simply a tax with low deadweight loss.” *Id.* The deadweight loss of a tax is “the loss in value to consumers in excess of the revenue raised by the government.” *Id.* at 1651.

³⁰⁶ For example, patients with blocked fallopian tubes will likely opt for surgery to repair the blocked tubes because the surgery is covered by insurance, rather than opt to bypass the blocked tubes with an IVF procedure, even if the surgery is the less effective procedure. See Bonny Gilbert, *Infertility and the ADA: Health Insurance Coverage for Infertility Treatment*, 63 DEF. COUNS. J. 42, 43–44 (1996).

³⁰⁷ See *infra* notes 471–73 and accompanying text.

³⁰⁸ For example, utilitarians sometimes look to total utility and sometimes look to average utility. See J.J.C. SMART & BERNARD WILLIAMS, *UTILITARIANISM: FOR AND AGAINST* 27–28 (1973).

³⁰⁹ Neumann, *supra* note 90, at 1222–24.

live seventy-five years.³¹⁰ Given these assumptions the cost per life-year-gained from IVF equals \$3,259.³¹¹ The cost per life-year-gained for many other common types of medical treatment is much higher: (1) \$23,000 for kidney dialysis; (2) \$28,000 for a two-vessel coronary artery bypass surgery (for the cost in excess of the cost of medical management); (3) \$100,000 for a heart transplant for a fifty-year-old patient with terminal heart disease; (4) \$300,000 for intensive care for a "very ill" patient undergoing major vascular surgery; and (5) \$2,700 for mammography every three years for a women age fifty to sixty-five.³¹²

Neumann's cost per life-year estimate may have to be adjusted upward because people may value life-years of unborn people less than life-years of people who have already been born. His cost per life-year estimate may also have to be adjusted downward because his estimate does not take into account the benefits to the child's parents.³¹³

b. *Adoption as an Alternative to Fertility Treatment*

Adoption also enables infertile patients to experience the joy of parenting, so infertile would-be parents often consider adoption as an alternative to fertility treatment.³¹⁴ According to Elizabeth Bartholet, infertile patients typically consider adoption only after they "have reached the end of a long medical road designed to produce a biological child."³¹⁵ Sociobiologists have long recognized the basic human urge to reproduce,³¹⁶ but Bartholet argues that societal forces are also at work in making adoption less desirable than bearing a biological child.³¹⁷ Bartholet notes that those who are infertile naturally want to

³¹⁰ *Id.* at 1222-23.

³¹¹ *Id.* at 1223.

³¹² *Id.* at 1224.

³¹³ *Id.*

³¹⁴ See William D. Mosher & Christine A. Bachrach, *Understanding U.S. Fertility: Continuity and Change in the National Survey of Family Growth, 1988-1995*, FAM. PLAN. PERSP., Jan.-Feb. 1996, at 4, 8. One study collecting data from 1988 to 1995 estimated that eleven to twenty-four percent of infertile couples decide to adopt. Evan B. Donaldson Adoption Inst., *Overview of Adoption*, at http://www.adoptioninstitute.org/FactOverview_print.html (last visited Mar. 11, 2004) (citing Mosher & Bachrach, *supra*, at 9).

³¹⁵ See ELIZABETH BARTHOLET, *FAMILY BONDS: ADOPTION, INFERTILITY, AND THE NEW WORLD OF CHILD PRODUCTION* 24 (1999).

³¹⁶ See generally RICHARD DAWKINS, *THE SELFISH GENE* (2d ed. 1989).

³¹⁷ See BARTHOLET, *supra* note 315, at 24. Bartholet explains:

Adoption is the choice of last resort for most infertile men and women who want to parent. If asked why this is true, many would say, "Because it is natural to want your own child." But it is hard to know what is natural, given the fact that society weighs in to *make* adoption the last resort. And it is not clear that we should characterize parenting decisions as the product of choice. We are all conditioned from early childhood to equate personhood with procreation and procreation with parenting.

seek medical attention to overcome the infertility.³¹⁸ She argues, however, that infertile patients who begin medical treatment often have difficulty deciding when to stop the medical treatment of their infertility, and that most of the information available to infertile patients is biased in favor of medical treatment and against adoption.³¹⁹ In addition, adoption is highly regulated, but the medical treatment of infertility is essentially unregulated.³²⁰ Bartholet therefore argues that society should promote adoption as an alternative to the medical treatment of infertility.³²¹

On the other hand, Maura Ryan has argued that we should not simply “assume that adoption is the obvious and unambiguous solution to the problem of infertility.”³²² Typically, infertile adoptive parents reach the decision to adopt only after experiencing the devastating losses associated with their infertility.³²³ Ryan argues:

To make a blanket assumption that infertility should be solved by adoption neglects the individual nature of the process of healing and the fact that not all infertile people will come to the place where they are able to positively embrace adoption. The many adoptable children who have special needs of some kind are not necessarily going to be well taken care of by someone for whom

Id. (emphasis in original) (citation omitted).

³¹⁸ See *id.* at 30.

³¹⁹ *Id.* at 30–32. Infertile patients are most often advised by their fertility doctors. See *id.* at 30. Their doctors often know little about adoption and rarely present it as an alternative to medical treatment. *Id.* Adoption agencies are wary of infertile couples, who may proceed with adoption before they have resolved their feelings of grief and loss about their infertility. See *id.* at 31.

³²⁰ See *id.* at 33.

Those entering the world of adoption agencies and home studies quickly realize that they have no right to become adoptive parents. Parental screening is the essence of what traditional adoption is all about, with the government determining through its agents who should be disqualified altogether from the parenting opportunity and then how those who are qualified should be rated for purposes of allocating the available children.

The parental screening requirement is a very real deterrent to many who might otherwise consider adoption. People don't like to become helpless supplicants, utterly dependent on the grace of social workers, with respect to something as basic as their desire to become parents. Screening also adds to the financial costs of adoption.

Regulation also sends a powerful message about the essential inferiority of adoption as a form of parenting. By subjecting adoptive but not biologic parents to regulation, society suggests that it trusts what goes on when people give birth and raise a birth child but profoundly distrusts what goes on when a child is transferred from a birth to an adoptive parent.

Id. at 33–34.

³²¹ See *id.* at 37–38.

³²² See MAURA A. RYAN, ETHICS AND ECONOMICS OF ASSISTED REPRODUCTION: THE COST OF LONGING 57 (2001).

³²³ Many infertile people “will find that after years of struggling to conquer infertility, they are too old, or too tired, or too poor, or too broken in spirit, to begin another uphill battle, and that of course is what adoption is.” BARTHOLET, *supra* note 315, at 36.

such an adoption is not really a positive and free choice. . . . [O]ne could argue for a greater obligation to adopt on the part of the fertile who would not, in principle, begin with the same vulnerabilities.³²⁴

In addition, pursuing adoption can be a difficult, expensive, and uncertain process.³²⁵ There is a shortage of healthy children available for adoption in the United States, in part because adolescent birth rates have declined significantly.³²⁶ In addition, only about one percent of American women give up their babies for adoption.³²⁷ As a result of this baby shortage, adoptive parents typically have to wait years to adopt a healthy American baby.³²⁸ Adoptive parents may be able to adopt "special needs" children³²⁹ more quickly, but many adoptive parents are hesitant to adopt such needy children.³³⁰ The wait is also frequently shorter for the adoption of foreign children.³³¹ The cost of adoption from private agencies or the cost of an independent adoption, including international adoption, ranges from \$4,000

³²⁴ See RYAN, *supra* note 322, at 58.

³²⁵ See BARTHOLET, *supra* note 315, at 36–37.

³²⁶ See Paula Span, *Parallel Lives*, WASH. POST MAG., June 18, 2000, at 12, 15 (noting an eighteen percent decline in the adolescent birth rate since 1991).

³²⁷ *Id.* at 16. During the 1950s and 1960s, forty to fifty percent of unmarried mothers in the United States gave up their babies for adoption. *Id.* As of 1995, only one percent of women gave up their babies for adoption. *Id.* There are various reasons for the dramatic reduction in relinquishment rates: (1) single parenthood carries less of a social stigma today; (2) sensational press accounts of the emotional difficulties of adopted children have made adoption appear to be a poor choice for the biological mother and child; and (3) few adolescent mothers seriously consider adoption or think about the potential benefits of adoption. See *id.* at 16–17.

³²⁸ *Id.* at 15–16 (stating that potential adoptive parents seeking a healthy, white, American-born baby face a wait of two to seven years); see also RYAN, *supra* note 322, at 59 (noting that many infertile couples are "interested, for both good and bad reasons, in adopting healthy, white infants").

³²⁹ A "special needs" child is a child with a "specific factor or condition (such as his ethnic background, age, or membership in a minority or sibling group, or the presence of factors such as medical conditions or physical, mental, or emotional handicaps) because of which it is reasonable to conclude that such child cannot be placed with adoptive parents without providing adoption assistance . . . or medical assistance." 42 U.S.C. § 673(c) (2000).

³³⁰ In one study, only about twelve percent of the parents adopting special needs children gave infertility as the reason for the adoption, but over eighty percent of parents adopting a child independently or through a private adoption agency gave infertility as the reason for the adoption. See Marianne Berry et al., *Preparation, Support, and Satisfaction of Adoptive Families in Agency and Independent Adoptions*, 13 CHILD & ADOLESCENT SOC. WORK J. 157, 165–66 (1996).

³³¹ See Span, *supra* note 326, at 26 (noting that international adoption is a quicker process).

to \$30,000.³³² Adoption of non-special needs children is particularly costly.³³³

Adoptions also involve uncertainty because a biological mother may decide, after the child is born, not to go through with the adoption.³³⁴ Adoptive parents who have paid the birth expenses of the biological mother are not reimbursed for those expenses.³³⁵

In 1996, Congress enacted two tax provisions, § 23 and § 137, to encourage adoption.³³⁶ Section 23 provides that adoptive parents can claim a tax credit of up to \$10,000 for adoption expenses.³³⁷ Section 137 allows employees to exclude up to \$10,000 of adoption expenses reimbursed from an employer-provided adoption assistance program.³³⁸ Both provisions can apply to a single adoption, but cannot apply to the same adoption expenses.³³⁹ The § 23 credit is phased out if the parents have gross income between \$150,000 and \$190,000.³⁴⁰ Parents with income of \$190,000 or more cannot qualify for the credit.³⁴¹ If the § 23 credit exceeds the parents' tax liability for the year in which the credit is taken, the parents may carry over the unused portion of the credit to the next year.³⁴²

Due to the shortage of non-special needs, American-born children available for adoption, these tax benefits probably have not increased the number of adoptions of such children.³⁴³ It is not clear whether these tax benefits have affected the number of special needs

³³² See Nat'l Adoption Info. Clearinghouse, *Cost of Adopting*, at http://naic.acf.hhs.gov/puhs/s_cost.cfm (last visited Mar. 11, 2004) [hereinafter NAIC, *Cost of Adopting*]. For public agency adoptions, which typically involve special needs children, costs range from zero to \$2,500. See *id.* In addition, parents who adopt special needs children may qualify for government reimbursement of their adoption expenses. See 42 U.S.C. §§ 670, 673(a). The Social Security Act provides payments to states so that they can reimburse adoptive parents for the costs of adopting special needs children. See *id.* Parents may receive additional federal assistance if the adopted child was eligible for other forms of federal assistance prior to the adoption. See Evan B. Donaldson Adoption Inst., *Costs of Adoption*, at http://www.adoptioninstitute.org/FactOverview/costs_print.html (last visited Mar. 11, 2004).

³³³ See *infra* notes 345–46 and accompanying text.

³³⁴ See, e.g., Lord et al., *supra* note 16, at 64 (describing one family's experience with a "fall-through").

³³⁵ See NAIC, *Cost of Adopting*, *supra* note 332.

³³⁶ See Small Business Job Protection Act of 1996, Pub. L. No. 104-188, § 1807, 110 Stat. 1899.

³³⁷ See I.R.C. § 23(b)(1) (2002).

³³⁸ See I.R.C. § 137(b)(1).

³³⁹ See I.R.C. § 23(b)(3)(A); DEP'T OF TREASURY, REPORT TO THE CONGRESS ON TAX BENEFITS FOR ADOPTION 1 (2000), available at <http://www.treas.gov/offices/tax-policy/library/adoption.pdf> (last visited Mar. 11, 2004) [hereinafter TREASURY REPORT ON TAX BENEFITS].

³⁴⁰ See I.R.C. § 23(b)(2)(A)(i), (ii).

³⁴¹ See *id.* §23(b)(2)(A).

³⁴² See I.R.C. § 23(c) (2000) (amended 2001) (permitting taxpayers to carry forward the unused portion of the credit up to five years).

³⁴³ See TREASURY REPORT ON TAX BENEFITS, *supra* note 339, at 3.

adoptions.³⁴⁴ The cost of a special needs adoption is lower than the cost of a non-special needs adoption³⁴⁵ and in eighty-five percent of special needs adoptions, direct government subsidies cover the adoptive parents' out-of-pocket expenses.³⁴⁶ Thus, special needs adoptions generate tax benefits in only fifteen percent of such cases.³⁴⁷

The tax benefits of § 23 and § 137 may have increased the number of foreign adoptions, however.³⁴⁸ The Treasury Department estimates that, in 1998, the average cost of adopting a foreign child was almost twice the cost of adopting a child from the United States.³⁴⁹ Sections 23 and 137 therefore provide greater tax benefits for foreign adoptions than for special needs adoptions or domestic adoptions.³⁵⁰ Given the greater tax benefit for foreign adoptions, these provisions may have augmented the number of such adoptions.

The tax law currently favors adoption over fertility treatment, even if fertility treatment expenses are characterized as medical expenses. This is, in part, because § 23 provides for a credit, while § 213 provides for a deduction.³⁵¹ The following example illustrates the comparative tax benefits of the § 23 credit and the § 213 medical expense deduction:

Lee and Shannon are infertile. They are deciding whether to adopt a foreign child or do a cycle of IVF. The cost of either option is \$10,000. Assume that their gross income for the year is \$100,000

³⁴⁴ *Id.* The number of special needs adoptions has increased, but it is unclear how much the number of special needs adoptions would have increased without the tax incentives of I.R.C. §§ 23 and 137. *See id.* at 4.

³⁴⁵ *Id.* at 2, 17.

³⁴⁶ *See id.* at 17.

³⁴⁷ *Id.* at 2.

³⁴⁸ *Id.* at 3 (noting that the adoption tax benefits may increase the number of foreign adoptions). The number of foreign adoptions has increased significantly in recent years. *See* Evan B. Donaldson Adoption Inst., *International Adoption Facts*, at <http://www.adoption-institute.org/FactOverview/international.html> (last visited Mar. 11, 2004). Although the number of foreign adoptions began to increase before Congress enacted §§ 23 and 137 in 1996, the number of foreign adoptions has surged since enactment of these sections. *See id.* (presenting data, which indicates that there were approximately 6,500 international adoptions in 1992; 7,400 in 1993; 8,300 in 1994; 9,700 in 1995; 11,300 in 1996; 13,600 in 1997; 15,600 in 1998; 16,400 in 1999; 18,500 in 2000; and 19,200 in 2001).

³⁴⁹ *See* TREASURY REPORT ON TAX BENEFITS, *supra* note 339, at 3. The Treasury Department estimated that the average cost of foreign adoption was approximately \$10,000 in 1998. *Id.* The actual average cost may have been higher, however. The tax benefits of §§ 23 and 137 are subject to gross income phase outs, so this cost estimate does not reflect the cost of adoption by higher income families. *See supra* note 340 and accompanying text.

³⁵⁰ *See* TREASURY REPORT ON TAX BENEFITS, *supra* note 339, at 3-4.

³⁵¹ A credit reduces the taxpayer's tax owed by the dollar amount of the credit. JOSEPH BANKMAN ET AL., *FEDERAL INCOME TAX: EXAMPLES & EXPLANATIONS* 6-7 (3d ed. 2002). "A deduction . . . reduces [a] taxpayer's taxable income[, on which tax due is computed]." *Id.* The tax savings from a deduction depend on the taxpayer's marginal tax rate and equal the product of the dollar amount of the deduction multiplied by the taxpayer's marginal tax rate. *Id.* at 7.

and their marginal tax rate is 30 percent. If they adopt, they can claim a section 23 credit of \$10,000. The credit saves them \$10,000 in taxes and reduces their net adoption cost to zero. If they do the IVF cycle and take a section 213 medical expense deduction, the deduction will be \$2,500 (their \$10,000 medical expense less \$7,500, which is 7.5 percent of their gross income).³⁵² The \$2,500 deduction will save them \$750 (\$2,500 deduction multiplied by the 30 percent tax rate) in taxes. Their net cost for the IVF procedure is \$9,250 (\$10,000 less \$750 tax savings).³⁵³

Although both fertility treatment and adoption can have a significant positive impact on welfare, the tax code currently provides greater tax incentives for adoption than for fertility treatment generally, even if the costs of fertility treatment are characterized as medical expenses. In other words, the current tax code favors adoption over fertility treatment.

2. *The Negative Consequences of Fertility Treatment*

a. *The Medical and Psychological Risks of Fertility Treatment*

Even without fertility treatment, pregnancy, labor, and delivery entail medical risks to both the mother and the child.³⁵⁴ In addition, the various surgical procedures employed to diagnose, cure, or treat infertile patients involve the normal medical risks associated with surgery.³⁵⁵ This section will address the risks that increase or may increase as a result of ovulation induction and high-tech treatments such as IVF and ICSI.³⁵⁶ The known and potential risks of these fertility treatments include risks to: (1) the woman whose ovaries are being stimulated; (2) the woman gestating the child or children; and (3) the child or children being gestated.

³⁵² See I.R.C. § 213(a) (2000).

³⁵³ The relative advantage of the credit is reduced if the adoption costs exceed \$10,000, or if the taxpayer's gross income is more than \$150,000. See I.R.C. § 23 (2001).

³⁵⁴ The risks of pregnancy and delivery increase as women get older. See KEARNEY, *supra* note 39, at 160 ("The risks of pregnancy-related death and of hypertension, diabetes, and complicated delivery all rise as women age. Many older women are willing to accept these risks, but they need to be carefully monitored during their pregnancies.").

³⁵⁵ See, e.g., *id.* at 274–75 (describing risks associated with assisted reproduction procedures that involve surgery, and noting that "[n]one of these risks are unique to assisted reproduction").

³⁵⁶ Infertility, by itself, sometimes increases the medical risks of pregnancy and delivery because certain underlying causes of infertility increase specific pregnancy and delivery risks. Some of the increased pregnancy and delivery risks associated with fertility treatment may thus be attributable to the underlying cause of infertility. See *id.* at 276–77. For example, women with disorders of the fallopian tubes, women with sexually transmitted diseases, and women who were exposed to DES in utero all have a higher risk of ectopic pregnancy. See *id.* at 278. In such cases, the cause of the infertility, rather than its treatment, may account for much of the increased medical risk of pregnancy and delivery. Fertile surrogates who gestate children are not subject to these increased risks. See *id.* at 276.

i. *The Medical Risks to the Woman Whose Ovaries are Being Stimulated*

(A) The Risk of Hyperstimulation

Ovarian Hyperstimulation Syndrome (OHS), a condition in which fluid accumulates in the abdomen, is the primary risk to women whose ovaries are stimulated by fertility drugs.³⁵⁷ The fluid accumulated in the abdomen may put pressure on the surrounding organs, including the heart and lungs.³⁵⁸ Hyperstimulation can cause dehydration, which may lead to kidney damage or dangerous blood clots.³⁵⁹ A patient suffering from hyperstimulation may have to rest in bed or, in more extreme cases, may have to be hospitalized.³⁶⁰ Hyperstimulation is relatively rare,³⁶¹ but certain groups of women are known to be more susceptible to it than others.³⁶² The fertility specialist can reduce the risk of hyperstimulation by monitoring blood estrogen levels during the ovarian stimulation and altering the course of treatment if blood estrogen levels are high.³⁶³

(B) The Uncertainty Regarding the Increased Risk of Ovarian Cancer

Some medical researchers have suggested that ovarian stimulation may increase a woman's risk of developing ovarian cancer, but the link between ovarian stimulation and increased cancer risk has not been established. Several controversial studies have concluded that ovarian stimulation increases ovarian cancer risk. The most widely publicized of these studies is the 1992 Whittemore study.³⁶⁴ This study concluded that, compared to fertile women, infertile wo-

³⁵⁷ See KEARNEY, *supra* note 39, at 264; RESOLVING INFERTILITY, *supra* note 2, at 114-15.

³⁵⁸ See KEARNEY, *supra* note 39, at 265.

³⁵⁹ *Id.*

³⁶⁰ Severe hyperstimulation can be fatal, especially if untreated, but such severe cases are rare. See KEARNEY, *supra* note 39, at 265.

³⁶¹ Hyperstimulation occurs in one to five percent of stimulated cycles. RESOLVING INFERTILITY, *supra* note 2, at 114. Severe hyperstimulation occurs in 0.4% to 1.3% of cases. KEARNEY, *supra* note 39, at 265.

³⁶² KEARNEY, *supra* note 39, at 265. Higher risk women include those who: (1) have polycystic ovarian syndrome (PCOS); (2) are very thin; (3) are under age thirty-four; or (4) have a history of producing over thirty follicles or high blood estrogen levels in previous stimulation cycles. See *id.* at 265.

³⁶³ See RESOLVING INFERTILITY, *supra* note 2, at 114-15. If a patient has very high blood estrogen levels, the doctor may cancel the cycle, or continue the cycle but stop the stimulation drugs. *Id.*

The risk of hyperstimulation increases if the patient becomes pregnant while hyperstimulated. See KEARNEY, *supra* note 39, at 265. If a patient has high blood estrogen levels, the doctor may decide to delay the transfer of embryos. *Id.* The doctor can retrieve the eggs, fertilize them, freeze them, and then transfer them at a later date, after the ovarian swelling has subsided. *Id.* at 266.

³⁶⁴ See Alice S. Whittemore et al., *Characteristics Relating to Ovarian Cancer Risk: Collaborative Analysis of 12 US Case-Control Studies*, 136 AM. J. OF EPIDEMIOLOGY 1184, 1184 (1992).

men whose ovaries had been stimulated had almost three times the lifetime risk of developing ovarian cancer.³⁶⁵ On the other hand, numerous organizations, including the National Cancer Institute and the Food and Drug Administration, have criticized the methodology and conclusions in the Whittimore study.³⁶⁶ In addition, numerous subsequent studies have failed to establish a connection between ovarian stimulation and ovarian cancer.³⁶⁷

In another well-known study, the 1994 Rossing study, researchers concluded that prolonged use of clomiphene citrate³⁶⁸ may increase the risk of ovarian cancer.³⁶⁹ The methodology of the Rossing study had fewer drawbacks than did the Whittimore study, but still had limitations.³⁷⁰ In addition, the Rossing study considered the risk associated with using clomiphene for twelve or more cycles, but the medical consensus is that clomiphene should not be used nearly that many times.³⁷¹

Other studies have posited that infertility itself, whether treated or not, increases a woman's risk of ovarian cancer.³⁷² Given that fact, the relationship between ovulation drugs and ovarian cancer may only be a correlation, not a cause-effect relationship. Researchers will continue to study the potential relationship between ovulation stimulation and ovarian cancer. For now, however:

None of these studies, either alone or together, conclusively demonstrates a link between ovulation drugs and ovarian cancer, but

³⁶⁵ *Id.* at 1188 (noting also that "infertile women without fertility drug use experienced no increase in risk" of ovarian cancer).

³⁶⁶ See KEARNEY, *supra* note 39, at 269.

³⁶⁷ See, e.g., Baruch Modan et al., *Cancer Incidence in a Cohort of Infertile Women*, 147 AM. J. OF EPIDEMIOLOGY 1038, 1042 (1998) (concluding that their data did not suggest that stimulation drugs increase the risk of ovarian cancer); Gad Potashnik et al., *Fertility Drugs and the Risk of Breast and Ovarian Cancers: Results of a Long-term Follow-up Study*, 71 FERTILITY & STERILITY 853, 853 (1999) (concluding that "[a]n association between the use of fertility drugs and an increased risk of breast and ovarian cancers has not been confirmed"). Kearney notes that these studies involved relatively small samples and urges further study. KEARNEY, *supra* note 39, at 269-72.

³⁶⁸ See *supra* note 62 and accompanying text.

³⁶⁹ See Mary Anne Rossing et al., *Ovarian Tumors in a Cohort of Infertile Women*, 331 NEW ENG. J. MED. 771, 776 (1994).

³⁷⁰ See *id.* at 774; KEARNEY, *supra* note 39, at 270-71. Kearney discusses both the strengths and weaknesses of the Rossing study. For example, he notes that the study did not control for the use of oral contraceptives, which reduces the risk of ovarian cancer. *Id.* at 271.

³⁷¹ See KEARNEY, *supra* note 39, at 271-72 (stating that clomiphene "should never be used" for twelve cycles and adding that "[f]ew women use clomiphene for more than six cycles, and those who do should be looking for a new doctor").

³⁷² See, e.g., Robert E. Bristow & Beth Y. Karlan, *Ovulation Induction, Infertility, and Ovarian Cancer Risk*, 66 FERTILITY & STERILITY 499, 499 (1996); Lynette Burmeister & David L. Healy, *Ovarian Cancer in Infertility Patients*, 30 ANNALS OF MED. 525, 527-28 (1998); Carmen Rodriguez et al., *Infertility and Risk of Fatal Ovarian Cancer in a Prospective Cohort of US Women*, 9 CANCER CAUSES & CONTROL 645, 645 (1998).

neither can the risk be entirely discounted. Based on what we know now, should a woman avoid using ovulation drugs and rely on natural cycles to produce eggs for fertilization? Most physicians would say no. . . . Pregnancy and childbirth have always been risky, but most women are willing to assume the risk in order to have children.³⁷³

A 1997 study bears out this last statement. The study indicates that about eighty percent of women requiring fertility treatment indicated that they would take ovulation induction drugs *even if* the drugs slightly increased their risk of ovarian cancer.³⁷⁴ In addition, there are certain things a woman can do that may reduce her risk of ovarian cancer, such as taking oral contraceptives or carrying a pregnancy to term. Various studies indicate that the use of oral contraceptives over a period of years reduces the risk of ovarian cancer.³⁷⁵ Other studies considering the relationship between pregnancy and ovarian cancer indicate that, the more recently a woman has given birth, the lower her risk of ovarian cancer.³⁷⁶ One theory for this phenomenon is that pregnancy somehow reverses malignant transformations in the ovaries.³⁷⁷

Taking birth control pills may be unacceptable to an infertile woman who continues to want to bear a child. For such women, bearing a child may be the only acceptable way to attempt to reduce their ovarian cancer risk. If the infertility is caused by an ovulation disorder, an infertile woman may have a much better chance of bearing a child if she enlists the assistance of an egg donor. Egg donors are usually stimulated fewer times than are fertility patients (often just once) and can reduce their ovarian cancer risk by taking oral contraceptives or bearing a child after donating eggs.

The data so far are inconclusive on the hypothesized link between fertility treatment and ovarian cancer. Unless and until such a link is established, the potential risk to women should not be treated as a significant negative in the welfare scorecard for fertility treatment.

³⁷³ See KEARNEY, *supra* note 39, at 272.

³⁷⁴ See Barry Rosen et al., *The Feasibility of Assessing Women's Perceptions of the Risks and Benefits of Fertility Drug Therapy in Relation to Ovarian Cancer Risk*, 68 FERTILITY & STERILITY 90, 90 (1997) (noting, however, that only twenty-four percent of the participants "understood that treatment for ovarian cancer usually was not curative").

³⁷⁵ See, e.g., Christine H. Holschneider & Jonathan S. Berek, *Ovarian Cancer: Epidemiology, Biology, and Prognostic Factors*, 19 SEMINARS IN SURGICAL ONCOLOGY 3, 3 (2000) (finding that using oral contraceptives for five years cuts a woman's risk of ovarian cancer approximately in half).

³⁷⁶ See, e.g., Francesca Chiaffarino et al., *Time Since Last Birth and the Risk of Ovarian Cancer*, 81 GYNECOLOGIC ONCOLOGY 233, 233 (2001) (observing an increased risk of ovarian cancer "with increasing time since last birth"). See also Glinda S. Cooper et al., *Pregnancy Recency and Risk of Ovarian Cancer*, 10 CANCER CAUSES & CONTROL 397, 399 (1999) (suggesting that ovarian cancer risk increased as time since last pregnancy increased).

³⁷⁷ See Cooper, *supra* note 376, at 397.

In addition, studies linking later pregnancy and reduced risk of ovarian cancer³⁷⁸ support favorable tax treatment for the costs of egg donor procedures.

ii. *The Medical Risks of Multifetal Pregnancies to the Children Gestated and the Gestating Woman*

(A) The Medical Risks of Multifetal Pregnancies

Fertility treatment, especially ovulation induction with clomiphene citrate, greatly increases the risk of pregnancies involving multiple fetuses.³⁷⁹ The risks of twin pregnancies are significantly higher than the risks of singleton pregnancies, and the risks of triplet or other higher-order pregnancies are *dramatically* higher than the risks of singleton pregnancies.³⁸⁰ In recent years, however, fertility specialists have begun to develop new protocols to reduce the risk of multiples.

Multifetal pregnancies are riskier both for the gestating woman and the gestated fetuses. For example, women gestating multiples are more likely to suffer from severe gestational hypertension, which may require hospitalization; fifteen percent of women gestating twins and thirty percent of women gestating triplets have to be hospitalized for this condition.³⁸¹ Multiple fetuses also increase the risk of caesarean delivery.³⁸²

The risks to the fetuses are even more distressing.³⁸³ Compared to singletons, multiples have a significantly higher risk of stillbirth.³⁸⁴ The risk of preterm delivery and low birth weight is also much higher in multifetal pregnancies, especially in triplet and higher-order pregnancies.³⁸⁵ Low birth weight babies in turn have a much higher

378 See *supra* note 376 and accompanying text.

379 See RESOLVING INFERTILITY, *supra* note 2, at 115–16.

380 See KEARNEY, *supra* note 39, at 283–84.

381 *Id.* at 283.

382 *Id.*

383 See, e.g., William N. Spellacy et al., *A Case-Control Study of 1253 Twin Pregnancies from a 1982–1987 Perinatal Data Base*, 75 OBSTETRICS & GYNECOLOGY 168, 170–71 (1990) (discussing the problems associated with twin pregnancies).

384 See *id.* at 169–70.

385 See Michael O. Gardner et al., *The Origin and Outcome of Preterm Twin Pregnancies*, 85 OBSTETRICS & GYNECOLOGY 553, 553 (1995) (“Twins accounted for a disproportional amount of preterm birth and associated morbidity and mortality.”); Laura A. Schieve et al., *Live-Birth Rates and Multiple-Birth Risk Using In Vitro Fertilization*, 282 JAMA 1832, 1832 (1999) (“Multiple-birth infants are at significant risk for . . . preterm delivery, low birth weight, congenital malformations, fetal and infant death, and long-term morbidity and disability among survivors.”). Thirty to fifty percent of twin deliveries are preterm and seventy-five to one hundred percent of triplet deliveries are preterm. See KEARNEY, *supra* note 39, at 283. Over fifty percent of IVF twins and seventy-five percent of IVF triplets are low birth weight. *Id.*

risk of cerebral palsy.³⁸⁶ Multiples also have a higher risk of congenital abnormalities and certain diseases.³⁸⁷ Compared to singletons, twins are five times more likely to die during the first year of life, and triplets and other higher-order multiples are thirteen times more likely to die during the first year of life.³⁸⁸

The medical costs of multifetal pregnancies are significantly higher than the medical costs of delivering singletons, largely due to the increased medical risks of multifetal pregnancies. The cost of a triplet delivery is often over \$100,000³⁸⁹ and, in some cases, can be more than \$1 million.³⁹⁰

Fertility treatment involving ovarian stimulation increases the risk of multiples.³⁹¹ Fertility doctors are better able to reduce the number of multifetal pregnancies if the fertility procedure is an IVF procedure, rather than a clomiphene cycle with artificial insemination or intercourse. Ovulation induction with clomiphene and ovarian stimulation by injectable gonadotropins both cause a woman's ovaries to produce multiple egg follicles.³⁹² In a typical clomiphene cycle, the patient attempts to fertilize the eggs either by artificial insemination or by intercourse.³⁹³ In this type of procedure, the fertility doctor does not limit the number of eggs that are fertilized.³⁹⁴

Patients injecting gonadotropins typically try to fertilize the eggs and implant the embryos in an IVF procedure.³⁹⁵ In an IVF procedure, the fertility doctor decides how many embryos to implant. Doctors trying to decide how many embryos to implant consider two competing concerns. First, infertile patients are often financially constrained by the high costs of IVF and are willing to risk a multifetal pregnancy to increase their chances of having a child, so they encourage their fertility doctors to transfer as many embryos as possible

³⁸⁶ See P.O.D. Pharoah & T. Cooke, *Cerebral Palsy and Multiple Births*, 75 ARCHIVES OF DISEASE IN CHILDHOOD 174, 174 (1996); see also KEARNEY, *supra* note 39, at 284 (“[T]he risk of cerebral palsy is about eight times higher for twins and forty-seven times higher [for] triplets than for singleton births.”).

³⁸⁷ See KEARNEY, *supra* note 39, at 284 (noting that low birth weight babies have a higher risk of “cardiovascular disease, diabetes, abnormal blood clotting, excessive fat, or obstructive lung disease later in life”); Spellacy, *supra* note 383, at 170–71 (finding that twins have a higher incidence of congenital abnormalities).

³⁸⁸ See Schieve et al., *supra* note 385, at 1832.

³⁸⁹ See McCullough, *supra* note 154.

³⁹⁰ See Jamie Malernee, *Blastocyst Transfer*, CHI. TRIB., Sept. 27, 1999, at 7C.

³⁹¹ See generally Allan Templeton & Joan K. Morris, *Reducing the Risk of Multiple Births by Transfer of Two Embryos After In Vitro Fertilization*, 339 NEW ENG. J. MED. 573, 573 (1998) (noting that “[t]he high rate of multiple births resulting from in vitro fertilization is a major health issue”).

³⁹² See generally KEARNEY, *supra* note 39, at 204–08 (discussing fertility treatment using clomiphene).

³⁹³ See McCullough, *supra* note 154.

³⁹⁴ See RESOLVING INFERTILITY, *supra* note 2, at 115.

³⁹⁵ *Id.* at 176–82.

in the hope of increasing their chances of getting pregnant.³⁹⁶ Second, the doctor must consider the significant medical risks of a multifetal pregnancy.³⁹⁷

(B) The Development of New Protocols to Reduce the Risk of Multifetal Pregnancies

Over the past decade, multiple birth rates have been increasing as a result of increasing utilization of fertility treatment.³⁹⁸ In 1997, forty percent of multifetal pregnancies were attributable to ovulation induction without IVF, and forty percent were attributable to ovarian stimulation with IVF.³⁹⁹ In recent years, the medical community has expressed serious concerns about rising multiple birth rates and has called for the adoption of measures to decrease the risk of multiples.⁴⁰⁰ Numerous researchers, including doctors from the Centers for Disease Control, have studied the relationship between fertility treatment and the risk of multiples in order to establish new protocols to reduce the risk of multiples.

Recent research indicates that the risk of multiples can be significantly reduced through a combination of IVF and new treatment protocols. Researchers have discovered that they now can better predict the risk of multiples in IVF procedures based on: (1) the number of embryos transferred; (2) the age of the eggs (i.e., the age of the woman whose eggs are fertilized); and (3) the quality of the embryos available for implantation.⁴⁰¹ Various studies have made recommendations regarding the optimal number of embryos to transfer in order to balance patients' interests in maximizing pregnancy rates with the risks of multifetal pregnancies.⁴⁰²

³⁹⁶ Jane E. Allen, *Limiting Embryos*, L.A. TIMES, Apr. 19, 2004, at F3 (noting that patients pressure doctors to transfer a greater number of embryos, especially where patients have incurred substantial treatment costs). See also *supra* notes 85, 90 and accompanying text (discussing the costs of IVF and financial strains caused by IVF).

³⁹⁷ See KEARNEY, *supra* note 39, at 281–85.

³⁹⁸ See McCullough, *supra* note 154 (observing that the rate of high-order multiples increased from 37 per 100,000 births in 1980 to 173 per 100,000 births in 1997); Richard J. Paulson, ASRM NEWS, Spring 2001, at 7 (2001) (“[T]he incidence of triplet and high order multiple births in the United States increased from 29 per 100,000 in 1971 to 174 per 100,000 in 1997.”).

³⁹⁹ See Paulson, *supra* note 398, at 7.

⁴⁰⁰ See, e.g., *id.* (“The high incidence of multiple gestations following assisted reproductive technologies (ART) is perhaps the most vexing problem confronting the reproductive endocrinologist today. . . . The most obvious strategy to [reduce the risk of multiples] involves transferring fewer embryos. . . . However, since pregnancy rates are directly related to the number of embryos transferred, this approach also decreases the clinical pregnancy rates.”).

⁴⁰¹ See, e.g., Schieve et al., *supra* note 385, at 1836.

⁴⁰² One study concluded that, where the ovarian stimulation resulted in at least four embryos, transferring more than two good-quality embryos did not increase the overall birth rate, but substantially increased the multiple birth rate. See Templeton & Morris,

In November 1999, the American Society of Reproductive Medicine (ASRM) issued new treatment guidelines regarding the number of embryos to be transferred in IVF procedures. These guidelines provide, for example, that no more than two embryos are to be transferred if the patient is thirty-four or younger and the quality and quantity of the embryos are good.⁴⁰³ In recent years, fertility doctors have transferred fewer embryos per cycle than in earlier years.⁴⁰⁴ The average number of embryos transferred has dropped from four embryos per cycle in 1995 to three embryos per cycle in 2001.⁴⁰⁵ Recent data also indicate that multiple birth rates attributable to IVF have declined significantly since the adoption of the new treatment protocols.⁴⁰⁶

Reducing the risk of multiples in ovulation induction with clomiphene is less precise. IUI is less precise because the doctor has less control over the fertilization process than in IVF. In all ovulation induction procedures, a doctor must monitor the developing follicles in order to determine how many will probably reach maturity during the cycle.⁴⁰⁷ If numerous follicles (i.e., six or more) will mature, various protocols can be used to reduce the risk of multiples. One protocol is to cancel the cycle and try again with a lower dose in a future cycle.⁴⁰⁸ A recent study indicates that, if six or more follicles are de-

supra note 391, at 573. Another study concluded that: (1) for women age thirty-four or younger, the optimal number of embryos to transfer is two; and (2) for women age forty or older, the optimal number of embryos to transfer is up to five regardless of quality. See Schieve et al., *supra* note 385, at 1832. Another study concluded that the optimal number of embryos to transfer was limited to three, even for older women, where there were at least four embryos available to transfer. See Selim Şenöz et al., *An IVF Fallacy: Multiple Pregnancy Risk Is Lower for Older Women*, 14 J. ASSISTED REPROD. & GENETICS 192, 192 (1997). Yet another study concluded that transferring two embryos instead of three does not reduce pregnancy rates significantly, provided that at least one good quality embryo is transferred. See Murat Taşdemir et al., *Two Instead of Three Embryo Transfer in In-Vitro Fertilization*, 10 HUM. REPROD. 2155, 2157 (1995).

⁴⁰³ See Am. Soc. of Reprod. Med., *Committee Opinion, Guidelines on Number of Embryos Transferred* (1999).

⁴⁰⁴ Allen, *supra* note 396.

⁴⁰⁵ *Id.*

⁴⁰⁶ *Id.* Allen reports that the rate of triplet and other higher order multiple births after IVF dropped from 11.4% in 1997 to 7.4% in 2001: "A key reason . . . is that doctors began voluntarily limiting the number of embryos they implant." *Id.* During 1997 to 2001, the rate of twins after IVF "held steady, even as the nation's overall rate of twins rose." See also Tarun Jain et al., *Trends in Embryo-Transfer Practice and in Outcomes of the Use of Assisted Reproductive Technology in the United States*, 350 NEW ENG. J. MED. 1639 (2004) (concluding that the rate of IVF pregnancies with three or more fetuses declined significantly between 1997 and 2001, as doctors followed the new treatment protocols and transferred fewer embryos).

⁴⁰⁷ See RESOLVING INFERTILITY, *supra* note 2, at 115-16. Some highly publicized multiple births resulted from the use of clomiphene without adequate medical monitoring. See *id.* at 116.

⁴⁰⁸ See *id.* Even if the doctor cancels the cycle (meaning the doctor stops the ovulation induction drugs and does not do an IUI), the patient may still get pregnant after inter-

veloping well, canceling the cycle significantly reduces the risk of multiples.⁴⁰⁹ Another approach is to extract some of the developing follicles by needle aspiration and proceed with the cycle.⁴¹⁰

A recent study concluded that the risk of multiples is more effectively controlled in IVF than in ovulation induction with IUI.⁴¹¹ The ASRM is considering whether IVF should be used more widely, instead of ovulation induction, to reduce the risk of multiples.⁴¹²

Reducing the patient's out of pocket cost for fertility treatment also reduces the rate of multiple births. *Significantly, the risk of multiples, especially triplets and higher-order multiples, is lower in states that mandate comprehensive insurance coverage of infertility.*⁴¹³ With insurance coverage of infertility, there is less financial pressure associated with each cycle, so patients are more willing to be treated conservatively.

iii. *Other Risks to the Child or Children Gestated*

(A) Other Medical Risks

For the child or children being gestated, almost all of the medical risks associated with fertility treatment are caused by multifetal pregnancies⁴¹⁴ or by the underlying cause of the infertility (such as in utero exposure to DES).⁴¹⁵ There is no conclusive evidence that IVF increases the risk that the child or children gestated will have birth defects or chromosomal abnormalities.⁴¹⁶

ICSI,⁴¹⁷ a new type of fertility treatment developed about ten years ago, has been found to increase the risk of certain types of chromosomal abnormalities, however.⁴¹⁸ ICSI is used in conjunction with IVF in cases involving severe male factor infertility.⁴¹⁹ In an ICSI procedure, an embryologist or technician injects a single sperm into a

course. *See id.* The resulting pregnancy may be a multifetal pregnancy, but some couples are willing to take this risk. *See id.*

⁴⁰⁹ *See* Richard P. Dickey et al., *Relationship of Follicle Numbers and Estradiol Levels to Multiple Implantation in 3,608 Intrauterine Insemination Cycles*, 75 *FERTILITY & STERILITY* 69, 69, 77 (2001).

⁴¹⁰ *See* McCullough, *supra* note 154.

⁴¹¹ *Id.*

⁴¹² *Id.*

⁴¹³ *See* *RESOLVE Responds to New Report on Trends in Multiple Births Following Infertility Treatment*, PR NEWSWIRE, June 22, 2000, available at LEXIS, Wire Service Stories.

⁴¹⁴ *See supra* notes 383–88.

⁴¹⁵ *See* *RESOLVING INFERTILITY*, *supra* note 2, at 137–38.

⁴¹⁶ *See* KEARNEY, *supra* note 39, at 286–87.

⁴¹⁷ *See supra* notes 70–72 and accompanying text.

⁴¹⁸ *See* KEARNEY, *supra* note 39, at 121–26.

⁴¹⁹ *See supra* note 72 and accompanying text.

single egg.⁴²⁰ ICSI dramatically increases fertilization rates,⁴²¹ and has been used much more frequently in the last few years.⁴²²

At the time ICSI was developed, geneticists expressed concerns that ICSI posed two types of potential risks: first, the physical process of injecting a needle into the egg to deposit the sperm might cause genetic damage; and second, ICSI may allow a father, who has a genetic defect and would have been unable to have children without ICSI, to pass that genetic defect on to his child.⁴²³ Thus far, the first potential problem has not materialized.⁴²⁴ There is no evidence that ICSI increases the risk of birth defects.⁴²⁵ The second concern, however, is a potential problem. Studies have concluded that ICSI increases the risk of passing various chromosomal abnormalities, some of which are serious, to children conceived through ICSI.⁴²⁶

The great benefit of ICSI is that it can permit men with severe male factor infertility to conceive.⁴²⁷ The problem is that many different genetic defects can cause male factor infertility, and only some of these defects have been identified.⁴²⁸ Given that fact, it is currently impossible to screen for all of the types of genetic defects that the father may pass on to the child.⁴²⁹ Some sex-based chromosomal defects will render the children infertile like their fathers.⁴³⁰ Others can cause serious conditions such as cystic fibrosis⁴³¹ and Turner's Syndrome.⁴³²

⁴²⁰ See KEARNEY, *supra* note 39, at 118.

⁴²¹ See *id.* at 115-16.

⁴²² During 1998, ICSI was used in about forty percent of ART cycles. CTRS. FOR DISEASE CONTROL & PREVENTION ET AL., 1998 ASSISTED REPRODUCTIVE TECHNOLOGY SUCCESS RATES 29 (1998). In 2001, ICSI was used in 45.8% of ART cycles. CTRS. FOR DISEASE CONTROL & PREVENTION ET AL., 2000 ASSISTED REPRODUCTIVE TECHNOLOGY SUCCESS RATES 37 (2000). In 2001, about seventy-eight percent of couples suffering from male factor infertility used ICSI in their ART cycles. See 2001 CDC REPORT, *supra* note 48, at 40.

⁴²³ See KEARNEY, *supra* note 39, at 120-21.

⁴²⁴ See *id.* at 121.

⁴²⁵ *Id.*

⁴²⁶ *Id.* at 121-23.

⁴²⁷ See *id.* at 116; *supra* note 71 and accompanying text.

⁴²⁸ See *id.* at 125.

⁴²⁹ *Id.*

⁴³⁰ See *id.* at 122.

⁴³¹ Some men do not have the tubes that connect the testes and the urethra. See *id.* at 126. This abnormality is called congenital absence of the vas deferens (CAVD). *Id.* Men with CAVD may produce normal sperm in the testes, but the sperm cannot leave the testes so they cannot fertilize an egg naturally. See *id.* The sperm of men with CAVD can be removed surgically and injected into an egg using ICSI, but men with CAVD carry the genetic defect that causes cystic fibrosis. *Id.* If such sperm is inserted into an egg that comes from a woman who is also a cystic fibrosis carrier, the child could have a very serious case of cystic fibrosis. *Id.* Women can be screened now to determine if they are cystic fibrosis carriers, but this genetic test was not available when ICSI was first used. *Id.*

⁴³² See *id.* at 122. Turner's Syndrome causes a variety of physical abnormalities, heart and kidney problems, and infertility. See *id.*

Still, the vast majority of children born as a result of ICSI are normal.⁴³³ In addition, some risks associated with using ICSI can be reduced. For example, genetic testing of the patient and his partner can detect certain chromosomal abnormalities.⁴³⁴ Also, the risk of transmitting defects carried on the Y chromosome can be reduced, but not eliminated, by transferring only female embryos in the IVF procedure.⁴³⁵

Children of older mothers have a higher risk of certain chromosomal abnormalities.⁴³⁶ For example, the child of a forty-year-old woman has a 1 in 100 probability of having Down syndrome.⁴³⁷ The age of the egg determines the age-related risks, so using eggs donated from a younger woman reduces these risks.⁴³⁸

(B) Potential Psychological Risks

The first IVF child was born in 1978,⁴³⁹ so researchers have had time to study the emotional and psychological development of children conceived through assisted reproductive technologies. Numerous longitudinal studies have concluded that the social and emotional development of IVF children is normal.⁴⁴⁰ Studies have also concluded that parents who become parents after fertility treatment generally parent well.⁴⁴¹

Mental health professionals caution, however, that children created through fertility treatment, especially third-party treatments like sperm donation, egg donation, or surrogacy, may be harmed psychologically if the parents keep the child's origins a secret.⁴⁴² Secrecy in connection with fertility treatment dates back 100 years to the early days of sperm donation.⁴⁴³ Medical doctors thought it would be best for the family and for the children to keep the sperm donation a secret, not realizing the negative impact that such a secret could have on the entire family in the future.⁴⁴⁴

⁴³³ See *id.* at 121.

⁴³⁴ See *id.* at 126.

⁴³⁵ See *id.*

⁴³⁶ See RESOLVING INFERTILITY, *supra* note 2, at 149.

⁴³⁷ *Id.*

⁴³⁸ See JARRETT & RAUSCH, *supra* note 28, at 143.

⁴³⁹ See RESOLVING INFERTILITY, *supra* note 2, at 12.

⁴⁴⁰ See, e.g., Susan Golombok et al., *The "Test-Tube" Generation: Parent-Child Relationships and the Psychological Well-Being of In Vitro Fertilization Children at Adolescence*, 72 CHILD DEV. 599, 605-08 (2001).

⁴⁴¹ See, e.g., Susan Golombok et al., *Families Created by the New Reproductive Technologies: Quality of Parenting and Social and Emotional Development of the Children*, 66 CHILD DEV. 285, 285 (1995) (concluding that "the quality of parenting in families with a child conceived by assisted conception is superior to that shown by families with a naturally conceived child").

⁴⁴² See COOPER & GLAZER, *supra* note 20, at 350-57.

⁴⁴³ See *id.* at 340.

⁴⁴⁴ See *id.* at 341.

As late as ten years ago, several studies indicated that most of the families that had resorted to sperm donation had decided not to tell the children.⁴⁴⁵ As mental health professionals have become much more involved in fertility treatment, however, they have urged parents to be open with their children about their origins because secrets can have very negative effects on family dynamics and on the child who later in life discovers the secret.⁴⁴⁶

b. *The Judgments About Fertility Treatment that May Be Affected by Heuristics and Biases*

i. *The Potential for Overestimating the Chances of Success*

Fertility patients need accurate information about their various treatment options in order to make informed decisions about their treatment. In 1992, Congress enacted the Fertility Clinic Success Rate and Certification Act to make it easier for infertile patients to obtain such information.⁴⁴⁷ This legislation requires the Centers for Disease Control and Prevention (CDC) to compile and publish success rates for assisted reproductive technology treatments performed at hundreds of U.S. fertility clinics.⁴⁴⁸

The December 2003 CDC report provides data for fertility treatment during calendar year 2001.⁴⁴⁹ This report, the 2001 Assisted Reproductive Technology Success Rates (2001 CDC Report), is based on national data, and includes the success rates for 384 specific fertility clinics.⁴⁵⁰ The national data are based on information gathered from 107,587 ART cycles administered in 2001.⁴⁵¹

The data indicate a twenty-seven percent live birth rate per ART cycle.⁴⁵² Broken down by age of the mother, the live birth rate per cycle was:

- (1) 35 percent for women ages 34 or younger;
- (2) 28 percent for women ages 35 to 37;

⁴⁴⁵ See *id.* at 343.

⁴⁴⁶ See *id.* at 351–52.

⁴⁴⁷ See Fertility Clinic Success Rate and Certification Act of 1992, Pub. L. No. 102-493, § 2, 106 Stat. 3146 (codified at 42 U.S.C.A. § 263a-1-a-7 (2004)). For a discussion of the events leading up to the enactment of this law, see KEARNEY, *supra* note 39, at 32–34.

⁴⁴⁸ See Fertility Clinic Success Rate and Certification Act of 1992 § 2(a). The CDC works with the Society for Assisted Reproductive Technology (SART), a professional organization of fertility doctors, and RESOLVE, the National Infertility Association, to compile the data. See 2001 CDC REPORT, *supra* note 48, at iv.

⁴⁴⁹ See 2001 CDC REPORT, *supra* note 48, at 4–5. The statistics in the report include the percentage of live births per treatment cycle for each clinic, which means that the most recent data relate back to fertility treatment cycles from a year earlier. A live birth is defined as “the delivery of one or more live-born infants.” *Id.* at 15.

⁴⁵⁰ *Id.* at 5.

⁴⁵¹ *Id.* at 11.

⁴⁵² *Id.* at 17.

- (3) 20 percent for women ages 38 to 40; and
- (4) 10 percent for women ages 41 to 42⁴⁵³

The report further breaks down the live birth rate per cycle for women forty and older:

- (1) 15.9 percent for 40-year-old women;
- (2) 11.4 percent for 41-year-old women;
- (3) 9 percent for 42-year-old women;
- (4) 5.9 percent for 43-year-old women; and
- (5) 2.9 percent for women ages 44 and older.⁴⁵⁴

Live birth rate per cycle is also broken down based on the infertility diagnosis:

- (1) Male factor: 32 percent;
- (2) Endometriosis: 30.8 percent;
- (3) Ovulatory dysfunction: 30.6 percent;
- (4) Tubal factor: 27.5 percent;
- (5) Uterine factor: 25 percent;
- (6) Other causes: 25.7 percent; and
- (7) Unexplained cause: 28.5 percent.⁴⁵⁵

These rates can be considered in relation to the overall probability of a couple getting pregnant in one natural cycle with no fertility treatment, which is ten percent or less per cycle.⁴⁵⁶ This comparison can be misleading, however, because couples trying to get pregnant naturally can try every month, but couples do not usually go through more than two or three ART cycles in a year because of the high costs and difficulties involved.⁴⁵⁷

Instead of focusing on per cycle success rates, infertile patients might want to know the *cumulative* success rates for ART cycles, meaning the end result success rates where the patient goes through multiple, sequential ART cycles.⁴⁵⁸ Geneticist Brian Kearney frames this issue in the following way:

If high-tech conception were like rolling dice, cumulative success rates could be calculated directly from the per-cycle success rates. Every time you roll a die, the probability of coming up with any of the numbers is 1 in 6 (17 percent). If you keep rolling, eventually you will come up with your target number. For example, the probability of rolling a six is 17 percent after a single throw. After three rolls the probability of rolling a six at least once is 43 percent, and after eight rolls it is 77 percent. The key here is that the die never changes. No matter how many times you roll it, it still has six

⁴⁵³ *Id.* at 25.

⁴⁵⁴ *Id.* at 23.

⁴⁵⁵ *Id.* at 27.

⁴⁵⁶ See KEARNEY, *supra* note 39, at 25–26.

⁴⁵⁷ See *id.* at 26.

⁴⁵⁸ See *id.* at 40.

sides, and the probability of rolling any of the numbers will always be 1 in 6 for each throw. *If high-tech conception worked the same way, a couple would eventually give birth if they started enough cycles . . .* The question is whether using high-tech conception is like rolling dice.⁴⁵⁹

Various studies have tried to determine cumulative success rates for IVF, but they have reached conflicting conclusions.⁴⁶⁰ Some studies have concluded that success rates drop sharply after the first unsuccessful IVF; others have concluded that success rates stay the same for six or more cycles.⁴⁶¹ Kearney believes these studies warrant some skepticism, however, because they all suffer certain methodological limitations.⁴⁶² In his view, the most reliable study is a United Kingdom study that included data from almost 37,000 cycles during the years 1991 through 1994.⁴⁶³ That study concluded: “[T]he probability of live births per cycle significantly declined with each successive attempt at IVF, even when the results were adjusted for the age of the mother.”⁴⁶⁴ Based on this study, Kearney argues that “IVF is not like rolling dice. It’s worse. If a couple doesn’t give birth by the fourth attempt, they are unlikely to be successful continuing the same treatment and should consider alternatives.”⁴⁶⁵

Infertile patients may assume, contrary to the conclusion reached in the U.K. study, that fertility treatment is like rolling dice and that they will get pregnant and have a baby if they simply persist with fertility treatment.⁴⁶⁶ Thus, patients may overestimate the chances of their treatment being successful.

Patients may also overestimate the odds of success in later individual cycles due to the “gambler’s fallacy.”⁴⁶⁷ For example, patients may

⁴⁵⁹ *Id.* at 40–41.

⁴⁶⁰ *See id.* at 43.

⁴⁶¹ *Id.*

⁴⁶² *See id.*

⁴⁶³ *See id.* at 43–44.

⁴⁶⁴ *Id.* at 44 (emphasis omitted).

⁴⁶⁵ *Id.*

⁴⁶⁶ *See supra* note 461 and accompanying text.

⁴⁶⁷ *See* Amos Tversky & Daniel Kahneman, *Judgment Under Uncertainty: Heuristics and Biases*, in *JUDGMENT UNDER UNCERTAINTY: HEURISTICS AND BIASES* 3, 7 (Daniel Kahneman et al. eds., 1982). Tversky and Kahneman explain the gambler’s fallacy:

People expect that a sequence of events generated by a random process will represent the essential characteristics of that process even when the sequence is short. In considering tosses of a coin for heads or tails, for example, people regard the sequence H-T-H-T-T-H to be more likely than the sequence H-H-H-T-T-T, which does not appear random, and also more likely than the sequence H-H-H-H-T-H, which does not represent the fairness of the coin. Thus, people expect that the essential characteristics of the process will be represented, not only globally in the entire sequence, but also locally in each of its parts. [A] consequence of the belief in local representativeness is the well-known gambler’s fallacy. After observing a long run of red on the roulette wheel, . . . most people erroneously believe

assume that, with a twenty percent per cycle success rate for IVF, the odds of success after four unsuccessful cycles would be much higher than twenty percent in their next IVF cycle. In fact, the chance of success may remain the same for each IVF cycle regardless of how many times the couple has tried IVF in the past.⁴⁶⁸ On the other hand, many other types of medical treatment require patients to make similar calculations of their odds of success. Some of these judgments may be as flawed as some of the judgments fertility patients make.

The point is that the tax system should encourage fertility patients to consider alternative treatment where a specific type of fertility treatment has failed repeatedly. In particular, it should encourage patients to consider egg donor or surrogate procedures where IVF has failed repeatedly.

ii. *The Potential for Underestimating the Risks of Multifetal Pregnancies*

Just as fertility patients may overestimate the odds of fertility treatment success, they may also underestimate the medical risks of fertility treatment, especially the risks associated with multifetal pregnancies. Recall that multifetal pregnancies, which are more likely with fertility treatment, pose significant risks for fetuses and the women gestating them.⁴⁶⁹ Although the risk of a multifetal pregnancy increases as the number of embryos implanted increases,⁴⁷⁰ fertility patients often press their doctors to implant many embryos in order to increase their chances of getting pregnant.⁴⁷¹ The patients also often are willing to risk a multifetal pregnancy “for a better chance of becoming pregnant.”⁴⁷² Fertility patients may not comprehend the magnitude of the

that black is now due [on the next individual spin], presumably because the occurrence of black will result in a more representative sequence than the occurrence of an additional red. Chance is commonly viewed as a self-correcting process in which a deviation in one direction induces a deviation in the opposite direction to restore the equilibrium. In fact, deviations are not “corrected” as a chance process unfolds, they are merely diluted.

Id. (citation omitted).

⁴⁶⁸ See KEARNEY, *supra* note 39, at 42–45.

⁴⁶⁹ See *supra* Part III.C.2.a.ii.

⁴⁷⁰ See *supra* note 402 and accompanying text; *cf.* Templeton & Morris, *supra* note 391, at 577 (concluding that transfer of two embryos, rather than four, reduces the risk of multiple births).

⁴⁷¹ See Templeton & Morris, *supra* note 391, at 573; *supra* note 396 and accompanying text.

⁴⁷² See KEARNEY, *supra* note 39, at 282. See also Allen, *supra* note 396. Allen reports that twenty percent of the infertile patients in a recent study indicated that they would *prefer* a multifetal pregnancy. The authors of that study concluded that, among infertile patients, “a sizable minority prefers the situation that the medical community is trying hard to avoid.” *Id.*

medical risks of twin or triplet pregnancies, or the difficulty of raising triplets.⁴⁷³

Recall also that it is not clear whether repeated stimulation of a woman's ovaries increases her risk of ovarian cancer.⁴⁷⁴ Although the studies linking ovarian stimulation and ovarian cancer risk have been discounted due to their methodological limitations, it does not necessarily follow that there is no risk.⁴⁷⁵ A 1997 study indicates, however, that women are willing to take ovulation induction drugs even if the drugs increase their risk of ovarian cancer.⁴⁷⁶ In addition, many other medicines have side effects. Viagra, for example, has immediate life-threatening side effects.⁴⁷⁷

3. *The Implications for the Tax Characterization of Fertility Treatment Costs*

a. *Medical Care that Cures or Treats Infertility*

Medical care that cures or treats infertility includes surgical correction of varicocele,⁴⁷⁸ blocked fallopian tubes,⁴⁷⁹ and endometriosis.⁴⁸⁰ In some cases, the benefits of these procedures may not be as great as the benefits of IVF, and these procedures have their own medical risks.⁴⁸¹ For example, a woman may be more likely to have an

⁴⁷³ See *supra* notes 383–88.

⁴⁷⁴ See *supra* Part III.C.2.a.i.(B).

⁴⁷⁵ See KEARNEY, *supra* note 39, at 269–70.

⁴⁷⁶ See Rosen, *supra* note 374, at 90. In the 1997 study, about eighty percent of women requiring fertility treatment indicated that they would take ovulation induction drugs, even if the drugs slightly increased their risk of ovarian cancer. Fertility patients may be suffering from the “it won’t happen to me” bias, however. This is described in Paul Slovic et al., *Facts Versus Fears: Understanding Perceived Risk*, in JUDGMENT UNDER UNCERTAINTY: HEURISTICS AND BIASES, *supra* note 467, at 463, 468–70. Slovic explains:

Accurate perception of misleading samples of information might also be seen to underlie another apparent judgmental bias, people’s predilection to view themselves as personally immune to hazards. The great majority of individuals believe themselves to be better than average drivers, more likely than average to live past 80, less likely than average to be harmed by products they use, and so on. Although such perceptions are obviously unrealistic, the risks look small from the perspective of each individual’s experience. Consider automobile driving: Despite driving too fast, tailgating, etc., poor drivers make trip after trip without mishap. This personal experience demonstrates to them their exceptional skill and safety. Moreover, their indirect experience via the news media shows them that when accidents happen, they happen to others.

Id. (citations omitted).

⁴⁷⁷ Lisa Thomlinson, *Viagra Linked to 17 Deaths*, THE EVENING STANDARD (LONDON), May 17, 1999, at 5.

⁴⁷⁸ See RESOLVING FERTILITY, *supra* note 2, at 166–67.

⁴⁷⁹ See *id.* at 132–35.

⁴⁸⁰ See *id.* at 125–27.

⁴⁸¹ See *id.* at 176 (noting that patients should think carefully about whether or not IVF is the best treatment for their fertility difficulties); KEARNEY, *supra* note 39, at 24–29 (discussing the comparative benefits of IVF).

ectopic pregnancy after tubal surgery.⁴⁸² On the other hand, these procedures do not involve the risks of ovarian stimulation, including the risks of hyperstimulation and multifetal pregnancies.⁴⁸³ This type of medical care should be characterized as a medical expense under § 213.

b. *Ovarian Stimulation with IUI or IVF*

The benefits of ovarian stimulation with IUI or IVF often exceed the benefits of surgical treatment. Patients express with their wallets their strong preference for this type of treatment.⁴⁸⁴ The biggest countervailing consideration is the large, negative effect on welfare caused by multifetal pregnancies.⁴⁸⁵ The fertility community and the CDC are currently developing effective new protocols to reduce the risk of multifetal pregnancies, so this risk will likely be significantly reduced as treatment protocols evolve.⁴⁸⁶

The risk of multifetal pregnancies will be reduced if IVF is subsidized. The risk of multifetal pregnancies is much easier to control with IVF than with IUI, but IVF is much more expensive per cycle.⁴⁸⁷ In addition, where patients have less at stake financially, they are more amenable to conservative treatment, which reduces the risk of multifetal pregnancies.⁴⁸⁸ Ovarian hyperstimulation is another medical risk, but serious cases are not common.⁴⁸⁹ Researchers have not established that ovarian stimulation causes ovarian cancer, but additional research will be done as patients age.⁴⁹⁰

Another concern is that infertile patients may overestimate the benefits of multiple cycles of high-tech treatment and underestimate the risks of treatment, especially the medical risks associated with multifetal pregnancies.⁴⁹¹ If patients fail to understand that their chances of success decline with each subsequent attempt,⁴⁹² as is likely the case, alternative treatments that are more effective, such as donor and surrogacy procedures, should be encouraged. Fertility treatment counseling should emphasize the risk of multifetal pregnancies, but the tax system does not need to eliminate the § 213 deduction for the costs of IUI and IVF to respond to this risk. In fact, empirical evidence

⁴⁸² See KEARNEY, *supra* note 39, at 278–81.

⁴⁸³ See *supra* Part III.C.2.a.i–ii.

⁴⁸⁴ See *supra* notes 80, 85 and accompanying text.

⁴⁸⁵ See *supra* Part III.C.2.a.ii.

⁴⁸⁶ See *supra* Part III.C.2.a.ii.(B).

⁴⁸⁷ See *supra* notes 85–86, 411 and accompanying text.

⁴⁸⁸ See Templeton & Morris, *supra* note 391, at 577 (concluding that transferring two embryos, rather than four, reduces the number of multiple births).

⁴⁸⁹ See *supra* note 360 and accompanying text.

⁴⁹⁰ See *supra* Part III.C.2.a.i.(B).

⁴⁹¹ See *supra* Part III.C.2.b.i–ii.

⁴⁹² See *supra* notes 464–65 and accompanying text.

indicates that subsidizing fertility treatment *reduces* the rates of multifetal pregnancies.⁴⁹³

The costs of IUI and IVF procedures should, on balance, be characterized as medical expenses, given the profound desire of patients to increase their chances of conceiving and bearing a child, and the positive effect of subsidies on the risk of multifetal pregnancies.

c. *Donor and Surrogate Procedures*

Collaborative reproduction, involving a donor or surrogate, produces great benefits for the parents and child.⁴⁹⁴ Although some patients choose to adopt if they cannot have a biological or gestational connection to a child, many patients strongly prefer collaborative reproduction to adoption.⁴⁹⁵ Also, many parents who would like to adopt non-special needs babies in the United States cannot because there is a shortage of such babies.⁴⁹⁶ In addition, the tax subsidy for adoption is typically more generous than the tax subsidy for fertility treatment costs that are characterized as medical expenses under § 213. Thus, the tax law currently favors adoption over collaborative reproduction, even if the costs of collaborative reproduction are deductible as a medical expense.⁴⁹⁷

Egg donation involves medical risks to the donor and to the woman who gestates the fetus or fetuses.⁴⁹⁸ Ovarian stimulation of an egg donor entails the serious but uncommon risk of hyperstimulation.⁴⁹⁹ Also, an increased risk of ovarian cancer from repeated ovarian stimulations is possible, although this risk has not been established.⁵⁰⁰ Even if a connection between stimulation and ovarian cancer is established, egg donors are usually stimulated fewer times than are fertility patients and they can reduce their ovarian cancer risk by taking oral contraceptives or bearing a child after donating eggs.⁵⁰¹ The infertile woman may also reduce her own risk of ovarian cancer by proceeding with egg donation and bearing a child, which is an-

⁴⁹³ Cf. McCullough, *supra* note 154 (reporting that the risk of a multifetal pregnancy is lower in states that mandate comprehensive insurance coverage of infertility).

⁴⁹⁴ See generally RESOLVING INFERTILITY, *supra* note 2, at 267–85 (providing an overview of donor and surrogacy procedures).

⁴⁹⁵ See COOPER & GLAZER, *supra* note 20, at 246–47.

⁴⁹⁶ See *supra* notes 326–28.

⁴⁹⁷ See *supra* notes 336–42, 351–53 and accompanying text.

⁴⁹⁸ See COOPER & GLAZER, *supra* note 20, at 207–09.

⁴⁹⁹ See *id.* at 208; *supra* Part III.C.2.a.i.(A).

⁵⁰⁰ See *supra* Part III.C.2.a.i.(B).

⁵⁰¹ See *supra* notes 375–77.

other benefit of the procedure.⁵⁰² The woman who gestates runs the risks associated with multifetal pregnancies.⁵⁰³

The basic donor fee should be deductible, in part to permit infertile women to conceive and bear a child and, in part, to encourage infertile women to proceed with a more effective alternative to repeated IVF procedures. The deduction for the fee charged by the donor should be capped by statute to prevent the deduction of exorbitant costs incurred to create a “designer” baby. From the perspective of the surrogate, the strongest negative is the medical risk associated with multifetal pregnancies, but, as noted above, this risk can be reduced.⁵⁰⁴ The cost of a surrogate procedure should be deductible as a medical expense, so that the tax treatment of surrogacy costs is less disadvantaged relative to the tax treatment of adoption, and is comparable to the tax treatment of IVF procedures.

CONCLUSION

The experience of infertility is devastating and produces multiple losses. The treatment of infertility is intensely medical and has been appropriately likened to the treatment of other chronic illnesses. Insurance does not typically cover fertility treatment.

Under current law, fertility treatment costs are properly characterized as deductible medical expenses. Internal Revenue Code § 213 provides that “medical expenses” include costs incurred for “the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body.”⁵⁰⁵ The term “medical expense” is defined by reference to a baseline of normal biological functioning, which includes reproductive and sexual functioning. Most people conceive and bear children without having to incur expenses for fertility treatment. Expenses incurred to try to return to or approximate this baseline of normal reproductive health are deductible, even if the taxpayer winds up “better off,” with a child after the fertility treatment. Infertility is a loss, just as a broken leg is a loss.

Some have argued that fertility treatment costs should not be deductible as medical expenses because people can lead a “normal” life without having children. This argument is flawed, however, because people who desperately want to bear a child, but cannot because of a physiological condition, are not leading a “normal” life.

⁵⁰² See *supra* notes 376–77. Taking oral contraceptives to reduce ovarian cancer risk will be unacceptable to many fertility patients.

⁵⁰³ See RESOLVING INFERTILITY, *supra* note 2, at 274; *supra* Part III.C.2.a.ii.(A).

⁵⁰⁴ See *supra* Part III.C.2.a.ii.

⁵⁰⁵ I.R.C. § 213(d)(1)(A) (2000).

The IRS has taken the position that certain types of fertility treatment costs are not medical expenses. For example, the IRS has argued that surrogacy expenses do not satisfy the second "structure or function" prong of the medical expense definition because the surrogate, not the taxpayer, bears the child. Surrogacy costs are medical expenses, however, under the first "disease or condition" prong of the definition.

The characterization of fertility treatment costs as medical expenses is also controversial from a normative perspective. Given the existence of the § 213 medical expense deduction, however, taxpayers *should* be able to deduct the cost of IVF, donor, and surrogate procedures. Similarly, they should be able to deduct the costs of medical care for sexual dysfunction, such as Viagra, and other types of medical care that facilitate reproductive choice.

Reproduction is extremely important to most people and the elasticity of demand for fertility treatment is likely low. In addition, allowing taxpayers to deduct the costs of various types of fertility treatment will: (1) encourage infertile taxpayers to elect the most effective medical treatment option for their particular fertility problem, whether it is an IVF procedure, an egg donor procedure, or a surrogate procedure; and (2) *reduce* the rate of risky multifetal pregnancies. Even if fertility treatment costs continue to be characterized as medical expenses, the tax code favors adoption over fertility treatment because the medical expense deduction saves taxpayers less money than the tax credit for adoption expenses. Due to the vital importance of reproduction to most people, fertility treatment costs should be deductible under either an "ability-to-pay" or a consequentialist normative approach.