

Inconceivable? Deducting the Costs of Fertility Treatment

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*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*

I. 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 are forced to bear fertility treatment costs themselves. Infertile patients may, however, be able to recoup some of these expenses by deducting their fertility treatment costs as medical expenses or having

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¹ Harriett Prescott Spofford, *Only, in* THE HOME BOOK OF AMERICAN QUOTATIONS 53 (1967), reprinted in DEBRA BRIDWELL, THE ACHE FOR A CHILD 22 (1994) [hereinafter THE ACHE FOR A CHILD]. Poetry is included in this article in order to convey the intensity of the emotions surrounding infertility and child-bearing. "Poetry is the art of letting the primordial word resound through the common word." THE RAG AND BONE SHOP OF THE HEART (Robert Bly et al., eds. 1992) 182 (quoting Gerhart Hauptman).

² THE STAFF OF RESOLVE, THE NATIONAL INFERTILITY ASSOC., RESOLVING INFERTILITY 3 (1999) [hereinafter RESOLVING INFERTILITY]. The American Society of Reproductive Medicine website, at www.asrm.org/Patients/faqs.html (last visited July 24, 2003) indicates that about 10 percent of the reproductive age population in the U.S. (about 6 million people) is affected by infertility.

³ Thomas D. Flanigan, Note, *Assisted Reproductive Technologies and Insurance under the Americans with Disabilities Act of 1990*, 38 BRANDEIS L.J. 777 (1999-2000); see also RESOLVING INFERTILITY, *supra* note 2, at 296 (describing insurance policy language that 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. The website of RESOLVE, a non-profit organization that addresses infertility issues, describes the scope of mandated insurance coverage in these states. [www.resolve.org/advocacy/updates/RESOLVE Fact Sheet and List of Current State Insurance Mandates](http://www.resolve.org/advocacy/updates/RESOLVE_Fact_Sheet_and_List_of_Current_State_Insurance_Mandates) (last visited Apr. 14, 2003).

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 There are no reported cases that address the issue. The Internal Revenue Service (IRS) recently issued a private letter ruling in which it classified certain fertility treatment expenses as medical expenses.⁷ On the other hand, the IRS challenged a taxpayer's deduction of certain fertility treatment costs in a case it litigated, but that case settled so there was no reported decision.⁸

During an exchange among tax professors on a law professor list service, a noted tax scholar argued that fertility treatment costs are not medical expenses because fertility treatment is a "lifestyle choice," not health care. The professor said, "I suppose reproduction is a bodily function, but it is one the exercise of which is purely optional -- a lifestyle choice."⁹ On the other hand, when asked about the tax treatment of the costs of Viagra, the professor said that Viagra costs are distinguishable and may qualify for the medical expense deduction.¹⁰

Another noted tax scholar took the position that the costs of both fertility treatment and Viagra should not be deductible as medical expenses, because, in his view,

⁴ I.R.C. §§ 213 and 105 (2000). The § 213 medical expense deduction and the § 105(b) medical flexible spending account reimbursement exclusion provide for the tax treatment of certain "medical expenses," as defined in § 213. The issue discussed in this article is whether fertility treatment costs are deductible under § 213 or excludable under §105 as medical expenses. References to § 213 deductibility in this article apply equally to § 105 reimbursability.

⁵ Kristin Davis, *The Agonizing Price of Infertility*, KIPLINGER'S PERSONAL FINANCE MAGAZINE, May 1996, at 50 [hereinafter *Price of Infertility*].

⁶ Two brief articles have considered the issue of deductibility under current law. James E. Maule, *Federal Tax Consequences of Surrogate Motherhood*, 60 TAXES 656 (Sept. 1982); Mark Reid & Daphne Main, *Tax Issues Surrounding Assisted Reproduction Expenses*, 78 TAXES 26 (2000). The issue has never been addressed in a law review article.

⁷ Private Letter Ruling 200318017 (January 9, 2003) (available in LEXIS, Tax Analysts, document number 2003 TNT 86-12 (May 5, 2003))(egg donor expenses and related costs are medical expenses).

⁸ *Sedgwick v. Commissioner*, No. 10133-94, LEXIS 94 PTT 13-53 (U.S. Tax Court filed June 7, 1994) (IRS argued that surrogacy expenses are not medical expenses).

⁹ E-mail submission from Professor Joseph Dodge, Florida State University College of Law, to Taxprof, a closed Internet discussion group for tax law professors at AALS-accredited law schools (Apr. 20, 2000) (copy on file with author).

¹⁰ *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 grey zone for many.

Id.

reproductive dysfunction and sexual dysfunction do not involve the sort of catastrophic losses that justify a medical expense deduction.¹¹

This article will consider whether the costs of fertility treatment are deductible under current tax law and whether they should be. Along the way, this article will also consider similarities between the costs of treatment for reproductive dysfunction, the costs of treatment for sexual dysfunction, and the costs of medical care that permit reproductive choice.

Part II discusses the experience of infertility, including the emotional distress caused by infertility, the medical treatment of infertility, and the financial burdens of fertility treatment. Part III explores the tax treatment of fertility treatment costs under current law, first for medical care that does not involve third parties, then for the additional costs of procedures involving donors and surrogates. Part IV considers whether, given the existence of a medical expense deduction, fertility treatment costs should be treated as medical expenses or as non-medical expenses. The thesis of this article is that fertility treatment expenses, like the costs of medical care that facilitate 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.

II. The Experience of Infertility.

A. The extreme emotional distress caused by infertility.

Most people want to have children at some point in their lives.¹² This does not mean that every person should want to have children. In addition, even people who want to have

¹¹ E-mail submission from Professor Calvin Johnson, The University of Texas School of Law, to Taxprof, a closed Internet discussion group for tax law professors at AALS-accredited law schools (Apr. 20, 2000) (copy on file with author).

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 section 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 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.

¹² Only a small percentage of married women decide not to have children. Lewis J. Lord et al., *Desperately Seeking Baby; Ten Million Americans Are Struggling To Have Children*, U.S. NEWS & WORLD REPORT, Oct. 5, 1987, at 58 (“Only 2 percent of married women actually prefer to be childless”).

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.

Professor Calvin Johnson argues that the medical expense deduction is for losses incurred to try to get the taxpayer back 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.¹³ In his view, "children are neither a broken leg nor a disease."¹⁴ On the other hand, the vast majority of couples can conceive and bear children without fertility treatment, so fertility treatment just gets the taxpayers back to where the taxpayers would have been absent the medical infertility. It is not the child that is the loss; it is the infertility that is the loss. The goal of the medical treatment is to restore the 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. Couples 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 to them. As one infertile patient has observed, "[f]inding out that you are infertile can feel like suddenly discovering a limb is paralyzed."¹⁵

¹³ E-mail submission from Professor Calvin Johnson, The University of Texas School of Law, to Taxprof, a closed Internet discussion group for tax law professors at AALS-accredited law schools (Apr. 20, 2000) (copy on file with author).

¹⁴ *Id.*

¹⁵ THE ACHE FOR A CHILD, *supra* note 1, at 93-94:

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.

Long-term treatment of infertility extracts a heavy toll, both emotionally and financially:

[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. As the experience of infertility continues, many losses come cascading towards them: 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. . . .¹⁶

Infertility often has a devastating emotional effect, especially for women.¹⁷ In numerous psychological studies, researchers have found that infertile women frequently suffer from severe depression.¹⁸ In a famous study, researchers found that infertile

Id.

¹⁶ SUSAN LEWIS COOPER & ELLEN SARASOHN GLAZER, CHOOSING ASSISTED REPRODUCTION: SOCIAL, EMOTIONAL, & ETHICAL CONSIDERATIONS 17 (1998) [hereinafter CHOOSING ASSISTED REPRODUCTION]. The authors also note that infertility and the treatment of it can imperil the infertile patient's marriage, relationships with others, and career. *Id.* Another author compares the stresses of infertility to the stresses of a chronic illness. These include the stresses associated with: "dealing with the schedules of doctor's appointments and medication, operations and uncomfortable procedures, the side effects of drugs, the emotional energy spent working through fears and grief, and needing to adjust to a different reality than [the intended parents] had planned." THE ACHE FOR A CHILD, *supra* note 1, at 129.

¹⁷ CHOOSING ASSISTED REPRODUCTION, *supra* note 16, at 17-18.

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 movements 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 a 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 is about women's experience of infertility.

¹⁸ See, e.g., Alice Domar et al., *The Prevalence and Predictability of Depression in Infertile Women*, 58(6) FERTILITY & STERILITY 1158 (Dec. 1992); I. Laffont & R.J. Edelman, *Psychological Aspects of In Vitro Fertilization: A Gender Comparison*, 15(2) J. OF PSYCHOSOMATIC OBSTETRICS & GYNECOLOGY 85 (1994); M.P. Lukse & N.A. Vacc, *Grief, Depression, and Coping in Women Undergoing Infertility Treatment*, 93 OBSTETRICS & GYNECOLOGY 245 (Feb. 1999); Anna Hjelmstedt et al., *Gender Differences in Psychological Reactions to Infertility Among Couples*

women's scores on the Beck Depression Index (a test used to measure severity of depression) were comparable to the scores of patients with *terminal* diseases like cancer.¹⁹

Infertility causes grief in men as well, but men sometimes feel constrained in their expression of grief. Here is the story of one grieving man:

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. . . . 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.²⁰

Many infertile patients report that infertility has been "the most upsetting experience of their lives."²¹ Infertile patients repeatedly experience a cycle of hope for a child and loss of their hoped-for child.²² Infertile patients report that their hoped-for child exists on an emotional level even if the child is never physically conceived.²³ The

Seeking IVF- and ICSI-treatment, 78 ACTA OBSTETRICIA ET GYNECOLOGICA SCANDINAVICA 42 (1999).

¹⁹ Domar, *supra* note 18, at 1158. One patient reports her surprise at 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 . . . I couldn't control my sobbing -- not crying -- uncontrollably sobbing." THE ACHE FOR A CHILD, *supra* note 1, at 95.

²⁰ THE ACHE FOR A CHILD, *supra* note 1, at 146.

²¹ In one study, 50 percent of women and 15 percent of men being treated for infertility reported that infertility has been "the most upsetting experience of their lives." Ellen W. Freeman et al., *Psychological Evaluation and Support in a Program of In Vitro Fertilization and Embryo Transfer*, 43 FERTILITY & STERILITY 48, 50 (Jan. 1985).

²² THE ACHE FOR A CHILD, *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. This cycle includes the losses of: privacy, sense of control, having grandchildren, purpose, time, money, career progress, innocence, giving to another, being needed, and the acquired credibility of being an adult who has raised children. This is why many women view infertility as the most upsetting experience of their lives.

Id.

²³ 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) 37, 38 (1998) [hereinafter THE FERTILITY GUIDE]. The following poem, *Uncharted Territory*, captures this common experience:

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.

feelings of loss experienced by infertile patients are real and recurrent, even though most people find them difficult to comprehend.²⁴

The failure of most people to understand the anguish of infertile patients adds to patients' feelings of isolation.²⁵ In addition, infertile patients have to deal with the stresses of their medical treatment, which have been likened to the stresses of being treated for a chronic illness.²⁶

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.

Id. at unnumbered page 3 after the title page.

²⁴ THE ACHE FOR A CHILD, *supra* note 1, at 128-29:

The stress of infertility can be enormous. Along with the general grieving process, there is the emotional stress of the constant cycle of hope and despair. One infertile woman dealt with this by never accepting an invitation to a child-oriented function until she checked her calendar. If the event were scheduled for day 16 of her cycle, when she would have just ovulated she would accept, but if it were scheduled for day 2, after her period might have started, she declined.

On the good days, there is just a mild tug at your heart; then there are the bad days when the pain is uncontrollable, and it's hard to function at all. In dealing with this roller coaster of stress and also the physical stress of medical testing and treatment, we may find we don't have much energy left over to deal with the rest of life.

Id.

²⁵ Alice D. Domar & Machel M. Seibel, *Emotional Aspects of Infertility*, in INFERTILITY: A COMPREHENSIVE TEXT 24 (Machel M. Seibel ed. 1990); Sandra R. Leiblum et al., *Unsuccessful In Vitro Fertilization: A Follow-Up Study*, 4 J. IN VITRO FERTILIZATION & EMBRYO TRANSFER 46, 49 (1987); Sandy Banks, 'Last' Chance for Couples Frustrated by Infertility, L.A. TIMES, June 12, 2001, Part 5 at 1.

²⁶ THE ACHE FOR A CHILD, *supra* note 1, at 128-29:

Infertility brings day-to-day stresses that are similar to living with a chronic illness: 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 we had planned. As in the case of chronic illness, we keep hoping for a miracle turnaround, and that may happen, but it isn't something we can count on. All of this can eventually lead to exhaustion.

Id.

In the words of an infertile woman:

I completely withdrew from the whole world for a while. . . . I had a hard time being around anybody. I would pretty much stay at home. I had a hard time going back to work. I was scared to face everybody there. Each day was a challenge. There were many days that I left work crying. My arms literally ached, and I felt so empty. I didn't want to cook or clean. I left the house dark. I wasn't sleeping, so the doctor prescribed sleeping pills. I would take a sleeping pill and end up crying myself to sleep every night.²⁶

Id. at 103.

Infertility deprives would-be parents of an “experience that is central to . . . identity and meaning in life.”²⁷ As Lori Andrews and Lisa Douglass have noted, “the lengths to which [infertile patients] will go to conceive a child attest to the intensity of the pain of infertility.”²⁸ The following poem about infertility 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.²⁹

²⁷ JOHN A. ROBERTSON, CHILDREN OF CHOICE: FREEDOM AND THE NEW REPRODUCTIVE TECHNOLOGIES 11 (1994).

²⁸ Lori B. Andrews & Lisa Douglass, *Symposium on Biomedical Technology and Health Care: Social and Conceptual Transformations: Technical Article: Alternative Reproduction*, 65 S. CAL. L. REV. 623, 629 (1991).

²⁹ Ella Rhoads Higginson, *The Childless Mother's Lullaby*, in A BOOK OF LULLABIES 383 (Elva S. Smith ed., 1925). Here is another expression of an infertile woman's despair:

So many times, I've waited,
Hoped,
Believed,
That God and nature
Would perform
A miracle
Incredible but common,
Nothing grew.
And oftentimes I feel
The mystery of life and growth
Is known to all but me,
Or that reality
Is not as it appears to be. . . .

Margaret Rampton Munk, *Mother's Day*, reprinted in ELLEN SARASOHN GLAZER, EXPERIENCING INFERTILITY 152-53 (revised ed. 1998).

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.”³⁰ There are many causes of infertility. Male factors and female factors each account for about a third of infertility cases.³¹ Infertility is attributable to a combination of male and female factors in about 10 percent of infertility cases.³² In about 20 percent of infertility cases, the infertility is “unexplained” (*i.e.*, it cannot be diagnosed).³³

Male factors include: (1) disorders related to sperm production, maturation, or transfer, including varicocele (testicular varicose veins);³⁴ (2) blocked or absent vas deferens (the tube that connects the testes and the urethra); and (3) absent or retrograde ejaculation.³⁵ These problems can be caused by a variety of factors, including: hormonal imbalances; genetic disorders; environmental factors; anatomical defects; sexually transmitted diseases; spinal cord injuries; and bladder, prostate gland, or testicular cancer or surgery.³⁶

Female factors include ovulation disorders, blocked fallopian tubes, cervical disorders, endometriosis, and uterine disorders.³⁷ These female factors can be caused by a variety of factors, including: hormonal imbalances; autoimmune reactions; genetic disorders; anatomical defects (including those caused by in utero exposure to DES³⁸ taken by the patient’s mother); pelvic inflammatory disease, venereal disease, and other types of infection; scar tissue; fibroid tumors; and reproductive cancers, including ovarian cancer, uterine cancer, and cervical cancer.³⁹

Fertility rates for women decline for women in their thirties and decline dramatically for women in their forties,⁴⁰ due to a combination of several factors, including increased rates of: (1) ovarian dysfunction, (2) uterine dysfunction, and (3)

³⁰ 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 the body’s ability to perform the basic functions of reproduction.” “Quick Facts About Infertility” ASRM website at <http://www.asrm.org/patients/faqs/> (last visited Apr. 3, 2003).

³¹ ASRM website at <http://asrm.org/patients/faqs/Q&A2> (last visited Apr. 3, 2003).

³² *Id.*

³³ *Id.*

³⁴ Ten to 15 percent of men may have varicocele and 40-50 percent of men treated for infertility have varicocele. RESOLVING INFERTILITY, *supra* note 2, at 165.

³⁵ BRIAN KEARNEY, HIGH-TECH CONCEPTION 14-15 (1998) [hereinafter HIGH-TECH CONCEPTION].

³⁶ *Id.*

³⁷ *Id.* at 11-14.

³⁸ During the mid-1900s, many pregnant women took a prescription drug called diethylstilbestrol (DES). Women who, as fetuses, were exposed to DES taken by their mothers can have various types of reproductive disorders that cause infertility, including various cervical disorders, various uterine disorders, tubal disorders, irregular menstrual cycles, and endometriosis. In utero exposure to DES also increases a woman’s risk of miscarriage and premature delivery. RESOLVING INFERTILITY, *supra* note 2, at 136-39.

³⁹ HIGH-TECH CONCEPTION, *supra* note 35, at 11-14; RESOLVING INFERTILITY, *supra* note 2, at 89-101, 121-145.

⁴⁰ THE FERTILITY GUIDE, *supra* note 23, at 37-38.

chromosomal abnormalities in their eggs.⁴¹ During perimenopause (the series of gradual hormonal changes that precede menopause), women can still conceive and bear children, but are less fertile.⁴²

Infertility has been derisively labeled “the yuppie woman’s disease.”⁴³ The stereotype of infertility is the yuppie career woman trying to “have it all,” achieving professional success in her thirties, and wanting children in her forties. Although more women, especially professional women, are delaying having children,⁴⁴ many of the female factors listed above are unrelated to age.

Medical treatment of infertility is progressive. The physician begins fertility treatment by taking the patient couple’s⁴⁵ medical history,⁴⁶ and conducting physical and pelvic examinations.⁴⁷ If the source of the infertility cannot be determined, based on this preliminary evaluation, the doctor selects from a number of tests and procedures.

⁴¹ There are three basic types of ovulation disorders that are caused by hormonal imbalances, one of which is common in older women approaching menopause. The three types of disorders are: (1) hypogonadotropic disorders; (2) hypergonadotropic disorders; and (3) euestrogenic disorders. FSH and LH are both in a class of reproductive hormones called gonadotropins. The hypothalamus generates gonadotropin-releasing hormone (GnRH), which triggers the release of gonadotropins by the pituitary gland. FSH stimulates the growth of egg follicles. LH stimulates the production of estrogen and progesterone. Rising estrogen levels inhibit the pituitary’s production of FSH. LH later surges to cause the dominant egg follicle to release an egg. Hypogonadotropic disorders involve low blood levels of FSH and LH. Hypergonadotropic disorders involve high blood levels of FSH and LH. As women approach menopause, their blood levels of FSH and LH increase, so this form of ovulation disorder is common in older women patients. HIGH-TECH CONCEPTION, *supra* note 35, at 11-14. Younger women (under age 40) with premature ovarian failure (POF) also have this type of disorder. POF can be caused by radiation or chemotherapy treatment for cancer, endometriosis, congenital defects, autoimmune disorders, genetics, and environmental factors. CHOOSING ASSISTED REPRODUCTION, *supra* note 16, at 196-97. Euestrogenic disorders involve gonadotropin and estrogen imbalances. This type of imbalance is most often attributable to polycystic ovarian syndrome (PCOS). HIGH-TECH CONCEPTION, *supra* note 35, at 13. Older women also have increased rates of a uterine disorder called Luteal Phase Defect. RESOLVING INFERTILITY, *supra* note 2, at 149.

⁴² RESOLVING INFERTILITY, *supra* note 2, at 14.

⁴³ Margaret Ann Mille, *The Fertility Center of Sarasota is One of About 350 Clinics Nationwide Using Technology to Help Women Have Babies; In-vitro Specialists Beget a Fertile Business*, SARASOTA HERALD-TRIBUNE, Oct. 23, 2000, Business Weekly Section, at 1.

⁴⁴ More older women are having children, despite the fact that a woman’s fertility declines with age. RESOLVING INFERTILITY, *supra* note 2, at 11, 14. Since, 1981, the birthrate for 40 to 44-year-old women has increased 74 percent. About 70 percent of the in vitro fertilization (IVF) cycles done in 1998 were for women between the ages of 30 and 39. CENTERS FOR DISEASE CONTROL AND PREVENTION, AMERICAN SOCIETY OF REPRODUCTIVE MEDICINE, & RESOLVE, 2000 ASSISTED REPRODUCTIVE TECHNOLOGY SUCCESS RATES 21, *available at* <http://www.cdc.gov/nccdphp/drh/ART00/PDFs/ART2000.pdf> (Dec. 2002) [hereinafter 2000 CDC REPORT].

⁴⁵ 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, this article will use nomenclature that fits the typical case, unless otherwise noted.

⁴⁶ RESOLVING INFERTILITY, *supra* note 2, at 66-67.

⁴⁷ *Id.* at 67-70.

Women patients are frequently asked to generate ovulation records (based on their temperature and ovulation indicator tests). Blood tests indicate whether the woman's hormones are within normal ranges at various times during her cycle.⁴⁸ Transvaginal ultrasound is also used to monitor the woman's ovulatory cycle. An X-ray of the fallopian tubes and uterus is often ordered to check for blockage of the patient's fallopian tubes and abnormalities in the uterus.⁴⁹ Women also sometimes have a diagnostic, outpatient surgical procedure (a laparoscopy), performed under general anesthesia in the hospital, if the doctor suspects that the infertility is caused by certain problems such as endometriosis or fibroid tumors.⁵⁰ The postcoital test is used to determine whether the woman's cervical mucus is normal or abnormal and whether any of the man's sperm are alive and moving.⁵¹

Male patients submit a semen sample so the laboratory can evaluate 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 (viscosity of the semen); and (6) seminal fructose levels.⁵² Other semen tests include tests for: (1) infection, such as chlamydia; (2) sperm antibodies; and (3) ability of the sperm to penetrate an egg.⁵³ Men also submit blood samples so the laboratory can determine whether the man's hormone levels are normal or abnormal.⁵⁴ A testicular biopsy is also sometimes used to evaluate sperm production.⁵⁵

This infertility workup usually enables the physician to identify and treat specific causes of infertility. For example, endometriosis can be treated with surgery, hormonal treatment, or a combination of the two.⁵⁶ Clomiphene citrate, a moderately priced pill taken orally, is often prescribed for certain types of ovulation and uterine disorders.⁵⁷ These disorders and others can also be treated with various injectable prescription drugs that stimulate the ovaries.⁵⁸ If the woman's ovaries are being stimulated, the physician 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

⁴⁸ RESOLVING INFERTILITY, *supra* note 2, 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.*

⁴⁹ *Id.* at 75-77. This diagnostic X-ray is called a hysterosalpingogram, or HSG. *Id.* at 75.

⁵⁰ *Id.* at 79-80.

⁵¹ *Id.* at 75.

⁵² *Id.* at 81-85.

⁵³ *Id.* at 85-86.

⁵⁴ *Id.* at 86-87.

⁵⁵ *Id.* at 86.

⁵⁶ *Id.* at 125-28.

⁵⁷ *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 cycle. The daily dose is one to four 50-milligram pills. The cost is \$10 or less per pill. *Id.*

⁵⁸ *Id.* at 105-10. These injectable drugs include: (1) FSH (brand names Fertinex, Metrodin, Follistim, and Gonaf); (2) human menopausal gonadotropin (brand names Humegon, Pergonal, Repronex); (3) human chorionic gonadotropin (hCG) (brand names Novarel, Pregny, Profasi); (4) gonadotropin-releasing hormone agonists (GnRH agonists) (brand names Lupron and Synarel); gonadotropin-releasing hormone antagonist (GnRH antagonist) (brand name Antagon). *Id.*

side effects of the medications.⁵⁹ Certain male factors can also be treated with surgery or hormonal treatment. For example, varicocele (testicular varicose veins), a common male factor, can be surgically repaired.⁶⁰ Intrauterine insemination (IUI) is used both for some female factors and some male factors.⁶¹

The vast majority of patients receive conventional drug and surgical treatment.⁶² If these treatments are not successful, infertile 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, including 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.⁶³ In an IVF procedure, the eggs are 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.⁶⁴

If the cause of the infertility is a sperm disorder (including low sperm count, poor sperm motility, or abnormal sperm morphology), a relatively new technique called Intracytoplasmic Sperm Injection (ICSI) can be used in conjunction with IVF. In an ICSI procedure, an embryologist injects a single sperm into each egg.⁶⁵ ICSI dramatically improves fertilization rates.⁶⁶ ICSI has been hailed as a "revolutionary" treatment for sperm disorders.⁶⁷

Some couples can only have a child with the help of a sperm donor, egg donor, or surrogate. If the intended father cannot produce healthy sperm, the couple may enlist the assistance of a sperm donor. Couples requiring sperm donation typically use the sperm of an anonymous donor from a sperm bank.⁶⁸ The cost of sperm donation is small because it is easy for the donor to provide the sperm sample.⁶⁹ Donor sperm can be used in an

⁵⁹ The most serious immediate side effect of ovarian stimulation is Ovarian Hyperstimulation Syndrome (OHS), which occurs in 1-5 percent of medicated cycles. OCS requires medical treatment and, in the most serious cases, hospitalization. *Id.* at 114-15.

⁶⁰ *Id.* at 166-67. Surgical repair of varicocele dramatically improves sperm counts, sperm motility, and fertility. *Id.* at 168.

⁶¹ *Id.* at 145-46, 171. In an IUI, the man's sperm is processed to concentrate the best sperm, then the physician transfers the sperm into the woman's uterus using a catheter through the cervix. *Id.* at 145-46.

⁶² The ASRM estimates that 85-90 percent of infertile patients are treated with conventional drug and surgical treatments. ASRM website at <http://www.asrm.org/patients/faqs/Q&A4> (last visited Apr. 3, 2003).

⁶³ RESOLVING INFERTILITY, *supra* note 2, at 178-80.

⁶⁴ *Id.* at 180-82.

⁶⁵ HIGH-TECH CONCEPTION, *supra* note 35, at 117-18. The first successful ICSI procedure occurred in 1992. It is now a common procedure. *Id.* at 115-16.

⁶⁶ *Id.* at 118-20.

⁶⁷ RESOLVING INFERTILITY, *supra* note 2, at 186. One fertility specialist, Dr. Sherman 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." HIGH-TECH CONCEPTION, *supra* note 35, at 115.

⁶⁸ CHOOSING ASSISTED REPRODUCTION, *supra* note 16, at 180. Couples sometimes use a known sperm donor. *Id.* at 211.

⁶⁹ The cost of sperm donation is incidental when compared to the cost of egg donation or surrogacy, so this article will limit discussion of third-party costs to the egg donor and surrogacy fees.

intrauterine insemination procedure (IUI)⁷⁰ or in an IVF procedure. Sperm banks test donors for sexually transmitted diseases at the time of donation and again six months later. The sperm is frozen until the second test has been completed.

If the intended mother cannot produce healthy eggs, the intended parents can arrange for an egg donor to give them eggs. An egg donor procedure is like an IVF procedure, except that the doctor stimulates the egg donor's ovaries instead of the intended mother's ovaries, and extracts the donor's eggs when they are mature; the resulting embryos are implanted in the intended mother's uterus.⁷¹ Couples enlisting the assistance of an egg donor may know the donor or may find the donor through an agency.⁷² There is a shortage of egg donors; many fertility clinics have long waiting lists for couples who want donated eggs.⁷³

If the intended mother can produce eggs, but cannot gestate the child, the intended parents can arrange for a surrogate to gestate the child. 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 for the intended parents.⁷⁴ If the intended mother cannot produce healthy eggs or carry the child, the intended parents can either arrange for: (1) a donor to give them eggs, which are fertilized, and implanted in the uterus of a surrogate who carries and bears the child; or (2) a surrogate to both provide the eggs and gestate the child.⁷⁵

The next section will consider the cost of these treatments and the effect on the infertile patient.

⁷⁰ IUI with donor sperm is commonly referred to as donor insemination (DI). RESOLVING INFERTILITY, *supra* note 2, at 267.

⁷¹ *Id.* at 273.

⁷² Intended parents often use known egg donors but only rarely use known sperm donors. CHOOSING ASSISTED REPRODUCTION, *supra* note 16, at 211. About 20 percent of egg donors are known and 80 percent are anonymous. RESOLVING INFERTILITY, *supra* note 2, at 277. Known egg donors typically do not want to be compensated for being a donor. Anonymous donors are paid fees that average around \$3,500. *See infra* note 85. The fees for egg donation are higher than the fees for sperm donation because the process of donating eggs is more time consuming, more elaborate, more uncomfortable, and riskier than the process of donating sperm. CHOOSING ASSISTED REPRODUCTION, *supra* note 16, at 209. In addition, sperm can be frozen and stored, but donated eggs cannot be frozen and stored. *Id.* at 211-12. The screening of egg donors is also much more elaborate than the screening of sperm donors. *Id.* at 180-83, 230.

⁷³ CHOOSING ASSISTED REPRODUCTION, *supra* note 16, at 212.

⁷⁴ RESOLVING INFERTILITY, *supra* note 2, at 280.

⁷⁵ Surrogates are typically paid a fee. The fee varies and can range from \$10,000 to \$25,000, with additional amounts paid for carrying multiples. Janet Zimmerman, *Path to Parenthood: An Inland Woman Steps In as a Surrogate to Help Other Couples Have Children*, PRESS ENTERPRISE (Riverside, CA), June 23, 2002, at E01 (surrogates are paid about \$20,000); Brian M. Schleter, *The Business of Babies*, THE CAPITAL (Annapolis, MD), August 6, 2001, at A1 (surrogate fee is \$10,000 to \$25,000); Liz Doup, *The New Extended Family*, SUN-SENTINEL (Fort Lauderdale, FL), April 6, 2003, at 1E (typical surrogate fee is \$15,000 to \$18,000, with extra compensation for carrying multiple fetuses).

C. The cost of medical treatment for infertility.

Financial pressures add additional stress to fertility treatment. Some fertility treatment is moderately priced, but other fertility treatment is very expensive. Consider the costs of several of the most common fertility treatments. The cost of clomiphene citrate for one month of treatment is usually between \$60 and \$200.⁷⁶ An IUI procedure usually costs a few hundred dollars.⁷⁷ Surgery to open a woman's blocked fallopian tubes costs \$10,000 to \$15,000.⁷⁸ The costs of injectable ovarian stimulation drugs for one month of treatment can total several thousand dollars.⁷⁹ Surgery to repair varicocele (testicular varicose veins) typically costs \$5,000 to \$8,000.⁸⁰ In many cases, conventional treatments enable the couple to have a child, but if various conventional treatments do not work, couples sometimes try assisted reproductive technologies.

Assisted reproductive technologies are very expensive.⁸¹ The cost of a single IVF procedure is typically around \$10,000, and infertile patients often do numerous procedures.⁸² ICSI adds about \$2,500 to the cost of a single IVF cycle.⁸³ In egg donor and surrogacy procedures, the intended parents incur additional expenses,⁸⁴ the largest of which is the fee paid to the egg donor or surrogate. 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.⁸⁵ The fee for surrogates also varies, but is usually in the \$10,000 to \$25,000 range.⁸⁶

⁷⁶ Patients take one to four pills for five days. The cost for one pill a day is \$15 to \$50. RESOLVING INFERTILITY, *supra* note 2, at 104.

⁷⁷ *Price of Infertility*, *supra* note 5, at 50.

⁷⁸ Vickie Chachere, "Test Tube" Babies Began 20 Years Ago, TAMPA TRIB., Jul. 25, 1998 (Nation/World section), at 1.

⁷⁹ JOAN LIEBMAN-SMITH ET AL., THE UNOFFICIAL GUIDE TO OVERCOMING INFERTILITY 320 (1999) [hereinafter, UNOFFICIAL GUIDE]

⁸⁰ Chachere, *supra* note 78.

⁸¹ Assisted reproductive technology expenses include: (1) the costs of various prescription drugs, including the drugs that are 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 for the egg extraction and implantation. UNOFFICIAL GUIDE, *supra* note 79, at 315-20.

⁸² RESOLVING INFERTILITY, *supra* note 2, at 303; *Price of Infertility*, *supra* note 5, at 50.

⁸³ *Price of Infertility*, *supra* note 5, at 50.

⁸⁴ 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. UNOFFICIAL GUIDE, *supra* note 79, at 320.

⁸⁵ 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, at N3 (describing full-page advertisements that were run in the Stanford campus newspaper); Kenneth R. Weiss, *Eggs Buy a College Education*, L.A. TIMES, May 27, 2001 at A1 (with photographs of advertisements offering up to \$100,000 to potential donors). Very few donors are paid such high fees; fees of \$3,500 or less are more common. *Id.* at 30, 31.

⁸⁶ See, e.g., Zimmerman, *supra* note 75, at E01 (surrogates are paid about \$20,000); Schleter, *supra* note 75, at A1 (surrogate fee is \$10,000 to \$25,000); Erica Noonan, *Breathing Life Into Hopes For A Family: Rare Lung Disease Won't Derail Goal*, BOSTON GLOBE, April 13, 2003, Globe Northwest Section, at 1 (cost of surrogacy procedure to overcome infertility can exceed \$40,000).

Insurance does not usually cover fertility treatments per se,⁸⁷ although insurance may pay for treatment of certain disorders, such as endometriosis, that can cause infertility.⁸⁸ Fertility patients therefore must pay for most of their fertility treatment. Patients are willing to spend vast sums of money to increase their chances of conceiving and bearing a child, even though two in five are never able to conceive and bear a child.⁸⁹ Patients often spend more than \$30,000 for treatment.⁹⁰

This willingness to pay large amounts for fertility treatment creates intense financial pressures for infertile patients. Patients often have to defer any non-medical expenses they can.⁹¹ In addition, patients may rely more heavily on less expensive treatments, like IUI after ovulation induction with clomiphene, even though that treatment is not effective for certain types of infertility problems.⁹² 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 infertility problem.⁹³ For example, where insurance covers the tubal surgeries but not IVF, a woman with blocked fallopian tubes may have several tubal surgeries to try to repair the tubes, instead of bypassing the tubes with IVF. The financial pressures cause strain over time.⁹⁴

⁸⁷ Insurance contracts often specifically exclude fertility treatment from coverage .

⁸⁸ Peter J. Neumann, *Should Health Insurance Cover IVF? Issues and Options*, 22 J. HEALTH POL. POL'Y & L. 1215, 1217-18 (1997).

⁸⁹ *Id.* at 1223. Neumann cites studies in which survey respondents indicated that they would pay very large sums to increase their chances of having a child. For example, he 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.

⁹⁰ *Price of Infertility*, *supra* note 5, at 50.

⁹¹ RESOLVING INFERTILITY, *supra* note 2, at 305. In order to fund their care, they may rent rather than buy a home, defer purchases like furniture or cars, not take expensive vacations, dip into retirement savings, or borrow from family or friends. *Id.* at 305-306.

⁹² *Id.* (Multiple cycles of IUI with blocked fallopian tubes are “a waste.”) The staff of RESOLVE note, in their book:

It is tempting to make dollar-based decisions, especially if your budget is already strained. It is more important to look at what you get when you write that check however. The least expensive alternatives may not turn out to be the least effective. If they work for you, great. But if they do not, the costs can quickly add up to equal or exceed what you would have paid for more expensive, although more effective treatment. It is a lesson many people learn the hard way.

Id. at 304.

⁹³ *Id.* .

⁹⁴ *Id.* at 306.

[Evi] estimates her current pregnancy has cost more than \$60,000 so far. “We don’t have much furniture in our house and we don’t take vacations. But it’s been very trying, very difficult. Now that I’m pregnant, we have no problems in our relationship. Before, we fought all the time about the infertility, mostly about the money.

Id.

Taxpayers may be able to recoup some of their fertility treatment costs under the tax code. Part III will consider whether fertility treatment costs are deductible or reimbursable under current law.

III. The Tax Treatment of Fertility Treatment Costs under Current Law.

A. The tax treatment of medical expenses.

Internal Revenue Code (IRC) section 262 provides that taxpayers generally may not deduct personal expenses.⁹⁵ Section 213 provides, however, that taxpayers can deduct their expenses for medical care (*i.e.*, care of the taxpayer, his spouse, or a dependent) to the extent those expenses exceed 7.5 percent of adjusted gross income.⁹⁶ For example, assume that a taxpayer in the 35 percent tax rate bracket has \$100,000 of adjusted gross income 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 adjusted gross income) by \$10,000. That deduction reduces the taxpayer's taxable income by \$10,000, which saves the taxpayer \$3,500 in taxes.

Taxpayers who participate in medical flexible spending accounts are reimbursed for their medical expenses.⁹⁷ The reimbursements from medical flexible spending accounts are funded by pre-tax deductions from the participants' income, so the participation in the medical flexible spending account allows the participants to pay medical expenses out of pre-tax dollars. For example, assume that a taxpayer in the 35 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

⁹⁵ I.R.C. § 262 (2000).

⁹⁶ I.R.C. § 213 (2000). 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 pay whichever tax liability is higher. I.R.C. § 55(a) (2000). The base of the AMT, "alternative minimum taxable income" (AMTI), is broader than under the regular income tax. I.R.C. §§ 55(b)(2), 56-58 (2000). The AMT tax rate for individuals is 26 percent on the first \$175,000 of the "taxable excess" and 28 percent of the "taxable excess" over \$175,000. I.R.C. § 55(b)(1)(A)(i) (2000). 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 AMTI). I.R.C. § 55(b)(1)(A)(ii), (b)(2), (d)(1), and (d)(3) (2000) (amended 2001). For purposes of the regular income tax, medical expenses can be deducted only to the extent they exceed 7.5 percent of the taxpayer's Adjusted Gross Income (AGI). For purposes of the AMT, medical expenses can be deducted only to the extent they exceed 10 percent of the taxpayer's Adjusted Gross Income (AGI). I.R.C. § 56(b)(1)(B) (2000).

In *Klaassen v. Commissioner of Internal Revenue*, 182 F. 3d 932 (10th Cir. 1999), taxpayers with AGI of \$83,056.42, many children, and medical expenses were subject to the AMT. The taxpayers, a husband and wife, had ten dependents and claimed twelve personal exemptions on their tax return. 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 percent of \$83,056 AGI). Under the regular income tax, they owed \$5,111. 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 10 percent of \$83,056 AGI).

⁹⁷ I.R.C. § 105 (2000).

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 that is 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). The reimbursement from the medical flexible spending account must be for expenses attributable to “medical care,” as that term is defined in section 213.⁹⁸

B. The characterization of fertility treatment expenses as medical expenses.

The characterization of some fertility treatment expenses as section 213 medical expenses is unsettled. There are no reported cases that squarely address the issue, and IRS administrative pronouncements have reached conclusions that are seemingly inconsistent. In 1957, the IRS ruled that the costs of IUI are not medical expenses.⁹⁹ Recently, the IRS stated, in a publication for taxpayers about deducting medical expenses, that the costs of fertility treatment are medical expenses.¹⁰⁰ 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 donor, are medical expenses.¹⁰¹ 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.¹⁰² The IRS is not bound to follow the position it has taken in private letter rulings¹⁰³ or in taxpayer publications,¹⁰⁴ and the single litigated case was settled, so the tax characterization of fertility treatment costs as medical expenses is not clear.

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 the body.”¹⁰⁵ The first prong of this two-part

⁹⁸ I.R.C. §§ 105(b), 125 (2000). The 7.5 percent floor of § 213 does not apply to these reimbursements.

⁹⁹ Private Letter Ruling 5707244900A (1957 PLR LEXIS 736).

¹⁰⁰ DEPARTMENT OF THE TREASURY, IRS PUBLICATION 502, MEDICAL AND DENTAL EXPENSES (FOR USE IN PREPARING 2002 RETURNS).

¹⁰¹ Private Letter Ruling 200318017 (Release Date: January 09, 2003) (available in LEXIS, citation 2003 TNT 86-12, May 5, 2003).

¹⁰² *Sedgwick v. Commissioner*, *supra* note 8.

¹⁰³ Private letter rulings may not be used or cited as precedent. I.R.C. § 6110(k)(3). Saltzman notes that the IRS sometimes considers such rulings internally, however, to determine its position on an issue. MICHAEL I. SALTZMAN, *IRS PRACTICE AND PROCEDURE* ¶ 3.03[3][c] and n. 56 (student ed. 1991).

¹⁰⁴ *See, e.g., Adler v. Commissioner*, 330 F.2d 91 (9th Cir. 1964) (language in a taxpayer publication does not bar the government from making a contrary argument based on the statutory language in the Internal Revenue Code); *see also* SALTZMAN, *supra* note 103, at ¶ 3.04[8] (taxpayer publications “perform a useful and laudable function” but “may not be relied on by taxpayers in planning future transactions”). *Id.*

¹⁰⁵ I.R.C. § 213(d)(1)(A) (2000). Treasury Regulation § 1.213-1(e) tracks this statutory language. Prescription drug expenses are treated as medical expenses, but over-the-counter drug expenses are not considered to be medical expenses for purposes of § 213. I.R.C. § 213(b) (2000).

definition is potentially underinclusive if read literally and narrowly, because it might fail to characterize as medical expenses the costs of medically treating injuries, conditions and defects. The Treasury Department has resolved some of this underinclusiveness problem by interpreting the term “disease” broadly to include conditions (including those caused by personal injury), impairments, and disorders.¹⁰⁶

The potential underinclusiveness of the first prong of the definition is, to some extent, offset by the broad second prong of the definition. This second part of the definition would correctly characterize 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 part of the section 213 definition would even characterize as medical expenses the costs of cosmetic surgery.¹⁰⁷

Consistent with this interpretation of section 213, the IRS ruled that the costs of cosmetic surgery were medical expenses under the “structure or function” prong of the definition.¹⁰⁸ 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 section 213 to specifically exclude “cosmetic surgery or other similar procedures” from the definition of medical expenses.¹⁰⁹

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 section 213 that medicine and drug costs are medical expenses only if the drugs are prescription drugs.¹¹⁰

The Treasury Department has also excluded from the definition of medical expenses any expenses incurred for the general well-being of the taxpayer.¹¹¹ Treasury Regulation section 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. . . . [A]n expenditure which is merely beneficial to the general health of an individual, such as an expenditure for a vacation, is not [deductible].”¹¹² For example, the cost of a gym membership is not a medical expense, despite the fact that exercise will improve the taxpayer’s health.¹¹³ On the other hand, the cost of a weight loss program for

¹⁰⁶ For example, Treasury Regulation § 1.213-1(e)(1)(v)(a) states that: “the 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. . . .” (emphasis added)

¹⁰⁷ Law professors who teach the basic income tax class like to give other extreme *reductio ad absurdum* examples of the overinclusiveness of the second prong of the medical expenses 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.

¹⁰⁸ Rev. Rul. 76-332, 1976-2 C.B. 81 (1976). See also G.C.M. 36515 (1975).

¹⁰⁹ I.R.C. § 213(d)(9)(A) (2000).

¹¹⁰ I.R.C. § 213(b) (2000).

¹¹¹ Treas. Reg. § 1.213-1(e)(1)(ii).

¹¹² *Id.*

¹¹³ Rev. Rul. 79-151, 1979-1 C.B. 116 (1979).

an obese taxpayer is a medical expense because obesity is recognized by doctors as a disease or condition.¹¹⁴

Much of the case law under section 213 involves taxpayers trying to deduct as a medical expense the cost of an item, such as a pool or a vacation, that is usually purchased for non-medical personal reasons.¹¹⁵ 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. 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 the body 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 for the other, thus eliminating expense incurred for general, as contrasted with some specific, physical improvement?”¹¹⁶

Section 213 cases and rulings also indicate that fees paid to non-medical providers are deductible as medical expenses only if the services provided by the person are necessary to treat the taxpayer’s medical condition. (This group of cases and rulings involves expenses incurred for items that are not “recreational” but may nonetheless be characterized as either personal or medical.) For example, in *Gerstacker v. Commissioner*, the court held that the taxpayers could take a section 213 deduction for the legal fees they paid to establish a guardianship for Mrs. Gerstacker, so that she could

¹¹⁴ Rev. Rul. 2002-19, 2002-1 C.B. 778 (2002).

¹¹⁵ See, e.g., *Evanoff v. Commissioner*, 44 T.C.M. (CCH) 1394 (1982) (in which the tax court denied a medical expense deduction for a home pool because there was a community pool nearby).

¹¹⁶ *Havey v. Commissioner*, 12 T.C. 409 (1949). Mr. and Mrs. Havey lived in Pittsburgh. Mrs. Havey had heart disease. Her doctor recommended that she go to the seashore in the summer and Arizona in the winter. The court held that the taxpayer could not deduct the cost of vacations in New Jersey and Arizona, despite the doctor’s recommendation. The court noted that: Mr. and Mrs. Havey had vacationed in New Jersey and Arizona before Mrs. Havey was diagnosed with heart disease; the Haveys took the first of the three vacations long after Mrs. Havey’s heart disease was diagnosed; the Haveys traveled to Arizona during late November and December, instead of during the coldest part of the winter; and Mrs. Havey did not seek out the services of any medical professionals on the trips. Although the court noted that the vacations probably improved Mrs. Havey’s health, the court concluded that the medical benefit of the vacations was incidental, so the taxpayers could not deduct the cost of the vacations as medical expenses.

be committed to a mental institution and receive the medical care she needed.¹¹⁷ On the other hand, the court, in *Levine v. Commissioner*, denied the taxpayers a medical expense deduction for fees they paid to a lawyer to help their mentally ill son with activities such as filling prescriptions, paying bills, buying clothes, hiring a housekeeper, and finding a job.¹¹⁸

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, not pure personal consumption motives.¹¹⁹ 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 non-medical reasons as medical expenses. This is what prompted Congress to amend section 213 in 1990 to provide specifically that the costs of cosmetic surgery are not section 213 medical expenses.¹²⁰

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 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."¹²¹ 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."¹²² This means that Congress in 1990 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.

Said another way, 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 section 213. For example, the section 213 regulations provide: "[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."¹²³

¹¹⁷ In *Gerstacker v. Commissioner*, 414 F.2d 448 (6th Cir. 1969), *rev'd* 49 T.C. 522 (1968). In Rev. Rul. 71-281, 1971-2 C.B. 165 (1971), the IRS ruled that it would follow the appellate court decision in *Gerstacker*.

¹¹⁸ 695 F.2d 57, 61 (2d Cir., 1982), *aff'd* 42 T.C.M. 763 (1981), *cert. denied*, 462 U.S. 1132 (1983).

¹¹⁹ Professor Kelman has challenged this assumption, pointing out the income elasticity and price elasticity of medical care. 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, 866-68 (1979).

¹²⁰ Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 11342(a), 104 Stat. 1388-471 (1990).

¹²¹ I.R.C. § 213(d)(9)(B) (2000).

¹²² *Id.* The IRS ruled in 1996 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. Private Letter Ruling 9625049, 1996 PRL LEXIS 518 (1996).

¹²³ Treas. Reg. § 1.213-1(e)(1)(v)(a) (emphasis added).

The section 213 regulations, revenue rulings, and case law also indicate that the cost of a *substitute* for the taxpayer's diseased or impaired body part is a medical expense. In Rev. Rul. 68-452,¹²⁴ the taxpayer received a kidney transplant and paid the travel, surgical, and hospital expenses of the kidney donor. The IRS ruled that the taxpayer could deduct the expenses attributable to the donor but paid by the taxpayer, under section 213.¹²⁵ 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 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 another person, the donor.

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 of the costs of care that "mitigates" or "ameliorates" the taxpayer's disease, condition or impairment. For example, the section 213 regulations specifically provide that taxpayers can take a medical expense deduction for the cost of a seeing eye dog.¹²⁶ In Rev. Rul. 64-163,¹²⁷ the IRS ruled that the taxpayers could deduct the amounts they paid to a person who served as a blind student's guide at school. The tax court has held that taxpayers could deduct the amounts they paid to a person who took class notes for their deaf child.¹²⁸ These various costs for substitutes for normal functioning do not affect the structure or function of the taxpayer's body, but qualify as medical expenses because the items in question mitigate a disease, condition, or impairment under the first prong of the definition. Note that in all of these examples, the payments are being made to non-medical providers, but the expenses are incurred for care. These examples are thus distinguishable from cases such as *Gerstacker*, because, in those cases, the payments that were made to non-medical providers were not for the care of the patient; instead, the expenses were for services that were *ancillary* to the care of the patient.

Next, we will consider how these rules and principles are applied to characterize the costs of fertility treatment.

2. Application to fertility treatment expenses.

a. Application to fertility treatment expenses in general.

First, consider the characterization of the costs of fertility treatment that does not involve a donor or surrogate. The costs are medical expenses under either prong of the section 213 definition. The purpose of non-third-party fertility treatment is to help the woman patient become pregnant and give birth to a child, so the treatment costs are incurred "for the purpose of affecting any structure or function of the [taxpayer's]

¹²⁴ Rev. Rul. 68-452, 1968-2 C.B. 111 (1968).

¹²⁵ *Id.*

¹²⁶ Treas. Reg. § 1.213-1(e)(1). It is irrelevant whether the blindness was caused by disease or injury, or was congenital. *Id.*

¹²⁷ Rev. Rul. 64-163, 1964-1 C.B. 121 (1964).

¹²⁸ *Baer Est. v. Commissioner*, 26 T.C.M. (CCH) 170, 173 (1967).

body”¹²⁹ Fertility treatment costs also qualify as medical expenses under the first prong of the section 213(d) definition: infertility is recognized by the medical profession as a disease or condition,¹³⁰ and fertility treatment costs are incurred for the diagnosis, cure, mitigation, or treatment of that disease or condition. The costs of the initial physician and laboratory workup are incurred to diagnosis the specific cause of the infertility. Some infertility treatment, such as surgical repair of blocked fallopian tubes, endometriosis, or varicocele, “cures” or “treats” the disease or condition of infertility. Some conventional treatments and assisted reproductive technologies do not “cure” the disease or condition of infertility, but “mitigate” it.

In spite of the fact that fertility treatment expenses seem to fit the medical expense definition, the IRS could argue that the fertility treatment expenses are nonetheless not deductible under section 213, because the decision to bear children is a nondeductible personal *consumption* decision instead of a *medical* decision.

The tax law, for purposes of defining the scope of the *business* expense deduction,¹³¹ has consistently treated child-rearing as a form of personal consumption. Since 1940, when *Smith v. Commissioner* was decided, the tax law has treated child care expenses as nondeductible personal consumption expenses, not as deductible business expenses.¹³² In that case, Mr. and Mrs. Smith had to pay for child care so that they could both work. They argued that their child care costs should be deductible as business expenses. 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.”¹³³

How could the IRS make this consumption argument in the context of the medical expense deduction? First, the IRS could argue that fertility treatment is within the cosmetic surgery exception of section 213(d)(9) because fertility treatment is a lifestyle choice and is thus “similar” to cosmetic surgery. Recall that section 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.”¹³⁴ Section 213(d)(9)(B) defines cosmetic

¹²⁹ I.R.C. § 213(d)(1)(A) (2000).

¹³⁰ The American Society of Reproductive Medicine, a non-profit organization of scientists, doctors, nurses, and other health professionals, characterizes infertility as a “disease of the reproductive system.” ASRM Resources for Patients, Frequently Asked Questions About Infertility at <http://www.asrm.org/Patients/faqs.html#Q1> (last visited Apr. 3, 2003).

¹³¹ Taxpayers deduct their ordinary and necessary business expenses under I.R.C. § 162 (2000).

¹³² *Smith v. Commissioner*, 40 B.T.A. 1038 (1938), *aff’d per curiam*, 113 F. 2d 114 (2d Cir. 1940).

¹³³ *Id.* at 1039. Professor Douglas Kahn summarizes the tax law’s treatment of child care costs in this way:

While the expenses of caring for children may be a necessary cost of freeing the parent from the home so that he can earn income, it is also 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 434, §10.2000 (4th ed. 1999).

¹³⁴ I.R.C. § 213(d)(9)(B) (2000).

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

The scope of section 213(d)(9), however, is too narrow for this argument to succeed. “Similar” in the context of section 213(d)(9) means procedures other than cosmetic surgery that are “directed at improving the patient’s appearance and [do] not meaningfully improve the proper function of the body,”¹³⁵ such as liposuction and hair transplants. The legislative history of this amendment to section 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.¹³⁶

Note that 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 function of the body. In other words, the cosmetic surgery amendment was supposed to limit the “structure or function” prong of the medical expense definition, not the first prong of the definition. (Said another way, the amendment limited the overbreadth of the second prong.) The cost of breast augmentation cannot qualify as medical expenses because the cost: (1) is not incurred because of disease or a medical condition, so is not within the first prong of the definition; and (2) does not affect the functioning of the body, so is not within the second prong of the definition.

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 medical expenses. Fertility treatment expenses, other than the costs of surrogacy, could be characterized as medical expenses under the “structure or function” prong of the definition, but all fertility treatment expenses can also be characterized as medical expenses under the first prong of the definition because fertility treatment costs are incurred for the diagnosis, cure, mitigation, or treatment of the disease or medical condition of infertility.¹³⁷

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 that fertility treatment

¹³⁵ *Id.*

¹³⁶ H.R. Rep. No. 101-37 (1990).

¹³⁷ The IRS might argue that fertility treatment is analogous to cosmetic surgery because fertility treatment is not a life or death matter for the infertile patient. On the other hand, cosmetic surgery is the only type of medical expense specifically addressed in § 213. Since Congress specifically excluded cosmetic surgery from the definition of medical care when it amended § 213 in 1990, the Congressional failure to exclude fertility treatment from the definition of medical care may have been deliberate. As the old maxim of statutory construction goes, *expressio unius, exclusio alterius*. See, e.g., GAIL LEVIN RICHMOND, FEDERAL TAX RESEARCH 40 (5th ed. 1997), citing *Becker v. United States*, 451 U.S. 1036 (1981).

expenses are therefore not deductible as medical expenses.¹³⁸ This argument is consistent with one of the views expressed in the exchange of e-mails on the tax professor list service: the idea was that a person can lead a “normal” life without ever having children, so the choice of whether to bear children is a consumption decision, not a medical decision. Note that, if this argument were persuasive, 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 medical expenses that relate to sexual conditions or dysfunction, such as the cost of Viagra, because a person can also lead a “normal” life without being sexually active.

Insurance companies have taken inconsistent positions regarding coverage of treatments that relate to reproductive choice. The majority of insurance plans cover abortion, vasectomy, and tubal ligation;¹³⁹ Fewer plans cover contraceptives and very few plans cover fertility treatment such as IVF.¹⁴⁰ 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.¹⁴¹ Insurance companies and employers who purchase insurance for their employees take into account the cost of treatments when they determine the coverage of plans. Given their need to ration care, it is not surprising that many insurance companies have not wanted to cover expensive treatments like IVF and widely used, low-cost treatments such as contraceptives. On the other hand, insurers have covered the costs of Viagra.¹⁴² According to an insurance industry spokesperson explaining the differing treatment of Viagra and contraceptives: “There is a clear distinction between Viagra, . . . approved as a cure for a medical dysfunction, and contraception, . . . a 'lifestyle drug.'”¹⁴³

During an e-mail discussion of this tax issue on the tax law professor list service, a prominent tax professor similarly took the position that fertility treatment costs are not deductible as medical expenses because fertility treatment constitutes a lifestyle choice, not medical treatment.¹⁴⁴ The professor also expressed the view that the cost of Viagra could be deductible as a medical expense when used to treat sexual dysfunction.¹⁴⁵

¹³⁸ Treasury Regulation § 1.213 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).

¹³⁹ Bob Rosenblatt, *Viagra Spurs New Questions About HMO Drug Coverage*, L.A. TIMES, June 8, 1998, at S8.

¹⁴⁰ *Id.*

¹⁴¹ Marie McCullough, *Infertile Couples Have New Ammo in Pushing for Insurance Coverage*, THE KNIGHT RIDDER/TRIBUNE NEWS SERVICE, July 9, 2000, at KR-K7973.

¹⁴² Paul Rauber, *It's a Man's World*, SIERRA, Sept.-Oct. 1998, at 20.

¹⁴³ Statement of Richard Coorsh, a spokesperson for the Health Insurance Association of America. Debra Baker, *Viagra Spawns Birth Control Issue*, 84 A.B.A. J. 36, 136 (1998).

¹⁴⁴ The professor said, “I suppose reproduction is a bodily function, but it is one the exercise of which is purely optional -- a lifestyle choice.” E-mail submission from Professor Joseph Dodge, Florida State University College of Law, to Taxprof, a closed Internet discussion group for tax law professors at AALS-accredited law schools (Apr. 20, 2000) (copy on file with author).

¹⁴⁵ *Id.* Professor Dodge took the position 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. He posited that expenditures for treatment that merely

The argument is that the cost of medical care that furthers reproductive choice is not deductible under section 213 where the medical care does not repair or treat a disease or a condition. Applying this approach, the cost of contraceptives, vasectomies, and tubal ligations would not be deductible. On the other hand, Viagra and IVF both ameliorate a disease or condition; the costs of fertility treatment to treat reproductive dysfunction may be deductible if the costs of Viagra to treat sexual dysfunction are deductible. (Viagra and IVF both simulate normal functioning by temporarily bypassing but not curing the underlying medical problem.¹⁴⁶)

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. The types of expenses involved in these cases, such as the cost of a pool, vacation, golf, gym membership, or 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. In contrast, a court applying the factors from these cases to fertility treatment expenses would conclude that: (1) the taxpayers' 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.¹⁴⁷

Said another way, pools, vacations, and golf are typically purchased primarily for fun, and only incidentally for health benefits, by healthy individuals; IVF, egg donor, and surrogacy procedures, on the other hand, are not undertaken by healthy individuals for fun. (In this respect, fertility treatment presents a clearer case for deduction that does Viagra, because many men who do not suffer from erectile dysfunction are using Viagra "recreationally."¹⁴⁸) If a doctor told an infertile patient to take a vacation in Hawaii to

counteracts the effects of aging are not deductible, but noted that erectile dysfunction is, in some cases, not age-related. *Id.*

¹⁴⁶ Erectile dysfunction has a variety of causes including diabetes, prostate disorders, side effects of medications, and psychological disorders. Viagra does not cure these disorders. It creates a temporary erection by blocking a specific enzyme in the penis. John Simons, *Taking on Viagra*, FORTUNE, June 9, 2003, at 110.

¹⁴⁷ *Havey v. Commissioner*, 12 T.C. 409 (1949).

¹⁴⁸ Christine Gorman, *Viagra Turns 5; Early Safety Concerns Proved Baseless, and Now the Competition Is Heating Up*, TIME MAGAZINE, Jan. 20, 2003, at 146.

One trend that has started to worry public-health officials, however, is the growing recreational use of Viagra in some settings. Gay men seem to be at the vanguard of this trend. 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,"

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.¹⁴⁹

The IRS has taken seemingly inconsistent positions on the characterization of the costs of reproductive medical care as deductible medical expenses. The section 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. . . .”¹⁵⁰ In other words, medical obstetrical care of a woman who is already pregnant is medical care.

Over the years, the IRS has changed its position on the deductibility of costs of medical care that permits reproductive choice. In 1957, the IRS ruled that the 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.”¹⁵¹ In other words, the IRS, in 1957, did not regard infertility as a defect or illness. The medical profession today recognizes infertility as a disease or medical condition, so the reasoning of the 1957 ruling may lead to a different conclusion today.

The IRS also issued a series of revenue rulings in the early 1970s, following the Supreme Court decision in *Roe v. Wade*.¹⁵² In these rulings, the IRS ruled that the costs of contraceptives, abortions, vasectomies, and sterilizations all qualify as section 213 medical expenses.¹⁵³

In addition, 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.¹⁵⁴ The publication states that section 213 medical expenses include “the cost of

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.

¹⁴⁹ During an e-mail exchange on the Taxprof list serve, Professor Joe Dodge argued: “I suppose reproduction is a bodily function but it 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 of Law, to Taxprof, a closed Internet discussion group for tax law professors at AALS-accredited law schools (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 such items are typically purchased by healthy individuals for fun, not for medical reasons. These expenditures are thus distinguishable from expenditures for medical fertility treatment under the § 213 cases.

¹⁵⁰ Treas. Reg. § 1.213-1(e)(1)(ii). The language in the regulation was promulgated before fertility treatment was common, so the term “obstetrical expenses” does not necessarily include fertility treatment expenses. Treasury Regulation § 1.231-1 was promulgated by the Treasury Department on December 14, 1957, T.D. 6279, 22 F.R. 10052.

¹⁵¹ Private Letter Ruling 5707244900A (1957 PLR LEXIS 736).

¹⁵² 410 U.S. 113 (1973.)

¹⁵³ See, e.g., Rev. Rul. 73-200, 1973-1 C.B. 140 (1973) (cost of birth control pills is a medical expense under § 213).

¹⁵⁴ DEPARTMENT OF THE TREASURY, IRS PUBLICATION 502, MEDICAL AND DENTAL EXPENSES (FOR USE IN PREPARING 2003 RETURNS).

... procedures to overcome your inability to have children,” specifically including IVF.¹⁵⁵

For purposes of characterizing costs as deductible medical expenses, the appropriate baseline in section 213 is a baseline of *normal biological functioning*.¹⁵⁶ The section 213(d)(1)(A) definition must be read in light of the benchmark of normal biological functioning. Recall that the costs of cosmetic surgery were thought to qualify as medical expenses, prior to the amendment, under the “structure or function” prong of the definition. For purposes of the Federal Trade Commission definition of a “drug” (from which the section 213 definition of medical care was borrowed),¹⁵⁷ a substance that affects the structure of the body should be treated as a drug – even if it does not affect the functioning of the body. *For purposes of section 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 affects the structure of the body and affects the function of the body.

Cosmetic surgery does affect the “structure” of the body, but is not medical care for purposes of section 213 because it does not affect normal biological functioning. The change in the structure of the body just affects appearance. In terms of normal biological functioning, large breasts and small breasts have the same function and large noses and small noses have the same function.

On the other hand, if 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 section 213, but a breast reconstruction surgery following surgical removal of breast cancer is medical care. The standard is not whether the patient would die or would appear in public to be disabled without treatment; the standard is whether the treatment is necessary to restore or approximate normal biological functioning.¹⁵⁸

Reproduction is part of normal biological functioning. Opinions in disability law and constitutional law cases can be cited for the proposition that reproduction is not only

¹⁵⁵ *Id.* at 6. 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.

¹⁵⁶ For example, recall that Treasury Regulation § 1.213-1(e)(1)(v)(a) 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.” (emphasis added)

¹⁵⁷ BORIS I. BITTKER & LAWRENCE LOKKEN, 2 FEDERAL INCOME TAXATION OF INCOME, ESTATES AND GIFTS, ¶ 36.1.2, text at n.9 (2000), citing 15 U.S.C. § 55(c) (LEXIS through P.L. 108-30, approved May 29, 2003).

¹⁵⁸ Recall that expenses for care that affects a structure of the body are within the § 213 definition of medical care – even if the care does not affect the functioning of the body. Medical care, for purposes of § 213, should not include care that affects the structure of the body but not functioning. Breast reconstruction surgery affects the structure of the body, but it also helps to repair a disfigurement that is caused by disease. It also helps the patient restore some of the bodily integrity lost in the cancer surgery and may permit the patient to resume normal sexual functioning. Regular cosmetic surgeries do not affect the functioning of the body. The cosmetic surgery amendment addresses one aspect of the overbreadth in the “structure and function” prong of the definition by specifically excluding cosmetic surgery from the definition of medical care.

a normal 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).¹⁵⁹ A person is disabled 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."¹⁶⁰ The ADA does not define the operative terms in this definition, so courts have had to interpret the terms.¹⁶¹

Courts have interpreted the term "major life activity" under the ADA by comparing the activity in question to an illustrative list of "major life activities" in a Rehabilitation Act regulation.¹⁶² The list includes activities "such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working."¹⁶³ Some courts have defined "major life activity" narrowly to require a showing that the activity in question meet three requirements: (1) microfrequency; (2) macrofrequency; and (3) universality.¹⁶⁴ Other courts, including the U.S. Supreme Court,

¹⁵⁹ 524 U.S. 624 (1998). The respondent in the case, who was HIV positive, needed a cavity filled by the petitioner dentist. After disclosing her HIV status, the dentist informed her that he would fill the cavity only in the hospital, for which the respondent would have to an extra hospital fee. 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," 42 U.S.C. § 12182(a). The District Court granted summary judgment for the respondent and the First Circuit affirmed the decision. 912 F. Supp. 580 (Me. 1995); 107 F.3d 934 (1st Cir. 1997). The Supreme Court vacated and remanded the case so that the Court of Appeals could consider whether an exception to the ADA applied in the case.

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."

¹⁶⁰ 42 U.S.C. 12102(2). A similar definition is used in the Rehabilitation Act and the Fair Housing Act. 42 U.S.C. 12102(2) (defining the term "handicapped individual" for purposes of the Rehabilitation Act); 29 U.S.C. 706(8)(B) (defining the term "handicap" for purposes of the Fair Housing Act).

¹⁶¹ *Bragdon*, 524 U.S. at 632. Regulations promulgated by the Department of Health, Education, and Welfare define "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[;] genitō 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 HEW regulation. For further discussion of this part of the ADA test for disability, see Sarah Lynn Oquist, *Casenote: 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 (1999).

¹⁶² See, e.g., *Bragdon*, 524 U.S. at 638 (ADA must be construed in a manner that is consistent with Rehabilitation Act regulations).

¹⁶³ 45 CFR § 84.3(j)(2)(ii) (1997); 28 CFR § 41.31(b)(2) (1997).

¹⁶⁴ See *Krauel v. Iowa Methodist Medical Center*, 915 F. Supp. 102, 106 (S.D. Iowa 1995) (concluding that reproduction is not a "major life activity" because it is an activity engaged in only infrequently); *Zatarain v. WDSU-Television*, 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").

have interpreted the term “major life activity” more broadly to include any activity of “comparative importance.”¹⁶⁵

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”.¹⁶⁶ The petitioner argued that, for purposes of the ADA, “major life activity” means activities that have a “public, economic, or daily character.”¹⁶⁷ The Court disagreed, on the theory that “reproduction could not be regarded as any less important than working and learning,” which are listed as major life activities in the Rehabilitation Act.¹⁶⁸

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 161, at 1413, and cases cited in notes 537-540.

Courts have interpreted the “substantial limitation” requirement, to mean: “(i) unable to perform a major life activity that the average person in the general population can perform; or (ii) significantly restricted as to the 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].” This definition is derived from EEOC regulations which provide that the term “substantially limits” means: “(i) unable to perform a major life activity that the average person in the general population can perform; or (ii) significantly restricted as to the 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” with regard to the same major life activity. 29 C.F.R. 1630.2(j)(i), (ii).

¹⁶⁵ *Bragdon*, 524 U.S. at 638: “As the Court of Appeals held, ‘the plain meaning of the word “major” denotes comparative importance’ and ‘suggests that the touchstone for determining an activity’s inclusion under the statutory rubric is its significance.’ *Id.* Some commentators have criticized the broader definition of “major life activity.” See, e.g., Oquist, *supra* note 161, at 1412-15 (arguing for the narrower three-part test).

¹⁶⁶ *Bragdon*, 524 U.S. at 638.

¹⁶⁷ *Id.*

¹⁶⁸ Justice Kennedy noted:

[T]he ADA must be construed to be consistent with regulations issued to implement the Rehabilitation Act. See 42 U.S.C. § 12201(a). 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, defining term to include “functions such as caring for one’s self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.” 45 CFR § 84.3(j)(2)(ii) (1997); 28 CFR § 41.31(b)(2) (1997). As the use of the term “such as” confirms, the 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

Constitutional cases have also treated reproduction as profoundly important. For an example, in *Skinner v. Oklahoma ex re. Williamson*,¹⁶⁹ the Supreme Court struck down a forced sterilization statute. 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.”¹⁷⁰

Reproductive medical care sometimes facilitates pregnancy, by treating or bypassing a diseased or impaired reproductive system, allowing an infertile patient to achieve the “normal” state of pregnancy that fertile patients can achieve without any medical intervention. On the other hand, reproductive medical care sometimes prevents or ends pregnancy. In the context of reproductive functioning, “normal” reproductive functioning does not always mean “natural” reproductive functioning; in this context, normal means a state of the body (pregnant or not pregnant) that the patient can choose and achieve with medical assistance. Said another way, the section 213 definition of “medical care” includes medical intervention that facilitates reproductive choice.

Since the early 1970s, the IRS has consistently taken the position that the costs of medical treatment to *prevent* pregnancy are deductible under section 213. Similarly, the costs of medical treatment to *facilitate* pregnancy are also deductible. In fact, the argument for deductibility of fertility expenses is arguably stronger; unlike medical means of birth control, fertility treatment diagnoses, treats, or mitigates a disease or condition. In other words, fertility treatment is more like the example of Viagra being used to treat sexual dysfunction. It is irrelevant that some people who choose not to have

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.
524 U.S. at 639.

Chief Justice Rehnquist, concurring in the judgment but dissenting in part (joined by Justices Scalia and Thomas), took the position that reproduction may not be “major,” for purposes of the ADA “major life activity” test. In his view, “major” may mean “greater in quantity, number, or extent,” instead of “comparative importance,” as the majority assumed:

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.
524 U.S. at 660.

Justice O'Connor, concurring in the judgment but dissenting in part, 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:

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.
524 U.S. at 670.

¹⁶⁹ 316 U.S. 535, 536 (1942).

¹⁷⁰ *Id.* at 541.

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 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, the cost of that medical care is deductible under section 213.

With a section 213 benchmark of normal functioning, the IRS might try to distinguish between fertility treatment costs of pre-menopausal women and post-menopausal women.¹⁷¹ 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 50-year old woman cannot have children without an IVF procedure (and perhaps an egg donor) because of her age, the IRS may argue that fertility treatment enables the woman to approximate *supernormal* functioning. On the other hand, the activity, child bearing, is part of normal functioning.

Normal reproductive functioning incorporates reproductive choice.¹⁷² 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 that is 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, are medical care despite the fact that these disorders are “natural” in older people. In addition, hormone replacement therapy for post-menopausal women is treated as medical care.¹⁷³ Said another way, “[i]t is certainly ‘unnatural’ for post-menopausal women to give birth, but virtually every medical intervention is ‘unnatural’ to some degree.”¹⁷⁴ The only difference between the medical treatment of infertility of post-menopausal women and medical treatment of other disorders related to aging is that the other disorders entail loss of more day-to-day functioning; but nothing in section 213 makes deductibility turn on such a distinction.

b. Application to the expenses of donor and surrogacy 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 (which can include the donor's fee, the broker's fee, the fee for the donor's attorney, the cost of insurance for the donor, and medical care of the donor) are characterized as medical expenses under section 213. In a surrogacy procedure, there are two issues: (1) are any of the costs of the procedure characterized as medical expenses under section 213; and (2) if so, are the additional costs of using the surrogate (which can include the surrogate's fee, the surrogate's fee, the fee for the surrogate's attorney, the

¹⁷¹ Fertility of women declines with age, but more and more older women are having children. RESOLVING INFERTILITY, *supra* note 2, at 11, 14. The birthrate for 40 to 44-year-old women has increased 74 percent since 1981.

¹⁷² This argument is consistent with the position of the IRS that contraceptives, abortion, vasectomy, and sterilization expenses are all medical expenses.

¹⁷³ I.R.C. § 213(b) and (d)(3) (2000).

¹⁷⁴ HIGH-TECH CONCEPTION, *supra* note 35, at 162.

cost of insurance for the surrogate, and medical care of the surrogate) characterized as medical expenses?

The goal of a donor procedure is still for the woman taxpayer to conceive and bear a child, which changes the structure of the taxpayer's body, and the procedure is undertaken to ameliorate the taxpayer's infertility. The costs of the donor procedure, including the costs of care for the taxpayer and the donor and the related costs of using the donor, are thus medical expenses under either prong of the section 213 definition. The IRS has, at least for now, conceded this issue and allowed a medical expense deduction for the costs of an egg donor procedure.¹⁷⁵ On the other hand, in the unusual case in which the taxpayer pays a super-model egg donor or super-brainy egg donor an exorbitant fee, the IRS could still challenge the deduction for the donor's fee, on the theory that the extra amount paid to the donor for her beauty or brains is the analogue of cosmetic surgery.¹⁷⁶

¹⁷⁵ Private Letter Ruling 200318017 (January 9, 2003) (available in LEXIS, Tax Analysts, document number 2003 TNT 86-12 (May 5, 2003))(egg donor expenses and related costs are medical expenses).

¹⁷⁶ Patients trying to find an egg donor are typically looking for a proxy for themselves. Most couples try to find an egg donor who physically resembles the intended mother or father. CHOOSING ASSISTED REPRODUCTION, *supra* note 16, 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. For example, one couple seeking ovum donation was so intent on finding a Jewish donor (regardless of physical or other characteristics) that the husband wrote a personal letter to every rabbi whose name was on a long list of Jewish clergy. When this search proved fruitless, he went on the internet, against in search of a "Jewish egg." While some would question his search and suggest that he was "not ready for ovum donation," there is a long history in both sperm donation and adoption of couples who wish to create or adopt children who share their ethnic history.

Id.

Ironically, one of the notorious "top dollar" egg donor advertisements that specified that the donor should be at least 5'10" was for a 5'11" woman and her 6'5" husband. Kenneth R. Weiss, *Eggs Buy a College Education*, L.A. TIMES, May 27, 2001, A1 at A31. According to Darlene Pinkerton, the egg donor broker who placed the advertisement: "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.* The article goes on to state: "It is true, brokers say, that women of Asian descent look for donors with similar heritage. Jewish families want Jewish donors. Most women seek to match their height, hair and eye color, and most brokers encourage parents to pick donors who resemble them." *Id.* Families selecting a sperm donor also typically try to find a sperm donor who looks like the intended father. CHOOSING ASSISTED REPRODUCTION, *supra* note 16, at 190 (1998).

Surrogate procedures differ from non-surrogate procedures because the goal in a surrogate procedure is to have the surrogate, not the woman taxpayer, get pregnant and bear a child. If the woman taxpayer can produce eggs, some of the medical treatment affects the structure or function of the woman taxpayer's 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 woman 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, so none of the treatment affects the structure or function of the woman taxpayer's body.¹⁷⁷

The fact that some or all of the surrogacy expenses do not qualify under the second prong of the medical expenses definition is irrelevant, however, if the expenses qualify under the first prong of the definition. The characterization of these expenses under the first prong of the section 213 definition turns on whether infertility is regarded by the medical profession as a disease or condition.

Recall that the section 213 regulations, revenue rulings, and case law indicate that the cost of a *substitute* for the taxpayer's diseased or defective body part is a medical expense. The section 213 regulations specifically provide that taxpayers can take a medical expense deduction for the cost of a seeing eye dog or artificial teeth or limbs.¹⁷⁸ In Rev. Rul. 68-452,¹⁷⁹ the taxpayer received a kidney transplant and paid the travel, surgical, and hospital expenses of the kidney donor. The IRS ruled that the taxpayer could deduct the expenses attributable to the donor but paid by the taxpayer, under section 213. In Rev. Rul. 64-163,¹⁸⁰ the IRS ruled that the taxpayers could deduct the amounts they paid to a person who served as a blind student's guide at school. The tax court has held that taxpayers could deduct the amounts they paid to a person who took class notes for their deaf child.¹⁸¹

Whether payments for a "substitute" uterus or for "substitute" eggs or sperm are analogous to the sanctioned substitutes again depends on whether reproduction is part of normal functioning. As discussed earlier, courts would likely conclude that reproductive functioning is part of normal functioning. As one author has stated about surrogacy:

[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

While some patients try to have a child with more desirable traits than the patient has, those cases are the exception, not the rule. Kenneth R. Weiss, *Eggs Buy a College Education*, L.A. TIMES, May 27, 2001, A1 at A31.

¹⁷⁷ Where the surrogate supplies the eggs and carries the child, the procedure is sometimes an artificial insemination procedure, which is less costly than an IVF procedure.

¹⁷⁸ Treas. Reg. § 1.213-1(e)(1).

¹⁷⁹ Rev. Rul. 68-452, 1968-2 C.B. 111 (1968).

¹⁸⁰ Rev. Rul. 64-163, 1964-1 C.B. 121 (1964).

¹⁸¹ *Baer Est. v. Commissioner*, 26 T.C.M. (CCH) 170, 173 (1967).

social agreements can allow them to enjoy the same rights as couples who are fertile.¹⁸²

This “substitute for normal functioning” argument would support a deduction for the additional costs of a donor procedure,¹⁸³ and would support a deduction for all of the costs of a surrogacy procedure.¹⁸⁴

The IRS might try to distinguish the kidney donor ruling on the grounds that, in the case of a donor or surrogate procedure, some of the extra treatment costs are paid to non-medical parties, including the lawyer and broker for the donor or surrogate and the donor or surrogate herself.¹⁸⁵ The payment to the egg donor or surrogate is payment for a substitute for the taxpayer’s diseased or impaired body part, so it is deductible just as the costs of seeing eye dogs and human guides and note-takers are deductible. In these cases, the payment to the non-medical provider is for care that mitigates the taxpayer’s disease or condition.¹⁸⁶

These expenses are distinguishable from payments to non-medical providers that are not for care, but instead are for services that are ancillary to care. In the context of fertility treatment, the ancillary expenses paid to non-medical providers would include

¹⁸² 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).

¹⁸³ More specifically, this “substitute for normal functioning” argument would support a deduction for the typical additional costs from a donor procedure, but would not support the deduction of extra amounts expended to create a “designer baby.” This would not be a problem in most cases, because parents enlisting the assistance of an egg donor are usually trying to match themselves. This raises a difficult issue. A much-criticized egg donor advertisement offered \$50,000 for a donor with certain attributes, but it turned out that the intended mother also had those attributes. Kenneth R. Weiss, *Eggs Buy a College Education*, L.A. TIMES, May 27, 2001, A1 at A31. If the intended mother is tall, pretty, athletic, and scored 1400+ on the SAT, the intended parents may have to pay an unusually large fee to find an egg donor who “matches” the mother. In this example, the parents are approximating *their* normal functioning. On the other hand, 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, so 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.

¹⁸⁴ These third party costs are analogous to the extra costs of the donor in the kidney donor ruling. The medical treatment in the kidney donor ruling is a lifesaving treatment, while fertility treatment is not lifesaving treatment, but there is nothing in § 213 that distinguishes between lifesaving treatment and treatment of other kinds of diseases and conditions.

¹⁸⁵ 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. These additional amounts are paid to non-medical 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, than the fees paid to the non-medical 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.

¹⁸⁶ In the kidney donor ruling, the recipient of the kidney did not pay the kidney donor for the donated kidney.

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. Are these additional fees medical expenses?

Consider the section 213 cases and rulings that indicate that fees paid to persons who are not medical professionals are deductible as medical expenses only if the services provided by the person are necessary to treat the taxpayer's medical condition. In *Gerstacker v. Commissioner*, the appellate court held that the taxpayers could take a section 213 deduction for the legal fees they paid to establish a guardianship for Mrs. Gerstacker, so that she could be committed to a mental institution and receive the medical care she needed.¹⁸⁷ On the other hand, the court, in *Levine v. Commissioner*, denied the taxpayers a medical expense deduction for fees they paid a lawyer to help their mentally ill son with activities such as filling prescriptions, paying bills, buying clothes, hiring a housekeeper, and finding a job.¹⁸⁸ In both cases, the court was trying 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 non-medical providers in egg donor and surrogacy procedures because infertile patients do not usually resort to such procedures unless they offer the only way to overcome the patients' medical infertility.

One potential problem with the "substitute for normal functioning argument" 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. section 23, which provides for an adoption credit for part of the expenses incurred by parents adopting a child.¹⁸⁹ Intended parents whose child is carried by a surrogate, then adopted by the intended parents, cannot claim the section 23 credit.¹⁹⁰ The enactment of section 23 might seem inconsistent with the broadest definition of medical expenses under section 213. On the other hand, donor and surrogacy procedures can be distinguished from adoption procedures for purposes of section 213. In both donor and surrogacy procedures, the intended parents initiate a medical procedure to bear their own child. In adoption, the adoptive parents do not set in motion a medical procedure to bear their own child; instead they initiate a non-medical process that enables them to adopt the child of another person, the biological parent or parents of the child. Adoption expenses are not, therefore, characterized as medical expenses under section 213, even if the adoption results from the medical infertility of the adoptive parents.

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

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

¹⁸⁸ 695 F.2d 57, 61 (2d Cir., 1982), *aff'd* 42 T.C.M. 763 (1981), *cert. denied*, 462 U.S. 1132 (1983).

¹⁸⁹ I.R.C. § 23 (2000) (amended 2001).

¹⁹⁰ 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 not incurred in violation of State or Federal law or in carrying out any surrogate parenting arrangement."

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.¹⁹¹

On the other hand, the IRS challenged a taxpayer's medical expense deduction for fertility treatment expenses involving a surrogate in *Sedgwick v. Commissioner*.¹⁹² Jeanne and Walter Sedgwick had gone through six years of unsuccessful fertility treatment, including seven surgeries, two IVF procedures, and two dangerous ectopic pregnancies.¹⁹³ 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.¹⁹⁴ The IRS argued that the costs of the surrogacy were not deductible medical expenses because:

[S]urrogacy is an elective procedure. Having a child through a surrogate mother is not a diagnosis, cure, mitigation, treatment, or prevention 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.¹⁹⁵

In other words, the IRS took the position 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.

¹⁹¹ Statement made by Senator Reigle, one of the sponsors of the adoption credit bill. 140 Cong. Rec. S6602 (daily ed. June 8, 1994) (emphasis added).

¹⁹² *Sedgwick v. Commissioner*, No. 10133-94, LEXIS, 94 PTT 13-53 (U.S. Tax Court filed June 7, 1994). Judge Jacobs noted that the case was one of first impression. He asked Ms. Hustad, 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. Official Transcript of Case at 22, *Sedgwick v. Commissioner*, No. 10133-94, LEXIS, 94 PTT 13-53 (U.S. Tax Court filed June 7, 1994).

¹⁹³ *Id.* at 9, 10.

¹⁹⁴ *Id.* at 46, 49, 50. The facts of the case were a bit unusual because the taxpayers were able to establish that the surrogate was their dependent, for tax purposes, for the year in which the surrogate fees were incurred. A surrogate can qualify as a dependent of the infertile taxpayers only if the taxpayers' home is the surrogate's principal home during the calendar year in which dependency is claimed. I.R.C. § 151(a)(9) (2000). Given this requirement, surrogates would not usually qualify as dependents of the taxpayers.

¹⁹⁵ *Id.* at 26. The IRS also argued that the expenses of surrogacy also 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. *Id.* The surrogate involved in the Sedgwick case miscarried. Later, the Sedgwicks had a child with the help of another surrogate. *Id.*

On the witness stand, Jeanne Sedgwick described the eight difficult years of medical treatment she and her husband experienced. During her testimony, Mrs. Sedgwick cried as she recounted the wrenching course of her medical treatment, 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.¹⁹⁶ Mrs. Sedgwick then explained that her doctors had eventually given her the medical advice that she should use a surrogate.¹⁹⁷ After her testimony and a conference in the judge's chambers, the IRS settled the case entirely favorably to the taxpayers.¹⁹⁸

The facts in the Sedgwick case illustrate the progression of medical treatment of infertility as described above in Part II.B. Infertile patients endure years of medical treatment precisely because their bodies are unable biologically to do something that healthy bodies do naturally. Said another way, the medical treatment of infertility allows patients to achieve or approximate normal biological functioning.

In summary, fertility treatment costs are, under current law, section 213 medical expenses. The next part will consider whether fertility treatment costs *should* be treated as section 213 medical expenses.

IV. Should Fertility Treatment Costs Be Treated as Medical or Non-Medical Expenses?

A. The normative starting point.

Our starting point in this normative discussion is a tax code with a section 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. Either of these worlds might be defended on various normative grounds.¹⁹⁹

We do not, however, live in these more idealized worlds. We live in a world with a partial patchwork of direct medical subsidies²⁰⁰ and the section 213 deduction.²⁰¹

¹⁹⁶ *Id.* at 41, 42.

¹⁹⁷ *Id.* at 39, 41, 48, 49.

¹⁹⁸ There was no reported decision in the case. There is a stipulated decision in the case. The stipulated decision, Docket No. 10133-94, dated Nov. 14, 1995, is on file with the author.

¹⁹⁹ See, e.g., NORMAN DANIELS, *JUST HEALTH CARE* (1985); 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 explicitly ration medical care).

If we repealed § 213 and adopted universal health care with explicit rationing, in order to provide a basic package of health care to the 42 million Americans who are uninsured, I would readily concede that fertility treatments would likely not be covered, along with many other types of other medical treatments, such as Viagra treatment for erectile dysfunction. If we converted § 213 into a credit with a dollar cap, I would concede that fertility patients would not receive a tax benefit for part of their treatment costs.

²⁰⁰ 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. 42 U.S.C. § 1396 (2000).

Given this normative starting point, should fertility treatment costs be characterized as medical expenses or non-medical expenses under section 213?

In order to resolve this normative issue, we can ask two questions. First, should fertility treatment costs be deductible in order to take account taxpayers' ability to pay?²⁰²

For an overview of Medicaid, see Thomas, *supra* note 199, at 79-91. Medicare is a federal medical insurance program for the elderly and disabled. 42 U.S.C. § 1395 (2000).

²⁰¹ In addition to the § 213 deduction, § 105(b) of the tax code permits taxpayers to exclude employer reimbursements from medical flexible spending accounts. The exclusion turns on whether the medical expense is within the § 213 definition of medical expenses, so the discussion in this section refers to the § 213 deduction. The same arguments apply to the §105(b) exclusion.

²⁰² 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. Professor Gergen has labeled the traditional normative approach to tax policy questions an "internal coherence approach." In the internal coherence approach, "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 (2001).

The traditional normative approach to tax policy typically incorporates the "horizontal equity" and "vertical equity" norms, both of which are controversial. The term "vertical equity" is used for the proposition that we should apply an appropriate pattern of differentiating between those who are unequally situated. The term "horizontal equity" is used for the proposition that equals should be treated alike. Paul A. McDaniel & 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 norms). Economic income is generally regarded as the measure of equality and inequality. 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. *Id.* at 90-115; Louis Kaplow, *Horizontal Equity: Measures in Search of a Principle*, 42 NAT'L TAX J. 139, 143, 147 (1989) [hereinafter Kaplow, *Horizontal Equity*]. 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. *See, e.g.,* McDaniel & Repetti, *supra*, at 611.

There is disagreement about whether the horizontal equity norm should be considered an independent equity norm. 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.").

However, other 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

Second, would a deduction for fertility treatment costs create improper incentives for taxpayers?²⁰³

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.²⁰⁴ This literature addresses the question of whether medical expenses in general are part of the ideal income tax base or not. As such, it does not really address the specific question here, which is whether fertility treatment expense 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 section 213 deduction.

horizontal equity norm gives no guidance if the situations of two persons vary at all. *See, e.g.*, Kaplow, *Horizontal Equity*, 42 NAT'L TAX J. 139, 143, 147 (1989); Louis Kaplow, *A Note on Horizontal Equity*, 1 FLA. TAX REV. 191 (1992); 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); McDaniel & Repetti, *supra*, at 613.

²⁰³ This normative question takes into account the 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, and 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, 154-55 (2001):

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.

The influential articles on the medical expense deduction written by Professors Kaplow and Griffith adopt a consequentialist approach. 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 *Income Tax as Insurance*]. Thomas D. Griffith, *Theories of Personal Deductions in the Income Tax*, 40 HASTINGS L. J. 343 (1989) [hereinafter *Theories of Personal Deductions*].

²⁰⁴ STANLEY SURREY & PAUL MCDANIEL, *TAX EXPENDITURES* (1985); William Andrews, *Personal Deductions in an Ideal Income Tax*, 86 HARV. L. REV. 309 (1972); Kelman, *supra* note 119.

Professor Surrey's influential tax expenditure model distinguished between tax provision that were part of the "normal tax structure" and "special preferences."²⁰⁵ The normal tax structure is based on Haig-Simons income, 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).²⁰⁶ 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."²⁰⁷ Surrey characterized the medical expense deduction as a tax expenditure.²⁰⁸ 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. Andrews acknowledged that amounts spent on medical care could be construed as consumption, but he took the position that the ideal income tax base should reflect "material well-being," not just consumption.²⁰⁹ 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 greater well-being or taxable capacity, but rather only greater medical need."²¹⁰ He observed 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.²¹¹

Andrews also considered the distributional implications of the medical expense deduction.²¹² Andrews created an example with three hypothetical taxpayers to consider the equity issues raised by the section 213 deduction.²¹³ Assume that 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 as A. C cannot afford treatment. Andrews asked whether A's \$20,000 of medical expenses should be excluded from the income tax base.

²⁰⁵ SURREY & MCDANIEL, *supra* note 204, at 3. For a critique of Surrey's tax expenditure approach, see *Theories of Personal Deductions*, *supra* note 203.

²⁰⁶ SURREY & MCDANIEL, *supra* note 204, at 4.

²⁰⁷ *Id.* at 3.

²⁰⁸ *Id.* at 79. Professor Surrey observed that tax expenditures are a form of government spending. *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. *Id.* at 103. He argued that we should eliminate many tax expenditures or replace them with direct expenditure provisions. *Id.* at 112-15.

²⁰⁹ Andrews agreed with earlier ideal income tax base theorists that the tax code should not have source-based distinctions. Andrews, *supra* note 204, at 316-17, n. 12, 375-76.

²¹⁰ *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.

²¹¹ *Id.* at 335.

²¹² *Id.* at 338.

²¹³ *Id.*

Andrews considered both vertical equity and horizontal equity in answering the question. He acknowledged that richer taxpayers can buy more medical care and better medical care, so A is better off than C. 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 effects 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.²¹⁴

Andrews acknowledged that some medical expenditures include “a considerable component of voluntary personal gratification.” On the other hand, he 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.” He thought that the medical expense deduction would, of course, present line-drawing difficulties, giving as an example the treatment of cosmetic surgery, which he admitted resembled the non-medical purchase of cosmetics.²¹⁵

Professor Mark Kelman challenged Andrews and argued against the section 213 deduction.²¹⁶ 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. Kelman criticized Andrews' approach to the medical expense deduction on various grounds. Kelman argued that good health is no different from other psychic pleasures, yet Andrews singled it out for special treatment.²¹⁷ 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? If we do not tax gains from risky behavior, but allow B a deduction for medical care, B is better off than A. In addition, Kelman challenged Andrews' assumption that all medical expenditures are price-inelastic and income-inelastic.²¹⁸ He argued that spending on emergency life-saving measures, like treatment of arterial bleeding, is consistent with Andrews' assumption, but most medical expenditures are price-elastic²¹⁹ and income-elastic.²²⁰

He also argued that medical expenditures often include payments for non-medical benefits, such as a private hospital room, but section 213 does not require taxpayers to

²¹⁴ *Id.* at 339.

²¹⁵ *Id.* at 337.

²¹⁶ Kelman, *supra* note 119. 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.

²¹⁷ *Id.* at 869.

²¹⁸ *Id.* at 865.

²¹⁹ *Id.* at 868.

²²⁰ *Id.* at 866. Kelman notes that richer taxpayers: buy more expensive, high-tech 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.*

segregate the payments for the non-medical expenses.²²¹ He noted that we 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.²²² He also considered other methods of dealing with mixed-motive expenses, but found them all lacking. In Kelman's view, we 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.²²³ He also argued that trying to apportion the mixed-motive expense and permitting the taxpayer to deduct only the medical portion of the expenditure is not administrable and is an unprincipled compromise between full deductibility and full inclusion in the base.²²⁴

The scope of section 213 under current law is consistent with Professor Andrews' normative position that a medical expenditure should be excluded from the base unless it constitutes an extreme "borderline" expenditure such as cosmetic surgery.²²⁵ Congress

²²¹ *Id.* at 864-65.

²²² *Id.* at 876.

²²³ *Id.* at 877.

²²⁴ *Id.* at 878.

²²⁵ 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 the medical expenses that exceed the 7.5 percent floor. "Health is basic to all human endeavor." Lawrence O. Gostin, *Securing Health or Just Health Care? The Effect of the Health Care System on the Health of America*, 39 ST. LOUIS L.J. 7, 13 (1994). Professor Gostin continues:

Health is basic to all human endeavor and, therefore, may be regarded as a foundational justification for government action. Health is a necessary condition for just about all aspects of human endeavor. First, health is necessary for the pursuit of livelihood. Without a certain level of health, a person cannot train, develop skills, or employ existing qualifications and skills in income-producing activities. This not only impedes individuals in obtaining the basic necessities of life such as food, shelter and clothing, but reduces their capacity to contribute to the production of goods and services in society generally.

Second, a certain level of health is a necessary condition for the exercise of fundamental rights and privileges. Persons with severe physical or mental disabilities, as well as acute and chronic diseases, may not be able to exercise their rights to liberty (e.g., travel), autonomy (e.g., decision-making in personal and financial affairs), or the franchise.

Third, health is of overriding importance in achieving personal satisfaction, happiness, and better personal relationships. Human fulfillment is much more difficult to achieve when human beings experience unrelenting pain and suffering, when they cannot meet their basic self-care needs, or when they lose mental and physical functioning. Nor can people as easily form close relationships with family and the community when they are dependent and have less physical and mental capacity to interact. Indeed, health 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. Persons whose morbidity and suffering could have been prevented or lessened through reasonable government interventions may understandably claim that they count less, that their dignity is undermined by governmental inaction.

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 non-medical element (such as laser eye surgery that corrects vision and eliminates the need for glasses). In the area of reproductive medical care, the IRS has specifically ruled that vasectomy, tubal ligation, prescription contraceptives, and abortions are medical care for purposes of section 213.²²⁶

Assuming that we are keeping the section 213 deduction, we could possibly redefine the section 213 term “medical care” to address some of Kelman’s concerns about the deduction. We could think of medical care as falling on a continuum, with emergency, life-saving treatment on one end, and cosmetic surgery on the other end. We 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 non-medical elements of the expense, we could decide that certain types of medical care are important enough to be regarded as involuntary, and other types of medical care are not important enough to be regarded as involuntary. It might seem incongruous to treat medical care that facilitates reproductive *choice* as *involuntary*, but we might place such care on the involuntary side of the line if such care is very important to most people.

We *could* develop a section 213 test that is comparable to the “major life activity” part of the ADA disability test. Recall that the broad interpretation of the term major life activity is an activity “of comparative importance.” The narrow interpretation of the term major life activity is an activity that satisfies the three requirements of microfrequency, macrofrequency, and universality. If we defined medical care by reference to this latter test, the term medical care would not include treatment that relates to an activity unless the activity is engaged in *all day, every day, by everyone*.

In other words, section 213 would then not cover any medical care involving sexual or reproductive functioning. Medical care would not include treatment related to sexual dysfunction, including Viagra, or reproductive treatments 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.

Said another way, the issue under section 213 should not be whether an activity is one in which all people engage; the test should be whether a person’s sexual and reproductive systems can function normally so the person can exercise choice over those biological systems. What a person decides to do with their normally functioning body is irrelevant. A person who wants very much to engage in sexual conduct 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 sex or reproduction.

Id. (footnotes omitted)

²²⁶ See, e.g., Rev. Rul. 73-200, 1973-1 C.B. 140 (1973) (cost of birth control pills is a medical expense under § 213).

This approach to drawing the section 213 line is consistent with the broader definition of “major life activity” adopted by the Supreme Court in *Bragdon*. The Court concluded that reproduction was a major life activity because reproduction is “central to the life process itself.”²²⁷ Under this approach to section 213, medical care would continue to be broadly defined and would include the reproductive medical care.²²⁸

It is interesting to note that courts seem to appreciate the importance of sex and reproduction more than insurers do.²²⁹ In part, this is due to the fact that insurers have had to narrow the scope of coverage in order to contain health care costs. Traditionally, insurers deferred to the medical judgment of doctors and covered the medical care ordered by doctors,²³⁰ but expensive new high-tech treatments began driving up the cost of health care dramatically.²³¹ Beginning in the 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.²³²

Private insurers have attempted to control skyrocketing health care costs by stating in their contracts that coverage is limited to treatment of a “disease” or “illness,”²³³ and is limited to care that is a “medical necessity”²³⁴ and is not “experimental” or “investigative.”²³⁵ Medicare and Medicaid also exclude from coverage services that are not “medically necessary.”²³⁶ Insurers use these definitions to support their denial of coverage.

Courts have had to define the terms “illness,” “disease” and “medical necessity,” in numerous cases, including some cases involving sexual and reproductive dysfunction.

²²⁷ 524 U.S. at 638.

²²⁸ One problem with narrowing the § 213 definition of medical care is that it is a form of rationing medical care. Americans (and their representatives in Congress) do not favor explicit health care rationing. Americans, and their representatives in Congress, generally recoil at the notion of explicit health care rationing. In part due to that fact, Congress has not enacted a directly subsidized universal health care plan. One might speculate that the scope of § 213 is as broad as it is because Congress and the IRS have been unable or unwilling to make the hard 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.

²²⁹ 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).

²³⁰ Mark A. Hall, *Health Insurer's Assessment of Medical Necessity*, 140 U. PA. L. REV. 1637, 1644-47 (1992).

²³¹ *Id.*

²³² *Id.* at 1663.

²³³ For example, the insurance contract in *Egert v. Connecticut General Life Insurance Co.* specified that coverage was limited to the treatment of “illness.” 900 F.2d 1032, 1033 (7th Cir. 1990).

²³⁴ Courts have in some cases 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) (court concluded 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 necessary”).

²³⁵ *Id.* at 1647.

²³⁶ The federal Medicare statute excludes from coverage medical services that are not “reasonable and necessary.” 42 U.S.C. § 1395y(a)(1) (2000). Medicaid also limits coverage to medically necessary treatment.. 42 C.F.R. § 440.230(d) (2002).

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.²³⁷ In several cases, courts have held that sex reassignment surgery to treat a transsexual with gender identity disorder was a “medical necessity.”²³⁸ Also, shortly after the FDA approved Viagra, the federal agency that administers the Medicaid program²³⁹ took the position that Viagra was a “medically necessary” treatment for erectile dysfunction and mandated that state Medicaid programs cover the drug.²⁴⁰

Private insurance companies also contain costs by specifying in their contracts that certain types of care are excluded from coverage. The vast majority of plans cover abortion, vasectomy, and tubal ligation,²⁴¹ but fewer plans cover contraceptives and very few plans cover fertility treatment such as IVF.²⁴² On the other hand, many insurers cover the cost of Viagra.²⁴³

Insurance companies and employers, unlike doctors determining medical necessity, take into account the cost of treatments when they determine the coverage of their plans, so it is perhaps not surprising that insurance companies have increasingly excluded from coverage: (1) expensive, but relatively uncommon, treatments, such as IVF; and (2) inexpensive, but common, treatments such as contraceptives. On the other hand, Viagra is also a common treatment, so why is a Viagra covered if IVF is not?

²³⁷ 900 F.2d 1032 (7th Cir. 1990). 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.” *Witcraft v. Sundstrand Health and Disability Group Benefit Plan*, 420 N.W.2d 785, 788 (Ia.1988). On the other hand, the court held, in *Kinzie v. Physician’s Liability Insurance Co.*, that IVF was “not a medically necessary service because it was elective and not required to cure or preserve [plaintiff’s] health.” 750 P.2d 1140 (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, 628-29 (1999).

²³⁸ See, e.g., *Pinneke v. Preisser*, 623 F.2d 546 (8th Cir. 1980).

²³⁹ The administrative agency, formerly known as the Health Care Financing Administration, is now called the Centers for Medicare and Medicaid Services.

²⁴⁰ 49 Fed. Reg. 35,247, 35,249(K) (1984). 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 a year. David F. Chavkin, *Medicaid and Viagra: Restoring Potency to an Old Program*, 11 HEALTH MATRIX 189, 208-09 (2001) [hereinafter, Chavkin, *Medicaid and Viagra*]. The concern was that covering Viagra would divert away funds badly needed for maternal and child care, H.I.V., and care of the disabled. Ninety percent of Medicaid beneficiaries are women and children. Carole 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). Some states later covered Viagra, but other states refused to cover it. Chavkin, *Medicaid and Viagra*, at Appendix A. According to Professor David Chavkin, “State claims of dire financial consequences and ‘unfunded mandates’ have proven to be grossly exaggerated and States have been able to comply with federal law without threatening their financial health.” *Id.* at 231.

²⁴¹ Rosenblatt, *supra* note 139.

²⁴² *Id.*

²⁴³ Paul Rauber, *It's a Man's World*, SIERRA, Sept.-Oct. 1998, at 20.

Some insurance companies have taken the position that Viagra is a “medical necessity,”²⁴⁴ but fertility treatment involves a “lifestyle choice,” not a “medical necessity.”²⁴⁵ Perhaps the difference in insurance coverage of Viagra and fertility treatments is in part due 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.²⁴⁶ Recently, coverage of both contraceptives and fertility treatment has been mandated in some but not all states.²⁴⁷ 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, claiming they had been denied treatment for a “vital human function.”²⁴⁸

If we think of medical care as falling on a continuum, with emergency, life-saving treatment on one end, and cosmetic surgery on the other end, we can argue about where on the continuum fertility treatment falls, and probably reach consensus about its relative importance. Probably the vast majority of people think that both sex and reproduction are vitally important.

Unfortunately, this ability-to-pay approach does not provide a clear normative foundation for figuring out where to draw the line on the health care continuum. Professor Griffith has argued that the normative underpinnings of both the Andrews and Kelman approaches to the medical expense deduction are incoherent.²⁴⁹ Professor Weisbach has also argued that we should adopt a consequentialist approach to line-drawing questions in the tax law.²⁵⁰ We will turn now to that approach to consider the normative question at hand.

C. The incentive effects of allowing a deduction for fertility treatment costs.

Adopting a consequentialist normative approach²⁵¹ to determine whether fertility treatment costs should be deductible, we must consider the ex ante incentive effects of characterizing fertility treatment costs as medical expenses or non-medical expenses.²⁵²

²⁴⁴ *Id.*

²⁴⁵ McCullough, *supra* note 141.

²⁴⁶ Sylvia A. Law, *Sex Discrimination and Insurance for Contraception*, 73 WASH. L. REV. 363, 363 (1998).

²⁴⁷ Lisa A. Hayden, *Gender Discrimination within the Reproductive Health Care System: Viagra v. Birth Control*, 13 J.L. & HEALTH 171, 189 (1998-99).

²⁴⁸ *Id.* at 180.

²⁴⁹ *Theories of Personal Deductions*, *supra* note 203, at 370, 385. At times, Andrews seems to be adopting an egalitarian ethic and at other times he seems to be adopting a utilitarian ethic. *Id.* at 370.

²⁵⁰ David A. Weisbach, *Line Drawing, Doctrine, and Efficiency in the Tax Law*, 84 CORNELL L. REV. 1627, 1649-51 (1999) [hereinafter *Line Drawing*]; David A. Weisbach, *An Efficiency Analysis of Line Drawing in the Tax Law*, 29 J. LEGAL STUD. 71, 74 (2000).

²⁵¹ There are various consequentialist theories that we could apply, including utilitarian theories or Rawlsian theories.

²⁵² *Income Tax as Insurance*, *supra* note 203. We note the second-best setting within which we are trying to make this normative determination. Again, our normative starting point assumes that we have a § 213 deduction and a patchwork of direct medical subsidies. The only question is how we should characterize fertility treatment costs.

Allowing the deduction (or reimbursement) would encourage fertility treatment by reducing the cost of such treatment; not allowing the deduction would discourage fertility treatment by increasing the cost of such treatment. If we allow the deduction for certain treatments, but not others, we would discourage the treatments with nondeductible treatment costs and encourage the treatments with deductible treatment costs. (Note at the outset of this normative discussion that, since section 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.)

We *might* want to *encourage* all fertility treatment, or certain types of fertility treatments, *if*: (1) fertility treatments are being underutilized, given the general lack of insurance coverage and extreme importance of reproduction; (2) infertile patients choose to undergo treatment that is covered by insurance, instead of pursuing less expensive, painful, or 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 risk of multi-fetal pregnancies, to both the woman bearing the children and the children, are lower for certain forms of fertility treatment than for other forms.

On the other hand, we *might* want to *discourage* all fertility treatments, or certain types of fertility treatment, for example, *if*: (1) ovarian stimulation poses health risks to the woman whose ovaries are being stimulated; (2) ovarian stimulation increases the rate of multi-fetal pregnancies, which poses health risks to the woman bearing the children and the children; (3) fertility treatment 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 multi-fetal pregnancies; or (5) adoption is a better alternative. We will consider the positive and negative consequences of various forms of fertility treatments in turn.

- 1. The consequences of fertility treatment that have a positive impact on welfare.**

- a. The benefits of fertility treatment to the parents and child.**

Fertility treatment dramatically improves the welfare of the intended parents. Part II.A. of this article documents the core despondence of infertile patients. That despair stands in stark contrast to the happiness of those who want to have children and are able to have them. Poetry captures the elemental experience of having children – for both men and women:

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.²⁵³

²⁵³ *Mother Song* (E. Nesbit trans.), in E. NESBIT, *THE RAINBOW AND THE ROSE* 69-70 (Longmans, Green & Co. 1905). Many other poems also describe the joy of parenting.

There is a calm upon her face

That marks the change that's taken place:
It seems as though her eyes now see
The wonder things that are to be,
An' that her gentle hands now own
A gentleness before unknown.
Her laughter has a clearer ring
Than all the bubbling of a spring,
An' in her cheeks love's tender flame
Glow brighter since the baby came. . . .
How sweet she was, an' yet how much
She sweetened by the magic touch
That made her a mother! In her face
It seems the angels left a trace
Of Heavenly beauty to remain
Where once had been the lines of pain
An' with the baby in her arms
Enriched her with a thousand charms

EDGAR ALBERT GUEST, *Sue's Got A Baby*, in EDGAR A. GUEST, JUST FOLKS 134-135 (The Reilly & Lee Co. 1917).

Give me the baby to hold my dear –
To hold and hug, and to love and kiss.
Ah! He will come to me, never a fear –
Come to the nest of a breast like this,
As warm for him as his face with cheer.
Give me the baby to hold my dear!
Trustfully yield him to my caress. . . .
To fill up my soul with such happiness
As the love of a baby that laughs to be
Snuggled away where my heart can hear!
Give me the baby to hold, my dear!

JAMES WHITCOMB RILEY, *Give Me the Baby*, in JAMES WHITCOMB RILEY, THE COMPLETE POETICAL WORKS OF JAMES WHITCOMB RILEY 299-300 (Indiana University Press 1993).

I have no wish, my little lad,
To climb the towering heights of fame.
I am content to be your dad
And share with you each pleasant game.
I am content to hold your hand
And walk along life's path with you,
And talk of things we understand -
The birds and trees and skies of blue.
Though some may seek the smiles of kings,
For me your laughter's joy enough;
I have no wish to claim the things
Which lure men into pathways rough.
I'm happiest when you and I,
Unmindful of life's bitter cares,
Together watch the clouds drift by, . . .
I would not trade one day with you
To wear the purple robes of power,
Nor drop your hand from mine to do

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

The financial sacrifices that infertile patients make to pay for fertility treatment provide an indication of the vital importance of fertility treatment to infertile patients. Numerous studies have demonstrated that infertile patients are prepared to pay dearly to increase their chances of conceiving and bearing a child. For example, survey respondents in a U.K. study “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.”²⁵⁴

Professor Weisbach has argued that we should draw lines in the tax law in a manner that minimizes deadweight losses.²⁵⁵ Studies such as the U.K. study demonstrate the paramount importance of fertility treatment to infertile patients,²⁵⁶ and suggest that permitting a deduction for fertility treatment will not increase deadweight losses.²⁵⁷ If fertility treatment is not covered by insurance and the cost of such treatment is not deductible, on the other hand, patients will be encouraged to either: (1) opt for less effective medical treatment that is covered by insurance;²⁵⁸ or (2) be very aggressive in their fertility treatment, which increases the risk of a multi-fetal pregnancy.²⁵⁹ Disallowing the deduction would thus likely increase deadweight losses.

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 ALBERT GUEST, *To The Boy*, in EDGAR A. GUEST, *THE PATH TO HOME* 156-157 (The Reilly & Lee Co. 1919).

²⁵⁴ Neumann, *supra* note 88, at 1223-24.

²⁵⁵ Weisbach, *Line Drawing*, *supra* note 250, at 1651. 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.*

²⁵⁶ Neumann, *supra* note 88, at 1223-24.

²⁵⁷ As Weisbach notes,

[T]he size of the deadweight loss from a tax on an item is related to the elasticity of demand of 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 250, at 1656. Studies such as the U.K. study indicate that the elasticity of demand of fertility treatment is relatively low.

²⁵⁸ For example, patients with blocked fallopian tubes will opt for surgery to repair the blocked tubes, because the surgery is covered by insurance, instead of bypassing the blocked tubes with an IVF procedure. The surgery is less effective medically than the IVF procedure.

²⁵⁹

Fertility treatment also improves the welfare of the children who would not have been born but for fertility treatment. The magnitude of this effect on the consequentialist conclusion depends on the specific consequentialist approach employed.²⁶⁰

Peter Neumann, a public health expert, computes the cost of IVF per life-year gained for a child conceived through IVF and compares it to the cost per life-year of other common medical treatments.²⁶¹ In Neumann's example, he assumes that a cycle of IVF costs \$8,000 and has a 12 percent chance of success, and that a child would live 75 years.²⁶² The cost per life-year gained from IVF, given these assumptions, equals \$3,259.²⁶³ The cost per life-year gained for many other common types of medical treatment is much higher. Consider the cost per life-year gained for the following treatments: (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 50 year-old patients with terminal heart disease; (4) \$300,000 for intensive care for very sick patients having major vascular surgery; and (5) \$2,700 for mammography every three years for women ages 50-65.²⁶⁴

Neumann's cost per life-year estimate may have to be adjusted upward because we may value life-years of unborn people less than life-years of people who have already been born. On the other hand, his cost per life-year estimate may have to be adjusted downward because his estimate fails to take into account the benefits to the child's parents.²⁶⁵

b. Adoption as an alternative to fertility treatment.

Adoptive parents also experience the joy of parenting. Infertile would-be parents often consider adoption as an alternative to fertility treatment.²⁶⁶ As Elizabeth Bartholet has noted, they typically consider adoption only as a last resort after they "have reached the end of a long medical road designed to produce a biological child."²⁶⁷ Many infertile couples who decide to adopt only want to adopt a healthy white baby.²⁶⁸ In one study, only half of the parents adopting special needs children gave infertility as the reason for the adoption. On the other hand, over 80 percent of parents adopting a child through a

²⁶⁰ For example, utilitarians sometimes look to total utility and sometimes look to average utility.

²⁶¹ *Id.* at 1222-23.

²⁶² *Id.* at 1222-23.

²⁶³ *Id.* at 1223.

²⁶⁴ *Id.* at 1224.

²⁶⁵ *Id.*

²⁶⁶ A study that covered the period from 1988 to 1995 estimated that 11 percent to 24 percent of infertile couples decide to adopt. The Evan B. Donaldson Adoption Institute, Overview of Adoption, at <http://www.adoptioninstitute.org/FactOverview/html> (last visited July 9, 2003), citing William D. Mosher & Christine Bachrach, *Understanding U.S. Fertility: Continuity and Change in the National Survey of Family Growth, 1988-1995*, 27(1) FAMILY PLANNING PERSPECTIVES 9 (Jan.-Feb. 1996).

²⁶⁷ ELIZABETH BARTHOLET, FAMILY BONDS: ADOPTION, INFERTILITY, AND THE NEW WORLD OF CHILD PRODUCTION 24 (1999) [hereinafter BARTHOLET, FAMILY BONDS].

²⁶⁸ MAURA A. RYAN, THE ETHICS AND ECONOMICS OF ASSISTED REPRODUCTION: THE COST OF LONGING 59 (2001). Ryan notes that they want to adopt healthy white babies "for both good and bad reasons." *Id.*

private adoption agency or independently gave infertility as the reason for the adoption.²⁶⁹

Maura Ryan has noted that we should not simply “assume that adoption is the obvious and unambiguous solution to the problem of infertility.”²⁷⁰ Infertile adoptive parents reach the decision to adopt only after experiencing the devastating losses associated with their infertility. Elizabeth Bartholet has observed that 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.”²⁷¹ Maura Ryan argues:

To make a blanket assumption that infertility should be resolved 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 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.²⁷²

Sociobiologists have long noted the basic human urge to reproduce,²⁷³ but Bartholet argues that societal forces are also at work in making adoption less desirable than bearing a biological child.²⁷⁴ Bartholet recognizes that those who are infertile naturally want to seek medical attention to try to overcome the infertility.²⁷⁵ She argues, however, that infertile patients who begin medical treatment often have trouble deciding when to stop the medical treatment of their infertility. The information that is most available to infertile patients is biased in favor of medical treatment and against adoption.²⁷⁶ In addition, adoption is highly regulated, but the medical treatment of

²⁶⁹ The Evan B. Donaldson Adoption Institute, Overview of Adoption, at <http://www.adoptioninstitute.org/FactOverview/html> (last visited July 9, 2003), citing Berry et al., *Preparation, Support and Satisfaction of Adoptive Families in Agency and Independent Adoptions*, 13(2) CHILD AND ADOLESCENT SOCIAL WORK JOURNAL 166 (April 1966).

²⁷⁰ RYAN, *supra* note 268, at 57.

²⁷¹ BARTHOLET, FAMILY BONDS, *supra* note 267, at 36.

²⁷² *Id.* at 58.

²⁷³ RICHARD DAWKINS, THE SELFISH GENE (1976).

²⁷⁴ BARTHOLET, FAMILY BONDS, *supra* note 267, at 24:

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.

Id. (emphasis in original) (citation omitted)

²⁷⁵ *Id.* at 30.

²⁷⁶ *Id.* at 32. Infertile patients are most often advised by their fertility doctors, who often know little about adoption as an alternative to medical treatment. Adoption agencies are wary of infertile

infertility is essentially unregulated.²⁷⁷ Bartholet argues that we should promote adoption as an alternative to the medical treatment of infertility.²⁷⁸

On the other hand, pursuing adoption can also be a difficult, expensive, and uncertain process. There is a shortage of healthy children available for adoption in the U.S. Adolescent birth rates have declined significantly.²⁷⁹ In addition, only about 1 percent of American women give up their babies for adoption.²⁸⁰ As a result of this baby shortage, adoptive parents typically have to wait years to adopt a healthy American baby.²⁸¹ Adoptive parents can adopt special needs children²⁸² more quickly, but many adoptive parents feel that they cannot respond adequately to the needs of such children.²⁸³

couples, who may proceed with adoption before they have resolved their feelings of grief and loss. *Id.* at 31.

²⁷⁷ *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 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.

²⁷⁸ *Id.* at 37.

²⁷⁹ Paula Span, *Parallel Lives; Nicole's 16 and Pregnant, Otto and Chanda are Desperate to Adopt*, WASHINGTON POST, June 18, 2000, at W12 (noting an 18 percent decline in the adolescent birth rate since 1991).

²⁸⁰ *Id.* During the 1950s and 1960s, 40-50 percent of unmarried women in the U.S. gave up their babies for adoption. *Id.* Today, only 1 percent of women give up their babies for adoption. There are various reasons for the dramatic reduction in relinquishment rates. First, single parenthood carries much less of a social stigma today. Span also notes that sensational press accounts of the emotional difficulties of adopted children have made adoption seem to be a poor choice for the biological mother and child. Few adolescent mothers seriously consider adoption or think about how adoption might benefit both the biological mother and child. *Id.*

²⁸¹ *Id.* (such adoptive parents face a wait of two to seven years).

²⁸² 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." Social Security Act § 473(c), 42 U.S.C. § 673(c) (2000).

²⁸³ Span, *supra* note 279.

The wait for adoption is also frequently shorter for the adoption of foreign babies and children.²⁸⁴

Adoptions also involve uncertainty because a biological mother often decides, after the child is born, to keep the child.²⁸⁵ Adoptive parents who have paid the birth expenses of the biological mother are often not reimbursed for those expenses.²⁸⁶

Adoption of non-special needs children is costly. The cost of adoption from private agencies or independent adoption, including international adoption, range from \$4,000 to \$30,000.²⁸⁷ (For public agency adoptions, which typically involve special needs children, costs range from zero to \$2,500.²⁸⁸ In addition, parents who adopt special needs children can qualify for government reimbursement of their adoption expenses.²⁸⁹)

In 1996, Congress also enacted two tax provisions, sections 23 and 137, to encourage adoption.²⁹⁰ Section 23 currently provides that adoptive parents can claim a tax credit of up to \$10,000 for adoption expenses.²⁹¹ Section 137 currently allows employees to exclude up to \$10,000 of adoption expenses reimbursed from an employer-provided adoption assistance program.²⁹² Both provisions can apply to a single adoption, but cannot apply to the same adoption expenses. The section 23 credit is phased out if the parents have gross income between \$150,000 and \$190,000.²⁹³ Parents with income of \$190,000 or more cannot qualify for the credit.²⁹⁴ If the section 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.²⁹⁵

Due to the shortage of non-foreign, non-special needs children available for adoption, these tax benefits have probably not increased the number of such adoptions.²⁹⁶ It is not clear whether these tax benefits have affected the number of special needs adoptions.²⁹⁷ The cost of special needs adoptions is lower than the cost of non-special needs adoptions.²⁹⁸ In 85 percent of special needs adoptions, direct government subsidies

²⁸⁴ *Id.* (international adoption is a quicker process).

²⁸⁵ Lord et al., *supra* note 12, at 58.

²⁸⁶ National Adoption Information Clearinghouse, Cost of Adopting, at http://www.calib.com/naic/pubs/s_cost.cfm (last modified Jan. 28, 2003) (last visited July 9, 2003).

²⁸⁷ *Id.*

²⁸⁸ *Id.*

²⁸⁹ The Social Security Act provides for payments to states so that states can reimburse adoptive parents for the costs of adopting special needs children. Social Security Act § 470, 42 U.S.C. §§ 670, 673 (2000). Parents can receive additional federal assistance if the adopted child was eligible for other forms of federal assistance prior to the adoption. The Evan B. Donaldson Adoption Institute, Costs of Adoption, at <http://www.adoptioninstitute.org/FactOverview/costs.html> (last visited July 9, 2003).

²⁹⁰ Small Business Job Protection Act of 1996, Pub. L. No. 104-188 § 1807, 110 Stat. 1757 (1996).

²⁹¹ I.R.C. § 23 (2000) (amended 2001).

²⁹² I.R.C. § 137 (2000) (amended 2001).

²⁹³ I.R.C. § 23(b) (2000) (amended 2001).

²⁹⁴ *Id.*

²⁹⁵ I.R.C. § 23(c) (2000) (amended 2001).

²⁹⁶ DEPT. OF THE TREASURY, REPORT TO THE CONGRESS ON TAX BENEFITS FOR ADOPTION 18 (Oct. 2000).

²⁹⁷ *Id.* The number of special needs adoptions has increased, but it is not clear how much such adoptions would have increased without the tax incentives of §§ 37 and 137.

²⁹⁸ *Id.* at 3, 18.

cover the adoptive parents' out-of-pocket expenses, so special needs adoptions generate tax benefits in only 15 percent of such cases.²⁹⁹

The tax benefits of sections 23 and 137 may have increased the number of foreign adoptions. The number of foreign adoptions has been increasing in recent years. Although such adoptions began to increase before 1996, the number of foreign adoptions has continued to increase since 1996.³⁰⁰ Foreign adoptions are more costly than U.S. adoptions. The Treasury Department estimates that, in 1998, the average cost of a foreign adoption was almost twice the cost of a non-foreign adoption.³⁰¹ Sections 23 and 137 therefore provide greater tax benefits for foreign-adoptions than for special needs adoptions.³⁰² Given the greater tax benefit for foreign adoptions, sections 23 and 137 may have increased 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 section 23 provides for a credit, while section 213 provides for a deduction.³⁰³ Consider the following example to illustrate the comparative tax benefits of the section 23 credit and the section 213 medical expense deduction.

Example: 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 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 income³⁰⁴). 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 \$250 tax savings).³⁰⁵

²⁹⁹ *Id.* at 3.

³⁰⁰ There have been around: 6,500 international adoptions in 1992; 7,300 in 1993; 8,300 in 1994; 9,700 in 1995; 11,300 in 1996; 13,600 in 1997; 15,600 in 1997; 16,400 in 1999; 18,500 in 2000; and 19,200 in 2001. The Evan B. Donaldson Adoption Institute, Overview of Adoption, *available at* <http://www.adoptioninstitute.org/FactOverview/html> (last visited July 9, 2003).

³⁰¹ *Id.* at 3. The Treasury Department estimated that the average cost of foreign adoption was \$10,000 in 1998. Note that the actual average cost may have been higher. The tax benefits of §§ 23 and 137 are subject to gross income phaseouts, so the figures in the Treasury report do not reflect the cost of adoption by higher income families.

³⁰² *Id.* at 18.

³⁰³ A credit reduces the taxpayer's tax owed by the dollar amount of the credit. A deduction reduces a taxpayer's taxable income, on which tax is computed. The tax savings from a deduction depend on the taxpayer's marginal tax rate. The tax savings from a deduction equal the product of the dollar amount of the deduction multiplied by the taxpayer's marginal tax rate.

³⁰⁴ I.R.C. § 213(a) (2000).

³⁰⁵ 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. I.R.C. § 23 (2000) (amended 2001).

Both fertility treatment and adoption can have a significant positive impact on welfare. Next we will consider the potential negative impact of fertility treatment on welfare.

2. The consequences of fertility treatment that have a negative impact on welfare.

a. The medical and psychological risks of fertility treatment.

Even without fertility treatment, pregnancy, labor, and delivery entail medical risks to the mother and child.³⁰⁶ In addition, the various surgical procedures employed to diagnose, cure, or treat infertile patients involve the normal medical risks associated with surgery.³⁰⁷ This section will address the risks that increase or may increase as a result of ovulation induction, high-tech treatments such as IVF, and ICSI.³⁰⁸ 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.

i. The medical risks to the woman whose ovaries are being stimulated.

(A) The risk of hyperstimulation.

Ovarian Hyperstimulation Syndrome, a condition in which fluid accumulates in the abdomen, is the main risk to the woman whose ovaries are being stimulated by fertility drugs.³⁰⁹ The fluid accumulated in the abdomen puts pressure on the surrounding organs, including the heart and lungs.³¹⁰ Hyperstimulation can also cause dehydration, which can in turn cause kidney damage or dangerous blood clots.³¹¹ The fertility specialist closely monitors patients showing symptoms of hyperstimulation.³¹² The

³⁰⁶ The risks of pregnancy and delivery increase as women get older. HIGH-TECH CONCEPTION, *supra* note 35, at 160. “The risks of pregnancy-related death and of hypertension, diabetes, and complicated delivery all rise as women age. Many older women are prepared to accept these risks, but they need to be carefully monitored during their pregnancies.” *Id.*

³⁰⁷ HIGH-TECH CONCEPTION, *supra* note 35, at 276.

³⁰⁸ The increased pregnancy and delivery risks of fertility treatment may be intertwined with the increased pregnancy and delivery risks associated with infertility. Infertility, by itself, sometimes increases the medical risks of pregnancy and delivery because certain underlying causes of infertility increase specific pregnancy and delivery risks. HIGH-TECH CONCEPTION, *supra* note 35, at 276-77. For example, women with disorders of the fallopian tubes and women exposed to DES in utero have a higher risk of ectopic pregnancy. *Id.* at 278. Fertile surrogates who gestate children are not subject to these increased risks.

³⁰⁹ RESOLVING INFERTILITY, *supra* note 2, at 114.

³¹⁰ HIGH-TECH CONCEPTION, *supra* note 35, at 264.

³¹¹ *Id.* at 265.

³¹² The symptoms of hyperstimulation are shortness of breath, nausea, weight gain of over a pound a day, decreased urine output, and pronounced abdominal swelling. RESOLVING INFERTILITY, *supra* note 2, at 106, 114.

patient may have to rest in bed or, in more extreme cases, be hospitalized.³¹³ Hyperstimulation is rare,³¹⁴ but certain groups of women are known to be more susceptible to hyperstimulation.³¹⁵ 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.³¹⁶

(B) The uncertainty regarding the increased risk of ovarian cancer.

Some medical researchers have posited 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 studies have concluded that ovarian stimulation does increase ovarian cancer risk. The most widely publicized of these studies is the 1992 Whittemore study.³¹⁷ This study drew the conclusion that, compared to fertile women, infertile women whose ovaries had been stimulated had almost three times the lifetime risk of developing ovarian cancer.³¹⁸ On the other hand, numerous organizations, including the National Cancer Institute and the FDA, have criticized the methodology and conclusions in the Whittemore study.³¹⁹ In addition, numerous subsequent studies have failed to establish a connection between ovarian stimulation and ovarian cancer.³²⁰

In another well-known study, the 1994 Rossing study, the researchers concluded that prolonged use of clomiphene citrate (the ovarian stimulation drug that is in pill form)

³¹³ Severe hyperstimulation can be fatal, especially if untreated, but this is quite rare. HIGH-TECH CONCEPTION, *supra* note 35, at 265.

³¹⁴ Hyperstimulation occurs in 1 to 5 percent of stimulated cycles. RESOLVING INFERTILITY, *supra* note 2, at 114. Severe hyperstimulation occurs in 0.4 percent to 1.3 percent of cases. HIGH-TECH CONCEPTION, *supra* note 35, at 265.

³¹⁵ The women at higher risk include women who: (1) have polycystic ovarian syndrome (PCOS); (2) are very thin; (3) are age 34 or younger; or (4) have a history of producing over 30 follicles or high blood estrogen levels in previous stimulation cycles. HIGH-TECH CONCEPTION, *supra* note 35, at 265.

³¹⁶ RESOLVING INFERTILITY, *supra* note 2, at 114. 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 is increased if the patient becomes pregnant while hyperstimulated. HIGH-TECH CONCEPTION, *supra* note 35, at 265. If a patient has blood estrogen levels, the doctor may decide to delay the transfer of embryos. The doctor can retrieve the eggs, fertilize them, cryopreserve them, then transfer them after the ovarian swelling has subsided. *Id.* at 266.

³¹⁷ Alice S. Whittemore, et al., *Characteristics Relating to Ovarian Cancer Risk: Collaborative Analysis of 12 US Case-Control Studies*, 136 AM. J. OF EPIDEMIOLOGY 1175 (Nov. 15, 1992).

³¹⁸ *Id.* at 1188.

³¹⁹ HIGH-TECH CONCEPTION, *supra* note 35, at 269.

³²⁰ See, e.g., Baruch Modan et al., *Cancer Incidence in a Cohort of Infertile Women*, 147 AM. J. OF EPIDEMIOLOGY 1038, 1042 (June 1, 1998) (concluding that their data do 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 (May, 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, so the issue probably warrants further study. HIGH-TECH CONCEPTION, *supra* note 35, at 270.

may increase the risk of ovarian cancer.³²¹ The methodology of the Rossing study had fewer drawbacks than did the Whittemore study, but still had some limitations.³²² In addition, the study looked to the risk associated with using clomiphene for 12 or more cycles, but the medical consensus is that clomiphene should not be used nearly that many times.³²³

Numerous other studies have posited that *infertility*, whether treated or not, increases a woman's risk of ovarian cancer.³²⁴ 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. In the meantime, in the words of one expert commentator:

None of these studies, either alone or together, conclusively demonstrates a link between ovulation drugs and ovarian cancer, but 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.³²⁵

A 1997 study bears out this last statement. The study indicates that about 80 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.³²⁶

In addition, there are certain things a woman may be able to do to reduce her risk of ovarian cancer, including taking oral contraceptives or carrying a pregnancy to term. Various studies indicate that the risk of ovarian cancer is reduced by use of oral

³²¹ M.A. Rossing, et al., *Ovarian Tumors in a Cohort of Infertile Women*, 331 NEW ENG. J. MED. 771, 776 (Sept. 22, 1994).

³²² HIGH-TECH CONCEPTION, *supra* note 35, at 271. Kearney discusses 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.*

³²³ *Id.* at 271 (saying that clomiphene “should never be used” for 12 cycles and adding: “[f]ew women use clomiphene for more than six cycles and those who do should be looking for a new doctor”).

³²⁴ See, e.g., Robert E. Bristow & Beth Y. Karlan, *Ovulation induction, infertility, and ovarian cancer risk*, 66(4) FERTILITY & STERILITY 499 (Oct., 1996); Carmen Rodriguez et al., *Infertility and the Risk of Fatal Ovarian Cancer in a Prospective Cohort of US Women*, 9(6) CANCER CAUSES & CONTROL (Dec. 9, 1998); Lynette Burmeister & David L. Healy, *Ovarian Cancer in Infertility Patients*, 30(6) ANNALS OF MED. 525 (Dec. 1998).

³²⁵ HIGH-TECH CONCEPTION, *supra* note 35, at 272.

³²⁶ 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(1) FERTILITY & STERILITY 90 (July, 1997). The article notes that only 24 percent of the women in the study understood that ovarian cancer is usually fatal.

contraceptives over a period of years.³²⁷ 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.³²⁸ The theory behind this phenomenon is that pregnancy somehow reverses malignant transformations in the ovaries.³²⁹

Taking birth control pills may be unacceptable to an infertile woman who continues to want to bear a child. In these situations, bearing a child may be the only acceptable way for the infertile woman to reduce her ovarian cancer risk. If the infertility is caused by an ovulation disorder, the infertile woman may have a much better chance of bearing a child if she enlists the assistance of an egg donor. Whether stimulation increases ovarian cancer risk or not, the cancer risk of egg donors would be reduced if they later took oral contraceptives or had a child.

ii. The medical risks of multi-fetal pregnancies to the children and the gestating woman.

(A) The medical risks of multi-fetal pregnancies.

Fertility treatment, especially ovulation induction with clomiphene, greatly increases the risk of pregnancies involving multiple fetuses.³³⁰ 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.³³¹ In recent years, however, fertility specialists have begun to develop new protocols to reduce the risk of multiples.

Multi-fetal pregnancies are riskier both for the woman gestating the fetuses and the fetuses. For example, woman gestating multiples are much more likely to suffer from gestational hypertension severe enough to require hospitalization; 15 percent of women gestating twins and 30 percent of women gestating triplets have to be hospitalized for this condition.³³² Multiple fetuses also increase the risk of cesarean delivery.³³³

The risks to the fetuses are even more distressing. Compared to singletons, multiples have a significantly higher risk of still birth.³³⁴ The risk of preterm delivery and low birth weight is also much higher in multi-fetal pregnancies, especially triplet and

³²⁷ See, e.g., Christine H. Holschneider & Jonathan S. Berek, *Ovarian Cancer: Epidemiology, Biology, and Prognostic Factors*, 18 SEMINARS IN SURGICAL ONCOLOGY 3 (July-Aug. 2000).

³²⁸ Francesca Chiaffarino et al., *Time Since Last Birth and the Risk of Ovarian Cancer*, 81(2) GYNECOLOGIC ONCOLOGY 233-236 (May 1, 2001) (being pregnant later in life reduces ovarian cancer risk); On the other hand, being pregnant early in life and increased number of years since last pregnancy are associated with an increased ovarian cancer risk. Glinda S. Cooper et al., *Pregnancy Recency and Risk of Ovarian Cancer*, 10 CANCER CAUSES CONTROL 397 (1999).

³²⁹ Cooper et al., *supra* note 328, at 397-402.

³³⁰ RESOLVING INFERTILITY, *supra* note 2, at 115-16.

³³¹ HIGH-TECH CONCEPTION, *supra* note 35, at 283-84.

³³² *Id.*

³³³ *Id.*

³³⁴ William N. Spellacy et al., *A Case-Control Study of 1253 Twin Pregnancies From a 1982-1987 Perinatal Data Base*, 75(2) OBSTETRICS & GYNECOLOGY 168 (Feb. 1990).

higher-order pregnancies.³³⁵ Low birth weight babies in turn have a much higher risk of cerebral palsy.³³⁶ Multiples also have a higher risk of congenital abnormalities and certain diseases.³³⁷ 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 13 times as likely to die during the first year of life.³³⁸ Largely due to the increased medical risks of multi-fetal pregnancies, the medical costs of multi-fetal pregnancies are significantly higher than the medical costs of delivering singletons; the cost of a triplet delivery is often over \$100,000³³⁹ and, in some cases, can be more than \$1 million.³⁴⁰

Fertility treatment involving ovarian stimulation increases the risk of multiples.³⁴¹ Ovarian induction with clomiphene causes a woman's ovaries to produce multiple egg follicles. Typically, a patient taking clomiphene would attempt to fertilize the eggs either by intercourse or artificial insemination. In such cases, many of the eggs may fertilize.

Ovarian stimulation by injectable gonadotropins also causes a woman's ovaries to produce multiple egg follicles. Patients injecting gonadotropins typically try to fertilize the eggs and implant the embryos in an IVF procedure. In an IVF procedure, the fertility specialist can determine how many embryos to implant. Physicians trying to decide how many embryos to implant have to consider two competing concerns. Infertile patients are often financially constrained by the high costs of IVF, so they encourage their fertility doctors to transfer as many embryos as possible in the hope of increasing their chances of getting pregnant. Infertile patients are usually delighted at the prospect of twins and are willing to risk triplets to increase their chances of having a child.³⁴²

³³⁵ Laura A. Schieve et al., *Live-Birth Rates and Multiple-Birth Risk Using In Vitro Fertilization*, 282 JAMA 1832 (Nov. 17, 1999); Michael O. Gardner et al., *The Origin and Outcome of Preterm Twin Pregnancies*, 85(4) OBSTETRICS & GYNECOLOGY 553 (April 1995). Thirty to fifty percent of twin deliveries are preterm and 75 to 100 percent of triplet or higher-order deliveries are preterm. HIGH-TECH CONCEPTION, *supra* note 35, at 283. Over half of twins and 75 percent of triplets are low birth weight. *Id.*

³³⁶ P.O. Pharoah & T. Cooke, *Cerebral Palsy and Multiple Births*, 75(3) ARCHIVES OF DISEASE IN CHILDHOOD (FETAL AND NEONATAL ED.) 174 (NOV. 1996). HIGH-TECH CONCEPTION, *supra* note 35, 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." *Id.*

³³⁷ William N. Spellacy et al., *A Case-Control Study of 1253 Twin Pregnancies From a 1982-1987 Perinatal Data Base*, 75(2) OBSTETRICS AND GYNECOLOGY 168 (Feb. 1990). Low birth weight babies have a higher risk of "cardiovascular disease, diabetes, abnormal blood clotting, excessive fat, or obstructive lung disease later in life." HIGH-TECH CONCEPTION, *supra* note 35, at 284.

³³⁸ Schieve et al., *supra* note 338.

³³⁹ McCullough, *supra* note 141.

³⁴⁰ Jamie Malernee, *Blastocyst Transfer*, CHI. TRIB., Sept. 27, 1999, at 7C.

³⁴¹ Allan Templeton & Joan K. Morris, *Reducing the Risk of Multiple Births by Transfer of Two Embryos After In Vitro Fertilization*, 339(9) NEW ENG. J. MED. 573-77 (Aug. 27, 1998).

³⁴² HIGH-TECH CONCEPTION, *supra* note 35, at 282. Kearney notes that having triplets is more difficult than patients realize. He cites a study in which *all* of the mothers of the 11 sets of triplets in the study "reported fatigue, emotional distress, and difficult relationships with their children even four years after birth." *Id.* at 284-85. Four of the mothers in the study said they regretted having triplets. *Id.* at 285.

Over the past decade, multiple birth rates have been increasing as a result of fertility treatment.³⁴³ In 1995, 40 percent of multi-fetal pregnancies were attributable to ovulation induction without IVF and 40 percent were attributable to stimulation with IVF.³⁴⁴ The medical community has expressed serious concerns about rising multiple birth rates and called for the adoption of measures to decrease the risk of multiples.³⁴⁵

(B) The development of new protocols to reduce the risks of multi-fetal pregnancies.

In recent years, numerous researchers, including doctors from the Centers for Disease Control, have been studying the relationship between fertility treatment and the risk of multiples to try to establish new protocols to reduce the risk of multiples.

The recent IVF research has been promising. In numerous studies, researchers have discovered that they can now better predict the risk of multiples in IVF procedures based on: (1) the number of embryos transferred; (2) the age of the eggs (the age of a mother's eggs or donor's eggs); and (3) the quality of the embryos from which the doctor can select those to implant.³⁴⁶ Various studies have made recommendations about the optimal number of embryos to transfer, in order to balance the patient's interest in maximizing pregnancy rates and the risks of multi-fetal pregnancies.³⁴⁷

Data for 1998 indicate that fertility doctors transferred fewer embryos per cycle than in earlier years.³⁴⁸ For example, the average number of embryos transferred for patients age 34 or younger dropped from 4 embryos per cycle in 1995 to 3.4 embryos per cycle in 1998. This drop in the number of embryos transferred did not reduce the rate of

³⁴³ McCullough, *supra* note 141. Richard L. Paulson, 35 ASRM NEWS 7 (Spring 2001) ("the incidence of triplet and higher-order multiple births in the United States increased from 29 per 100,00 in 1971 to 174 per 100,000 in 1997").

³⁴⁴ Paulson, *supra* note 343.

³⁴⁵ See, e.g., Paulson, *supra* note 343, at 7 ("The high incidence of multiple gestations following assisted reproductive technologies (ART's) 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.")

³⁴⁶ See, e.g., Schieve et al., *supra* note 335.

³⁴⁷ 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 birth rate but substantially increased the multiple birth rate. Templeton & Morris, *supra* note 341, at 573-77. Another study concluded that: (1) for women age 35 or younger, the optimal number of embryos to transfer is two to four depending on egg quality; and (2) for women age 40 or older, the optimal number of embryos to transfer is up to five regardless of quality. 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. Selim Senoz et al., *An IVF Fallacy: Multiple Pregnancy Risk is Lower for Older Women*, 14(4) J. OF ASSISTED REPRODUCTION AND GENETICS 192-98 (Apr. 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. Murat Tasdemir et al., *Two Instead of Three Embryo Transfer in In-Vitro Fertilization*, 10(8) HUMAN REPRODUCTION 2155-58 (Aug. 1995).

³⁴⁸ *New Data From CDC Show No Decline in Multiple Births Associated With Advanced Fertility Treatment*, PR NEWSWIRE, Jan. 16, 2001 (citing data from THE 1998 CDC REPORT).

multiples, but further reductions in the number of embryos transferred will likely reduce the rate of multiples, based on the research on the optimal number of embryos to transfer.

In November, 1999, the American Society of Reproductive Medicine issued new treatment guidelines on the number of embryos to be transferred in IVF procedures. For example, the new guidelines provide that no more than two embryos are to be transferred if the patient is 34 or younger and the quality and quantity of embryos is good.³⁴⁹

Reducing the risk of multiples in ovulation induction with clomiphene is less precise. In ovulation induction with IUI,³⁵⁰ the doctor has less control over the fertilization process than in IVF. In all cases, a doctor must monitor the developing follicles in order to determine how many will probably reach maturity during the cycle.³⁵¹ If numerous (*e.g.*, six or more) follicles 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.³⁵² A recent study indicates that, if six or more follicles are developing well, canceling the cycle significantly reduces the risk of multiples.³⁵³ Another protocol is to extract some of the developing follicles by needle aspiration and proceed with the cycle.

A recent study concluded that the risk of multiples is more effectively controlled in IVF than in ovulation induction with IUI.³⁵⁴ The ASRM is currently considering whether IVF should be used more widely, instead of ovulation induction, to reduce the risk of multiples.³⁵⁵

*Ironically, the risk of multiples, especially triplets and higher-order multiples, is lower in states that mandate comprehensive insurance coverage of infertility.*³⁵⁶ 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 multi-fetal pregnancies³⁵⁷ or by the underlying

³⁴⁹ American Society of Reproductive Medicine, Committee Opinion, *Guidelines on Number of Embryos Transferred* (Revised and Amended, Nov. 1999).

³⁵⁰ The same is true for stimulation by injectable gonadotropins followed by IUI.

³⁵¹ Some of the recent, highly publicized multiple births resulted from the use of clomiphene without adequate medical monitoring. RESOLVING INFERTILITY, *supra* note 2, at 116.

³⁵² Even if the doctor cancels the cycle (meaning the doctor stops the ovulation induction drugs, does not trigger the release of the follicles with an hCG shot and does not do an IUI), the patient may still get pregnant with intercourse, in which case the pregnancy may be a multi-fetal pregnancy.

³⁵³ Richard P. Dickey et al., *Relationship of Follicle Numbers and Estradiol Levels to Multiple Implantation in 3,608 Intrauterine Insemination Cycles*, 75(1) FERTILITY & STERILITY 69 (Jan. 2001).

³⁵⁴ McCullough, *supra* note 141.

³⁵⁵ *Id.*

³⁵⁶ RESOLVE Responds to New Report on Trends in Multiple Births Following Infertility Treatment, PR Newswire, June 22, 2000.

³⁵⁷ The medical risks of multi-fetal pregnancies are discussed *supra* at ____.

cause of infertility (such as in utero exposure to DES).³⁵⁸ There is no evidence that IVF or GIFT increases the risk that the child or children gestated will have birth defects or chromosomal abnormalities.³⁵⁹

ICSI, a new type of fertility treatment that was developed about 10 years ago, has been found to increase the risk of certain types of chromosomal abnormalities. Recall that ICSI is used in conjunction with IVF, where there is severe male factor infertility. In ICSI, an embryologist or technician injects a single sperm into a single egg. Using ICSI dramatically increases fertilization rates, so it has been hailed as a revolutionary treatment for severe male factor infertility.³⁶⁰ In the last few years, ICSI has been used much more frequently. During 1998, for example, ICSI was used in about 40 percent of ART cycles.³⁶¹

From the time it was developed, geneticists expressed concerns that ICSI posed two types of potential risks: (1) first, the physical process of injecting a needle into the egg to deposit the sperm might cause genetic damage; and (2) second, ICSI may allow a father, who has a genetic defect and would not have been able to have children without ICSI, to pass that genetic defect on to his child.³⁶² So far, the first problem has not materialized; there is no evidence that ICSI increases the risk of birth defects.³⁶³ On the

³⁵⁸ RESOLVING INFERTILITY, *supra* note 2, at 138.

³⁵⁹ HIGH-TECH CONCEPTION, *supra* note 35, at 286. A single Australian study concluded that children conceived by IVF and GIFT had increased rates of neurological defects, but the study had certain limitations and researchers have subsequently reaffirmed the view that IVF and GIFT do not increase the risk of neurological defects. *Id.* at 286-87. The author of HIGH-TECH CONCEPTION, a geneticist with a Ph.D., cautions that we should continue to monitor children conceived with IVF and GIFT in case problems show up years from now. *Id.* at 287-89.

³⁶⁰ HIGH-TECH CONCEPTION, *supra* note 35, at 115-16.

³⁶¹ CENTERS FOR DISEASE CONTROL AND PREVENTION, AMERICAN SOCIETY OF REPRODUCTIVE MEDICINE, & RESOLVE, 1998 ASSISTED REPRODUCTIVE TECHNOLOGY SUCCESS RATES 29 (2000) [hereinafter THE 1998 CDC REPORT]. The rate mentioned is for all ART cycles that involved fresh, nondonor eggs or embryos. *Id.*

³⁶² *Id.* at 120-21.

³⁶³ *Id.* at 121 (describing research being conducted in Brussels and New York). The geneticist author of HIGH-TECH CONCEPTION cautions that it is very difficult to detect some defects that are caused by minute changes in chromosomes:

[A] problem with these studies is the limited power of the measurements they have used to detect genetic defects. Chromosomal abnormalities are major-sized genetic defects. The human genome contains more than three billion individual pieces (nucleotides) of information in its DNA. . . . ICSI children have been examined for loss of chromosomes, additional chromosomes, large-scale scrambling of chromosomes, and so on. These techniques can visualize genetic damage only encompassing from millions to tens of millions of nucleotides. But important genetic defects can be caused by much smaller changes. For example, most people with the genetic disease cystic fibrosis have a deletion of only three nucleotides in an essential gene. Trying to observe minute changes like these using chromosomal analysis is equivalent to standing on the surface of the moon and using binoculars to try to read the license plates of cars on a freeway in Los Angeles. More refined techniques do exist to identify genetic defects, but they are only used when we know where to look – in other words, when the gene responsible for the condition has been identified, as is the case, for example, with cystic fibrosis.

other hand, studies have concluded that ICSI does increase the risk of various chromosomal abnormalities, some of which are extremely serious.³⁶⁴

The great benefit of ICSI is that it can permit men with severe male factor infertility to conceive. The problem is that many different genetic defects can cause male factor infertility, and only a few of these problems have been identified.³⁶⁵ 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.³⁶⁶ Some of the sex chromosomal defects will render the children infertile, as their fathers were.³⁶⁷ Cystic fibrosis³⁶⁸ and Turner's Syndrome³⁶⁹ are two of the more serious defects that can be attributable to ICSI.

On the other hand, the vast majority of children born as a result of ICSI are normal. In addition, certain of the risks of ICSI can be reduced. For example, genetic testing of the patient and his partner can detect certain chromosomal abnormalities.³⁷⁰ In addition, 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.³⁷¹ A spate of recent medical articles recommends genetic counseling and genetic testing for couples considering ICSI.

Children of older mothers have a higher risk of certain chromosomal abnormalities, even without any fertility treatment.³⁷² For example, the child of a 40-year old woman has a 1 in 100 probability of having Downs Syndrome.³⁷³ The age of the egg determines the age-related risks, so using eggs donated from a younger woman reduces these risks.³⁷⁴

Id.

³⁶⁴ *Id.*

³⁶⁵ *Id.* at 124-25.

³⁶⁶ *Id.*

³⁶⁷ For example, Klinefelter's Syndrome (having two X chromosomes and a Y chromosome) can be passed from a father to a son by ICSI. The abnormalities cause by Klinefelter's Syndrome can be severe or limited. About 15 percent of men with Klinefelter's Syndrome look normal but are "mosaics," meaning that some of their cells have the normal XY chromosomal pattern and other cells have the XXY pattern. HIGH-TECH CONCEPTION, *supra* note 35, at 122.

³⁶⁸ Some men do not have the tubes that connect the testes and the urethra. This abnormality is called congenital absence of the vas deferens (CAVD). Men with CAVD may produce normal sperm in the testes but the sperm cannot leave the testes so they cannot fertilize an egg naturally. The sperm of men with CAVD can be removed surgically and injected into an egg using ICSI. The problem is that men with CAVD carry the genetic defect that causes cystic fibrosis. If the egg comes from a woman who is also a cystic fibrosis carrier, the child could have a very serious case of cystic fibrosis. Brian Kearney, the author of HIGH-TECH CONCEPTION, notes that women can now be screened to determine if they are cystic fibrosis carriers, but this genetic test was not available when ICSI was first used. He mentions this problem with screening for cystic fibrosis as an example of "[t]he risk of using a powerful technology like ICSI without understanding all the underlying disease processes." HIGH-TECH CONCEPTION, *supra* note 35, at 126.

³⁶⁹ Turner's Syndrome causes a variety of physical abnormalities, as well as heart and kidney problems. *Id.* at 122.

³⁷⁰ *Id.* at 126.

³⁷¹ *Id.*

³⁷² RESOLVING INFERTILITY, *supra* note 2, at 149.

³⁷³ *Id.*

³⁷⁴ THE FERTILITY GUIDE, *supra* note 23, at 143 (1998).

(B) Potential psychological risks to the child or children.

The first IVF child was born in 1978,³⁷⁵ 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.³⁷⁶ Studies have also concluded that parents who become parents after fertility treatment parent well.³⁷⁷

That being said, mental health professionals caution 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.³⁷⁸ Secrecy in connection with fertility treatment dates back 100 years to the early days of sperm donation.³⁷⁹ Medical doctors thought it would be best for the family and children to keep the sperm donation a secret, not realizing the negative impact that such a secret could have in the future.³⁸⁰

Mental health professionals were not consulted until fairly recently. As late as 10 years ago, a group of international studies indicated that most of the families in the study who had resorted to sperm donation had decided not to tell the children.³⁸¹ As mental health professionals have gotten more involved in fertility treatment, they have urged parents to be open with their children about their origins. They have argued that secrets can have very negative effects on family dynamics, and on the child who later in life discovers the secret, so parents should be forthcoming.³⁸²

b. The judgments about fertility treatment that may be affected by heuristic 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

³⁷⁵ RESOLVING INFERTILITY, *supra* note 2, at 12.

³⁷⁶ 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(2) CHILD DEVELOPMENT 599 (March-Apr. 2001).

³⁷⁷ 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(2) CHILD DEVELOPMENT 285 (April 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").

³⁷⁸ CHOOSING ASSISTED REPRODUCTION, *supra* note 16, at 350-57 (1998).

³⁷⁹ *Id.* at 340.

³⁸⁰ *Id.* at 341.

³⁸¹ *Id.* at 343.

³⁸² CHOOSING ASSISTED REPRODUCTION, *supra* note 16, at 351 (1998), quoting from Patricia Mahlstedt & Dorothy Greenfield, *Assisted Reproduction with Donor Gametes: The Need for Patient Preparation*, FERTILITY & STERILITY (1989).

Fertility Clinic Success Rate and Certification Act.³⁸³ This legislation requires the Centers for Disease Control and Prevention (the CDC) to compile and publish success rates for assisted reproductive technology (ART) treatments at hundreds of U.S. fertility clinics.³⁸⁴ The CDC works with the Society for Assisted Reproductive Technology (SART), an organization of fertility doctors, to compile the data.

The most recent report, which was issued in December 2002, is for fertility treatment during calendar year 2000.³⁸⁵ The report, 2000 Assisted Reproductive Technology Success Rates (the “2000 CDC Report”), includes a report based on national data, as well as success rates for 383 specific fertility clinics. The national data are based on information gathered from 99,639 ART cycles in 2000.

The national data indicate a 25.4 percent live birth rate per ART cycle.³⁸⁶ Broken down by age of the mother, the live birth rate per cycle was:

- (1) 32.8 percent for women ages 34 or younger;
- (2) 26.7 percent for women ages 35-37;
- (3) 18.5 percent for women ages 38 to 40; and
- (4) 10.1 percent for women ages 41-42.³⁸⁷

The report further breaks down the live birth rate per cycle for over-forty women. For over-forty women, the live birth rate per cycle was:

- (1) 15.2 percent for 40-year-old women;
- (2) 11.7 percent for 41-year-old women;
- (3) 8.1 percent for 42-year-old women;
- (4) 5.3 percent for 43-year-old women; and
- (5) 2.2 percent for women ages 44 and older.³⁸⁸

Live birth rate per cycle is also broken down based on the infertility diagnosis. The various diagnoses had the following live birth rates per cycle:

- (1) Male factor: 29.3 percent;
- (2) Endometriosis: 28.4 percent;
- (3) Ovulatory dysfunction: 28.6 percent;
- (4) Tubal factor: 26.7 percent;
- (5) Uterine factor: 19.7 percent;
- (6) Other identifiable causes: 22 percent; and
- (7) Unexplained cause: 28 percent.³⁸⁹

³⁸³ Fertility Clinic Success Rate and Certification Act of 1992, Pub. L. No. 102-493, § 1, 106 Stat. 3146. For a discussion of the events leading up to the enactment of this law, *see* HIGH-TECH CONCEPTION, *supra* note 35, at 32-33.

³⁸⁴ Fertility Clinic Success Rate and Certification Act of 1992, Pub. L. No. 102-493, § 1, 106 Stat. 3146.

³⁸⁵ 2000 CDC REPORT, *supra* note 44.

³⁸⁶ Live birth means “a delivery of one or more living babies.” *Id.* at 17.

³⁸⁷ *Id.* at 73.

³⁸⁸ *Id.* at 23.

These rates can be considered in relation to the overall probability of a couple getting pregnant in one natural cycle with no medical treatment; the pregnancy probability is 10 percent or less per cycle.³⁹⁰ On the other hand, this comparison can be misleading 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 cost and difficulty involved.³⁹¹

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. Geneticist Brian Kearney notes:

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 always has six 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.³⁹²

Various studies have tried to determine *cumulative* success rates for IVF, but have reached conflicting conclusions. Some studies have concluded that success rates drop sharply after the first failed IVF; others have concluded that success rates stay the same for six or more cycles.³⁹³ Geneticist Brian Kearney believes these various studies warrant some skepticism because of certain methodological limitations of the studies.³⁹⁴ In his view, the best study was a study from the U.K. that included data from almost 37,000 cycles during the years 1991 to 1994.³⁹⁵ That study concluded that “the 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.”³⁹⁶ Based on this study, Kearney argues: “In short, IVF is not like rolling dice. It’s worse. If a couple doesn’t

³⁸⁹ *Id.* at 27.

³⁹⁰ HIGH-TECH CONCEPTION, *supra* note 35, at 26.

³⁹¹ *Id.* at 26.

³⁹² *Id.* at 40-41.

³⁹³ *Id.* at 43.

³⁹⁴ *Id.*

³⁹⁵ *Id.* at 43-44.

³⁹⁶ *Id.* at 44.

give birth by the fourth attempt, they are unlikely to be successful continuing the same treatment and should consider alternatives.”³⁹⁷

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 just persist with their fertility treatment. If so, they may overestimate the chances of their treatment being successful. They may overestimate their chances of success *even more* if they assume that fertility treatment has cumulative odds like rolling dice *and* they overestimate the odds of success in later individual cycles due to the “gambler’s fallacy.”³⁹⁸ For example, they may assume that, with a 20 percent per cycle success rate for IVF, their odds of success after four unsuccessful cycles would be much higher than 20 percent in their next IVF cycle.

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 for purposes of our discussion is that we should encourage fertility patients to consider alternative treatment where a specific type of fertility treatment has already failed repeatedly. Specifically, we should encourage patients to consider egg donor or surrogacy procedures where IVF has failed repeatedly.

ii. The potential for underestimating the risk of multi-fetal 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 multi-fetal pregnancies. Recall that multi-fetal pregnancies, which are more likely with fertility treatment, pose very significant risks for the fetuses and the women gestating them. The more embryos implanted, the more likely it is that the pregnancy will be multi-fetal. Fertility patients nonetheless usually press their doctors to

³⁹⁷ *Id.*

³⁹⁸ AMOS TVERSKY & DANIEL KAHNEMAN, *Judgment Under Uncertainty: Heuristics and Biases*, in DANIEL KAHNEMAN ET AL., *JUDGMENT UNDER UNCERTAINTY: HEURISTICS AND BIASES* 7 (1999).

People expect that a sequence of events generated by a random process will represent the essential characteristics of the 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 the local representativeness is the well-known gambler’s fallacy. After observing a long run of red on the roulette wheel, ... most people erroneously believe 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. (reference omitted).

implant many embryos in order to increase their chances of getting pregnant. The patients often prefer twins to a single child, and are willing to risk a triplet or higher order multi-fetal pregnancy. Fertility patients may not comprehend the magnitude of the medical risks of twin or triplet pregnancies, or the difficulty of raising triplets.³⁹⁹

Recall also that it is not clear whether repeated stimulation of a woman's ovaries increases her risk of ovarian cancer. The studies that have linked ovarian stimulation and cancer risk have been discounted due to their methodological limitations, but that does not mean that there is definitely no risk.

In a 1997 study, about 80 percent of women requiring fertility treatment indicated that they would take ovulation induction drugs even if the drugs increased their risk of ovarian cancer slightly.⁴⁰⁰ The article also notes, however, that only 24 percent of the women in the study understood that ovarian cancer is usually fatal. In addition, fertility patients may be assuming that "it won't happen to me."⁴⁰¹

Of course, other medicines also have side effects. Viagra, for example, has life threatening side effects.⁴⁰²

3. Implications for various types of fertility treatments.⁴⁰³

(a) Surgical treatment that cures or treats infertility.

Treatments that cure or treat infertility include surgical correction of varicocele, blocked fallopian tubes, and endometriosis. In some case, the benefits of these procedures may not be as great as the benefits of IVF, and these procedures have their own medical risks. For example, a woman may be more likely to have an ectopic pregnancy after tubal surgery. On the other hand, these procedures do not run the risks of

³⁹⁹ HIGH-TECH CONCEPTION, *supra* note 35, at 282. Kearney notes that having triplets is more difficult than patients realize. In one study of 11 triplet families, four of the mothers in the study said they regretted having triplets. *Id.* at 285.

⁴⁰⁰ Barry Rosen et al., *supra* note 326, at 90.

⁴⁰¹ The "it won't happen to me" bias is described in Paul Slovic et al., *Facts Versus Fears: Understanding Perceived Risk*, in DANIEL KAHNEMAN ET AL., JUDGMENT UNDER UNCERTAINTY: HEURISTICS AND BIASES 470 (1999).

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 from 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 the 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.

⁴⁰² Lisa Thomlinson, *Viagra Linked to 17 deaths*, THE EVENING STANDARD (LONDON), May 17, 1999, at 5.

⁴⁰³ This section draws on many points made earlier in this article, which are not separately footnoted when they are mentioned here.

ovarian stimulation, including the risks of hyperstimulation and multi-fetal pregnancies. The costs of the surgical treatment of reproductive diseases and structural abnormalities should be treated as medical costs.

(b) Ovarian stimulation with IUI or IVF.

The benefits of ovarian stimulation with IUI or IVF often exceed the benefits of surgical treatment. (The relative benefits depend on the nature of the infertility.) Patients express with their wallets their strong preference for this type of treatment. The biggest countervailing consideration is the large, negative effect on welfare caused by multi-fetal pregnancies. The fertility community and the Centers for Disease Control are developing new protocols to reduce the risk of multi-fetal pregnancies, so this risk will likely be reduced as treatment protocols evolve.

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

Another concern is that patients may overestimate the benefits of multiple cycles of high-tech treatment and underestimate the risks of treatment, especially the medical risks associated with multi-fetal pregnancies. If patients fail to understand that their chances of success decline with each subsequent attempt, as is likely the case, alternative treatments that are more effective, such as donor and surrogacy procedures, should be encouraged. The risk of multi-fetal pregnancy should be emphasized in fertility treatment counseling, but the subsidy does not need to be reduced to respond to this risk. In fact, subsidizing fertility treatment ironically *reduces* the rates of multi-fetal pregnancies.

On balance, the cost of this treatment should be treated as a medical expense, given the profound desire of patients to increase their chances of conceiving and bearing a child and the effect of subsidies on the risk of multi-fetal pregnancies.

(c) Donor and surrogate procedures.

Collaborative reproduction, with a donor or surrogate, produces very great benefits for the parents and child. Some patients choose to adopt if they cannot have a biological or gestational connection to a child, but many patients vastly prefer collaborative reproduction to adoption. Also, many parents who would like to adopt healthy babies in the U.S. cannot because there is a shortage of such babies. In addition, the tax subsidy for adoption is typically more generous than the tax subsidy for the medical treatment of infertility, so the tax law favors adoption over collaborative reproduction, even if the cost of collaborative reproduction is deductible as a medical expense.

Egg donation involves medical risks to the donor and the woman who gestates the fetus or fetuses. Ovarian stimulation of an egg donor entails the serious but uncommon

rik of hyperstimulation. Also, an increased risk of ovarian cancer from repeated ovarian stimulations is possible but has not been established. Even if a connection between stimulation and ovarian cancer is later made, egg donors are usually stimulated fewer times than are fertility patients (often just once) and can reduce their cancer risk by later taking oral contraceptives or bearing a child. The infertile woman could also reduce own her risk of ovarian cancer by proceeding with egg donation and bearing a child, which is another benefit of the procedure. (The alternative, taking oral contraceptives to reduce ovarian cancer risk, will be unacceptable to most fertility patients.) The woman who gestates runs the risks associated with multi-fetal pregnancies.

The basic donor fee should be deductible or reimbursible, in part to permit older women to conceive and bear a child and, in part, to encourage older 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 the increased costs of creating a “designer” baby.

From the perspective of the surrogate, the strongest negative is the medical risk associated with multi-fetal pregnancies, but this risk can be reduced. The cost of a surrogacy 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.

VI. Conclusion.

The experience of infertility is devastating entails 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, but under current law fertility treatment costs, including the additional costs of surrogacy, are “medical expenses” for purposes of the section 213 medical expense deduction. The IRS has taken the position that surrogacy expenses are not deductible as medical expenses, arguing that surrogacy does 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.

Most people conceive and bear children without having to incur expenses for fertility treatment. Some have argued that the costs of fertility treatment should not be deductible because people can lead a “normal” life without having children. On the other hand, people who would like to bear a child, but cannot because of a physiological condition, are not leading a “normal” life. Infertility is a loss, just as a broken leg is a loss. Under section 213, the term “medical expense” is defined by reference to a baseline of normal biological functioning, which includes reproductive and sexual functioning. Expenses incurred to try to return to or approximate the baseline of normal reproductive health are deductible, even if the taxpayer winds up “better off,” with a child, after the fertility treatment.

Given the existence of the section 213 medical expense deduction, taxpayers also *should* be able to deduct the cost of fertility treatments, including conventional treatments, ovarian stimulation with IUI or IVF, and collaborative reproduction with a donor or surrogate. They should also be able to deduct the costs of medical care for

sexual dysfunction, such as Viagra (which, in many ways, is similar to fertility treatment), and medical care that facilitates reproductive choice (which, in some ways, presents a tougher case for deductibility under section 213).

Reproduction is extremely important to most people and the elasticity of demand of 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 treatment option, which in some cases is IVF, an egg donor procedure, or a surrogate procedure; and (2) ironically, *reduce* the rate of risky multi-fetal pregnancies.

Even if fertility treatment costs are characterized as medical expenses, the tax code still favors adoption over fertility treatment, because the medical expense deduction, which functions like a co-pay, 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 consequentialist normative approach.