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# ARTICLES

## THE MEDICAL EXPENSE DEDUCTION: A PRELIMINARY POSTMORTEM

JOEL S. NEWMAN\*

The passage of a universal health care plan, in any of its suggested forms,<sup>1</sup> would signal the end of an era for section 213 of the Internal Revenue Code.<sup>2</sup> By reducing the amount of unreimbursed expenditures for medical care incurred by American taxpayers, the proposed health care plans would significantly diminish the expenditures that would have been subject to the section 213 deduction. Furthermore, a massive increase in federal subsidization of medical care at the consumer level might make many members of Congress more receptive to proposals to reduce the scope of the remaining deduction.<sup>3</sup> In fact, some of the proposals now in Congress would reduce the deduction.<sup>4</sup>

In light of its impending demise, the time is now appropriate for a review of the application of section 213 in its heyday. A focus upon certain categories at the fringes of the definition of medical care is especially appropriate for two reasons. First, the experience of section 213

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1. H.R. 6405, 96th Cong., 2d Sess. (1980); S. 350, 96th Cong., 1st Sess. (1979); S. 748, 96th Cong., 1st Sess. (1979); S. 760, 96th Cong., 1st Sess. (1979); S. 1590, 96th Cong., 1st Sess. (1979); S. 1720, 96th Cong., 1st Sess. (1979); S. 1812, 96th Cong., 1st Sess. (1979); STAFF OF SENATE COMM. ON FINANCE, 96TH CONG., 1ST SESS., SUMMARY OF ACTION ON HEALTH LEGISLATION 96-22 (Comm. Print 1979); SENATE COMM. ON FINANCE, PRESS RELEASE NO. 158, *Finance Committee Continues Action on Catastrophic Health Insurance* (Nov. 1, 1979).

2. Hereinafter, references to sections without further description will be to the Internal Revenue Code of 1954. "1939 Code" will refer to the Internal Revenue Code of 1939.

3. See *The President's 1978 Tax Reduction and Reform Proposals: Hearings before the House Committee on Ways and Means*, 95th Cong., 2d Sess. 153 (1978) (statement of Rep. Keys).

4. See notes 229-46 and accompanying text *infra*.

in these areas is relevant to the continuing debate concerning the scope of "medical care" under the proposed health care legislation. Second, if any of the current health care proposals are enacted, some of the most significant categories of medical care to which section 213 will still apply will be those upon the fringes of the definition. For these reasons, this Article will review the experience under section 213 of the categories of (1) incidental travel expenses,<sup>5</sup> (2) expenses of coping with, as opposed to curing, medical problems,<sup>6</sup> and (3) extravagant medical expenses.<sup>7</sup>

Even a passing glance at these categories under section 213 reveals that, with but one exception,<sup>8</sup> the parameters of section 213 have been interpreted more narrowly than those of other deductions, especially those of the business-oriented deductions. Therefore, before getting into specifics, this Article will examine what there is about section 213, if anything, that justifies this more restrictive treatment.

## I. CHARACTERIZATIONS OF THE MEDICAL EXPENSE DEDUCTION

### A. SECTION 213 AS A PERSONAL DEDUCTION

The medical expense deduction is clearly a personal deduction. C. Harry Kahn comments:

Under the federal personal income tax law—as indeed under many foreign and most state income tax laws—provision has been made for two kinds of deductions. There are, first, those intended to refine gross income to economic net income by subtraction from gross receipts of the expenses and losses incurred in the pursuit of income. Second, there are the deductions that, at the discretion of Congress, are intended to attain a particular goal of social or economic policy, or to help establish a measure of a person's capacity to pay taxes, which transcends the limits of a strictly economic concept of income.<sup>9</sup>

In general, Kahn's first category describes business deductions and his second category describes personal deductions. The case for allowing the deduction of business expenses is clearly more compelling. Deduction of business expenses from gross income is necessary to reach the economic net income, which, it is generally agreed, is the proper tax

5. See notes 34-80 and accompanying text *infra*.

6. See notes 82-120 and accompanying text *infra*.

7. See notes 139-57 and accompanying text *infra*.

8. See the discussion of medical commuting, notes 58-80 and accompanying text *infra*.

9. C. KAHN, PERSONAL DEDUCTIONS IN THE FEDERAL INCOME TAX 1 (1960).

base for the entire system. In contrast, deduction of personal expenses is not necessary for the determination of the net income tax base. Moreover, there is no inherent limiting factor on personal expenses. Business expenses are controlled by the profit maximization motives of the rational businessman: the lower his expenses, the higher are his profits. There is no such motivation to limit personal expenses. Indeed, deductibility of personal expenses would encourage extravagant living, and thus both violate the goal of tax neutrality and create a distortion in the efficient allocation of economic resources. Therefore, absent special circumstances, personal expenses are not deductible.<sup>10</sup>

### B. SECTION 213 AS A HARDSHIP DEDUCTION

Although medical expenditures are usually considered a category of personal expenses, special reasons have traditionally been advanced to support their deductibility. The prevailing view is that section 213 was intended to alleviate the hardships of extraordinary medical expenses that often had the effect of significantly reducing the ability of some taxpayers to pay their proportionate share of the tax burden. If the deduction is truly intended to encompass only extraordinary medical expenses, then it should be construed narrowly to prevent taxpayers who are not in real hardship from receiving unintended benefits.

The evidence in the legislative history for the medical expense deduction as a hardship provision is impressive. The medical expense deduction first appeared as section 23(x), added to the 1939 Internal Revenue Code by the Revenue Act of 1942.<sup>11</sup> This section was generally thought to be a response to a suggestion of the late Randolph Paul. In the course of Paul's testimony before the House Ways and Means Committee in support of the bill, the following dialogue took place:

Mr. Boehne. What about the possibility where the husband has an invalid wife? Of course there may not be so many of those cases.

Mr. Paul. Presumably—

Mr. Boehne. Where the husband has an invalid wife and he needs somebody at home to take care of her. Do you think that would come under extraordinary medical expenses?

Mr. Paul. You will notice, Mr. Boehne, that that only refers to extraordinary medical expenses. We think of that in terms of expenses over 5 percent.

Mr. Boehne. I was going to say that that is rather hard to define; is it not? Is it not hard to define an extraordinary medical expense.

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10. See I.R.C. § 262.

11. Pub. L. No. 77-753, 56 Stat. 798 (1942).

Mr. Paul. We have to think of the revenue as well as the considerations of equity, and we do not want to open the door to a deduction for the ordinary medical expenses which go along in ordinary course in the average family. But we do think there should be some allowance, and we think of the allowance in terms of medical expenses in excess of 5 percent of the income, but not to exceed \$2500.<sup>12</sup>

The five percent floor mentioned by Mr. Paul was clearly intended to eliminate those expenses incurred by the average American family from the hardship category of deductible, extraordinary medical expenses.<sup>13</sup> The Senate Finance Committee report on the bill commented:

The term "medical care" is broadly defined and includes amounts paid for accident and health insurance.

. . . .

This allowance is recommended in consideration of the heavy tax burden that must be borne by individuals during the existing emergency and of the desirability of maintaining the present high level of public health and morale.

. . . .

. . . It is not intended, however, that a deduction should be allowed for any expense that is not incurred primarily for the prevention or alleviation of a physical or mental defect or illness.<sup>14</sup>

In discussion of the Conference Committee Report on the bill before the House, Representative Hinshaw commented: "This amendment will be a help to persons or families having to undergo unusual outlays for medical purposes in any year. It is not intended to take care

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12. *Revenue Revisions of 1942: Hearings before the House Committee on Ways and Means*, 77th Cong., 2d Sess. 1613 (1942) (statement of Randolph Paul).

13. The 5 per cent floor was decided on when the data compiled by the National Resources Committee on consumer expenditures in 1935-1936 had already been well digested, and when figures from the Bureau of Labor Statistics' *Study of Family Spending and Savings in Wartime* were just appearing. It is therefore fair to assume that the general effect of the minimum exclusion on the amount and distribution of the deduction was understood from the outset. The data showed that, like expenditures for food and shelter, medical outlays rose as income rose, but not in proportion. They were generally close to 5 per cent of money income for families and single individuals with incomes below \$2,000 and about 3 per cent of income for those with \$5,000 and over. The average for all groups was around 4 per cent. Since the figures showed that the percentage of income spent on medical care tends to vary inversely with income, it was fairly evident that medical hardship, as defined by the tax law, would be most likely to occur among persons in the lower part of the income distribution.

C. KAHN, *supra* note 9, at 129.

14. S. REP. NO. 1631, 77th Cong., 2d Sess. 6, 95-96 (1942), *reprinted in part in* 1 J. SEIDMAN, SEIDMAN'S LEGISLATIVE HISTORY OF THE FEDERAL INCOME AND EXCESS PROFITS TAX LAWS 1953-1939, at 1397 (1954).

of the ordinary medical expenses, which on the average do not exceed 5 percent of net income."<sup>15</sup>

In 1951, when five percent limitation was removed in cases where the taxpayer or the taxpayer's spouse was age 65 or over,<sup>16</sup> the Senate Finance Committee commented: "Persons in that age bracket have generally reached a period of lowered earning capacity. These same individuals typically are confronted with increased medical expenses. Disallowance of the deduction of many of these expenses under present law merely serves to accentuate this existing hardship."<sup>17</sup>

By 1954, it had become apparent that the five percent floor was too high — that it eliminated some extraordinary expenses, as well as the average ones, from deductibility. President Eisenhower's Budget Message noted: "The present tax allowances for unusual medical expenses are too limited to cover the many tragic emergencies which occur in too many families. I recommend that a tax allowance be given for medical expenses in excess of 3 percent of income instead of 5 percent as at present."<sup>18</sup> As a result, the floor was lowered to three percent and the ceilings were raised. The House Ways and Means Committee commented:

Several problems have been raised in connection with the medical-expense deduction. There is general agreement that limiting the deduction only to expenses in excess of 5 percent of adjusted gross income does not allow the deduction of all "extraordinary" medical expenses. Also, in many cases the maximum limitation has created a hardship by preventing the deduction of large medical expenses actually incurred.<sup>19</sup>

The ceilings were raised again in 1962.<sup>20</sup> The Senate Finance Committee report commented:

In some cases, for example the expenses actually exceed the individual's income for the year. Your committee agrees with the House that in these and other such hardship cases the taxpayer should not be required to pay income tax with respect to income which must be

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15. 88 CONG. REC. 8469 (1942).

16. Revenue Act of 1951, Pub. L. No. 82-183, § 307, 65 Stat. 452.

17. S. REP. NO. 781, 82d Cong., 1st Sess. 51, *reprinted in* [1951] U.S. CODE CONG. & AD. NEWS 1969, 2022.

18. The President's Budget Message for 1955, 100 CONG. REC. 570 (1954). *See also* Jensen, *Rationale of the Medical Expense Deduction*, 7 NAT'L TAX J. 274 (1954).

19. H.R. REP. NO. 1337, 83d Cong., 2d Sess. 30, *reprinted in* [1954] U.S. CODE CONG. & AD. NEWS 4017, 4054-55.

20. Revenue Act of 1962, Pub. L. No. 87-834, 76 Stat. 960.

devoted to the payment of legitimate medical bills.<sup>21</sup>

The ceilings were eliminated completely by the subsequent Social Security Amendments of 1965.<sup>22</sup>

The five percent and three percent floors of the medical expense deduction, and the raising and ultimate elimination of all ceilings upon the deduction, give rise to an inference that the deduction was intended to focus upon extraordinary medical expenses — upon medical hardship, not merely average medical activity. The legislative history gives ample support to this inference. As a hardship deduction, section 213 should be construed narrowly. Yet, there is also evidence that even if the medical expense deduction was originally a hardship deduction, events outside the scope of the tax law have changed its function, and Congress has not acted to bring it back into line.

### C. THE CASE AGAINST SECTION 213 AS A HARDSHIP DEDUCTION

When the hardship against which a deduction was directed disappears and yet the deduction remains, it can no longer be considered a hardship deduction. Similarly, if the scope of the deduction expands beyond the scope of the hardship, the rationale of the deduction must be re-examined. Because both of these things have happened to the medical expense deduction, its basis deserves a second look.

First, it should be noted that the original 1942 legislation was directed against two forms of hardship: medical hardship, and "the existing emergency."<sup>23</sup> That emergency was World War II; nevertheless, the deduction was not repealed when the war ended in 1945.

Second, as section 213 becomes available for average medical expenditures, its viability as an extraordinary hardship measure is weakened, and it begins to look more like an across-the-board subsidy for medical expenditures. The notion that expenditures for medical care of up to three percent of adjusted gross income are average, while expenditures exceeding the three percent floor are extraordinary, is no longer tenable. In 1970, consumers' expenditures for medical care averaged 5.9% of personal income.<sup>24</sup> In 1978 the Department of the Treasury predicted that the average taxpayer would spend approximately eight percent of income on medical care.<sup>25</sup>

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21. S. REP. NO. 2274, 87th Cong., 2d Sess. 2 (1962), *reprinted in* 1962-3 C.B. 1208, 1209.

22. Pub. L. No. 89-97, 79 Stat. 286 (1965).

23. C. KAHN, *supra* note 9, at 129.

24. R. GOODE, *THE INDIVIDUAL INCOME TAX* 157 (1976).

25. *The President's 1978 Tax Reduction and Reform Proposals: Hearings before the House*

Congress has been aware of the changing nature of the medical deduction. In 1974 the House Ways and Means Committee tentatively agreed to increase the floor to five percent, but this increase was not enacted into law.<sup>26</sup>

In 1978 President Carter recommended that a floor of ten percent of adjusted gross income be placed under the combined medical and casualty loss deductions.<sup>27</sup> The President's proposal did not survive the House Ways and Means Committee. Instead, a more limited change in the medical expense deduction went to the floor of the House, only to be eliminated in the Senate. It must be noted, however, that the failure of this attempted reform of the medical expense deduction was not due to overwhelming sentiment in the Congress in favor of the present three percent limitation. When a substitute bill was drafted in the House Ways and Means Committee containing compromise legislation on capital gains, the point of greatest controversy, Carter's proposals on raising the medical and casualty expense floors were left out.<sup>28</sup> Although testimony before the House Ways and Means Committee on Carter's proposals showed public sentiment both for and against the proposal,<sup>29</sup> there is evidence from the hearings that at least one Congresswoman was opposed to raising the medical and casualty expense floor because in times of increasing medical costs, it seemed inappropriate to reduce tax relief for medical care without concurrently instituting governmental programs designed to mitigate the hardship of high medical costs.<sup>30</sup>

Perhaps if one of the health care proposals is passed, the climate will be improved for further amendment of section 213. At the moment, however, in light of the high cost of medical care, it would be hard to argue that section 213 is not a partial subsidy. Viewed as a

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*Comm. on Ways and Means, 95th Cong., 2d Sess. 205 (1978) (Dept. of Treasury Statement) [hereinafter cited as 1978 Hearings].*

26. STAFF OF JOINT COMM. ON TAXATION, 95TH CONG., 2D SESS., 1 TAX REDUCTION AND REFORM PROPOSALS 23 (Comm. Print 1978).

27. H.R. 12078, 95th Cong., 2d Sess. (1978).

28. Telephone conversations with House Committee on Ways and Means staff members (June 1979).

29. For testimony in favor of the President's proposal, see *1978 Hearings, supra* note 25, at 977 (statement of Thomas J. Reese for Taxation with Representation); *id.* at 1807 (Report of Comm. on Personal Income, Tax Section, N.Y. St. B.A.). For testimony against the President's proposal, see *1978 Hearings, supra* note 25, at 1540 (statement of Ernst & Ernst), *id.* at 1776-77 (statement of Fed. Tax Div., AICPA); *id.* at 1841 (statement of James Hacking for Am. Assoc. of Retired Persons, Nat'l Retired Teachers Assoc.); *id.* at 5673 (statement of Health Ins. Assoc. of America).

30. See *1978 Hearings, supra* note 25, at 153 (statement of Rep. Keys).

subsidy rather than a hardship remedy, restrictive application is not necessarily required.

#### D. MEDICAL EXPENSES AS NON-CONSUMPTION

Characterization of section 213 as either a hardship deduction or a subsidy is based upon the premise that medical expenses, as a subset of personal expenses, require special justification for deductibility. This premise assumes that our income tax base generally requires business expenses to be deductible, and personal expenses to be nondeductible, absent special circumstances. Yet this income tax base is not clearly defined in the Code. Perhaps a more refined definition of taxable income will give a reason for the deduction of medical expenses without any requirement that special circumstances be shown.

The Haig-Simons definition of taxable income has considerable academic credence. Simons defines income as follows: "Personal income may be defined as the algebraic sum of (1) the market value of rights exercised in consumption and (2) the change in the value of the store of property rights between the beginning and end of the period in question."<sup>31</sup> Basically, Simons characterizes income as consumption plus accumulation. Since medical expenses clearly cannot be accumulation, the key question is whether they can be consumption. Professor Andrews suggests:

[T]he purpose for which personal consumption is used in specifying a personal tax base is . . . to provide an index of relative material well-being on the basis of which to distribute tax burdens . . . . [D]ifferences in health affect relative material well-being. It would be impractical to try to include robust good health directly as an element of personal consumption for those who have it, but the difference between good and poor health can be partially reflected — or the failure to include the difference directly can be partially offset — by also excluding or allowing a deduction for the medical services that those in poorer health will generally need more of.<sup>32</sup>

Most expenditures that would be characterized as consumption expenditures are discretionary, and raise the spender's standard of living from some pre-established norm to a higher level. Medical expenditures are largely nondiscretionary. Moreover, the problems that give rise to medical expenditures normally bring the spender below the

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31. H. SIMONS, *PERSONAL INCOME TAXATION* 50 (1938).

32. Andrews, *Personal Deductions in an Ideal Income Tax*, 86 HARV. L. REV. 309, 335 (1972).

norm of material well-being, thus making the expenditures necessary to regain that norm, not to surpass it. It follows that if consumption is to be used to measure taxable income, then medical expenditures should not be part of that consumption. Under this theory, the medical expense deduction would be just as crucial to the definition of taxable income as the business expense deduction. If so, both would be applied with equal liberality.

#### E. DEFINITIONAL PROBLEMS

Regardless of whether section 213 should function as a hardship deduction, a subsidy, or a necessary adjustment to the definition of taxable income, one must also consider whether there is something inherent in the category of medical care, taxation aside, that requires special, restrictive treatment. The concepts of medical illness and medical care are extremely open-ended. The definition of these concepts is difficult enough for the medical profession; it can be virtually impossible for the legal system. Moreover, because medical care shades so easily into personal gratification, the medical care deduction provides a clear target for abuse.

##### 1. *Medical Illness*

Medical illness is easily detected in the case of a broken limb or a heart attack. When one is dealing with a general feeling of physical malaise, however, the problems multiply. The difficulty level takes a quantum jump with the category of mental illness. Mental illness is difficult to define, and when the legal system is asked to differentiate those periods of depression that normally occur in emotionally healthy people from true mental illness, the task approaches impossibility.

##### 2. *Medical Care*

Even if medical illness can be successfully defined, one must still define medical care. As medical care becomes more sophisticated and less traditional, this task becomes increasingly formidable. Again, there are no definitional problems with an appendectomy. However, when one reaches the myriad of exercise programs designed to speed convalescence, the difficulty of defining medical care is increased.

Medical care in the context of mental illness is even more difficult to define. As the illness becomes more difficult to define, so does the cure. When the goal of the cure is, in lay terms, to feel better, the forms of therapy look increasingly like nondeductible personal consumption. Psychiatric therapy often involves those recreational and vacation ex-

penses that have heretofore been considered the very paradigm of the nondeductible personal expense.

Preventive medicine also raises the spectre of opening the floodgates to the deductibility of many, if not all, personal expenses. If one does not eat, one will starve. Starvation leads to a host of medical problems. Does it follow that the cost of food should be deductible as a preventative medical expenditure? Similarly, if one is not adequately sheltered, one will get sick. Does such reasoning demand that all lodging expenses be deductible as medical expenditures? Clearly, some purely preventative medical expenditures are deductible. The most common example is the routine medical checkup. If some preventative medicine falls within the definition of medical care, how can other clearly personal expenditures be excluded?

The confusion that results from the search for the nature and function of section 213 is mirrored in, or perhaps is the result of, the problems in defining the parameters of "medical illness" and "medical care." Congress and the courts have been aware of these definitional problems and the opportunities for abuse.<sup>33</sup> The uncertainties about function and definition, and the possibilities for abuse engendered thereby, have led to the pattern of inconsistency and suspicion that

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33. The ceilings put on the original legislation were clearly a reflection of this Congressional awareness, and subsequent amendments have reflected these problems as well. In 1954, in comments probably alluding to subsection (e) of the new section 213, the House Committee on Ways and Means commented that "it has been the practice of many taxpayers to deduct amounts spent for ordinary household remedies, which do not represent extraordinary medical expense items." H.R. REP. NO. 1337, 83d Cong., 2d Sess. 30; *reprinted in* [1954] U.S. CODE CONG. & AD. NEWS 4025, 4055.

The ceilings were raised in 1962. Revenue Act of 1962, Pub. L. No. 87-863, § 213(c), 76 Stat. 1141 (codified at I.R.C. § 213(c)) (repealed by Social Security Amendments of 1965, Pub. L. No. 39-97, § 106(d), 79 Stat. 286, 337). The Senate Finance Committee did so with some reluctance:

[I]t is also recognized that it is difficult to accurately determine what constitutes a medical expense, and cases have arisen where items involving large expenses, which may not constitute proper medical expense deductions, nevertheless have been taken and allowed. In order to foreclose the deduction of these questionable types of items, it is necessary to retain some ceiling limitations on medical expense deductions, at least until it is possible to more accurately define proper medical expenses.

S. REP. NO. 2274, 87th Cong., 2d Sess. 2 (1962), *reprinted in* 1962-3 C.B. 1203, 1204.

This 1962 legislation was opposed by the Treasury Department. In a letter to the Senate Committee on Finance, Stanley Surrey, Assistant Secretary of the Treasury, commented:

The principal problem in the administration of the medical expense deduction is determining what is a medical expense. In the past there has been some abuse in the claiming of ordinary living expenses as medical expenses.

The Treasury is presently considering as part of its studies on major tax reform the whole subject of medical expense deduction. In this study, an appraisal is to be made not only of the limitation in present law but also of the definition of items includible in the term "medical expense" as well as other related matters. It would seem inopportune at this point to proceed with a partial amendment of a provision that is under conpre-

emerges in the categories of travel expenses, coping expenses, and extravagant expenses.

## II. TRAVEL EXPENSES

Even if a patient has a doctor willing to treat him, it will not do him much good unless he can get to the doctor's office. Nevertheless, except for the category of medical commuting,<sup>34</sup> travel expenses have been viewed with a jaundiced eye under section 213. Perhaps because they

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hensive study since recommendations shortly may be forthcoming for revision of the whole provision, including the portion which the House bill would now change.

For this reason the Department is opposed to the enactment of H.R. 10620 at this time.

*Id.* at 3, 1962-3 C.B. at 1210.

When all ceilings were removed by the Social Security Amendments of 1965, the Conference Committee Report noted:

The conferees on the part of the House, in accepting this amendment, recognize that the removal of the ceiling on medical expense deductions, while generally desirable, may raise problems in connection with amounts claimed as medical expense deductions for facilities, devices, services, and transportation which are of the types customarily used, or taken, primarily for other than medical purposes. In some cases, for example, taxpayers have been able to sustain claims for medical deductions for part or all of the costs of installing swimming pools in their yards, air-conditioning systems in their homes, and transportation expenses which may be relatively extensive. Removing the ceiling on medical expense deduction may increase the aggregate amount claimed for deductions of these types. Therefore, the conferees, both on the part of the House and on the part of the Senate, in removing the ceiling on medical expense deductions recognize the desirability of considering legislation dealing with the definition of allowable medical expense deductions.

CONG. REP. NO. 682, 89th Cong., 1st Sess. 48, *reprinted in* [1965] U.S. CODE CONG. & AD. NEWS 1943, 2243.

Concern has been consistently reflected by the courts. In *Havey v. Commissioner*, 12 T.C. 409 (1949), the court commented:

[M]any expenses, such as the cost of vacations, though undoubtedly highly and directly beneficial to the general health, or athletic club expenses by means of which an individual keeps physically fit, are not deductible because they fall within the category of personal or living expenses. To be deductible as medical expense, there must be a direct or proximate relation between the expense and the diagnosis, cure, mitigation, treatment, or prevention of disease or the expense must have been incurred for the purpose of affecting some structure or function of the body.

*Id.* at 411-12.

This concern has also been codified in the Regulations. The pertinent regulation section provides, in part, "deductions for expenditures for medical care allowable under section 213 will be confined strictly to expenses incurred primarily for the prevention or alleviation of a physical or mental defect or illness." Treas. Reg. § 1.213-1(e)(1)(ii), T.D. 6985, 33 Fed. Reg. 19,815 (1968).

Moreover, one leading case has set forth an additional guideline which has been followed consistently by later cases:

[T]he language used in the statutory definition and the report of the Senate Finance Committee is sufficiently specific to exclude, except as to diagnosis, amounts expended for the preservation of general health or for the alleviation of physical or mental discomfort which is unrelated to some particular disease or defect.

*Stringham v. Commissioner*, 12 T.C. 580, 584 (1949), *aff'd per curiam*, 183 F.2d 579 (6th Cir. 1950).

34. *See* notes 58-80 and accompanying text *infra*.

are incidental, rather than a primary expense of medical care, Congress and the courts have had a predictably suspicious reaction to a category that they perceive to be on the fringe of abuse. Whether this restrictive treatment is just or consistent is another matter.

#### A. MEALS AND LODGING

Before the enactment of the changes in the medical expense deduction in the 1954 Code as interpreted by *Commissioner v. Bilder*,<sup>35</sup> the meals and lodging expenses of travel necessary to medical care were generally thought to be fully deductible. The pre-1954 cases began with *Havey v. Commissioner*.<sup>36</sup> In *Havey*, the taxpayer had a heart attack and a lung infarction. The lung healed, but the heart was still weak. The doctor recommended living at the seashore during the summer and in Arizona during the winter. The patient did so, and deducted the meals, lodging, and transportation costs of the trip.

The court first noted that the medical expense deduction was not enacted to finance vacation trips. Then, in an effort to narrow the scope of the deduction to specific physical improvement, as opposed to general well-being, the court suggested a case by case analysis with the following guidelines:

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. To accord it conclusive weight would make nugatory the prohibition against allowing personal, living, or family expenses. Thus also 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 bodily condition as to justify a reasonable belief the same would be efficacious; was the treatment so proximate in time to the onset or recurrence of the disease or condition as to make one the true occasion of the other, thus eliminating expense incurred for general, as contrasted with some specific, physical improvement.<sup>37</sup>

Deductions were allowed only for those travel expenses incurred primarily for the prevention or alleviation of the medical condition.

*Havey* was followed by a number of decisions that routinely al-

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35. 369 U.S. 499 (1962).

36. 12 T.C. 409 (1949).

37. *Id.* at 412.

lowed meals and lodging expenses.<sup>38</sup> Most notable was *Winderman v. Commissioner*,<sup>39</sup> in which the taxpayer deducted all of the subsistence expenses of annual trips from California to New York for medical checkups. The taxpayer had formerly lived in New York and had confidence in his New York physician. The court saw no reason to require the taxpayer to find another competent doctor in Los Angeles and thus allowed the travel expense deduction.

A growing number of cases, however, denied the deduction. The deductibility in general of meals and lodging expenses for medical trips was not questioned by these decisions. Instead, the courts found that the trips themselves were not primarily medical in motivation.<sup>40</sup> Clearly, these courts were increasingly conscious of the possible abuse inherent in the meals and lodging deduction. In *Hoffman v. Commissioner*,<sup>41</sup> the taxpayer deducted all costs of her son's attendance at UCLA. She claimed that the southern California climate was medically necessary in light of her son's rheumatic fever some nine years before. Understandably, the court was reluctant to grant the deduction for meals and lodging expenses for the rest of the man's life:

If we were to hold here, under the facts, that the expenses in question are deductible by the petitioner under 23(x), it would follow as a matter of logic, the facts continuing to be the same, that the expenses of his meals and lodging in a later year or years would be deductible . . . .<sup>42</sup>

The court denied the deduction and commented that "where meals and lodging are involved, the line must be drawn at some point very much closer to the time of actual illness and the immediate recovery from such illness than can be found in this proceeding."<sup>43</sup>

It was in light of this growing concern for abuse that the statute was modified with respect to travel expenses in the 1954 Code. Al-

38. See, e.g., *Estate of Embry v. Gray*, 143 F. Supp. 603 (W.D. Ky. 1956), *appeal dismissed per curiam*, 244 F.2d 718 (6th Cir. 1957); *Stringham v. Commissioner*, 12 T.C. 580 (1949), *aff'd per curiam*, 183 F.2d 579 (6th Cir. 1950); *Watkins v. Commissioner*, 23 T.C.M. (P-H) ¶ 54,045, at 54-177 (1954); *Duff v. Commissioner*, 22 T.C.M. (P-H) ¶ 53,362, at 53-116 (1953). See also Rev. Rul. 55-261, 1955-1 C.B. 307, at 308.

39. 32 T.C. 1197 (1959).

40. See *Rodgers v. Commissioner*, 25 T.C. 254, 260-61 (1955); *Ring v. Commissioner*, 23 T.C. 950, 953 (1955); *Dobkin v. Commissioner*, 15 T.C. 886, 888-89 (1950); *Foyer v. Commissioner*, 29 T.C.M. (P-H) ¶ 60,244, at 60-1521,-1524 (1960); *Flett v. Commissioner*, 29 T.C.M. (P-H) ¶ 60,157, at 60-913,-916 (1960); *Erickson v. Commissioner*, 23 T.C.M. (P-H) ¶ 54,303, at 54-962,-963 (1954).

41. 17 T.C. 1380 (1952).

42. *Id.* at 1386.

43. *Id.*

though section 24(a)(1) of the 1939 Code had excepted "extraordinary medical expenses deductible under section 23(x)" from the nondeductibility of personal, living, or family expenses, section 262 of the 1954 Code merely denied deductions for living expenses unless "expressly provided in this chapter." Additionally, new language appeared in section 213(e)(1)(B) of the 1954 Code:

(e) Definitions—For purposes of this section—

(1) The term "medical care" means amounts paid—

. . . .

(B) for transportation primarily for and essential to medical care referred to in subparagraph (A) . . . .

The House Ways and Means Committee report commented:

[T]he deduction permitted for "transportation primarily for and essential to medical care" clarifies existing law in that it specifically excludes deduction of any meals and lodging while away from home receiving medical treatment. For example, if a doctor prescribes that a patient must go to Florida in order to alleviate specific chronic ailments and to escape unfavorable climatic conditions which have proven injurious to the health of the taxpayer, and the travel is prescribed for reasons other than the general improvement of a patient's health, the cost of the patient's transportation to Florida would be deductible but not his living expenses while there. However, if a doctor prescribed an appendectomy and the taxpayer chose to go to Florida for the operation not even his transportation costs would be deductible. The subsection is not intended otherwise to change the existing definitions of medical care, to deny the cost of ordinary ambulance transportation nor to deny the cost of food or lodging provided as part of a hospital bill.<sup>44</sup>

Two circuits handed down opposite rulings on the new language before the matter reached the Supreme Court. The Second Circuit in *Carasso v. Commissioner*<sup>45</sup> disallowed the meals and lodging expenses of a taxpayer who spent nine days in Bermuda convalescing from an illness pursuant to section 213(e) as explained by the Committee report. The Third Circuit, however, reached the opposite result. In *Commissioner v. Bilder*,<sup>46</sup> the taxpayer, after having suffered four heart attacks, was advised by a heart specialist to spend the winter seasons in a warm climate. The Commissioner had cited the House Ways and Means Committee report, but the court responded: "What the Commissioner

44. H.R. REP. NO. 1337, 83d Cong., 2d Sess. A59-A60, reprinted in [1954] U.S. CODE CONG. & AD. NEWS 4025, 4197.

45. 292 F.2d 367 (2d Cir. 1961). See also *Lichterman v. Commissioner*, 37 T.C. 586 (1961).

46. 289 F.2d 291 (3d Cir. 1961), rev'd, 369 U.S. 499 (1962).

is really urging here is the repeal 'by implication', by the legislative history, of subparagraph (A) of Section 213 to the extent that it, as the counterpart of Section 23(x), permitted allowance of lodging and meals as 'medical expenses' in proper cases."<sup>47</sup> The court, noting that legislative history may not be used to repeal or modify an unambiguous statute, refused to consider the legislative history, and allowed a full deduction for the taxpayer's lodging expenses in Florida.

The Supreme Court noted a conflict between the Second and Third Circuits and granted certiorari to *Bilder*.<sup>48</sup> The Court commented that the very conflict between the Circuits was proof that the statute was indeed ambiguous. On that ground it was deemed appropriate to consider the legislative history, and in light of the House Committee report, the lodging expenses were disallowed.<sup>49</sup>

Since 1962, the courts have disallowed meals and lodging expense deductions either on the strength of *Bilder*,<sup>50</sup> or because the travel itself was not sufficiently related to medical care.<sup>51</sup> Attempts to distinguish *Bilder* have generally failed.<sup>52</sup> However, it is now clear that the meals and lodging expenses incurred en route to medical treatment are deductible,<sup>53</sup> and that meals and lodging expenses incurred while at a hospital, or while living in circumstances deemed tantamount to hospital care, are also deductible.<sup>54</sup>

While the wisdom of the Supreme Court's interpretation of section 213(e) is not seriously questionable, the wisdom of Congress' enact-

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47. 289 F.2d at 303.

48. 368 U.S. 912 (1961).

49. *Commissioner v. Bilder*, 369 U.S. 499, 500-03 (1962).

50. *Oliver v. Commissioner*, 364 F.2d 575 (8th Cir. 1966); *Rose v. Commissioner*, 52 T.C. 521 (1961), *aff'd per curiam*, 435 F.2d 149 (5th Cir. 1970), *cert. denied*, 402 U.S. 907 (1971); *Lucas v. Commissioner*, 35 T.C.M. (P-H) ¶ 66,253, at 66-1469 (1966); *Hoffman v. Commissioner*, 32 T.C.M. (P-H) ¶ 63,237, at 63-1369 (1963); *Grimaldi v. Commissioner*, 32 T.C.M. (P-H) ¶ 63,156, at 63-837 (1963); *Phares v. Commissioner*, 31 T.C.M. (P-H) ¶ 62,273, at 62-1600 (1962); *Prem v. Commissioner*, 31 T.C.M. (P-H) ¶ 62,157, at 62-958 (1962).

51. *Brown v. Commissioner*, 62 T.C. 551 (1974), *aff'd per curiam*, 523 F.2d 365 (8th Cir. 1975); *Kellner v. Commissioner*, 48 T.C.M. (P-H) ¶ 79,116, at 79-502 (1979); *Horvat v. Commissioner*, 47 T.C.M. (P-H) ¶ 78,153, at 78-671 (1978); *Tautolo v. Commissioner*, 44 T.C.M. (P-H) ¶ 75,277, at 75-1170 (1975); *Armour v. Commissioner*, 38 T.C.M. (P-H) ¶ 69,245, at 69-1376 (1969); *Estate of Diamond v. Commissioner*, 32 T.C.M. (P-H) ¶ 63,214, at 63-1220 (1963). *See also* Rev. Rul. 76-79, 1976-1 C.B. 70.

52. *Rose v. Commissioner*, 42 T.C.M. (P-H) ¶ 73,001, at 73-1 (1973), *aff'd per curiam*, 485 F.2d 581 (5th Cir. 1973), *cert. denied*, 419 U.S. 833 (1976); *Wilks v. Commissioner*, 37 T.C.M. (P-H) ¶ 68,220, at 68-1194 (1968).

53. *Montgomery v. Commissioner*, 428 F.2d 243 (6th Cir. 1970).

54. *Kelly v. Commissioner*, 440 F.2d 307 (7th Cir. 1971); *Treas. Reg. § 1.213-1(e)(1)(v)*, 26 C.F.R. § 1.213-1(e)(1)(v) (1979); *Rev. Rul. 72-226*, 1972-1 C.B. 96.

ment of section 213(e) is. It cannot be questioned that the category of travel expenses incidental to medical care is a prime target for taxpayer abuse. However, before 1954, the courts had recognized this problem, and were evolving a solution based upon the ultimate relationship of the travel to the medical care. The choice of an across-the-board legislative solution rather than a case by case judicial solution has a tendency to "deny relief in a real hardship situation by clothing a true medical cost in the guise of a luxury living expense."<sup>55</sup>

The only problem not capable of solution by the pre-*Bilder* case law approach is the one alluded to in *Hoffman* — a possibility that a taxpayer who moved for reasons of health would thereby be able to deduct all costs of meals and lodging for the rest of his life. This problem is also faced under section 162(a)(2), which allows a deduction for "traveling expenses (including amounts expended for meals and lodging other than amounts which are lavish or extravagant under the circumstances) while away from home in the pursuit of a trade or business." It is equally plausible for one to make a permanent move for business reasons as it is for one to make a permanent move for medical reasons. In either case, there is a colorable argument that all meals and lodging expenses for the remainder of one's life would be deductible.

The case law under section 162(a)(2), however, has done a much more effective job of avoiding this dilemma by careful definition of the phrase "away from home." Tax considerations notwithstanding, when one is required to make a trip of sufficient duration, there comes a point at which it is no longer reasonable to live in motels and to eat in restaurants. When the trip is long enough, the reasonable man makes more permanent arrangements. The courts have done a creditable job of defining this point, either using a reasonableness test,<sup>56</sup> or applying the "temporary-indefinite"<sup>57</sup> rule. Either way, when the court determines that this point has been reached the taxpayer is no longer deemed to be "away from home" for the purposes of section 162(a)(2). Therefore, the meals and lodging expenses become nondeductible.

If the "away from home" method has worked in the business context, it ought to work in the medical context. In both cases, it would be

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55. *Kelly v. Commissioner*, 440 F.2d 307, 311 (7th Cir. 1971).

56. *Six v. United States*, 450 F.2d 66 (2d Cir. 1971); *Stidger v. Commissioner*, 355 F.2d 294 (9th Cir. 1965), *rev'd*, 386 U.S. 287 (1967); *Harvey v. Commissioner*, 283 F.2d 491 (9th Cir. 1960).

57. *Commissioner v. Stidger*, 386 U.S. 287 (1967); *Peurifoy v. Commissioner*, 358 U.S. 59 (1958) (per curiam).

very effective in preventing the worst traveling abuse, that of allowing a taxpayer to deduct meals and lodging expenses for excessively long periods. The "tax home" concept, coupled with a common sense case by case approach to the issue of when trips are primarily medical in nature, would do far greater equity in the meals and lodging area than the current meat-axe approach of section 213(e).

## B. MEDICAL COMMUTING

The expenses of commuting from home to the place of work are virtually never deductible.<sup>58</sup> Even when the commuting is made necessary, or at least more expensive, due to medical reasons, the commuting is held to be too personal an expense, and therefore nondeductible.<sup>59</sup> Nevertheless, the costs of commuting from home to the place of medical care are routinely allowed.<sup>60</sup> Why the difference?

The difference is in the nature of the personal choice involved in the two commutes. Business commuting costs would not be incurred but for the business need to get to work; medical commuting costs would not be incurred but for the medical need to go to a doctor. Yet the business commuting costs would be reduced, or perhaps eliminated, by a personal choice to live closer to the place of employment. Hence, the business commuting costs are a result of a personal choice to live further from the place of employment. Therefore, they are nondeductible.<sup>61</sup>

In medical commuting, this personal choice is illusory. While the proximity of a prospective home to one's place of work is clearly a major factor when one is deciding where to live, the proximity of the doctor's office is at most a minor factor, if considered at all. How should a taxpayer be expected to know when he chooses his home in 1980 that he will be afflicted with a back problem in 1995, requiring frequent trips to an orthopedist? While the expenses of business commuting are largely the result of the personal choice of where to live, there is considerably less evidence of personal discretion affecting the

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58. Treas. Reg. § 1.262-1(b)(5), 26 C.F.R. § 1.262-1(b)(5) (1979).

59. See notes 86-89 and accompanying text *infra*.

60. *Weary v. United States*, 510 F.2d 435 (10th Cir.), cert. denied, 423 U.S. 838 (1975); *Gordon v. Commissioner*, 37 T.C. 986 (1962); Rev. Proc. 74-24, 1974-2 C.B. 477. See also *Montgomery v. Commissioner*, 51 T.C. 410 (1968), *aff'd*, 428 F.2d 243 (1970); *Meister v. Commissioner*, 28 T.C.M. (P-H) ¶ 59,202 at 59-776 (1959).

61. See *Commissioner v. Flowers*, 326 U.S. 465 (1946); Klein, *Income Taxation and Commuting Expenses: Tax Policy and the Need for Nonsimplistic Analysis of "Simple" Problems*, 54 CORNELL L. REV. 871 (1969).

nature or amount of medical commuting. With the personal factor absent, the costs are related solely to the medical problem, and are therefore totally deductible.<sup>62</sup>

### C. DEPRECIATION

If a taxpayer uses an automobile for a business purpose, he may deduct not only the out-of-pocket expenses of that use, but also the depreciation and general maintenance and repair expenses attributable to that automobile. Even if the automobile is used only partially for business, a pro rata portion of the depreciation expense may be deducted.<sup>63</sup> Moreover, if the automobile expenses cannot be substantiated, the taxpayer may deduct 18.5 cents per mile. This figure is intended to include the depreciation expense, as well as the out-of-pocket costs.<sup>64</sup>

By contrast, one may not deduct the depreciation expense of an automobile used for transportation primarily for and essential to medical care, even if the automobile expenses generally are deductible pursuant to section 213. If the taxpayer wishes to deduct an amount based purely on mileage for medical use of an automobile, he may only deduct 8 cents per mile, not 18.5 cents. This differential is explicitly intended to deny any possible deduction for automobile depreciation.<sup>65</sup>

What is there about the medical expense deduction that gives rise to this difference? The justification is found in the words "expenses paid" in section 213(a). In *Bassett v. Commissioner*,<sup>66</sup> the court construed identical language in section 23(x) of the 1939 Code to mean that expenses must actually have been incurred and paid within the taxable year in question to be deductible. A prepayment of medical expenses was held to be a payment of expenses not yet incurred, and therefore not yet deductible. In *Gordon v. Commissioner*,<sup>67</sup> a claim for automobile depreciation expense attributable to 700 miles of driving to and from a doctor's office was disallowed. The court cited *Bassett*, and the relevant regulation which provided in part, "[A] deduction is allowable only to individuals and only with respect to medical expenses ac-

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62. For a similar analysis with respect to commuting to and from a place of charitable activity, see Newman, *The Inequitable Tax Treatment of Expenses Incident to Charitable Service*, 47 *FORDHAM L. REV.* 139, 141-42 (1978).

63. I.R.C. § 167(a); Treas. Reg. § 1.162-1(a), 26 C.F.R. § 1.162-1(a) (1979).

64. Rev. Proc. 77-40, 1977-2 C.B. 574, *modified*, Internal Revenue News Rel. No. I.R.-2165 (Sept. 27, 1979), *reprinted in* [1980] 2 *STAND. FED. TAX REP.* (CCH) ¶ 1354.55, at 17,110.

65. Rev. Proc. 77-24, 1974-2 C.B. 477, *modified*, Internal Revenue News Rel. No. I.R.-2165 (Sept. 27, 1979), *reprinted in* [1980] 2 *STAND. FED. TAX REP.* (CCH) ¶ 1354.55, at 17,110.

66. 26 T.C. 619 (1956).

67. 37 T.C. 986 (1962).

tually paid during the taxable year. . . ."<sup>68</sup> The court also cited *Massey Motors, Inc. v. United States*<sup>69</sup> for the proposition that depreciation is a "decrease in value" and not an "expense paid." Barring a possible exception, inconsistently applied, which would allow automobile depreciation in those cases in which the travel or the automobile itself is therapy,<sup>70</sup> automobile depreciation expenses have consistently been disallowed under section 213.<sup>71</sup>

In an interesting attempt to circumvent the "expenses paid" problem, the taxpayer in *Weary v. United States*<sup>72</sup> purchased an automobile in January, 1967, used it seventy percent of the time to transport his wife to and from weekly psychiatric outpatient care, and resold the car to the same dealership in December, 1967. The taxpayer then argued that although depreciation may normally be a mere accounting item not reflecting actual out-of-pocket expense, the depreciation in his case was reflected by a real out-of-pocket loss — the difference between what he paid for the automobile in January and what he received for the automobile in December. The court ruled that the taxpayer was simply trying to circumvent a clear provision of the statute, and disallowed the deduction.

There are two problems with the treatment of depreciation in section 213. First, and most importantly, it makes no sense. No explanation has been found for the presence of the words "expenses paid" in the legislative history to the 1942 Revenue Act. It is quite possible that the language was simply mechanically transferred from a similar provision relating to charitable contributions which first appeared in the 1938 Revenue Act.<sup>73</sup>

The House Report to the 1938 Revenue Act provided in part as follows:

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68. Treas. Reg. § 1.213-1(a)(1), 26 C.F.R. § 1.213-1(a)(1) (1961).

69. 364 U.S. 92 (1960).

70. Therapy argument accepted: *Weinzimer v. Commissioner*, 27 T.C.M. (P-H) ¶ 58,137, at 58-608 (1958); *Estate of Pepper v. Commissioner*, 25 T.C.M. (P-H) ¶ 56,167, at 56-703 (1956); *Misfeldt v. Kelm*, 52-2 U.S. Tax Cas. ¶ 9495, at 46,280 (D. Minn. 1952). Therapy argument rejected or distinguished: *Volwiler v. Commissioner*, 57 T.C. 367 (1971); *Buck v. Commissioner*, 47 T.C. 113 (1966); *Goldpaper v. Commissioner*, 46 T.C.M. (P-H) ¶ 77,343, at 77-1376 (1977); *Coopersmith v. Commissioner*, 40 T.C.M. (P-H) ¶ 71,280, at 71-1264 (1971); *Bordas v. Commissioner*, 39 T.C.M. (P-H) ¶ 70,097, at 70-509 (1970).

71. *Weary v. United States*, 510 F.2d 435 (10th Cir.), cert. denied, 423 U.S. 838 (1975); *Gordon v. Commissioner*, 37 T.C. 986 (1962); *Calafut v. Commissioner*, 33 T.C.M. (P-H) ¶ 64,239, at 64-1566 (1964).

72. 510 F.2d 435 (10th Cir.), cert. denied, 423 U.S. 838 (1975).

73. Revenue Act of 1938, Pub. L. No. 75-552, § 23, 52 Stat. 447.

Under the various revenue acts the deduction for contributions is allowed for the taxable year in which the contribution is made. Hence, a taxpayer on an accrual basis of accounting may claim that he is entitled to a deduction for the amount of a charitable pledge in one year, although he does not actually pay it until a later year, or indefinitely postpones payment. The doubt and confusion in such cases is aggravated by reason of the uncertainty and diversity in the law of the various States on the question as to when the liability of a subscriber to a charitable fund is fully incurred. In the interest of certainty in the administration of the revenue laws, it is desirable to dispel this confusion by enacting a clear and uniform statutory rule to govern this situation.

The bill provides that the deduction for contributions or gifts for charitable and other purposes shall be allowed only for the taxable year in which the contribution is actually paid regardless of whether the taxpayer is reporting income on the cash or the accrual basis. The allowance of the deduction in the year when actually paid . . . will eliminate the uncertainty in the administration of the deduction.<sup>74</sup>

Note that the reason for the 1938 change with respect to charitable contributions related to timing problems. It would be difficult to argue that Congress had depreciation in mind. If the "expenses paid" language in section 23(x) of the 1939 Code was indeed lifted from the 1938 charitable contributions legislation, it would be even more difficult to argue that there was any intent that depreciation would be disallowed as a medical expense. Because no other plausible reason can be found for the "expenses paid" language in section 23(x), it is submitted that the disallowance of depreciation expenses could not have been intended.

The second problem with the treatment of automobile depreciation is its inconsistency with the holding of *Commissioner v. Idaho Power Co.*<sup>75</sup> In that case, the Supreme Court held that depreciation is an "amount paid" within the meaning of section 263(a)(1) which provides: "No deduction shall be allowed for . . . [a]ny amount paid out for new buildings or for permanent improvements or betterments made to increase the value of any property or estate." The Court commented in a footnote:

The taxpayer contends that depreciation has been held not to be

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74. H.R. REP. NO. 1860, 75th Cong., 3d Sess. 19 (1938), reprinted in J. SEIDMAN, SEIDMAN'S LEGISLATIVE HISTORY OF THE FEDERAL INCOME TAX LAWS 1938-1861 at 16-17 (1938).

75. 418 U.S. 1 (1974).

an expenditure or payment for purposes of a charitable contribution under § 170 of the Code, . . . or for purposes of a medical-expense deduction under § 213 . . . . Section 263 is concerned, however, with the capital nature of an expenditure and not with its timing, as are the phrases "payment . . . within the taxable year" or "paid during the taxable year," respectively used in §§ 170 and 213. The treatment of depreciation under those sections has no relevance to the issue of capitalization here.<sup>76</sup>

In *Weary* and *Elwood v. Commissioner*,<sup>77</sup> *Idaho Power* was considered in light of its pronouncements upon depreciation as an "amount paid." In both cases, the courts held that the quoted footnote to the opinion made it clear that the opinion was not a holding with respect to the status of depreciation within the meaning of the "expenses paid" language in section 213.

It is undeniable that the Supreme Court did not wish to interpret section 213. The Court's logic, however, is still questionable. The Court speaks of section 213 being concerned with the timing of the medical expense. Perhaps this inference can be drawn from the case law on the point following *Bassett*. However, if the hypothesis is correct that the phrase "expenses paid" came into section 213 circumstantially from the charitable contribution deduction, then it would be inappropriate to understand the phrase to be some form of timing refinement to the section. Accordingly, section 263 and the other sections are not that dissimilar, and the Supreme Court's treatment of depreciation should be applied across the board.

The *Elwood* case made another comment which must be considered:

We also note that the law under section 213 is consistent with our holding here. Where a taxpayer acquires some medically necessary asset, the deduction allowed with respect thereto is not taken over the assets' useful life as would be the case with depreciation, but rather is taken in full in the year of acquisition.<sup>78</sup>

The *Elwood* court's remarks are inapposite for two reasons. First, the cases that it cites involve capital assets.<sup>79</sup> It should be remembered

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76. *Id.* at 16 n.11 (citations omitted).

77. TAX CT. REP. DEC. (P-H) ¶ 72.21, at 72-143 (1979).

78. *Id.* at 72-145.

79. *Oliver v. Commissioner*, 364 F.2d 575 (8th Cir. 1966); *Riach v. Frank*, 302 F.2d 374 (9th Cir. 1962); *Hollander v. Commissioner*, 219 F.2d 934 (3d Cir. 1955); *Gerard v. Commissioner*, 37 T.C. 826 (1962); Treas. Reg. § 1.213-1(e)(1)(iii), 26 C.F.R. § 1.213-1(e)(1)(iii) (1979).

that originally capital assets were not deductible as medical expenses at all, precisely because their useful lives extended beyond one year. Moreover, the expenses of the acquisition of new capital assets for medical purposes are vastly different from the expenses of using existing assets for medical purposes. Therefore, the same rule should not be applied. Second, as to the capital assets area, there were two ways that the system could have reflected the acquisition costs. Either the entire costs could be deducted at once, or the acquisition costs could have been deducted over the period of medical use. However, in the case of automobile depreciation, there is no real choice. No one would argue that the entire acquisition cost of an automobile ought to be deductible as a medical expense if the automobile was used partially for medical reasons. Therefore, the only legitimate way of recognizing the real expense of additional wear and tear on the automobile caused by the medical use is to allow depreciation.<sup>80</sup>

Thus, although the possibilities for taxpayer abuse are undeniable as medical travel shades into personal vacation, the protective reaction of the legal system has gone too far. In denying meals and lodging expenses, and in denying treatment of automobile expenses that would parallel treatment in the business area, the system has been overly restrictive in its application of section 213. If section 213 has any valid purpose whatsoever, this treatment is tantamount to throwing out the baby with the bath water.

### III. COPING

#### A. INTRODUCTION

The expenses of medical illness come in two categories: the expenses of curing the illness, and the expenses of coping with the illness. The expenses of curing illness are those most normally understood to be medical care — the expenses of seeking professional help to restore the individual to health, or perhaps to prevent the medical illness. The expenses of coping encompass all excess expenditures incurred by the sick person that he would not have incurred but for the illness. One example of such an expense would be a guide dog for a blind person. The guide dog does not cure blindness in any way, it merely helps the

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80. For another justification of the special treatment of capital assets in § 213, see Feld, *Abortion to Aging: Problems of Definition in the Medical Expense Tax Deduction*, 58 B.U.L. REV. 165, 168 (1978). For a similar analysis with respect to § 170, see Newman, *supra* note 62, at 152-54.

afflicted individual to cope with his condition. Although not a "curing" expense, it is clearly an expense caused by the illness.

Are coping expenditures deductible under the statutes and regulations? It would appear that they are. Part of the definition of medical care found in section 213(e)(1)(A) is "amounts paid for the . . . mitigation of disease." This language is repeated in Regulation 1.213-1(e)(1)(i): "deductions for expenditures for medical care allowable under section 213 will be confined strictly to expenses incurred primarily for the prevention or alleviation of a physical or mental defect or illness."<sup>81</sup>

"Mitigation" and "alleviation" are synonyms. "Mitigation" means, *inter alia*, "to soften, to make less . . . painful."<sup>82</sup> "Alleviation" means, *inter alia*, "to make easier to be endured (as physical or mental suffering)."<sup>83</sup> Clearly, then, coping expenses fall within the statutory definition of medical care.

Are coping expenses deductible pursuant to the case law and rulings? Here, the response is inconsistent; the cases must be broken down into categories before any pattern emerges.

## B. COMMUTING EXPENSES

It has already been noted that although medical commuting is deductible, business commuting is not. Yet, when the particular exigencies of a taxpayer's line of work give rise to extraordinary commuting expenses, these excess expenses are deductible.<sup>84</sup> Such excess expenses cannot possibly have any relation to the personal choices that normally make commuting nondeductible. Similarly, some taxpayers have excess commuting expenditures due to medical problems. Again, the excess expenditures can have no possible relation to any personal choice. Nevertheless, unless either the employment or the travel is itself considered to be medical therapy,<sup>85</sup> these medically caused excess commuting expenditures are not deductible either as a business expense or as a medical expense.<sup>86</sup>

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81. Treas. Reg. § 1.213-1(e)(1)(i), 26 C.F.R. § 1.213-1(e)(1)(i) (1980).

82. WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY 1447 (1966).

83. *Id.* at 56.

84. Sullivan v. Commissioner, 368 F.2d 1007 (2d Cir. 1966). *But see* Fausner v. Commissioner, 413 U.S. 838 (1973) (per curiam).

85. *See* note 70 *supra*.

86. Buck v. Commissioner, 47 T.C. 113 (1966); Bruton v. Commissioner, 9 T.C. 882 (1947); Coopersmith v. Commissioner, 40 T.C.M. (P-H) ¶ 71,280, at 71-1264 (1971); Ranstead v. Commissioner, 20 T.C.M. (P-H) ¶ 51,033, at 51-109 (1951).

Some of the inconsistencies in this area are highlighted by *Donnelly v. Commissioner*.<sup>87</sup> In *Donnelly*, the taxpayer, a victim of infantile paralysis and abdominal cancer, commuted to work in a specially designed car. The taxpayer contended that the special automobile served the same function to him that braces and crutches served for other crippled individuals. If the braces and crutches were deductible, as they normally are, the automobile should have been deductible as well. The Tax Court responded that the automobile was not primarily for the alleviation of a physical defect or illness and held that the excess commuting costs were nondeductible.<sup>88</sup> The Second Circuit affirmed, holding that there would be no exception to the normal rule that commuting expenses were nondeductible and that the indirect medical benefits resulting from the specially designed car did not meet the test of being primarily for medical care.<sup>89</sup>

### C. TRAVELING COMPANIONS

Some taxpayers with medical problems are unable to travel without being accompanied by a companion. Sometimes such a companion is needed to help the afflicted individual in and out of wheelchairs, to administer routine injections and other medical care, to summon emergency medical help if required. Even if the travel itself is an otherwise nondeductible personal activity, it is clear that the excess costs of bringing a companion along are directly related to the medical problem. Moreover, if the travel itself is a deductible business activity, the expenses of the companion should be deductible as a business expense as well because such business travel would be impossible without the presence of the companion.

In fact, with one exception for a blind student,<sup>90</sup> the expenses of such a companion have not been allowed under section 213, and have rarely been claimed.<sup>91</sup> Claims under section 162 have been made more often,<sup>92</sup> but have been successful only once.<sup>93</sup> In two instances, how-

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87. 262 F.2d 411 (2d Cir. 1959).

88. 28 T.C. 1278 (1957).

89. 262 F.2d at 412-13.

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

91. *Reisner v. Commissioner*, 34 T.C. 1122 (1960); Rev. Rul. 75-317, 1975-2 C.B. 57. *But see Cohn v. Commissioner*, 38 T.C. 387 (1962); *Rodgers v. Commissioner*, 25 T.C. 254 (1955), *aff'd*, 241 F.2d 552 (8th Cir. 1957). For a criticism of Revenue Ruling 75-317 see Feld, *supra* note 80, at 185.

92. *Reisner v. Commissioner*, 34 T.C. 1122 (1960); *Megeath v. Commissioner*, 5 B.T.A. 1274 (1927), *acq.* VI-2 C.B. 5 (1927); *Zubrod v. Commissioner*, 36 T.C.M. (P-H) ¶ 67,204, at 67-1109 (1967); *Rieley v. Commissioner*, 33 T.C.M. (P-H) ¶ 64,066, at 64-496 (1964).

93. Rev. Rul. 75-317, 1975-2 C.B. 57.

ever, corporations that reimbursed their employees for the traveling expenses of a medically necessary companion were allowed to deduct the reimbursements as ordinary and necessary business expenses. The employees in these two cases were not required to include these reimbursements in their taxable income.<sup>94</sup>

#### D. HOUSEKEEPERS

Some taxpayers with medical problems need help not only when traveling, but all the time. Often this help does not take the form of a nurse rendering clearly medical services, but that of a housekeeper. Sometimes the housekeeper is needed to perform services necessary to the maintenance of the household. Sometimes the sick individual can recover faster or avoid a possible relapse if someone else performs these chores. Sometimes it is not the household chores themselves that are necessary, but merely the presence of an individual in the household, so that a doctor can be called in the event of a medical emergency. None of these reasons have been considered sufficient to give rise to a deduction under section 213.<sup>95</sup>

In *Ochs v. Commissioner*<sup>96</sup> the taxpayer's wife had thyroid cancer and was unable to speak above a whisper. Because she found it impossible to raise children without speaking above a whisper, she, on the advice of her doctor, put her children in boarding school. The court refused to allow deduction for the expenses of the boarding school, holding that those expenses were parallel to the expenses of hiring a cook or hiring someone generally to replace the services of the wife. The court noted that such expenses would not be deductible, and therefore denied a deduction for the boarding school expenses.

In *McVicker v. United States*<sup>97</sup> the taxpayer, a victim of tuberculosis, adopted a child. A physician advised the taxpayer to get a maid upon peril of having a relapse. The taxpayer argued that the maid performed the same functions for this taxpayer as the inclinator did in the *Hollander*<sup>98</sup> case. The court responded that the facts paralleled those

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94. *Quinn v. United States*, 77-1 U.S. Tax Cas. ¶ 9369, at 86,863 (D. Md. 1976); *Allenberg Cotton Co. v. United States*, 61-1 U.S. Tax Cas. ¶ 9131, at 79,205 (W.D. Tenn. 1960).

95. *Womack v. Commissioner*, 44 T.C.M. (P-H) ¶ 75,232, at 75-987 (1975); *Estate of Hentz v. Commissioner*, 22 T.C.M. (P-H) ¶ 53,110, at 53-349 (1953); Rev. Rul. 76-106, 1976-1 C.B. 71; Rev. Rul. 58-339, 1958-2 C.B. 106. *But see* *Estate of Baer v. Commissioner*, 36 T.C.M. (P-H) ¶ 67,034, at 67-185 (1967); *Duckworth v. Commissioner*, 31 T.C.M. (P-H) ¶ 62,145, at 62-829 (1962); Rev. Rul. 75-316, 1975-2 C.B. 54.

96. 195 F.2d 692 (2d Cir.), *cert. denied*, 344 U.S. 827 (1952).

97. 194 F. Supp. 607 (S.D. Cal. 1961).

98. 219 F.2d 934 (3d Cir. 1955). *See* note 107 and accompanying text *infra*.

of the *Ochs* case more closely, and therefore denied the deduction.

In *Borgmann v. Commissioner*<sup>99</sup> the primary reason for hiring the housekeeper was to have someone present to call the doctor in the event of another heart attack. However, the housekeeper also relieved the taxpayer from chores that otherwise may have aggravated his heart condition. The court denied the deduction, commenting that the expense "did not bear such a direct and proximate therapeutic relation to some physical or mental function or structure of the body as to constitute a deductible medical expense."<sup>100</sup>

In *Van Vechten v. Commissioner*<sup>101</sup> a psychotic, alcoholic taxpayer hired a maid upon the recommendation of his psychiatrist upon his release from a mental institution. The purpose for the maid was to "create an environment [wherein] illness is mitigated."<sup>102</sup> The maid had no medical training, but it was thought that without the maid the patient might relapse to a destructive level. The court cited *Borgmann* and denied the deduction. The court noted that if the taxpayer had proved that but for the maid the patient would have remained in the mental institution, then a deduction might have been allowable. The court also noted that the maid was helpful not only to the sick taxpayer, but to her entire family.

#### E. PHYSICAL ACCESSORIES: ELEVATORS

Physical accessories necessary for coping comprise a special category. When such accessories were capital improvements, early case law held that the present section 263 would override section 213. Therefore, capital expenditures were nondeductible even if medically motivated.<sup>103</sup> Later cases, and the regulations under section 213<sup>104</sup> have made it clear that such capital expenditures will be deductible although any increase in value to the prior capital asset will be subtracted.<sup>105</sup>

99. 438 F.2d 1211 (9th Cir. 1971) (per curiam).

100. *Id.* at 1212.

101. 42 T.C.M. (P-H) ¶ 73,282 (1973).

102. *Id.* at 73-1314.

103. *Seymour v. Commissioner*, 14 T.C. 1111 (1950); *Benesch v. Commissioner*, 23 T.C.M. (P-H) ¶ 54,323, at 54-1023 (1954); Rev. Rul. 54-57, 1954-1 C.B. 67.

104. *See, e.g.*, Treas. Reg. § 1.213-1(e)(1)(iii), 26 C.F.R. § 1.213-1(e)(1)(iii) (1979).

105. *Oliver v. Commissioner*, 364 F.2d 575 (8th Cir. 1966); *Berry v. Wiseman*, 174 F. Supp. 748 (W.D. Okla. 1958), *acq.*, Rev. Rul. 59-411, 1959-2 C.B. 100; *Post v. United States*, 150 F. Supp. 299 (N.D. Ala. 1956); *Snellings v. United States*, 149 F. Supp. 825 (E.D. Va. 1956); *Gerard v. Commissioner*, 37 T.C. 826 (1962); *Alexander v. United States*, 52 Am. Fed. Tax Rep. 1195 (W.D. Tenn. 1956).

However, the issue still remains as to the degree of relation to the medical problem that is necessary to support a deduction.

In *Estate of Hayne v. Commissioner*<sup>106</sup> the taxpayer was incapacitated by a stroke, and had an elevator installed which detracted from the value of his home. The court held that this was a capital expenditure and therefore would not be deductible even if it was medically related, and furthermore that there was no evidence to show that the elevator helped the taxpayer's medical condition, although it clearly improved his morale. The deduction was disallowed on both grounds.

In *Hollander v. Commissioner*<sup>107</sup> the taxpayer installed an inclinator, an elevator that runs up a normal stairway, to prevent recurrence of his coronary thrombosis. The Tax Court held that the capital expenditure was nondeductible. The Third Circuit reversed, holding that the expenditure was clearly medical. The Commissioner had argued that there was no proximate relation to the prevention of illness, but the Tax Court had found against the Commissioner on this point.

In *Riach v. Frank*<sup>108</sup> the taxpayer, following two heart attacks, found himself unable to go to his backyard, which sloped very steeply downward. Therefore, he installed a "Hill-a-Vator." The Service argued that the device was not necessary for an "essential living function," but was only necessary to allow the taxpayer to be with his family in his backyard. The court rejected the IRS argument, noting that there was nothing in the statute that limited medical deductions to those necessary for essential living functions. The court noted further that anything that would help mitigate or prevent the taxpayer's disease in "the reasonable use of his property" would be deductible. Therefore, the deduction was allowed.

#### F. OTHER PHYSICAL ACCESSORIES

Many other physical accessories have been the subject of possible medical claims, with mixed results. The costs of hearing aids<sup>109</sup> and wheel chairs<sup>110</sup> were originally nondeductible, but are now routinely allowed. Costs of eye glasses, artificial teeth and limbs,<sup>111</sup> guide dogs for both

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106. 22 T.C. 113 (1954).

107. 219 F.2d 934 (3d Cir. 1955).

108. 302 F.2d 374 (9th Cir. 1962).

109. *Bakewell v. Commissioner*, 23 T.C. 803 (1955); *Armes v. Commissioner*, 47 T.C.M. (P-H) ¶ 78,258, at 78-1101 (1978).

110. *Treas. Reg.* § 1.213-1(e)(1)(iii), 26 C.F.R. § 1.213-1(e)(1)(iii) (1980); *Rev. Rul.* 55-261, 1955-1 C.B. 307.

111. *Treas. Reg.* § 1.213-1(e)(1)(ii) - (iii), 26 C.F.R. § 1.213-1(e)(1)(ii)-(iii) (1980).

the deaf and the blind,<sup>112</sup> and braille books and magazines<sup>113</sup> are all routinely deductible. The excess costs of automobiles specially designed to accommodate wheel chairs are deductible as capital expenditures.<sup>114</sup> The cost of oxygen equipment needed to alleviate breathing difficulties caused by a heart condition is deductible,<sup>115</sup> as is an attached garage for a crippled taxpayer.<sup>116</sup> Vacuum cleaners for those allergic to dust are not.<sup>117</sup>

In Revenue Ruling 58-223,<sup>118</sup> the parents of a child who was progressively becoming blind sought to deduct the cost of special equipment to help his continued schooling without further deterioration of his eyesight. These items included a tape recorder, a special typewriter, and an enlarging lamp with special lenses. The Service ruled that these items were in mitigation of his condition, and were therefore deductible.

In *Phares v. Commissioner*<sup>119</sup> the taxpayer, after having had a heart attack, moved to a warmer climate. He had a phone installed in order to call a doctor in an emergency, and had power steering installed in his automobile, because the doctor had advised that he would be unable to drive without power steering. The power steering was held nondeductible as a capital expenditure, and the telephone was held to be not within the narrow confines of section 213 under the *Bilder* case.

In *Ross v. Commissioner*,<sup>120</sup> the taxpayer's dependent father suffered from terminal cancer. When the parents' home was destroyed by a tornado, the taxpayer flew to Iowa to help her parents move to another house. She also installed a gas furnace in her father's bedroom to keep him warm, a lavatory on the ground floor to reduce the number of times her father would have to climb the stairs, and a new washer to wash her father's linens daily. None of these expenditures were held to be deductible under section 213.

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112. Treas. Reg. § 1.213-1(e)(1)(iii), 26 C.F.R. § 1.213-1(e)(1)(iii) (1980); Rev. Rul. 68-295, 1968-1 C.B. 92; Rev. Rul. 57-461, 1957-2 C.B. 116.

113. Rev. Rul. 75-318, 1975-2 C.B. 88.

114. Rev. Rul. 70-606, 1970-2 C.B. 71.

115. Rev. Rul. 78-221, 1978-1 C.B. 75.

116. *Pols v. Commissioner*, 34 T.C.M. (P-H) ¶ 65,222, at 65-1246 (1965).

117. Rev. Rul. 76-80, 1976-1 C.B. 71.

118. 1958-1 C.B. 156.

119. 31 T.C.M. (P-H) ¶ 62,273, at 62-1600 (1962).

120. 41 T.C.M. (P-H) ¶ 72,122, at 72-510 (1972).

## G. TENTATIVE CONCLUSIONS

Guide dogs and wheelchairs are deductible; traveling companions and excess commuting expenses are not. Clearly, all coping expenses are not afforded the same treatment. Is there a theory that explains the differences?

1. *Preventive Medicine*

One possibility is that only those coping expenses that function as preventive medicine are deductible. *Ginsberg v. United States*<sup>121</sup> raised this possibility explicitly. In denying a disabled taxpayer his excess commuting expenses, the court used the elevator cases as precedents. The court noted: "The distinction between Hayne and the other elevator cases appears to depend ultimately on the fact that in Hayne the paralytic was unable to walk in any event; therefore, the elevator could not mitigate the deterioration of his physical condition resulting from walking stairs."<sup>122</sup> The *Ginsberg* court also cited some of the prior commuting cases noting that only when the commuting was therapy was it deductible. The suggestion, then, would be that coping as a category in itself is never deductible; only when the coping activity actually functions to prevent the aggravation of the illness, as opposed to merely making it easier to live with the illness, would it be deductible.

Unfortunately, this theory does not fit the case law. Guide dogs clearly have no preventive medicine function, nevertheless, they are routinely deductible. Both elevators and excess commuting expenses are sometimes necessary to prevent further medical problems, and sometimes not. Yet, elevators are now routinely deductible, while excess commuting costs are routinely nondeductible. Some other theory must be sought that better fits the pattern of cases.

2. *Incidental Benefits Upon Others*

Another possible theory is that those coping expenditures that also confer benefits upon persons other than the taxpayer are nondeductible. It should be remembered, for example, that in *Van Vechten*<sup>123</sup> the court was impressed by the fact that the maid, although perhaps hired primarily to help the mentally ill wife, also conferred housekeeping services upon the entire family. In contrast, it cannot be said that a wheelchair confers any benefit on anyone but the crippled individual.

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121. 237 F. Supp. 968 (S.D.N.Y. 1964).

122. *Id.* at 970.

123. 42 T.C.M. (P-H) ¶ 73,282, at 73-1313 (1973); see text accompanying notes 101-02 *supra*.

Indeed, this theory does fit a large majority of the coping cases. None of the expenses for maids and housekeepers were deductible. Perhaps this result can be explained because the housekeepers generally were performing services for the entire family, and not only for the afflicted individual. The same can be said for the installation of a telephone in the *Phares*<sup>124</sup> case. Conversely, the elevators, the guide dogs, and the special automobiles for wheelchairs are useful only to the afflicted individual, and they have all been held deductible.

This theory, however, does not explain the denial of the deduction generally to those who require a companion in their travels. This category, however, is unique in two respects. First, many of the cases involve business deductions and not medical deductions. Of course, the logic for the business deduction ought to be equally as strong as the logic for the medical deduction, but it does furnish a difference in viewpoint. Second, one might ask whether there is indeed a benefit conferred upon the companion. In most of the cases, the companion is the spouse of the afflicted individual. Therefore, one might argue that it is a benefit to the spouse to accompany the husband or wife on a business trip. In fact, in *Quinn*,<sup>125</sup> one of the few cases allowing a deduction of sorts for such expenses, it was specifically noted that most of the destinations of the business travel were not resort spots. This comment by the *Quinn* court comports some apprehension on the part of the court that there were motivations for the spouse's trip that went beyond medical motivations.

The problem of possibly conferring personal benefits upon the companion is indeed a sticky one, as are all problems of mixed motivations. However, the problem is similar to that of the famous Flugeladjutant described by Simons, who was forced to accompany the Crown Prince on his nightly visits to the opera, despite the fact that the Flugeladjutant detested opera.<sup>126</sup> There, as here, the enjoyment of the trip or the lack of it ought to be irrelevant. The crucial inquiry ought to be into the motivation for the trip.

Another category of cases that does not fit the pattern of benefits conferred upon others is that of commuting expenses. Clearly, the excess expenditures of commuting benefit no one other than the afflicted taxpayer. Yet in virtually all of these cases the commuting expenses are denied. Perhaps the explanation for the result here is historical: it may

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124. 31 T.C.M. (P-H) ¶ 62,273, at 62-1600 (1962); see text accompanying note 119 *supra*.

125. 77-1 U.S. Tax Cas. ¶ 9369, at 86,863 (D. Md. 1976).

126. H. SIMONS, PERSONAL INCOME TAXATION 123 (1938).

be so deeply ingrained in the tax system that commuting expenses are personal and nondeductible that they form a separate pattern even when medically motivated.

Even for those areas in which this pattern furnishes a likely explanation, the explanation is not justifiable. In other areas of the law incidental benefits conferred upon others are either ignored or allocated. For example, in the medical area itself, when a taxpayer is forced to install a pool or air conditioning in the home to alleviate a medical problem, any increase in the value of the home is subtracted from the deduction. There is no further subtraction, however, to take account of the fact that others in the household derive undeniable benefits from the air conditioning or the pool. Thus the medical expense area itself furnishes an example of ignoring benefits to others caused by the inurrence of a medical expense.

In the area of business, some or all of the expenses of a business trip combined with a vacation are deductible, depending on the outcome of the "primarily" test in section 162, in spite of the fact that there are benefits conferred upon the taxpayer that have no relation to the business contracts.<sup>127</sup> It is hard to see, therefore, why the case law treats expenses of coping with medical problems less liberally than it treats other expenses with similar attributes.

#### H. STATUTORY EXEMPTIONS

Another approach to tax relief for coping expenses would be to grant across-the-board deductions or credits to those who have excess personal expenditures due to medical problems. This approach would make substantiation of these expenses unnecessary. However, it would require careful definition of the category of afflicted taxpayers for whom the deduction or credit would be allowed. This approach has in fact been taken in section 151(d). The definitional problems have been solved by limiting the relief to blind taxpayers. Therefore, ease of administration is purchased by a denial of relief to many other categories of afflicted individuals who have equal claims to tax relief.<sup>128</sup>

The history of this provision is of interest. Special provision for

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127. Treas. Reg. § 1.162-2(b), 26 C.F.R. § 1.162-2(b) (1980); see Klein, *The Deductibility of Transportation Expenses of a Combination Business and Pleasure Trip — A Conceptual Analysis*, 18 STAN. L. REV. 1099 (1966).

128. *But see* I.R.C. § 44A(c)(1)(B), which allows some relief to households with a dependent who is physically or mentally incapable of caring for himself.

the blind first appeared in the tax laws in the Revenue Act of 1943.<sup>129</sup> That Act added to the 1939 Code section 23(y), which provided an across-the-board \$500 special deduction for blind individuals. The idea for this deduction came from the Social Security Act.<sup>130</sup> The House Report to the 1943 Revenue Act, in commenting on the definition of blindness used in this section, noted: "This definition corresponds to that adopted by the Social Security Board for the purpose of carrying out Title X of the Social Security Act, as amended, relating to grants to States for aid to the blind."<sup>131</sup>

In 1948, a new approach was taken for blind taxpayers. The Revenue Act of 1948<sup>132</sup> repealed Section 23(y), but added instead a \$600 exemption for blind taxpayers.<sup>133</sup> The Senate Finance Committee Report commented:

The special exemption of \$600 for the blind is a substitute for a \$500 deduction allowed under present law. Blind persons receive material benefits from this change. The amount allowed is, of course, larger and, in addition, the substitution of an exemption for a deduction in itself has some very real advantages. Because of this change blind persons do not forfeit the right to use the standard deduction as they do when they claim the special deduction under existing law. This is important because in most cases the itemized deductions of blind persons, other than the special deduction, will aggregate considerably less than the standard deduction. Moreover, an exemption can be taken into account in withholding, while a deduction cannot. Thus with an exemption, the relief provided will be effective throughout the year. Blind persons will not have to wait for a refund after the close of the year in order to obtain the relief which the law provides.<sup>134</sup>

This system of tax exemption has been continued in current law; section 151(d) grants an additional \$1,000 exemption to a blind taxpayer, and an additional \$1,000 exemption for the spouse of a blind taxpayer in certain instances.

It is unknown why this special treatment is afforded to blind taxpayers and not to others with medical afflictions that lead to similar financial hardship. The Canadian system has done slightly better, al-

129. Pub. L. No. 78-235, § 155, 58 Stat. 21 (1943).

130. 42 U.S.C. §§ 301-1397 (1976).

131. H. R. REP. No. 871, 78th Cong., 1st Sess. 47 (1943).

132. Pub. L. No. 80-471, 62 Stat. 110 (1948).

133. Revenue Act of 1948, Pub. L. No. 80-471, §§ 201, 202(e), 62 Stat. 110.

134. S. REP. No. 1013, 80th Cong., 2d Sess. (1948), *reprinted in* [1948] U.S. CODE CONG. & AD. NEWS 1163, 1183-84.

lowing a \$500 deduction not only to the blind but also to those persons necessarily confined to a bed or wheelchair, by reason of illness, injury, or affliction.<sup>135</sup> Curiously, the Canadian statute allows the special deduction only if the taxpayer has made no claim for medical expenses for remuneration of an attendant or a nursing home, by reason of his blindness, illness, or afflictions.<sup>136</sup> The Royal Commission on Taxation, commenting on this provision, noted:

Because a deduction of actual expenses without ceiling is permissible, it is difficult to understand the need for the alternative treatment provided under section 27(1)(d), which is used only when the actual deductible expenses are less than \$500.

Accordingly, it is our recommendation that section 27(1)(d) should be repealed.<sup>137</sup>

Perhaps coping expenses ought to be a separate category. If so, no coping expenses ought to be deductible pursuant to section 213. That section should be limited to the actual expenses of curing illness, and not merely coping with it. Instead, section 151 might be expanded to grant additional exemptions to all of those taxpayers who have extraordinary expenses due to the problems of coping with their medical problems. Of course, the problem is one of definition. Expanding the scope of the exemption to cover not only blind people, but those confined to a wheelchair or bed, and deaf people would clearly be a considerable help. However, the case law suggests several other categories of medical problems which also ought to qualify for special relief. Heart attacks, asthma, and certain aspects of cancer are some examples. It should be clear that justice would require either that all expenses of coping be given special exemptions similar to that for blindness, or that none of them be so favored.<sup>138</sup>

It is submitted that the category of coping expenses should be deductible whether or not section 213 was intended to function as a hardship deduction, subsidy, or defined exclusion from consumption. The current mixture of statutory favoritism for the blind, and a case law pattern that is only partially explained and not justified by the possibilities of incidental benefits to other taxpayers, is totally inadequate

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135. Canadian Income Tax Act §§ 27(1)(c)-27(1)(d).

136. *Id.*

137. 3 REPORT OF THE ROYAL COMMISSION ON TAXATION 220 (1966).

138. See Comment, *Tax Expenditure Analysis of I.R.C. § 151(d), The Additional Exemption for the Blind — Lack of Legislative Vision?*, 50 TEMP. L.Q. 1086 (1977). See also H.R. 6405, 96th Cong., 2d Sess., § 201(c)(1) (1980) (proposed I.R.C. § 280 D).

to deal with the real burdens of coping imposed upon taxpayers with medical problems.

#### IV. SHOULD MEDICAL EXPENDITURES BE REASONABLE?

Only rarely in the Internal Revenue Code is there a requirement that deductible expenditures be reasonable. Perhaps this is because most deductions are business related, and business expenses must be kept at a reasonable level if profits are to be maximized. Two exceptions occur in the deductibility of compensation<sup>139</sup> and business travel.<sup>140</sup> The reasonable compensation requirement of section 162(a)(1) guards against dividends in disguise. The prohibition in section 162(a)(2) against deductions for "lavish or extravagant" meals and lodging while traveling in pursuit of a trade or business is necessary because the meals and lodging of business travel come so close to personal consumption that the normal restraints upon business expenditures do not function effectively. Accordingly, if there is to be a reasonableness requirement, it makes more sense in the area of personal deductions than it does in the area of business deductions.

Should there be a reasonableness requirement for medical expenses? Viewing medical expenses as a subcategory of personal expenses, they ought to be limited to reasonable amounts. Unlike business expenses, there are no profit considerations to provide a limitation on medical expenses. Viewing the medical expenses deduction as a hardship deduction, it ought to be limited. Those who can afford extravagant medical expenditures are usually not in the hardship category. Viewing the medical expense deduction as a necessary adjustment to income defined in terms of consumption, once again it ought to be limited. Normal medical expenditures are more likely nondiscretionary, and do not function as consumption expenditures. However, as the expenditures become extravagant, the discretion factor increases dramatically. Hence extravagant medical expenditures do look like consumption expenditures and ought not to be deducted. Thus, no matter what function the medical expense deduction is thought to perform, it ought to be limited to a reasonable amount under the circumstances.

There are two categories of medical reasonableness. First, some medical activity is not reasonably necessary. There was some concern voiced in this area in 1942. Randolph Paul, during his testimony in

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139. I.R.C. § 162(a)(1).

140. I.R.C. § 162(a)(2).

support of the original deduction in the Revenue Act of 1942, commented, "We felt that we did not want to extend this deduction to families with chronic invalids who spend a great deal of money and perhaps enjoy their illnesses."<sup>141</sup> However, the issue of whether a particular medical activity is reasonably necessary to a particular patient is not the type of issue that the judicial system is competent to decide. Accordingly, this issue has virtually never arisen under section 213.

The second aspect of reasonableness is whether, given the necessity of the medical activity itself, the activity was conducted in a reasonable manner. Here, except for *Ferris v. Commissioner*<sup>142</sup> there have been virtually no limitations. Even *Ferris* itself recognizes that there is no requirement that one engage the least expensive physician possible, or that one take the least expensive room in the hospital.<sup>143</sup> Moreover, once travel expenses and meals and lodging incidental to medical care are allowed, there is no restriction upon traveling first class, upon staying in first class hotels, and upon eating at the finest restaurants.

It is possible that, if the medical nature of the expenditure is itself in doubt, extravagant expenditures can tip the scales in favor of a finding of a personal, nonmedical motive. For example, the taxpayers who alleged that they changed vacation plans from Switzerland to Monte Carlo on the advice of their physician, did not get a medical deduction.<sup>144</sup> The taxpayer in *Rodgers v. Commissioner*,<sup>145</sup> was not allowed to deduct the expenses of spending winters in the south and summers in the north, when she could have obtained the same medical effect more cheaply by spending the entire year in one temperate climate.

*Ferris* presents a novel exception.<sup>146</sup> The taxpayer in *Ferris*, who was the victim of a back ailment, was advised by her physician to swim twice a day to alleviate the possible onset of paralysis. Accordingly, the taxpayer had a pool built in her home. To make the architecture of the indoor pool compatible with the architecture of the \$275,000 house, the pool cost \$194,660. The taxpayer subtracted the costs of some parts of the pool that were clearly not medically related, including a bar, cooking area, sauna, and an open terrace. After taking the remaining \$172,160 and subtracting an appraiser's estimate of the increase in the

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141. *Revenue Revision of 1942: Hearings Before the House Comm. on Ways and Means, 77th Cong., 2d Sess. 1623 (1942)* (statement of Randolph E. Paul).

142. 582 F.2d 1112 (7th Cir. 1978).

143. *Id.* at 1116.

144. *Armour v. Commissioner*, 38 T.C.M. (P-H) ¶ 69,245, at 69-1376 (1969).

145. 25 T.C. 254 (1955).

146. 582 F.2d 1112 (7th Cir. 1978).

value of the house attributable to the pool, the taxpayer deducted \$86,000.<sup>147</sup> In the Tax Court, the taxpayer's deduction for the pool was allowed, and the court noted that if a lesser pool had been built there probably would have been no increase in the value of the house, so the deduction would have remained unchanged.<sup>148</sup>

As a result of this decision President Carter's 1978 tax proposals included a proposal to allow medical deductions "only if such amounts are paid for property or services of a type normally used primarily for such a purpose."<sup>149</sup> In the Treasury Department analysis of these proposals, it was noted:

The definition of medical care expenses should be tightened. Frequent disputes arise over the deductibility of expenditures which produce substantial nonmedical benefits. For example, the Tax Court recently sustained a medical expense deduction for a substantial portion of the cost of a \$194,000 indoor swimming pool. Disputes such as this can be prevented by restricting deductions to expenses incurred primarily for medical purposes.<sup>150</sup>

The staff of the Joint Committee on Taxation responded:

The committee may wish to consider whether it is feasible to draw clear statutory lines which would deal effectively with the many factual situations which may arise in this regard or whether the IRS and the courts will be able adequately to interpret the current statutory provisions, and whether the issue of appropriate rules for deducting such capital expenditures should be addressed in the future as part of a general review of all aspects of qualifying medical expenses.<sup>151</sup>

The *Ferris* taxpayers lost on appeal. The Court of Appeals for the Seventh Circuit noted the concern of Congress in 1965 with just such expenditures,<sup>152</sup> and the provisions of the Carter tax reform proposals.<sup>153</sup> The court then commented:

Where a taxpayer makes a capital expenditure that would qualify as

147. *Id.* at 1114.

148. *Ferris v. Commissioner*, 46 T.C.M. (P-H) ¶ 77,186, at 77-764 (1977), *rev'd*, 582 F.2d 1112 (7th Cir. 1978).

149. H.R. 12078, 95th Cong., 2d Sess. § 221 (1978).

150. *The President's 1978 Tax Reduction and Reform Proposals: Hearings Before the House Comm. on Ways and Means*, 95th Cong., 2d Sess. 206 (1978) (Report of the Treasury Department).

151. STAFF OF JOINT COMM. ON TAXATION, 95TH CONG., 2D SESS., TAX REDUCTION AND REFORM PROPOSALS 26 (Comm. Print 1978).

152. *See note 33 supra.*

153. 582 F.2d at 1115 & n.2.

being "for medical care," but does so in a manner creating additional costs attributable to such personal motivations as architectural or aesthetic compatibility with the related property, the additional costs incurred are not expenses for medical care.

It is no answer to say, as the Tax Court did, that taxpayers are not limited to choosing the cheapest form of medical treatment available to them. A taxpayer with the means and the inclination to patronize a relatively expensive physician or to select a private room for his stay in a hospital will undoubtedly deduct more from his taxable income than a taxpayer with lesser means or more frugal tastes, but the fact remains that both taxpayers are incurring costs unquestionably directly related to medical care. That cannot be said here.

The task in cases like this one is to determine the minimum reasonable cost of a functionally adequate pool and housing structure. Taxpayers may well decide to exceed that cost and construct a facility more in keeping with their tastes, but any costs above those necessary to produce a functionally adequate facility are not incurred "for medical care."<sup>154</sup>

The court purports to be making a determination of what constitutes medical care by inquiring into the taxpayer's motive. It would seem, however, that the court has already stipulated that the pool would not have been built but for the medical need, and that some sort of pool clearly constituted medical care for this taxpayer. In fact, the court's holding did not mention motivation, but merely remanded the case to determine the minimum reasonable cost of a functionally adequate pool.<sup>155</sup> Therefore, motivation is ultimately irrelevant; the requirement is that medical expenditures for capital assets be reasonable.

*Ferris*, therefore, represents a departure from the usual treatment of medical deductions, and a curious one at that. The pool must not be an extravagant one, yet, no consideration is given to the possibility that any pool might be extravagant if there is a public pool, or even a private health club, convenient to the taxpayer.<sup>156</sup> Moreover, no adjustments are suggested to take account of the possibility that even a minimal pool might furnish recreational benefits to other members of the *Ferris* family. Perhaps only a pool wide enough for one person to swim in should be allowed.

The attempt in *Ferris* to distinguish the costs of physicians and

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154. *Id.* at 1116.

155. *Id.* at 1117.

156. This consideration was relevant in *Haines v. Commissioner*, 71 T.C. 644 (1979).

hospital rooms from the cost of a pool has some persuasiveness, but is also deficient. It is true that hospital rooms and physicians are more directly related to medical care, yet one must still ask if the additional costs of a lavish hospital room or the most expensive doctor are really medically motivated. It seems likely that the choice of a lavish hospital room is a personal one. Although it is possible that the most expensive doctor is the most competent doctor, and therefore will have a greater chance of succeeding with a medical procedure, it is more likely that there is some snob appeal involved.

*Ferris* reaches a result that is generally inconsistent with the law on section 213. Yet, in light of the function of section 213, *Ferris* is probably right on policy grounds in adding a reasonableness requirement. This requirement would probably be impossible to administer in the area of unreasonable medical activity. In addition, in the case of the choice of an expensive physician, proof of motivation would probably be too difficult to allow a reasonableness requirement to function effectively. In other aspects of providing medical care, however, a reasonableness requirement is both administrable and appropriate. In fact, a reasonableness requirement might be the necessary compromise that would make the courts willing to allow tax relief for all medical travel and medical coping expenses. With expenditures limited to reasonable amounts, the courts will not be fearful of taxpayer abuse and will analyze more objectively expenses which are truly additional costs of medical problems.

Unfortunately, the *Ferris* court was a court, and not a legislature. As a court, it was limited to the facts before it. The legislative history notwithstanding, there is nothing special about swimming pools. A reasonableness requirement should be added by statute, not case-law, and should be applied wherever administratively feasible.<sup>157</sup>

## V. THE HEALTH CARE PROPOSALS IN LIGHT OF SECTION 213

The reason for the analysis of the experience of section 213 with respect to travel expenses, coping expenses and extravagant expenses is that it will provide some insight into the appropriate definition of medical care for the new health care legislation. Furthermore, this analysis

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157. See 42 U.S.C. § 1395x(v) (1976) for a workable statutory definition of "reasonable cost" for the purposes of Medicare. For contrasting analyses of *Ferris*, see Feld, *supra* note 80, at 191-92 (1978); Note, *Limitations on Capital Expenditure Deductions For Medical Expenses*, 15 WAKE FOREST L. REV. 114 (1979).

should give some indication as to the proper function and scope, if any, of section 213 after the enactment of new legislation. Before these applications can be made, however, the new proposals themselves must be considered.

#### A. THE NEW PROPOSALS

Five health care bills have been introduced in the Senate by, respectively, the Administration,<sup>158</sup> Senator Kennedy,<sup>159</sup> Senator Long,<sup>160</sup> Senator Dole<sup>161</sup> and Senator Schweiker.<sup>162</sup> The Senate Finance Committee, rather than reporting out any of these bills to the Senate, has decided to draft its own Committee bill.<sup>163</sup> However, as of this writing, the available information about the Committee bill is limited. In addition, one bill has been introduced in the House by Representative Martin.<sup>164</sup> Accordingly, in view of the fact that the five Senate bills provide a broad spectrum of the possibilities for future legislation in this area, all five Senate bills plus the Committee bill and Martin bill will be discussed.

##### 1. *The Kennedy Bill*

a. *Coverage*: The Kennedy bill covers all American citizens; it expands Medicare coverage<sup>165</sup> and provides that those not covered by Medicare must be offered a health care insurance package by their employers.<sup>166</sup> All persons not covered by these two provisions have the right to enroll in the insurance program if they so choose.<sup>167</sup>

b. *Co-Insurance, floors, ceilings, and premium payments*: There is no co-insurance provided in the Kennedy bill. All expenses of covered medical care are reimbursed by the insurance plan.

Employees receiving the plan as a fringe benefit may be required by their employers to pay a share of the premiums not to exceed thirty-

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158. S. 1812, 96th Cong., 1st Sess., 125 CONG. REC. S13382 (daily ed. Sept. 25, 1979).

159. S. 1720, 96th Cong., 1st Sess., 125 CONG. REC. S12048 (daily ed. Sept. 6, 1979).

160. S. 350, 96th Cong., 1st Sess., 125 CONG. REC. S1133 (daily ed. Feb. 6, 1979); S. 760, 96th Cong., 1st Sess., 125 CONG. REC. S3350 (daily ed. Mar. 26, 1979).

161. S. 748, 96th Cong., 1st Sess., 125 CONG. REC. S3297 (daily ed. Mar. 26, 1979).

162. S. 1590, 96th Cong., 1st Sess., 125 CONG. REC. S10669 (daily ed. July 26, 1979).

163. STAFF OF SEN. FINANCE COMM., 96TH CONG., 1ST SESS., SUMMARY OF SENATE FINANCE COMMITTEE ACTION ON HEALTH LEGISLATION AS OF JUNE 29, 1979 (Comm. Print 1979).

164. H.R. 6405, 96th Cong., 2d Sess. (1980).

165. S. 1720, 96th Cong., 1st Sess. §§ 611-636 (1979).

166. *Id.* § 112.

167. *Id.* §§ 111-114.

five percent of the premium amount;<sup>168</sup> premiums for nonemployees are to be set by government administrators. Nonemployee premiums will correspond with the participant's income level,<sup>169</sup> with many categories of welfare recipients, including the aged and disabled, having the total premium paid by the government.

There are two limitations on mental health expenses. The amount of reimbursement for inpatient hospital care for mental health problems will be limited to 150 consecutive days for those on Medicare, and forty-five consecutive days for others.<sup>170</sup> Reimbursements for physician services for mental health care will not exceed the cost of twenty psychiatric visits per year.<sup>171</sup>

Reimbursement for home health services will not exceed the cost of 100 visits per year;<sup>172</sup> reimbursement for post-hospital skilled nursing facility services will not exceed the cost of 100 days of service during any illness.<sup>173</sup>

c. *Definitions of medical care:* The definition in the bill generally tracks the Medicare definition.<sup>174</sup> In addition, however, the following preventive health items are covered: immunizations, pre-natal and post-natal maternal care, as well as child care for children up to the age of eighteen. Other items of preventive health care are to be added later. However, the aggregate amount of expenditure on preventive health care is not to exceed \$500,000,000 in the first year after enactment, with the \$500,000,000 ceiling indexed to the cost of living thereafter.<sup>175</sup> The costs of eyeglasses, dental care, flat feet treatment, and custodial care are excluded from the coverage of the plan.<sup>176</sup>

d. *Changes in section 213:* The Kennedy bill would eliminate the deduction in section 213 for medical insurance premiums. Otherwise, section 213 is unchanged.<sup>177</sup>

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168. *Id.* § 341(a)(3)(A).

169. *Id.* § 342.

170. *Id.* § 201(b)(1)(2).

171. *Id.* § 202(b).

172. *Id.* § 203.

173. *Id.* § 204.

174. Medical care under Medicare includes physician, hospital, diagnostic, and outpatient physical therapy services, drugs, x-rays, surgical dressings, medical equipment, ambulance services, prosthetic devices, and x-ray, radium, and radioisotope therapy. 42 U.S.C. § 1395x (s)(1)-(9).

175. *Id.* § 205(b)(2)(A).

176. *Id.* § 210(a).

177. *Id.* § 641.

## 2. *The Long Bill*

a. *Coverage*: Senator Long's bill would cover two categories of people. First, employers would be required to provide catastrophic health insurance for their employees.<sup>178</sup> Second, Medicaid would be expanded to cover other low-income individuals or members of low-income families.<sup>179</sup> Low-income individuals are defined as those who earn not more than \$3,000 per year. Low-income families are defined in terms of family size. Two-member families must earn \$4,200 per year or less to qualify; larger families must earn less than \$5,400 plus \$400 for each member of the family in excess of four.<sup>180</sup> In determining income, however, the aggregate medical expenditures of the family would be subtracted first.<sup>181</sup>

b. *Co-Insurance, floors, ceilings, and premium payments*: Under the catastrophic health insurance program of the Long bill, insurance coverage begins when the covered individual or his immediate family have incurred expenses aggregating \$2,000 in one calendar year and in the final three months of the preceding calendar year. Once this aggregate expense has been incurred, all further medical expenses of the individual and his family will be covered until the family incurs less than \$500 of medical expenses in a ninety day period.<sup>182</sup> Both the \$2,000 and \$500 amount will be adjusted for inflation. In determining the \$2,000 and \$500 deductible amounts, however, all expenses in excess of \$500 incurred in connection with the treatment of mental, psychoneurotic, and personality disorders are to be disregarded.<sup>183</sup>

The Long bill appears to contemplate that all premiums for catastrophic health insurance will be paid by the employer. The employer will have the choice of deducting such premiums as business expenses under section 162 of the Internal Revenue Code, or taking a fifty percent tax credit.<sup>184</sup>

c. *Definition of medical care*: The definition of medical care

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178. S. 760, 96th Cong., 1st Sess., § 101 (proposed § 2101(a) of the Social Security Act).

179. *Id.* § 201(a) (amending Title XIX of the Social Security Act, 42 U.S.C. §§ 1396-1396j (1979)).

180. *Id.*

181. *Id.*

182. *Id.* § 101.

183. *Id.* (proposed § 2103(b)(4)(F) of the Social Security Act).

184. *Id.*

tracks the Medicare definition.<sup>185</sup>

d. *Changes in section 213*: There are no changes in section 213.

### 3. *The Dole Bill*

a. *Coverage*: Senator Dole's Catastrophic Health Insurance and Medicare Improvements Act of 1979 is comparable to the Long bill. The coverage of Medicare is also extended, and its benefits are expanded to cover catastrophic illness.<sup>186</sup> As to those not on Medicare, the Dole bill requires catastrophic health insurance to be offered by all employers to their full time employees. As to those who do not receive the insurance coverage through Medicare or through their employers, the government would subsidize the individual purchase of catastrophic health insurance.<sup>187</sup>

b. *Definition of medical care*: The definition of medical care tracks the Medicare definition.

c. *Co-Insurance, floors, ceilings, and premium payments*: Once the appropriate floor amounts have been reached, there are no co-insurance provisions in the Dole bill.

The Dole bill provides for two floor amounts with respect to employee plans, and three with respect to individual plans. As in the Long bill, the threshold amounts, which must be met before coverage is provided, have a time factor as well as a money factor. Under the employee plans, inpatient hospital services are fully reimbursed during a period that begins on the sixty-first day of the hospital stay and ends on the earlier of the last day of the calendar year, or after ninety days have elapsed during which no member of the insured's family was receiving inpatient hospital services. In accumulating the sixty day threshold period of hospital care, hospital stays occurring within the three months immediately prior to the applicable calendar year are counted as well.<sup>188</sup>

Medical benefits under the employee plans are fully reimbursed for the period beginning when the individual and his family have incurred expenses of \$5,000 and ending on the earlier of the last day of

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185. *Id.* § 101 (proposed §§ 2103(b)(1)(A)-2103(b)(1)(D) of the Social Security Act).

186. S. 748, 96th Cong., 1st Sess., § 201 (1979).

187. *Id.* (proposed Title XXI of the Social Security Act).

188. *Id.* (proposed § 2106(a)(1) of the Social Security Act).

the calendar year, or whenever ninety days have elapsed during which the aggregate family medical care expenses were less than \$500. In aggregating the \$5,000 threshold amount, expenditures incurred in the three months immediately prior to the calendar year may be recognized. The \$5,000 and \$500 amounts are adjusted for inflation.<sup>189</sup>

Individual plans use the same thresholds for medical benefits and hospital benefits. However, a third threshold period, "total benefit period," applies as well. Even if the hospital benefit threshold and the medical benefit threshold have not been met, the plan must fully reimburse hospital and medical expenses whenever the aggregate hospital and medical expenditures of a family exceed fifteen percent of the family income for the calendar year and the three months immediately prior to the calendar year. These expenses, however, must aggregate at least \$200. The total benefit period ends on the last day of the applicable calendar year.<sup>190</sup>

Employees may be required to pay up to twenty-five percent of the premiums of employee plans. The premiums paid by individuals for their catastrophic health insurance would be partially subsidized by the government. The amount of the subsidy would be determined by the Secretary of Health, Education and Welfare, taking into account the following factors: (1) the amount of the premium, (2) family income, (3) family size, and (4) whether the policy coverage exceeded the minimum amount.<sup>191</sup>

d. *Changes in section 213*: The only change in section 213 is a provision that medical insurance must meet the requirements of this legislation before the premiums for such insurance will be deductible.<sup>192</sup>

#### 4. *The Schweiker Bill*

a. *Coverage*: Those eligible for Medicare under the Schweiker bill are affected by some improvements in Medicare coverage for catastrophic illness.<sup>193</sup> All who receive medical insurance as a fringe benefit from their employers are covered in that the costs of such medical

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189. *Id.* (proposed § 2106(b)(1) of the Social Security Act).

190. *Id.* (proposed § 2155(c)(1) of the Social Security Act).

191. *Id.* (proposed § 2156(b)(2) of the Social Security Act).

192. *Id.* § 301.

193. S. 1590, 96th Cong., 1st Sess. § 201 (1979) (proposed § 1922 of proposed Title XIX of the Public Health Service Act, 42 U.S.C. §§ 201 to 300v-3 (1979)).

insurance will no longer be deductible by employers under section 162 unless the requirements of this bill are met.<sup>194</sup> All others are covered in that insurance carriers would be required, as a condition of participating in federal health programs such as Medicare and Medicaid, to participate in pooling arrangements to provide catastrophic health insurance to anyone who desires it.

b. *Definition of medical care*: The definition generally tracks the Medicare definition. However, a number of items of preventive health care are added to the coverage. These include comprehensive maternal care, newborn and childhood screening and counseling for heritable and acquired diseases, vision and hearing examinations for children, childhood immunizations, hypertension screening, screening and counseling for cervical cancer, and periodic health examinations for adults.<sup>195</sup>

c. *Co-Insurance, floors, ceilings, and premium payments*: There is a co-insurance amount of twenty-five percent, until such time as out-of-pocket medical expenses during the calendar year exceed twenty percent of family income. Once that threshold has been reached, all further expenses are fully covered.<sup>196</sup>

The Schweiker bill proposes to lower premium costs by making the insurance industry more competitive. Each employer having at least 200 full-time employees must offer his employees a choice of three health benefit plans.<sup>197</sup> The employer must make the same premium expenditure per employee enrolled in such plan, regardless of the actual premium cost of that employee's coverage. If an employee chooses a plan with a premium cost for his coverage less than the amount expended by the employer, the excess is paid directly to the employee tax free. Therefore, there will be an incentive for employees to shop for the least expensive insurance.<sup>198</sup>

d. *Changes in section 213*: There are no changes in section 213.

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194. *Id.* §§ 101, 301, 401.

195. *Id.* § 301 (proposed § 1942(a)(1)-(7) of proposed Title XIX of the Public Health Service Act).

196. *Id.* § 101.

197. *Id.* (proposed § 1904(a) of proposed Title XIX of the Public Health Service Act).

198. *Id.* (proposed § 1903(a) of proposed Title XIX of the Public Health Service Act).

### 5. *The Administration Bill*

a. *Coverage*: The Administration bill,<sup>199</sup> introduced by Senator Ribicoff, covers all Americans by inclusion in one of four categories.<sup>200</sup> The first category is low-income families, defined as those whose income, less twenty percent of earned income, some child care expenses, and estimated medical expenditures, does not exceed fifty-five percent of the poverty income guidelines.<sup>201</sup> The remaining categories are the aged and the disabled, the employed, and others.<sup>202</sup> Low-income families, the aged, and the disabled will have the insurance plan provided by the government. Employees will have the benefits provided by their employers, and others will have the option to purchase catastrophic health insurance.<sup>203</sup>

b. *Definition of medical care*: The definition of medical care generally tracks the Medicare definition, but includes preventive medicine services such as family planning, immunizations, pregnancy, maternity, and newborn care through the first year, as well as dental, vision, and hearing items, and services for individuals up to eighteen years of age.<sup>204</sup> Items excluded from the definition of medical care include dental services, eyeglasses and hearing aids for persons eighteen and over, services relating to flat feet, and custodial care.<sup>205</sup>

c. *Co-Insurance, floors, ceilings, and premium payments*: These items differ with the category of insurance coverage. As to employer plans, the co-insurance plan deductibles may not exceed \$2,500 per year. This \$2,500 threshold, which is indexed to inflation, also applies to those who voluntarily purchase insurance.<sup>206</sup> As to all categories of insurance plans, however, items paid for children under one year of age are totally reimbursed.<sup>207</sup>

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199. S. 1812, 96th Cong., 1st Sess. (1979).

200. *Id.* § 2(6).

201. *Id.* § 101 (proposed amendment to § 1831 of Title XVIII of the Social Security Act, 42 U.S.C. § 1395j (1974)).

202. *Id.* § 2(6).

203. *Id.* § 4.

204. *Id.* § 101 (proposed amendment to § 1801 of Title XVIII of the Social Security Act, 42 U.S.C. § 1395 (1979)).

205. *Id.* § 101 (proposed amendment to § 1802 of Title XVIII of the Social Security Act, 42 U.S.C. § 1395a (1974)).

206. *Id.* § 101 (proposed amendment to § 1813(a)(6) of Title XVIII of the Social Security Act, 42 U.S.C. § 1395e (1976)).

207. *Id.* § 101 (proposed amendment to §§ 1833(f), 1834(b)(1) of Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395b, 1395m (1979)).

As to the aged and disabled, co-insurance and deductibles may not exceed \$1250 per person per year. Until that threshold is reached, however, there is a basic co-insurance amount of twenty percent, and there are a number of deductibles, including the costs of the first day of hospitalization.<sup>208</sup>

There are a number of ceilings that apply to employer plans, the aged and disabled, and to those who voluntarily purchase insurance. The costs of inpatient nursing after the first hundred days; the cost of inpatient mental hospital treatment for mental and nervous conditions, alcoholism, and drug abuse after the first thirty days; the costs of items and services furnished on an outpatient basis after such costs exceed \$1,000; and the cost of home and health items and services furnished after more than 200 visits per year, are not to be reimbursed.<sup>209</sup>

Employees may not be required to pay more than twenty-five percent of the premium cost of their insurance.<sup>210</sup> Premiums for those who voluntarily purchased the plans are not to exceed certain ceilings which relate to the costs of similar coverage for larger groups.<sup>211</sup>

d. *Changes in section 213:* Section 213(b) would be repealed.<sup>212</sup> Therefore, there would no longer be different floor amounts for regular medical expenses and for drugs. Instead, the three percent floor in section 213(a) would be raised to a ten percent floor. Medical expenses, however, would continue to include the costs of insurance.<sup>213</sup>

e. *The Administration plan fully implemented:* In the Administration proposal, Senate Bill 1812 would only represent Phase I of a more ambitious plan. Fully implemented, coverage would be increased by adding part-time employees to those covered under employer plans, and by raising the low-income standard from 55% to 100% of the poverty line amounts.<sup>214</sup> The deductible amount for the aged and disabled would be lowered to \$750 per person.<sup>215</sup> As to the employed and voluntary purchaser categories, co-insurance would be twenty-five per-

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208. *Id.* § 101 (proposed amendment to § 1833(c)).

209. *Id.* § 101 (proposed amendment to § 1833(b)).

210. *Id.* § 101 (proposed § 1812(c)(1) of Title XVIII of the Social Security Act, 42 U.S.C. § 1395(d) (1974)).

211. *Id.* § 101 (proposed amendment to § 1834).

212. *Id.* § 103.

213. *Id.*

214. The Carter administration's outline of a fully implemented national health plan, President's press release 4, 8-9 (June 12, 1979).

215. *Id.* at 5, 11.

cent, and the deductible amount would be lowered to \$1,500 per family.<sup>216</sup>

## 6. *The Martin Bill*

a. *Coverage*: The Medical Expense Protection Act, introduced by Congressman Martin and nineteen fellow Republican congressmen, provides catastrophic health insurance for everyone.<sup>217</sup> In addition to the catastrophic coverage, it provides coverage for low-income groups by making improvements in Medicare,<sup>218</sup> and for the employed by setting forth new requirements before employer-provided medical insurance is deductible by the employer.<sup>219</sup>

b. *Definition of medical care*: The definition of medical care generally tracks the Medicare definition, but includes services related to pregnancy, delivery and care of a child through one year after birth, and immunizations against some communicable diseases. The definition excludes the costs of inpatient psychiatric care after such care has been provided for forty-five days in a calendar year.<sup>220</sup>

c. *Co-Insurance, floors, ceilings, and premium payments*: The co-insurance, floors, and ceilings all vary with income level. The floor amount is \$300, plus twenty percent of the amount by which annual income exceeds \$4000.<sup>221</sup> The co-insurance rates are ten percent for incomes up to \$4,000, fifteen percent for incomes from \$4,000 to \$10,000, and twenty percent for incomes in excess of \$10,000.<sup>222</sup> The ceiling, or stop-loss amount is \$500 plus twenty-five percent of the amount by which annual income exceeds \$4,000.<sup>223</sup>

For the costs of employer health plans to be deductible by the employer and excludible by the employee, the employer must pay at least fifty percent of the premium cost.<sup>224</sup>

216. *Id.*

217. H.R. 6405, 96th Cong., 2d Sess., § 101 (1980) (proposed Title XXI of the Social Security Act).

218. *Id.* §§ 301-304.

219. *Id.* §§ 201, 202.

220. *Id.* § 101 (proposed § 2121(5) of proposed Title XXI of the Social Security Act).

221. *Id.* § 101 (proposed § 2103(a)(1) of the proposed Title XXI of the Social Security Act).

222. *Id.* § 101 (proposed § 2106(c)(1) of the proposed Title XXI of the Social Security Act).

223. *Id.* § 101 (proposed § 2106(d)(1) of the proposed Title XXI of the Social Security Act); see 126 CONG. REC. H526 (daily ed. Feb. 4, 1980).

224. *Id.* § 201(b)(2) (proposed amendment to I.R.C. § 106(b)(1)).

d. *Changes in section 213*: The scope of section 213 would be drastically reduced, leaving only two categories. The first would be the expenses of medical care for the blind, the disabled, those who have end-stage renal disease, and those who are residents of a long-term care facility or of an institution for the care, rehabilitation or training of the physically or mentally handicapped. The threshold amount of three percent of adjusted gross income would be retained for this category.<sup>225</sup> The second category would be one half, but not more than \$250, of insurance premiums for health plans which qualify under the bill.<sup>226</sup>

### 7. *The Committee Bill*

The Committee bill is similar in pattern to some of the other proposals. Everyone would be covered, either through employer plans, expanded Medicare, or a guaranteed opportunity to purchase insurance through a pool. The definition of medical care would track the Medicare definition. The floor amount would be \$3,500 per year for those with family earnings of \$14,000 or more, and twenty-five percent of gross income for those who earn \$14,000 or less. Employer plans would be required, and employees could be required to pay up to twenty-five percent of the premium costs.<sup>227</sup> The Committee has not yet discussed changes to section 213.<sup>228</sup>

### B. THE EFFECT OF THE HEALTH CARE PROPOSALS ON SECTION 213

In analyzing what will be left of section 213 after the enactment of the health care proposals, medical expenditures must be divided into two groups: those which will be covered under the definition of medical care in the health care proposals, and those which will not. In every proposal, those expenses that will not be within the definition of medical care fall within one of three categories. First, there are the expenses that are never mentioned in the definition. For example, the traveling expenses discussed in this Article are never mentioned in the health care definitions, with the exception of certain ambulance expenses in narrowly defined circumstances.<sup>229</sup> In addition, the coping expenses

225. *Id.* § 201(d)(1) (proposed amendment to I.R.C. § 213(a)).

226. *Id.*

227. STAFF OF SENATE FINANCE COMM., 96TH CONG., 1ST SESS., SUMMARY OF SENATE FINANCE COMMITTEE ACTION ON HEALTH LEGISLATION AS OF JUNE 29, 1979 at 1 (Comm. Print 1979); Senate Finance Comm., Finance Committee Continues Action on Catastrophic Health Insurance (Press Release No. 158, Nov. 1, 1979).

228. Telephone conversation with Senate Finance Committee staff member (Jan. 16, 1980).

229. 42 U.S.C. § 1395x(s)(7) which includes specific ambulance services is referred to in most of the proposals.

described in this Article are never mentioned, with the possible exception of wheelchairs.<sup>230</sup> Because these expenses are never mentioned, they clearly do not fall within the definition of medical care. Second, there are other categories of expenses that are specifically excluded from the definitions. Eyeglasses and custodial care, for example, are specifically excluded from the Kennedy<sup>231</sup> and Administration bills.<sup>232</sup> Third, there is the category of those expenses that would otherwise be covered, but for the fact that they exceed certain ceiling limits, such as the cost of home health care in excess of 100 visits under the Kennedy bill.<sup>233</sup> The pattern of treatment of these three categories is essentially the same in all of the proposals, except for the Martin bill. They are never reimbursed by insurance. In addition, they are not deductible pursuant to section 213 unless the sum of such expenditures and any other unreimbursed expenditures exceeds the applicable percentage of adjusted gross income. The percentage is essentially three percent in all proposals except the Administration's. In the Administration proposal, it is ten percent.<sup>234</sup> In the Martin bill, such expenses are deductible if incurred by the blind, the disabled, kidney patients, or residents of long-term facilities, and then only if they exceed three percent of adjusted gross income.<sup>235</sup>

The applicability of the section 213 deductions to those medical expenditures within the definitions of medical care is subject to a great deal more variation. The spectrum runs from the Kennedy and Martin bills, in which virtually none of such expenditures would be subject to a tax deduction, to portions of the Dole bill, at the other extreme.

Under the Kennedy bill, because all such medical expenditures will be reimbursed by insurance, with no co-insurance or deductible features, there will be nothing left to be deducted under section 213.<sup>236</sup> Accordingly, the only room for section 213 under the Kennedy bill would be those expenditures that fall outside of the definition of medical care.

Under the Administration proposal as fully implemented, such expenditures would be deductible under section 213 only when they ex-

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230. 42 U.S.C. § 1395x(s)(6) which includes wheelchairs is referred to in most of the proposals.

231. S. 1720, 96th Cong., 1st Sess., §§ 210(a)(4)-210(a)(5) (1979).

232. See note 205 *supra*.

233. S. 1720, 96th Cong., 1st Sess., § 203 (1979).

234. See note 210 *supra*.

235. See note 225 *supra*.

236. See text accompanying notes 168-77 *supra*.

ceed ten percent of adjusted gross income.<sup>237</sup> When such expenditures exceed \$1,500 per year per family, they would be fully reimbursed by the insurance plan. For the average American family in 1978, the result of this proposal would be that no ordinary medical expenditures would be deductible under section 213. In 1978, the median income of the American family was \$18,264.<sup>238</sup> Accordingly, such a family would not have been allowed to deduct medical expenditures under section 213 until those expenditures exceeded \$1,826. Before the expenditures reached \$1,800, however, the insurance deductible amount of \$1,500 would already have been reached.

In fact, under the Administration proposal as fully implemented, section 213 would only have possible application to a very narrow income range, and in very small amounts. Those with incomes below the poverty line, which is currently at \$7,500 per year, would have their medical expenditures fully reimbursed.<sup>239</sup> Those with incomes up to \$8,333 will have spent their way down to the poverty line, and therefore will have entered the fully insured low-income class before their medical expenditures exceed ten percent of their adjusted gross income. On the upper limit, those with incomes at \$15,000 or more will have reached the deductible amount of \$1,500 before they have expended more than ten percent of their adjusted gross income. Therefore, section 213 would only have possible application to those with annual incomes between \$8,333 and \$15,000. In addition, even as to this narrow income range, the only amounts deductible under section 213 would be those expenditures that fall between ten percent of adjusted gross income and \$1,500. There would, therefore, be precious little left to section 213.

Under the Martin bill, section 213 would be available only for a very narrowly defined group. As to all others, the only governmental relief would come from the insurance provisions. For an American family earning the 1978 median national income, there would be no governmental relief for annual medical expenditures from \$0 to about \$3,000. Between \$3,000 and about \$4,000, the insurance would cover eighty percent of expenses, and the family would pay twenty percent. The insurance would pay 100% of all expenses over \$4,000. Therefore, adding the floor amount and the co-insurance, this family would pay a

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237. See notes 212-13 and accompanying text *supra*.

238. U.S. DEP'T OF COMMERCE; STATISTICAL ABSTRACT OF THE UNITED STATES 456 (1978).

239. See note 214 *supra*.

maximum of about \$3,200 per year in medical expenses, with no tax relief except for half the amount of the premium payments.

Under the Long bill, three percent of income would be the threshold for the tax deduction, and \$2,000 would be the threshold for insurance reimbursement.<sup>240</sup> Therefore, for an American family earning the 1978 median national income of \$18,264, there would be no governmental relief for annual medical expenditures from \$0 to about \$500. Between \$500 and \$2,000, there would be no tax relief. Therefore, for such a family, section 213 would be applicable to no more than \$1,500 of expenditures per year.

Under the Dole bill, the coverage varies with the category of the participant and the nature of the expenditure. For example, the hospital benefit threshold is a stay of sixty days in a hospital.<sup>241</sup> Given the average cost of \$118.69 for one day's stay in a hospital in 1975,<sup>242</sup> this threshold would have exceeded \$7,000, and thus, would have been the highest dollar threshold in any of the proposals.

For individually purchased plans, it would appear that for most income levels the total benefit period, rather than the medical benefit period, would furnish the insurance threshold.<sup>243</sup> Accordingly, three percent of adjusted gross income would be the threshold for the tax deduction, and fifteen percent of income would be the threshold for insurance reimbursement. For the average American family, there would be no governmental relief for the first \$500 of annual medical expenditures, there would be tax relief for those expenditures between \$500 and \$2,700, and insurance reimbursement for the rest. Therefore, section 213 would be applicable to no more than \$2,100 of expenditures per year.

For employer plans, the medical benefit period would furnish the floor for the insurance.<sup>244</sup> Therefore, three percent of adjusted gross income would be the threshold for the tax deduction, and \$5,000 would be the threshold for insurance reimbursement. For the average American family, there would be no relief for the first \$500 of annual medical expenditures, there would be tax relief for expenditures from \$500 to \$5,000 per year, and insurance reimbursement for the rest. Therefore,

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240. See text accompanying notes 178-85 *supra*.

241. See text accompanying note 188 *supra*.

242. U.S. DEP'T OF COMMERCE, BUREAU OF THE CENSUS, STATISTICAL ABSTRACT OF THE UNITED STATES 104 (98th ed. 1977).

243. See text accompanying note 190 *supra*.

244. See text accompanying note 190 *supra*.

section 213 would be applicable to no more than \$4,500 of expenditures per year.

Under the Schweiker bill, three percent of adjusted gross income would be the threshold for the tax deduction, and twenty percent of income would be the threshold for insurance reimbursement.<sup>245</sup> For the average American family, there would be no governmental relief for the first \$500 of annual medical expenditures. Expenditures from \$500 to approximately \$3,500 would get tax relief, and the excess would get insurance reimbursement. Therefore, section 213 would cover a maximum of \$3,000 of expenditures per year.

In the Committee proposal, assuming that the three percent floor is retained for section 213, the ranges for the average American family would provide no governmental relief to the first \$500 of expenditures, tax relief to those expenditures between \$500 and \$3,500 per year, and insurance reimbursement for the excess.<sup>246</sup> Again, section 213 would apply to no more than \$3,000 of expenditures per year.

In summary, it will be hard to get a tax deduction for expenditures not within the definition of medical care, regardless which proposal is enacted. Under all of the proposals, those expenditures would not be deductible until the applicable percentage of adjusted gross income has been exceeded. That threshold will be relatively more difficult to reach than it is now, largely because so many otherwise deductible expenditures will then be reimbursed by insurance. The percentage threshold amounts will be easier or more difficult to reach depending upon how many other medical expenditures are left unreimbursed by the plan in question.

As to those expenditures within the definition of medical care, the Kennedy bill, the Martin bill, and the fully implemented Administration proposal leave virtually no room for the operation of section 213. The other proposals set up three tiers of medical expenditure: the lowest tier subject to no governmental relief, the middle tier subject to tax relief, and the upper tier subject to insurance reimbursement. For the average American family in 1979, the maximum annual amount of expenditures subject to section 213 varies from \$1,500 in the Long bill to \$4,500 for employer plans in the Dole bill.

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245. See text accompanying notes 193-98 *supra*.

246. See text accompanying note 228 *supra*.

### C. SHOULD SECTION 213 AND THE HEALTH CARE PROPOSALS CO-EXIST?

Perhaps section 213 ought to be repealed. Under some of the bills, so few expenditures remain deductible under section 213 that there appears to be little reason to retain the law for such a limited application.

Even with respect to those proposals that still leave section 213 some room for maneuvering, one might ask if there is really that much difference between the catastrophic expenses, which are supposed to be the only ones reimbursed under these bills, and the extraordinary expenses, which were supposed to be the only expenses that were deductible under section 213 as originally enacted. If a difference exists, it is only in degree. Perhaps the concepts are similar enough so that it would make the most sense to repeal section 213 on the theory that the only expenditures that Congress now thinks are a proper subject for governmental relief are those catastrophic expenditures that will be reimbursed by the insurance scheme.

In the event that section 213 is repealed, however, one must ask whether or not the definition of medical care in the various health care proposals ought to be expanded to cover such categories as coping expenses and traveling expenses. Accordingly, the prospect of the enactment of any one of the health care proposals presents three alternatives for section 213. First, section 213 could be repealed, with no change in the health care proposals. Second, section 213 could be repealed, and the definition of medical care in the health care proposal could be expanded. Third, section 213 could be left intact, to afford some tax relief to any items of medical expenditure not covered by the health care proposals.

The first alternative seems unjust. The expenses of traveling incident to medical care, and the expenses of coping, as discussed in this Article, are largely not covered by the health care proposals. Yet it should be apparent that these expenditures are real and can be substantial enough to impose real hardship upon those who incur them. Perhaps, as a category, they are not as worthy of governmental subsidy as are the more standard items of medical expenditure. Yet if the government is to afford some relief for medical expenditures, there is no apparent rational basis for affording direct subsidy for some and giving no relief whatsoever for others.

The second alternative is unwise. All of the health care proposals are basically insurance plans. It is inherent in any insurance plan that

the insured items will be rigidly defined, so that claims can be administered mechanically and economically. Many of the medical expenses that would not be covered by the health care proposals, but have been covered by section 213, are very difficult to define. They have given the judicial system trouble under section 213; they would be a nightmare for insurance administrators. It would make much more administrative sense to handle these items of medical expenditure on a case-by-case basis through the court system reviewing the tax laws, rather than through an insurance mechanism. Moreover, although expenditures in these categories can constitute real hardship, there is a difference in degree when these expenditures are contrasted with those in the basic Medicare definition. It would not be inappropriate, therefore, to differentiate the governmental response by providing full reimbursement for the basic medical expenses, and the lesser subsidy of tax relief for the categories on the fringe.

Accordingly, the remaining alternative, that of leaving section 213 essentially intact, makes the most sense. In fact, this approach appears to be the one taken by most of the proposals. A question remains as to the continued justification for percentage thresholds if section 213 is retained. The three percent floor retained by all but the Administration bill makes no sense at all. First, if it is intended to reflect the average annual family expenditures on medical care, it is clear that it has lost its validity. Second, it should be clear that the entire concept of average family medical expenditures will have to be revised once any one of the health care proposals is enacted. The important statistic is unreimbursed, out-of-pocket medical expenditures. Clearly, such expenditures will be considerably lower after the enactment of some of these health care proposals than they are today. Therefore, no historical statistics will be of any use in deriving this figure.

In addition, if the continuing justification for a percentage floor would be to afford tax deductions only to expenditures that constitute hardships, one would have to inquire about whether the mere fact that a family is spending a greater than average percentage of its income on medical care will still mean that that family is experiencing hardship. For example, if the Kennedy bill were enacted, it would be quite possible that even above average unreimbursed expenditures would still be too low to be considered a hardship for most families.

The ten percent floor proposed by the Administration at least has some basis. Since 1954 average medical expenditures as a percentage

of income have risen from three percent to eight percent.<sup>247</sup> Presumably, average medical expenditures will soon reach ten percent, if they are not already there. However, one must again ask if the notion of limiting section 213 deductions to those expenses that are above average will continue to make sense after the enactment of some of the more substantial health care proposals.

In addition, there is a special problem when one is considering such expenses as coping expenses. Does it make any sense to require coping expenditures to exceed a percentage floor before they are to be deductible? If the rationale of the percentage threshold is to deny tax relief unless the expenditures are extraordinary, it can be argued that the category of coping expenses is in itself extraordinary, without any need for percentage thresholds. If there is still some attraction to the notion of not affording tax relief to the first stirrings of medical activity, it should be pointed out that coping expenses virtually never occur by themselves. Such expenditures only occur in conjunction with some form of basic illness. Therefore, the basic medical problem already furnishes a type of threshold expenditure.

Perhaps the feeling that some percentage threshold should be retained for coping expenses stems from a continued awareness of the fact that these categories of medical expenditure have been subject to abuse in the past. In this light, perhaps the percentage threshold amounts furnish one sure way of limiting that abuse. However, if abuse is the problem, it would seem that a more rational response would be to codify the *Ferris*<sup>248</sup> approach, and put the reasonableness limitation in the statute. The court system has done a reasonably good job at preventing abuse in this area in the past. Putting a reasonableness limitation in the statute would give the courts what remaining teeth they need to administer these tax benefits equitably, with no need for any percentage thresholds.

### CONCLUSION

The definition of medical care has always been a problem for the legal system. In the application of section 213 to the areas on the fringes of the definition, the system has guarded against possible abuse by an unwarranted enthusiasm in denying deductions. The abuses have been held in check, but at the expense of the denial of tax relief to many who were suffering real medical hardship. This protective reaction cannot

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247. See note 13 and accompanying text *supra*.

248. 582 F.2d 1112 (7th Cir. 1978).

be justified by reference to any of the possible philosophical foundations for the medical expense deduction. Moreover, it is all the more unfortunate in light of the possibility that a reasonableness limitation, in concert with other devices that have proven successful in administering other deductions, could protect tax revenues with much less injustice.

The appearance of major health care proposals in Congress makes this a good time to reconsider the function of section 213. Even if a significant portion of medical expenditures is to be reimbursed by insurance under a health care proposal, it is submitted that section 213 should continue to have an important role. First, section 213 should retain a role with respect to those categories of medical expenditure included in the basic definitions of medical care in the various proposals. It should be noted that a tax deduction is a moderate form of governmental relief when compared to full reimbursement. This moderate governmental response would be perfectly attuned to medical expenditures that impose moderate hardship—those that are above average, but are not large enough to be termed catastrophic.

Finally, section 213 should continue to function with respect to those medical expenditures not covered under the basic definitions. Profiting from past errors, the system should grant section 213 deductions on a case-by-case basis for the reasonable costs of those categories of medical care that cannot be mechanically defined. With a reasonableness limitation in the statute, no percentage threshold would be necessary for these items. Recast in this manner, section 213 will finally find itself a comfortable niche, no longer forced into the jaundiced vision that has plagued its interpretation.