Freezing the Future: Elective Egg Freezing and the Limits of the Medical Expense Deduction

Tessa R. Davis

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# TABLE OF CONTENTS

**INTRODUCTION** .................................................................................. 374

**I. NEW FRONTIERS: ELECTIVE EGG FREEZING** ........................................ 377

A. Technology and Process ................................................................. 379

B. Framing the Use of Elective Egg Freezing ................................. 382
   i. Why Employers Offer An Elective Egg Freezing Benefit ........ 382
   ii. Why Women Use Elective Egg Freezing ............................... 386

**II. MEDICAL EXPENSES: THE CURRENT LANDSCAPE** .................. 388

A. Framework of § 213 ................................................................. 389

B. Sorting the Medical From the Personal—Preventative Care ........ 393

C. Sorting the Medical from the Personal—Reproductive Care ......... 398
   i. Structure/Function and the Diagnosis, Prevention, and Termination of Pregnancy ........................................ 398
   ii. Treating the Disease of Infertility ........................................ 399

**III. CATEGORIZING ELECTIVE EGG FREEZING** .................................. 407

A. Elective Egg Freezing Under Pre-Morrissey Precedent ............... 407
   i. The Argument for Full Classification as Medical Care .......... 407
   ii. The Argument for Partial Classification as Medical Care ...... 409

B. A Narrower § 213: Elective Egg Freezing Post-Morrissey and the Argument Against Deductibility .................. 411

C. Equity Impacts of Classification ................................................. 414

**IV. INCUBATING ARGUMENTS: ELECTIVE EGG FREEZING AND THE FUTURE OF THE MEDICAL EXPENSE DEDUCTION** ......................... 416

A. Scope of § 213 and Medical Care ............................................. 416

B. Defining the Baseline Taxpayer ................................................... 417

C. The Future of Preventative Care ............................................... 418
   i. Prophylactic Surgery ....................................................... 418
   ii. CRISPR-Cas9 Gene Editing ............................................. 421

**CONCLUSION** ..................................................................................... 424

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1 Assistant Professor of Law, University of South Carolina School of Law. The author would like to thank the participants of the Junior Tax Workshop 2017 for their comments on an incubator version of this piece, the participants of the Tax Expenditure Panel of the National Tax Association Conference 2017, Seth Davis, Rick Handel, and Clint Wallace. Thanks to Jessica Engen and Max Wesemann for their excellent research assistance.
INTRODUCTION

Death and taxes may be certain, but tax law's treatment of new medical technologies is anything but. Nowhere is that more true than in the area of reproductive technologies. This Article takes stock of the Internal Revenue Code's (hereinafter "the Code") treatment of emergent reproductive technologies, focusing upon categorization of elective egg freezing, in order to lay the groundwork for a more principled approach than the Internal Revenue Service (hereinafter "IRS") has mustered thus far. This Article's thesis is that elective egg freezing presents a conundrum that lays bare the incoherence of the Service's approach to defining costs for "medical care" that a taxpayer may deduct under the Code.

Elective egg freezing is an emergent reproductive technology. Consider, for example, the case of Jennifer, a recent law school graduate. She works long hours in a challenging law firm job that she enjoys. She wants to get married and have children someday. Recently, a friend mentioned that she was considering freezing her eggs "just in case." Now Jennifer is considering freezing her eggs too. The procedure may be costly, however, and Jennifer's employer may not cover elective egg freezing under its primary insurance plan. Some employers have moved to provide a full subsidy for the extraction and storage of eggs. But other employers structure the benefit as a reimbursement arrangement, such as a health reimbursement arrangement ("HRA"), health savings account ("HSA"), or flexible spending account ("FSA"). Still other employers provide no egg freezing benefit. Perhaps Jennifer will consider the tax treatment of these costs, or perhaps not.

Such a scenario is precisely described by some women who pursue egg freezing. See, e.g., Dara Kerr, Egg Freezing, So Hot Right Now, CNET (May 22, 2017, 5:00 AM), https://www.cnet.com/news/egg-freezing-so-hot-right-now/ ("Although Kennedy wasn’t really thinking of getting her eggs frozen, she began to hear lots of buzz around the office as colleagues took advantage of the benefit. ‘It just came up if you were above 30 and single,’ Kennedy says."); Heather Murphy, Lots of Successful Women Are Freezing Their Eggs. But It May Not Be About Their Careers, N.Y. TIMES (July 3, 2018), https://www.nytimes.com/2018/07/03/health/freezing-eggs-women.html [https://perma.cc/XLC3-A7DJ] ("Instead, most women focused on another reason: they still hadn’t found a man to build a family with.").


Unless, of course, Jennifer took Income Tax and recalled the discussion of 26 U.S.C. § 213, tax considerations are unlikely to be at the forefront of her mind as she makes her decision.
Either way, determining the probable tax treatment of this type of costs presents vexing questions for tax law and policy.

Vexing because the Service seems of more than one mind when it comes to emergent reproductive technologies. The Code defines “medical care” as “amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body.” 6 Within the broad outlines that this definition provides, the Service has struggled to categorize fertility costs. 7 Sometimes it has viewed fertility costs as disqualified personal expenses, on the theory that paying for fertility treatments is merely another form of personal consumption. 8 Other times the Service has categorized fertility costs as qualifying medical care. 9 What the Service has not done is adopt a principled approach. Instead, its treatment of fertility costs has depended upon not only the shifting state of medical knowledge, but also prevailing social norms, marital status, sexual orientation, and gender of the individual who has paid the fertility costs. 10

How will the Service treat any expenses Jennifer makes for elective egg freezing? That remains to be seen, but if its approach to fertility costs is any guide—and I will argue it is—then the Service is unlikely to allow Jennifer to deduct those expenses. In reaching that result, however, the Service will have to confront its shallow and inconsistent understanding of preventative care under the Code. Section 213 clearly defines “medical care” to include preventative care. And, therefore, § 213 of the Code allows a taxpayer to deduct the costs of preventative care. For instance, a taxpayer may deduct the costs of an annual physical as “medical care,” even if the individual does not have a medical condition at the time of the exam. 11 Jennifer’s costs of elective egg freezing may plausibly, even easily, qualify as preventative care under § 213, or so I shall also argue. 12 For the Service to conclude that elective egg

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8 See Tessa Davis, Reproducing Value: How Tax Law Differentially Values Fertility, Sexuality & Marriage, 19 CARDOZO J. L. & GENDER 1, 12–13 (2012) (discussing the IRS’s position “that surrogacy expenses do not qualify as medical expenses under Section 213.”).
9 See id. at 12 (summarizing the IRS’s stance that treatments aimed at overcoming an inability to have children qualify as a medical expense).
12 For information on the type of preventative care readily qualified as medical care, see Women’s Preventive Services Initiative, ACOG, https://www.acog.org/About-ACOG/ACOG-Departments/Annual-Womens-Health-Care/Womens-Preventive-Services-Initiative [https://perma.cc/NW6D-L5AL] (detailing guidelines of recommended screenings and preventive health services for women); Ages 19–39 Years: Exams and Screening Tests, ACOG,
freezing is not preventative would thus further complicate its already complicated categorization of expenses under § 213.

Elective egg freezing, after all, is neither traditional fertility care nor traditional preventive care. Unlike traditional fertility care, in which an individual or couple seeks to have a child in the present, elective egg freezing is about delaying reproduction until some later date. It seeks, in other words, to prevent the loss of the ability to reproduce that comes with growing older. Yet unlike traditional preventative care, elective egg freezing does not aim to prevent a condition that we typically think of as a “disease.” Nor does it aim to prevent a condition that an individual might develop. Instead, it hedges against a condition that is a natural and certain result of the passage of time. It aims to prevent the end result of infertility in the future. As such, it is a nontraditional form of preventative care.

In exploring the complexities that elective egg freezing presents, this Article makes four contributions to the literature on tax policy and medical care. The first contribution is analytical. This Article provides a comprehensive analysis of the tax law implications of elective egg freezing. It considers how best to categorize elective egg freezing in light of § 213 and the Service’s existing approaches. This comprehensive evaluation of elective egg freezing lays a foundation for future doctrinal development.

The second contribution, therefore, is doctrinal: This Article explores the Code’s definition of “preventative care” from a new vantage. It seeks to clarify the category of preventative care and to better distinguish its role within § 213. The Service’s precedent is unclear as to whether—and when—reproductive care is too bound up with the general health and well-being of the individual to qualify as deductible.

It is because there is no disease present that elective egg freezing, and other similar emergent technologies, likely fall outside the mitigation language of § 213. See 26 U.S.C. § 213 (2012); infra Parts II, III.

The likelihood of this question reaching the Service in the near future is high due to the high costs of care, which may surmount the § 213 Adjusted Gross Income (AGI) threshold, and the sparse coverage of such costs. Further, increasing numbers of women are utilizing elective egg freezing services. Ariana Eunjung Cha, The Struggle to Conceive with Frozen Eggs, WASH. POST, (Jan. 27, 2018), https://www.washingtonpost.com/news/national/wp/2018/01/27/feature/she-championed-the-idea-that-freezing-your-eggs-would-free-your-career-but-things-didnt-quite-work-out/?utm_term=.31ca521bf364 (citing a Society for Assisted Reproductive Technology survey that found the number of women freezing their eggs increased from 475 in 2009 to nearly 8,000 in 2015).
medical care. In exploring this precedent, and applying it to elective egg freezing, this Article clarifies the lack of rigor in the medical care category broadly, and the preventative care precedent specifically, emphasizing its implications for elective egg freezing.

This Article's third contribution is critical. In particular, this Article builds upon my prior work to critique the Service's treatment of fertility costs. Therein, I argued that the Service failed to recognize the culturally-contingent nature of terms such as "normal" or "natural" reproduction. That failure, explains, at least in part, the Service's struggles in applying section 213 to fertility care. This Article's critical contribution extends beyond the treatment of fertility costs, however. In particular, I lay a foundation for future work on the incoherence of the Service's use of "personal choice" to distinguish deductible medical costs from non-deductible personal consumption. The Service's definition of preventative care displays this incoherence, as it appeals to the idea that the presence of personal choice disqualifies much preventative care, while ignoring or understating the role of personal choice in a wide swath of qualifying medical care.

Fourth, and finally, this Article contributes to the analysis of the tax implications of other emergent medical technologies. I argue that elective egg freezing is analogous to many emerging medical technologies. It thus presents a particularly important litmus test for how the Service will employ concepts like "choice," "consumption," and "preventative care," among others, in addressing a wide array of tax policy questions. In particular, I argue that how the Service approaches elective egg freezing may determine the future classifications of state-of-the-art medical technologies such as prophylactic surgery and gene therapy.

This Article unfolds in four Parts. Part I provides background on elective egg freezing by describing the technology and contextualizing its use, both of which are important factors in a tax analysis. Part II addresses the relevant tax precedent. Part III, the heart of the Article, applies the tax precedent to elective egg freezing, showing how this test case lays bare the incoherence of the Service's analytical approach. Part IV concludes by connecting Part III's analysis to broader questions of the definition of "medical care" and its application to emerging medical technologies.

I. NEW FRONTIERS: ELECTIVE EGG FREEZING

Elective egg freezing—sometimes referred to as social egg freezing—17—is an emergent medical technology in two important ways. The technology itself is only newly-approved for widespread use and continues to develop. Assuming the reader

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15 Davis, supra note 8, at 1–2, 12.
17 See, e.g., Angel Petropanagos, Reproductive ‘Choice’ and Egg Freezing, in ONCOFERTILITY: ETHICAL, LEGAL, SOCIAL AND MEDICAL PERSPECTIVES 223 (Teresa K. Woodruff et al. eds., 2010) ("As oocyte and ovarian tissue cryopreservation techniques continue to improve, there is a growing need to address the moral permissibility of what has been called ‘social’ egg freezing." (endnotes omitted)); Angel Petropanagos et al., Social Egg Freezing: Risk, Benefits and Other Considerations, 187 CMAJ 666, 666–69 (2015) (evaluating the phenomenon of social egg freezing).
is unfamiliar with the area, this Part details the procedure. But elective egg freezing is an emergent technology in another critical way: the social context of its provision and use. Why women use elective egg freezing, why employers provide coverage, and how clinics market the care should shape policy responses to its use. For tax law and policy, this social context makes situating elective egg freezing within the existing § 213 framework challenging and exposes the weaknesses therein. Because the social context of elective egg freezing is important to its analysis, this Part explores that context, providing the necessary foundation for the tax analysis of subsequent parts.

In late 2016, Extend Fertility opened the nation’s first fertility clinic offering only elective egg freezing services. Rather than acting as a full-service infertility clinic, this Manhattan clinic expressly targets women interested in delaying pregnancy by protecting fertility through elective egg freezing. Clinic materials distinguish the Manhattan practice from other, more comprehensive, clinics:

We recognize that the physical and emotional needs of women interested in fertility options are vastly different from the needs of women struggling with infertility issues. This might seem obvious. But most practices serve both sets of women in the same office and focus mainly on the latter, who hope to get pregnant immediately through techniques like in vitro fertilization (IVF)—which is efficient for the practice, but not ideal for you if you’re not in that camp.

That’s what’s different about Extend Fertility: we believe that women interested in fertility options for the future deserve the same level of service, emotional support, and physician excellence as women trying for a baby now.

... What’s new about Extend Fertility is our focus on creating a program centered around the unique, busy lives of women who want to freeze their eggs—at a price that makes sense at this point in their lives...

Every woman has her own dreams and aspirations. And for many, setting aside the worry about fertility can help them focus on achieving


See Pesce, supra note 18.
their goals. If that’s the case for you, come talk to us to learn more about Extend Fertility. We’re here to help.20

The promise of Extend Fertility, then, is not resolving the discrete medical condition of diagnosed infertility, but instead is that a woman can buy time—time to find a partner, time to develop her career, time to spend childfree without losing her ability to have children. It is a tantalizing but controversial promise.21

A. Technology and Process

Considered experimental until 2012, mature oocyte cryopreservation (colloquially egg freezing) remains a controversial technology.22 The process is invasive, costly, and its chances of success—of leading to a future child—are unclear.23 Though elective egg freezing may have complicated impacts on women’s equality, interpersonal relationships, and employment, the process itself is easy to describe.24 To prepare, a woman consults a reproductive endocrinologist to determine if she is a good candidate for egg freezing.25 If she is a good candidate, the woman will begin the first of three separate phases. First, the woman will undergo daily hormone injections for a little over one week.26 The drugs used—a “stimulator”, an “antagonist”, and a “trigger”—cause the woman’s body to produce

20 About Extend Fertility, supra note 18 (emphasis added).
21 This Part will address the criticisms of elective egg freezing. One is worth noting here, however, and that is that employers are offering to subsidize elective egg freezing for their own benefit—to recruit, retain, and extract more hours from employees by subsidizing their delaying having children. This criticism raises a fascinating question as to whether an employer-provided elective egg freezing is not compensation because the primary benefit accrues to the employer. This Article focuses on the categorization of elective egg freezing under § 213 and only opines on the compensation issue.
24 The focus of this Article is not exploring whether elective egg freezing is “good” as a matter of policy. That it should qualify as medical care is a doctrinal rather than a policy position.
25 AM. SOC’Y FOR REPROD. MED., CAN I FREEZE MY EGGS TO USE LATER IF I’M NOT SICK? 1 (2014), http://www.reproductivefacts.org/globalassets/ff/news-and-publications/bookletsfact-sheets/english-fact-sheets-and-info-booklets/can_i_freeze_my_eggs_to_use_later_if_im_not_sick_factsheet.pdf [https://perma.cc/3UXT-YXKC]. Age plays an important part in this analysis though some studies have considered cost-effectiveness as well. Tolgu B. Mesen et al., Optimal Timing for Elective Egg Freezing, 103 FERTILITY & STERILITY 1551 (2015) (“Oocyte cryopreservation can be of great benefit to specific women and has the highest chance of success when performed at an earlier age.”).
more eggs (the stimulator) and then control the release (the antagonist and the trigger). 27 Throughout the hormone stimulation phase, a woman regularly visits her doctor for blood tests and/or ultrasounds to evaluate the efficacy of the hormone treatments. 28 At the close of the hormone stimulation phase, the woman is ready for the second phase: egg retrieval.

Egg retrieval is an outpatient procedure. 29 At this stage, an ultrasound is performed to locate the ovaries and confirm the presence of the eggs to be harvested. 30 To retrieve the eggs, an anesthesiologist provides an intravenous anesthetic. 31 Another physician then extracts the eggs from the woman’s ovaries, passing a catheterized needle through the vaginal wall to do so. 32 The woman then remains in the office until the anesthesia wears off and she can safely return to her day. 33 While the woman recovers, clinic staff transfers her eggs to test tubes for a flash-freezing process known as vitrification. 34 Because freezing twenty to thirty eggs increases the chances of eventual successful fertilization and implantation, a woman may undergo as many as four or five rounds of ovarian hormonal stimulation and egg retrieval. 35

Unsurprisingly, egg freezing is expensive. 36 Though numbers vary across clinics, the average costs are instructive. A woman can anticipate paying at least $10,000 per

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27 Id. The drugs commonly used are:

Gonal-F or follistim (follicle stimulating hormone), used to stimulate egg production;[;]
Menopur, a combination hormonal medication (follicle stimulating hormone and luteinizing hormone), also used to stimulate egg production;[;] Ganirelix Acetate or Cetrotide, medications used to prevent premature release of the eggs before you’re ready for your egg retrieval procedure;[;] Lupron (also known as leuprolide acetate), a type of trigger medication used to initiate the final egg maturation before the retrieval and freezing;[; and,] hCG (human chorionic gonadotropin), also sold as Ovidrel or Novarel, an alternative kind of trigger medication.


28 AM. SOC’T FOR REPROD. MED., supra note 25.


30 See The Egg Retrieval Process, supra note 29.

31 Id.

32 Id.

33 Though the procedure is outpatient, clinics recommend a woman rest for the balance of the day after the procedure. See id.


Infertility and reproductive health organizations compile information on state law and insurance coverage for infertility care. There is less information available on elective egg freezing. See Infertility Coverage by State, RESOLVE, https://resolve.org/what-are-my-options/insurance-coverage/infertility-coverage-state/ [https://perma.cc/C6EB-UG2R]; RI Becomes First State to Explicitly Require Coverage of Fertility Preservation for At-Risk Patients, Women & Infants (July 31, 2017), http://www.womenandinfants.org/news/fertility-preservation-legislation.cfm [https://perma.cc/ CX9X-UH4J] (Noting that Rhode Island became the first state to require coverage for egg freezing in 2017 but only prior to medical treatment that could lead to infertility); Michelle Andrews, Few Employers Cover Egg Freezing for Women with Cancer, NPR (Dec. 16, 2014, 8:22 AM),
round of care. That cost does not include the required hormone treatments which add an additional $3,000 to $5,000. Thereafter, a woman will pay approximately $500 annually for storage. The final significant cost comes when the woman decides to use her frozen eggs, at which point she will incur the costs of in vitro fertilization which averages $20,000 per round. Assuming a woman undergoes two rounds of the process and stores her eggs for ten years, she will have incurred approximately $20,000 to $30,000 in up-front costs and another $5,000 to $10,000 for storage, hardly insignificant sums.

Until recently, egg freezing was utilized in conjunction with another medical procedure. For example, a woman would freeze her eggs during the process of her infertility treatment or after a cancer diagnosis, but before radiation or chemotherapy. Only after the American Society for Reproductive Medicine removed the experimental label from egg freezing in 2012 did the procedure begin...
to move into the realm of elective egg freezing. Between 2012 and 2013, the number of women who used egg freezing increased by over 60%. Comparing 2009 to 2015 shows an even more dramatic increase of 1600%. Though the numbers are still low—under 10,000 annually—the trend is toward increasing use of the technology. Indeed, reports indicate that women may be traveling to the United States from other countries to undergo the process. In short, egg freezing is an emerging and increasingly popular form of care.

B. Framing the Use of Elective Egg Freezing

Elective egg freezing differs from the first uses of the technology, not in substance but in the social context of its use. A woman who chooses to freeze her eggs absent a diagnosis of infertility or need for treatment that may harm her fertility simply hedges against the risk of future infertility. Stated differently, she is engaging in highly-medicalized preventative care. The employer who decides to subsidize elective egg freezing has a different set of motivations. Because the woman’s and the employer’s motivations in using or subsidizing elective egg freezing may come to bear on its classification for tax purposes, this Section explores both.

i. Why Employers Offer an Elective Egg Freezing Benefit

Early in 2016, the Department of Defense joined tech giants Facebook and Apple in offering coverage for the costs of egg freezing. More employers...
followed. As of mid-2017, more than a dozen tech companies provided an egg freezing benefit, including Netflix, Spotify, Google, Uber, and Yahoo!. Details of how each company provides the benefit are hard to acquire, but some consistencies emerge. This Article analyzes both of two basic benefit structures: inclusion of egg freezing as a covered benefit under the primary employer-provided health insurance plan and coverage via employer reimbursement for medical costs through a medical expense account or reimbursement program, such as an HRA, HSA, or FSA. The specific form of the benefit and its amount impact the tax consequences, as will be addressed in Part III.

Employer motivation in providing a benefit matters. Employer motivation helps determine whether a transfer to an employee is income, for example. At the intersection of § 213 and elective egg freezing, employer motivation shapes the social context of the use of the care. Social context, in turn, plays a role in the tax analysis of categorization under § 213, as will be explored later in this Part and in Part III. Though the number of employers that have made public statements on why they are subsidizing elective egg freezing is limited, those that have focus on the notion of empowerment. In an interview with Bloomberg, Virgin Group CEO Richard Branson scoffed at the notion that someone should be criticized for using or providing elective egg freezing. He stated simply: “it’s women’s choice” as to when and with whom she wants to have a child. In the same interview, COO of Facebook Sheryl Sandberg characterized the decision to support elective egg freezing as consistent with its offering broad “benefits for all life stages.” Apple’s public statement strikes a similar tone:

52 See Kerr, supra note 2.
53 I reached out to companies that had publicly acknowledged the availability of an elective egg freezing benefit to determine how the benefit is provided but received no response.
54 To be clear, most transfers from an employer to employee raise no real interpretive challenges. An employer benefits from paying wages to an employee in so far as the employer retains the employee and receives the employee’s efforts, but there is no question that the wages have a compensatory motive and are, therefore, income. Some vexing cases emerge, however. For examples, see Comm’r v. Kowalski, 434 U.S. 77, 83–84 (1977) and United States v. Gotcher, 401 F.2d 118, 123–24 (5th Cir. 1968), two important cases in the area. Herein, the structure of an elective egg freezing benefit raises no real doubt as to the compensatory motive.
56 Id.
57 Id.
58 Id. Sandberg noted that the initial decision to consider covering egg freezing came after an employee wanted to freeze her eggs ahead of a cancer diagnosis. Id. She then suggested that there should be no distinction between egg freezing in this more traditional scenario and one in which a woman chooses to do so with age-related fertility decline in mind. Id.; see also Danielle Friedman, Perk Up: Facebook and Apple Now Pay for Women to Freeze Eggs, NBC NEWS (Oct. 14, 2014, 2:56 PM), [https://www.nbcnews.com/news/us-news/perk-facebook-apple-now-pay-women-freeze-eggs-n225011]
Apple cares deeply about our employees and their families, and we are always looking at new ways our health programmes can meet their needs. We continue to expand our benefits for women, with a new extended maternity leave policy, along with cryopreservation and egg storage as part of our extensive support for infertility treatments... We want to empower women at Apple to do the best work of their lives as they care for loved ones and raise their families.⁵⁹

Employers’ framing of elective egg freezing closely tracks that of the elective egg freezing industry itself;⁶⁰ elective egg freezing is, it seems, about empowering women to be in control of their personal and professional lives.

Critics question the empowerment narrative.⁶¹ Rather than meaningful support, skeptics view provision of the benefit as stemming from one of three motives: first, the desire to retain female talent in male-dominated industries plagued by gender inequity;⁶² second, the desire to encourage women to delay childbearing for the benefit of the employer;⁶³ or third, as a distraction from meaningful, pro-work/life


⁶⁰ See supra notes 20–21 and accompanying text.

⁶¹ See, e.g., Friedman, supra note 58 (“Companies may be concerned about the public relations implications of the benefit—in the most cynical light, egg-freezing coverage could be viewed as a ploy to entice women to sell their souls to their employer, sacrificing childbearing years for the promise of promotion.”).

⁶² See, e.g., id. (“With notoriously male-dominated Silicon Valley firms competing to attract top female talent, the coverage may give Apple and Facebook a leg up among the many women who devote key childbearing years to building careers. Covering egg freezing can be viewed as a type of ‘payback’ for women’s commitment, said Philip Chenette, a fertility specialist in San Francisco.”); Kerr, supra note 2 (“[Tech companies are] also under pressure to attract more female employees to their mostly male workforces.”).

⁶³ See, e.g., Kelly Phillips Erb, Apple Seeds Perk Wars, Adds Egg Freezing as Employee Benefit, FORBES (Oct. 17, 2014, 8:01 PM), https://www.forbes.com/sites/kellyphillipserb/2014/10/17/apple-seeds-perk-wars-adds-egg-freezing-as-employee-benefit/#4fc7b2e4174d (https://perma.cc/YDW2-RB47) (“Companies say they’re just giving female employees what they want but it’s not unlikely that there’s a more selfish reason: keeping female employees at their jobs a little longer.”); Friedman, supra note 58 (“Will the perk pay off for companies? The benefit will likely encourage women to stay with their employer longer, cutting down on recruiting and hiring costs. And practically speaking, when women freeze their eggs early, firms may save on pregnancy costs in the long run, said Westphal. A woman could avoid paying to use a donor egg down the road, for example, or undergoing more intensive fertility treatments when she’s ready to have a baby. But the emotional and cultural payoff may be more valuable, said Jones: Offering this benefit ‘can help women be more productive human beings.’”).
balance reforms, such as flexible work schedules or parental leave. As one commentator cautioned: "When you’re in a situation of your employer offering you a choice, you really have to be careful that you’re distinguishing between something that’s an expanded option and something that’s actually subtle or even explicit pressure to do what your employer wants you to do."

A healthy skepticism of employer motivations seems appropriate and the implications of elective egg freezing for gender equality, employer-employee relations, family policy, wealth inequality, and women’s health should be explored across disciplines. While presumably employers have different motivations for subsidizing egg freezing, this Article assumes, consistent with the structure of the benefits and relevant doctrine, that any employer benefit for elective egg freezing is compensatory. The inquiry then becomes how § 213 applies to elective egg freezing and the weaknesses of current doctrine that such inquiry exposes. How women use elective egg freezing is an important part of that analysis.

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64 See, e.g., Samantha Allen, Don’t Be Fooled by Apple and Facebook, Egg Freezing Isn’t Cool, DAILY BEAST (Oct. 17, 2014, 5:48 AM), https://www.thedailybeast.com/dont-be-fooled-by-apple-and-facebook-egg-freezing-isnt-cool [https://perma.cc/RMJ7-UX8M] (“In this context, the decision to cover egg freezing reads as Silicon Valley at its most typical, deploying a hasty technological stopgap for a cultural problem.... It is telling that these top tech firms have opted to splurge on a measure that seems to be targeted at delaying childbirth among female employees before adopting even more measures to accommodate women who have children early in or midway through their careers.”).

65 Laura Sydell, Silicon Valley Companies Add New Benefit for Women: Egg-Freezing, NPR (Oct. 17, 2014 3:21 AM), http://www.npr.org/sections/alltechconsidered/2014/10/17/356765423/silicon-valley-companies-add-new-benefit-for-women-egg-freezing [https://perma.cc/W8B3-8TZL] (“But Marcy Darnovsky, executive director at the Center for Genetics and Society, says that expanding benefits to cover egg-freezing could put pressure on women to delay childbearing so that their employer can get more hours out of them. Darnovsky is an advocate for the responsible use of reproductive technologies.”).


67 Employers should nevertheless be cautious when providing egg freezing as a benefit. See Erb, supra note 63 (“What this means is that employers must tread lightly when contemplating nontraditional benefits. While it may be advantageous to think out of the box, a number of issues are raised when it comes to offering these kinds of benefits to employees including privacy concerns and whether it’s a ‘fair’ perk to offer when only a small percentage of employees may take advantage of it. When it comes to egg freezing, for example, women who opt not to take advantage of the perk may worry how that decision will be regarded: are they sending a message that they are not willing to put their career ahead of family? What about men who opt not to share the benefit with a spouse? Typically, employees don’t discuss their plans for family with an employer but taking advantage of this kind of benefit - or opting out - may signal your intentions.”).

68 Whether there is a theoretical argument that the employer motivations in covering elective egg freezing call into doubt if such coverage should be understood as compensatory is a fascinating discussion for another day.
ii. Why Women Use Elective Egg Freezing

Despite the increasing availability of employer coverage, the majority of working women have no employer-provided coverage of elective egg freezing.\(^{69}\) Thus, many women who undergo elective egg freezing do so without expectation of an employer subsidy.\(^{70}\) The only potential, partial subsidy available to this group is, then, a deduction for the costs of egg freezing under § 213.\(^{71}\) Whether a woman utilizes an employer benefit or self-pays, however, her reasons for undergoing egg freezing influence the tax classification of the care.\(^{72}\) Understanding women’s motivations for seeking such care is, therefore, important to determining the tax treatment of elective egg freezing costs.

Egg freezing clinics strongly promote the idea that egg freezing gives women control; control of their careers, control of their personal lives, and control of their bodies.\(^{73}\) Clinics hail that elective egg freezing enables a couple to “circumvent age-related [fertility] limitations.”\(^{74}\) Extend Fertility promises that “[p]utting your eggs on ice will give you more flexibility and freedom for your future.”\(^{75}\) The University of North Carolina’s fertility clinic notes that education and career may mean that “[t]he ‘right time’ for a woman to become pregnant does not always align with her biological clock” and that egg freezing pauses that clock.\(^{76}\) Echoed by employers’ rhetoric on elective egg freezing, clinics emphasize the language of choice, empowerment, and control.

Women are increasingly receptive to the promises of elective egg freezing.\(^{77}\) The common threads of women’s reasons for using elective egg freezing map well onto the marketing claims of the clinics themselves. Women cite feelings of freedom and increased choice in and control over their personal lives and careers as motivators to

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\(^{69}\) See Kerr, supra note 2 (stating that only around 5% of companies with 500+ employees offer an egg freezing benefit).

\(^{70}\) See Friedman, supra note 58 (“[T]he more likely explanation for lack of coverage is simply that egg freezing is still new, and conversation around the procedure has only recently gone mainstream.”); cf. Clare O’Connor, Carrot Fertility Raises $3.6M to Help Take IVF, Egg Freezing Benefits Mainstream, Forbes (Sept. 14, 2017, 8:17 AM), https://www.forbes.com/sites/clareoconnor/2017/09/14/carrot-fertility-raises-3-6m-to-help-take-ivf-egg-freezing-benefits-mainstream/#2f1517c [https://perma.cc/G24X-4YQB] (discussing a startup attempting to make egg freezing more accessible to smaller companies and female employees).

\(^{71}\) See discussion infra Part III.

\(^{72}\) See discussion infra Part III.

\(^{73}\) See Lisa C. Ikemoto, Egg Freezing, Stratified Reproduction and the Logic of Not, 2 J.L. & BIOSCIENCES 112, 113 (Feb. 2015) (discussing the targeting of specific groups of women and the branding of the procedure).

\(^{74}\) When It Comes to Age and Fertility, How Old Is Too Old for Fertility Treatments?, USC FERTILITY, http://uscfertility.org/fertility-treatments/age-and-fertility/ [https://perma.cc/U5H8-QTQB]; see also Egg Freezing & Embryo Banking, supra note 18.


\(^{76}\) Egg Freezing Extending the Biological Clock, UNC FERTILITY, https://uncfertility.com/treatment-options/egg-freezing/ [https://perma.cc/8M6N-GB9U].

\(^{77}\) See Cha, supra note 15.
use elective egg freezing. As actress Olivia Munn summarized: “Every girl should do it. For one, you don’t have to race the clock anymore. You don’t have to worry about it, worry about your job or anything. It’s there.” When the natural consequence of delaying reproduction is a decline in fertility that will end in infertility, the prospect of time to delay the inevitable is tantalizing. But hedging against the inevitable—age-related infertility—is readily distinguished from freezing one’s eggs to prevent infertility that may result from treatment for a current disease or disorder. The former is a type of highly-medicalized preventative care—preventing the meaningful consequences of age-related changes that are years or decades off—while the latter is part of treatment for an existing condition.

Though supporters of the move toward employer-provided coverage of elective egg freezing have hailed such expanded coverage as long overdue, critics raise many concerns. Some are beyond the scope of this paper—the impact elective egg freezing may have on employer/employee relations, for example—but two merit discussion. First, many caution that the technology falls far short of guaranteeing future fertility. The freezing process is imperfect. When layered upon the challenges of the IVF process and the variability in the health of a woman’s eggs and ability to carry a child, the success rate of elective egg freezing is far from 100%.

Though there is insufficient data to make definitive estimates, experts posit the following probabilities of success: “[A] woman who is 35 with 10 eggs has a 69 percent chance of a baby. At age 37, she has a 50-50 chance. And at age 39, she has a mere 39 percent chance.” A second criticism proceeds from the first: that the costs—both psychic and monetary—of elective egg freezing may frequently exceed

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79 Cha, supra note 23.

80 See Erb, supra note 63 (“Nowadays, however, not all women are content to simply take their chances. They’re taking matters into their own hands by planning for the future with a technological twist: freezing their eggs in order to have children on a schedule. And in some industries, such as the tech sector, employers are more than happy to help.”).


83 Cha, supra note 23.

84 See id.

85 Id.; see also La Ferla, supra note 22 (noting that women may not be aware of their own fertility ahead of undergoing egg freezing as well as similarly low results).
the benefits. As one fertility specialist succinctly characterized the idea that a woman can “control” her fertility: “It’s total fiction. It’s incorrect.”

If elective egg freezing gives a woman a false sense of security, she may not only lose the money she spent pursuing that security but also endure the emotional toll of infertility itself.

As the next part details, both the nature and purpose of a potential medical expense may influence its tax consequences. Considering the technology of elective egg freezing itself, alongside its social context, four potential tax classifications emerge. When an employer subsidizes the cost of elective egg freezing, the benefit may be nonexcludable taxable compensation or excludable (either in whole or in part) compensation. In the absence of an employer-provided benefit, elective egg freezing is either a nondeductible personal consumption expense or deductible medical care. Because section § 213 plays an important role in determining whether elective egg freezing is either excludable compensation or a deductible medical expense, the next Part details § 213 itself and relevant precedent.

II. MEDICAL EXPENSES: THE CURRENT LANDSCAPE

All medical care toes the line dividing personal consumption and deductible expense. Nevertheless, since 1942, Congress has provided tax relief for individuals with significant medical expenses. A widely-accepted rationale for such relief is that medical expenses reduce a taxpayer’s ability to pay tax and should, therefore, impact the individual’s taxable income. For example, Individual A with gross income of $100,000 and no medical expenses is meaningfully distinct from Individual B with the same gross income but $20,000 of medical expenses. The

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86 Cha, supra note 15
87 Id. (quoting Dr. James Grifo, an NYU fertility specialist).
88 See id.
90 See id. § 213, 262.
93 See S. REP. NO. 77–1631, at 6 (1942) ("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.").
intuition is that though medical care may be understood as personal consumption, it is a different class of consumption from a vacation or a new car. Stated differently, an individual does not choose to develop lung cancer while he does choose to travel to the Bahamas. Thus, income spent to treat cancer is different from other nondeductible consumption. The challenge, then, of § 213 is to sort between qualifying medical care that warrants a subsidy (in Congress’s view) and that which is disqualified. A working knowledge of § 213 lays the foundation for understanding how elective egg freezing fits within existing precedent.

A. Framework of § 213

Section 213 authorizes a deduction for qualifying medical care to the extent the costs of that care exceed 10% of the taxpayer’s adjusted gross income. Section 213(d) defines medical care, in pertinent part, as “amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body.” This two-pronged, disjunctive definition

94 As a general rule, in an income tax system, personal consumption is subject to tax. The dominant definition, from which there are many exceptions within the Code, derives from the Haig-Simons concept of income where income equals consumption plus changes in wealth. See Joseph A. Pechman, Comprehensive Income Taxation: A Comment §1 HARV. L. REV. 63, 64–65 (1967).

95 See Andrews, supra note 91 and Bittker, supra note 91 for early analysis of the weakness of the tax expenditure concept and Surrey, supra note 91 for a definition of tax expenditure concept.

96 26 U.S.C. § 213 (2012). Adjusted gross income is defined in id. § 62. For Tax Years 2017 and 2018, the Tax Cuts and Jobs Act lowers that threshold back to the historic 7.5% AGI. Act to provide for reconciliation pursuant to titles II and V of the concurrent resolution on the budget for fiscal year 2018, Pub. L. No. 115–97, § 11027, 113 Stat. 2054, 2077 (2017) (hereafter, the Tax Cuts and Jobs Act). Expenses must also be unreimbursed and for the taxpayer, her spouse, or her dependents (though this latter point is construed broadly in certain scenarios, such as kidney donation). This article assumes that the healthcare system moving forward continues to be one in which individuals are likely to lack insurance for preventative care and, therefore, may incur substantial unreimbursed costs.


(d) Definitions
For purposes of this section—
(1) The term “medical care” means amounts paid—
(A) for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body,
(B) for transportation primarily for and essential to medical care referred to in subparagraph (A),
(C) for qualified long-term care services (as defined in section 7702B(c)), or
(D) for insurance (including amounts paid as premiums under part B of title XVIII of the Social Security Act, relating to supplementary medical insurance for the aged) covering medical care referred to in subparagraphs (A) and (B) or for any qualified long-term care insurance contract (as defined in section 7702B(b)).

In the case of a qualified long-term care insurance contract (as defined in section 7702B(b)), only eligible long-term care premiums (as defined in paragraph (10)) shall be taken into account under subparagraph (D).
provides two avenues for classifying a cost as medical care: a disease prong and a struc‐
ture/function prong.98

Importantly, Congress expanded §213 beyond expenses readily identifiable as medical. Expressly included as qualifying medical care are the costs of “transportation primarily for and essential to medical care,”99 certain insurance payments,100 and qualified lodging while away from home to receive medical care.101 Consider the example of lodging: allowing a deduction for the costs of lodging “primarily for and essential to” medical care is consistent with the provision’s goal of relieving the burden of high medical care costs.102 Such lodging costs are likely duplicative of the rent or mortgage the individual pays for her primary residence and are, at least somewhat, out of the individual’s control. Yet lodging costs are also intensely personal. Stated simply, everyone needs to live somewhere and, in tax, the decision of where to live or stay is a paradigmatic personal expense.103 Allowing a deduction for lodging expenses then raises the risk of §213 improperly subsidizing insufficiently medical expenses. Cognizant of this thin dividing line, Congress limited the deduction for lodging under §213 not only to lodging “primarily for and essential to medical care” but in which “there is no significant element of personal pleasure, recreation, or vacation in the travel away from home.”104 The essential work of §213 is, then, to sort between nondeductible personal expenses and personal expenses that qualify for deductibility because they are sufficiently medical. It is precisely upon this line that elective egg freezing teeters.

The Service looks to the basis of care—its social context—to help do the work of sorting the personal from the medical. Cosmetic surgery provides an example. Though the core definition of medical care has remained unchanged since the provision became part of the Code in 1942,105 Congress, the Treasury, and courts have fleshed out the scope of definition. For example, after years of the Service

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98 See Davis, supra note 8 at 20–21; Pratt, supra note 10, at 1140; Katherine Pratt, The Tax Definition of “Medical Care”: A Critique of the Startling IRS Arguments in O’Donnabhain v. Commissioner, 23 MICH. J. GENDER & L. 313, 322 (2016) [hereinafter Pratt, Definition of “Medical Care”].


100 See id. § 213(d)(1)(D).

101 See id. § 213(d)(2) (“Amounts paid for lodging (not lavish or extravagant under the circumstances) while away from home primarily for and essential to medical care referred to in paragraph (1)(A) shall be treated as amounts paid for medical care if—(A) the medical care referred to in paragraph (1)(A) is provided by a physician in a licensed hospital (or in a medical care facility which is related to, or the equivalent of, a licensed hospital), and (B) there is no significant element of personal pleasure, recreation, or vacation in the travel away from home.”). Treasury Regulation § 1.213-1(e)(1) (2014) provides further examples of potentially qualifying outlays that fall outside the bounds of being indisputably medical (e.g. an air conditioner).


103 See id. § 162, 262. Commuting expenses and the doctrine surrounding them provide the classic view that where an individual lives is a textbook personal, consumption decision. The foundational case in the area is Comm’r v. Flowers, 326 U.S. 465, 473–74 (1946) (disallowing a deduction for commuting expenses on the rationale that the taxpayer’s choice of residence is a wholly-personal decision).


permitting deductions for cosmetic surgery, Congress responded in 1990 with a new limitation on the definition of medical care. \footnote{26 U.S.C. § 213(d)(9) (2012).} Adding §213(d)(9), Congress specifically excluded elective cosmetic surgery from the definition of medical care. \footnote{Id.; see also 136 CONG. REC. 30570 (1990) ("[T]he committee determined that expenses for cosmetic surgery and other similar procedures should not be eligible for the medical expense deduction, unless the procedure is necessary to ameliorate a deformity arising from a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease. Expenses for purely cosmetic procedures that are not medically necessary are, in essence, voluntary personal expenses, which like other personal expenditures (e.g., food and clothing) generally should not be deductible in computing taxable income.").} Cosmetic surgery is defined as “any procedure which is directed at improving the patient’s appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.” \footnote{Id. ("There would seem to be little doubt that the expense connected with items which are wholly medical in nature and which serve no other legitimate function in everyday life is incurred primarily for the prevention or mitigation of disease.").} In contrast, cosmetic surgery that “is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease,” remains qualifying medical care. \footnote{See Gerstacker v. Comm’r, 414 F.2d 448 (6th Cir. 1969) (highlighting that all medical expenses remain personal, Section 213(a) is in the Code to create an exception from 26 U.S.C. § 262, and it does not make medical expenses non-personal but declares a deduction for personal expenses within the meaning of “medical care.”). For a case discussing these issues in the context of sex reassignment surgery, see O’Donnabhain v. Comm’r, 134 T.C. 34 (2010).} Stated differently, Congress took the position that while the procedures themselves were medical, the motivation that underlay pursuing plastic surgery removed the basis for the medical expense deduction. Elective cosmetic surgery is too personal to be medical and the social context of its use is important. \footnote{Treas. Reg. § 1.213-1(e) (2014).}

Cosmetic surgery aside, § 213’s task of sorting medical expenses from personal consumption is ostensibly easier when expenses are readily identifiable as medical. A fact that should be relevant when the Service analyzes elective egg freezing, Treasury Regulation 1.213-1(e) sets out a laundry list of qualifying expenses including surgical expenses, hospital services, laboratory services, diagnostic services, and “other healing services.” \footnote{See Pratt, Definition of “Medical Care”, supra note 98 at 321–22, 361.} The broad language of the Code itself and expansive list of qualifying care within the regulations suggests that if an expense can be described as “inherently medical,” \footnote{Id. § 213(d)(9)(A).} “wholly medical,” \footnote{Jacobs v. Comm’r, 62 T.C. 813, 819 (1974). In Jacobs, the Tax Court does not define what constitutes an expense that is wholly medical but implies that such an expense has little or no personal consumption element. Id. ("There would seem to be little doubt that the expense connected with items which are wholly medical in nature and which serve no other legitimate function in everyday life is incurred primarily for the prevention or mitigation of disease.").} or is, as this Article describes, readily identifiable as medical, it clearly qualifies for deductibility. Yet the concept of what is inherently, wholly, or readily identifiable as medical is not fully defined. And when the Service or the courts view an expense as
marginal—either because of its nature or purpose—both are quick to rely upon language that they view as restricting the scope of § 213. This oft-cited language has its origin in the legislative history of § 213 (then § 23) and found echoes in case law and two sentences of Treasury Regulation 1.213-1(e).

In its discussion of then § 23, Senate Report 77-1631 stated both that the concept of medical care should be broadly defined, but also cautioned against interpreting the provision too broadly: “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.” In a similar vein, the regulations state, in pertinent part, that “[d]eductions 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” and that expenditures which are “merely beneficial to the general health of an individual, such as an expenditure for a vacation” are not medical care. Courts often use this language to frame the interpretation of § 213 and limit its scope.

Thus, interpreting § 213 is a balancing act between the scope of its seemingly broad language and the reach and validity of its arguably narrower purpose.

The Service’s and courts’ success in this endeavor is mixed. With an eye to ensuring that § 213 does not overstep § 262’s disallowance of personal expenses, the Service has driven the development of inconsistent precedent. Alongside precedent that suggests that the Service embraces a robust and diverse concept of medical care—including viewing nonbiomedical naturopathy as medical care—exists precedent and pronouncements that retreat from such a view with an eye toward the concern that § 213 is at risk of being stretched beyond its intended scope. As medical expertise and social mores advance, the scope of qualifying

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114 See S. REP. NO. 77-1631, at 6 (1942).
115 Id. at 96.
117 See infra Part IV.
118 See Haines v. Comm’r, 71 T.C. 644, 646 (1979) (“In considering the question of deductibility of expenditures for ‘medical care’ under section 213, it is necessary to bear in mind that section 262 prohibits deductions for personal, living, and family expenses.”).
120 In Havey v. Commissioner, the Tax Court analyzed § 213 in light of § 262, formerly § 24(a)(1), as follows:

In approaching this question it is necessary to have in mind the basic concept of section 24(a)(1) of the code that personal, living, and family expenses are not deductible. Thus, many 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 expenses and the diagnosis, cure, mitigation, treatment, or prevention of disease or the expense must have been incurring for the purpose of affecting some structure or function of the body.
medical care must evolve.\textsuperscript{12}\textsuperscript{1} As an advancement of medical technology that does not fall neatly within existing precedent, elective egg freezing presents a fascinating test of the definition of medical care. With the basic framework of § 213 in mind, examining the specific precedent that is most relevant to categorizing elective egg freezing is now appropriate.

\textbf{B. Sorting the Medical from the Personal—Preventative Care}

Elective egg freezing is, this Article argues, a highly medicalized form of preventative care. Accordingly, understanding the preventative care precedent is essential to the analytical goal of this paper: determining the tax classification of elective egg freezing. Whether and to what extent preventative care qualifies as medical care are deceptively challenging questions to consider and not ones with consistent precedent; a fact that informs the doctrinal and critical contributions of this Article.

By its terms, § 213(d) includes as medical “amounts paid for the diagnosis . . . or prevention of disease.”\textsuperscript{12}\textsuperscript{2} The Service has long held, that the costs of an annual physical qualify as medical care, regardless of whether the individual has any particular condition at the time of the exam.\textsuperscript{12}\textsuperscript{3} Yet allowing such care seems inconsistent with oft-cited limiting language such as that in the \textit{Stringham v. Commissioner} case: “The Congressional intent is sufficiently evident to require the showing of the present existence or the imminent probability of a disease, physical or mental defect, or illness as the initial step in qualifying an expenditure as a medical expense.”\textsuperscript{12}\textsuperscript{4} \textit{Stringham} expressly exempted diagnostic care from this requirement,\textsuperscript{12}\textsuperscript{5} but precedent is less clear on preventative care. Further

\begin{itemize}
\item \textsuperscript{12}\textsuperscript{1} See generally, Davis, supra note 8 (discussing the influence of social mores on the definition of medical care in § 213); Pratt, \textit{Definition of “Medical Care”}, supra note 98 (arguing against IRS position that sought to deny § 213 deduction for gender transition surgery).
\item \textsuperscript{12}\textsuperscript{2} 26 U.S.C. § 213(d) (2012) (emphasis added).
\item \textsuperscript{12}\textsuperscript{3} See IRS, PUB. 502: MEDICAL AND DENTAL EXPENSES 12 (2017), https://www.irs.gov/pub/irs-pdf/p502.pdf [https://perma.cc/4V65-XXHR] (“You can include in medical expenses the amount you pay for an annual physical examination and diagnostic tests by a physician. You don’t have to be ill at the time of the examination.”).
\item \textsuperscript{12}\textsuperscript{4} Stringham v. Comm’r, 12 T.C. 580, 584 (1949).
\item \textsuperscript{12}\textsuperscript{5} The court described its finding as follows:

\begin{quote}
In other words, the 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. Secondly, it is clear that a deduction may be claimed only for such expense as is incurred primarily for the prevention or mitigation of the particular physical or mental defect or illness. The real difficulty arises in connection with determining the deductibility of expenses which, depending upon the peculiar facts of each case, may be classified as either “medical” or “personal” in nature. There would seem to be little doubt that the expense connected with items which are wholly medical in
\end{quote}

\end{itemize}
complicating the inquiry is the fact that diagnostic care is, at least in part, preventative care. Practitioners and insurers commonly characterize an annual physical exam as a “preventative visit” because it uses early detection and diagnosis of risk factors in order to prevent development of disease, yet precedent relies on its diagnostic role. Is it, then, the diagnostic or preventative power of the annual physical that justifies its treatment as medical care? The precedent is unclear. The overlapping nature of diagnostic and preventative care and the precedent’s failure to clearly define either, contribute to confusion over the requirements for such care to satisfy the medical care definition. Nevertheless, three important insights can be distilled from what precedent exists in this area.

First, categorizing diagnostic or preventative care as medical places great pressure on the concept of care that is wholly or readily identifiable as medical. This concept is, however, poorly defined. The Stringham case was the first to use the “wholly medical” language and offered the limited clarification that if care is “wholly medical” it “serve[s] no other legitimate function in everyday life,” leaving undefined those critical terms. Wholly medical is, then, related to the general health and wellbeing of the individual, but this, in turn, is not defined. It is also highly subjective, making the social context of the care deeply relevant. Further, the legislative history may support a broad reading as it states that a purpose of the deduction is to maintain “the present high level of public health and morale.” Treasury Regulation 1.213-1(e) provides other examples deemed medical care. Notably, diagnostic but not preventative care makes the list. And this fact points

Id. Compare id. (exempting diagnostic care from the requirement of showing the “present existence or imminent probability” of a disease, defect, or illness), with I.R.S. Priv. Ltr. Rul. 2001-40-017 (Oct. 5, 2001) (finding that DNA collection and storage cannot qualify as medical care without a showing that “the DNA will actually be used for medical diagnosis”).


Stringham, 12 T.C. at 584.

S. REP. NO. 77-1631, at 6 (1942).


See id. § 1.213-1(e)(1)(ii) (“Amounts paid for operations or treatments affecting any portion of the body, including obstetrical expenses and expenses of therapy or X-ray treatments, are deemed to be for the purpose of affecting any structure or function of the body and are therefore paid for medical care. Amounts expended for illegal operations or treatments are not deductible. 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. Thus, payments for the
to the second insight: the Service relies heavily upon the diagnostic category for care it views as marginal.

Care that is readily identifiable as medical has the greatest chance of being classified as medical care. But when that care cannot also be construed as treatment, the Service frequently places such care in the diagnostic category to justify its categorization. A pregnancy test is medical care because it "test[s] for healthy functioning of the body." Amounts paid for an annual physical exam for an asymptomatic person are medical because the cost "is for diagnosis." The Service's tendency to emphasize the diagnostic role of care outside the treatment context, rather than its potential preventative role, leads to the third insight: care which is dominantly preventative care is subject to greater scrutiny.

The greater scrutiny to which preventative care is subject is, at least partially, understandable. To date, many of the scenarios that developed the precedent involved care not readily identifiable as medical, such as dance lessons or gym memberships. Stated differently, much of the precedent invoked when considering preventative care involved costs not readily identifiable as medical. But boundaries of the concept of preventative care are not clear.

Consider the example of a weight loss program. In Revenue Ruling 2002-19, the Service held that the costs of a weight loss program to two taxpayers, one with a diagnosis of obesity and the other hypertension, were deductible as medical care. In doing so it distinguished earlier precedent in which the Service held that participation in a weight loss program, in the absence of a diagnosis for which weight loss was the treatment, was a nondeductible personal cost. Substantially similar care was, then, differently categorized when understood as preventative. Though a weight loss program ahead of a diagnosis may be effective in staving off disease, it is too tied to the "preservation of general health or for the alleviation of a physical... discomfort... unrelated to some particular disease or defect" to qualify as medical care. Preventative care, then, because of its very nature as preventative

following are payments for medical care: hospital services, nursing services (including nurses' board where paid by the taxpayer), medical, laboratory, surgical, dental and other diagnostic and healing services, X-rays, medicine and drugs (as defined in subparagraph (2) of this paragraph, subject to the 1-percent limitation in paragraph (b) of this section), artificial teeth or limbs, and ambulance hire.

See Stringham, 12 T.C. at 584 ("There would seem to be little doubt that the expense connected with items which are wholly medical in nature... is incurred primarily for the prevention or mitigation of disease.").

raisesthe concern that § 213 will create a backdoor means of deducting expenses that are too personal.\footnote{See Stringham v. Comm'r, 12 T.C. 580, 584 (1949) ("The real difficulty arises in connection with determining the deductibility of expenses which, depending upon the peculiar facts of each case, may be classified as either 'medical' or 'personal' in nature.... [I]t is obvious that many expenses are so personal in nature that they may only in rare situations lose their identity as ordinary personal expenses and acquire deductibility as amounts claimed primarily for the prevention or alleviation of disease.").} To police the boundaries of § 213 and preventative care, the courts and the Service appeal to or create limiting language. The Service reiterates the oft-articulated standard that the care must be rendered in the face of “the present existence or imminent probability of a disease, defect, or illness.”\footnote{Jacobs v. Comm'r, 62 T.C. 813, 818 (1974).} Both courts and the Service recite the regulatory language stating that “[d]eductions 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.”\footnote{Treas. Reg. § 1.213-1 (2014).} To establish the necessary connection between the expense and medical care, courts look for a “direct and proximate relationship” between the expense and a disease or condition.\footnote{Havey v. Comm'r, 12 T.C. 409, 412 (1949) ("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 the 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?").} Thus, in the context of preventative care, the Service and the courts are quick to require a close connection between the care provided and a disease or condition.

Yet the close connection requirement is flawed for at least two reasons. First, it is flawed because, as scholars and even the Service have noted, the line of precedent that excludes preventive care and the limiting language of the regulations and legislative history of § 213, cannot apply broadly lest they improperly limit the scope
145 See, e.g., IRS, PUB 502: MEDICAL AND DENTAL EXPENSES 5-15 (2017), https://www.irs.gov/pub/irs-pdf/p502.pdf. (listing care classified as medical, much of which would not qualify if this limiting language was strictly applied); Pratt, supra note 10, at 1322–24. If the care is not “wholly medical”, the court applies a “but for” test to determine whether the expenses are deductible. Specifically, the taxpayer must establish “both that the expenditures were an essential element of the treatment and that they would not have otherwise been incurred for nonmedical reasons.” Jacobs, 62 T.C. at 819; see also id. (“The real difficulty arises in connection with determining the deductibility of expenses which, depending upon the peculiar facts of each case, may be classified as either ‘medical’ or ‘personal’ in nature. There would seem to be little doubt that the expense connected with items which are wholly medical in nature and which serve no other legitimate function in everyday life is incurred primarily for the prevention or mitigation of disease. On the other hand, it is obvious that many expenses are so personal in nature that they may only in rare situations lose their identity as ordinary personal expenses and acquire deductibility as amounts claimed primarily for the prevention or alleviation of disease.”). Further, preventative care may not be inconsistent with the legislative history, as the stated purpose of the Act was both to assist individuals with unanticipated medical costs but also to “maintain[] the present high level of public health and morale.” S. Rep. No. 77-1631, at 6 (1942).

146 See supra notes 136–137 and accompanying text.

147 The relevant 1972 IRS General Counsel Memorandum writes that Regulation 1.213-1:

[C]annot be given a broad interpretation without conflicting with other parts of the regulations. This is so because the regulations specifically allow a deduction for obstetrical expenses (generally not related to any physical or mental defect or illness) and because the fourth sentence of section 1.213-1(e)(1)(ii) . . . concludes from statements made in the first three sentences, that payments for medical and surgical services (among others) are payments for medical care.

Accordingly, we conclude that the third sentence . . . of the regulations, confining allowable medical expenses strictly to those incurred primarily for the prevention or alleviation of a physical or mental defect or illness, was not intended to, and does not, apply to any medical expenses otherwise meeting the statutory definition of medical care, such as amounts paid for legal surgical operations, since those operations affect a structure or function of the body.

C. Sorting the Medical from the Personal—Reproductive Care

Recently, reproductive care has tested the boundaries of § 213 and exposed the weaknesses and biases of the Service's understanding of that area, including its reliance upon the idea of choice in interpreting § 213. Because elective egg freezing falls under the umbrella of reproductive care, this precedent is highly-relevant. Though the authority in the area is limited (and not all has precedential value), a recent case brings both greater clarity and, this Article contends, a sense of change. That case—Morrissey v. U.S.—will be discussed at length but an understanding of prior authority lays the necessary foundation.

i. Structure/Function and the Diagnosis, Prevention, and Termination of Pregnancy

Much elective reproductive care qualifies as medical care under §213. When a procedure is inherently medical—such as surgery—and does not fall within the cosmetic surgery exception, the Service has viewed the costs of such procedures as medical care because the procedures affect a structure or function of the body. Under current law, care to diagnose, prevent, or end pregnancy qualifies as medical care, for example. Though it previously implied that elective use of birth control did not qualify as medical care, in 1973 the IRS ruled that birth control costs qualified as medical care regardless of whether the use of birth control was considered elective or medically necessary. Permanent or semi-permanent forms of sterilization also qualify as medical care per additional 1973 revenue rulings. The deductibility of all such care is grounded in the structure/function prong of § 213(d). Birth control, sterilization procedures, and abortion each impact the woman's reproductive

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149 Elsewhere I explore the Service's and court's struggle with applying § 213 to fertility treatments and detail the state of current law. See generally Davis, supra note 8. Since the publication of that article, however, the Eleventh Circuit decided Morrissey which involved the deductibility of IVF and surrogacy costs that provides further, important precedent.
150 Rev. Rul. 73-201, 1973-1 C.B. 140; see also O'Donnabhain v. Comm'r., 134 T.C. 34, 70 (2010) (reiterating that abortion qualifies as "medical care" because it affects a structure or function of the body, a triggering condition outlined by Treas. Reg. § 1.213-1(e)(1)(ii) (2014)).
151 Rev. Rul. 67-339 (explaining that the Chief Counsel for the IRS permitted a deduction in "circumstances [where], in the opinion of the physician[,] the possibility of childbirth raises a serious threat to the life of the wife."); see also Davis, supra note 8, at 8 (describing the Commissioners position that a woman who could not carry a child was "clearly suffering from a physical defect or illness" and the use of birth control was, therefore, medical care under the disease prong (quoting Frederick R. Parker, Jr., Federal Income Tax Policy and Abortion in the United States, 13 Mich. St. U. J. Med. & L. 335, 342 (2009))).
152 Rev. Rul. 73-200, 1973-1 C.B. 140. Deductibility was presumably permitted under the structure/function prong. See I.R.S. Notice 2018-12, 2018-12 I.R.B. 441, for an analysis of vasectomies in a different statutory context.
function. Sterilization and abortion also impact the structure of the woman’s body. Similarly, a vasectomy impacts both a structure of the male’s body and his reproductive function. So too are the costs of surgery to reverse prior, elective, sterilization deductible as fertility enhancing care.

Such precedent is consistent with the core definition of medical care itself. And yet such care is open to the criticism that it, not unlike cosmetic surgery, is too personal to be medical. Stated differently, like cosmetic surgery, a vasectomy impacts a function of the body but the motivation for having the procedure performed is not within the scope of what Congress intended for § 213. And yet decisions to delay or forego childbearing may be driven exclusively by personal choices regarding how to structure one’s life. Reproductive care, in this view, in the absence of a disease or condition, is wholly personal consumption despite its impact on a structure or function of the body. It is, the Service has inconsistently contended, a matter of choice and, therefore, not medical regardless of how it fairs under § 213(d).

This position comes into the fore in the precedent on § 213 and fertility care.

ii. Treating the Disease of Infertility

A smattering of IRS pronouncements and limited case law set the backdrop for the Morrissey case. What can be distilled from the precedent makes clear that the core debate in applying § 213 in this realm, is whether reproduction is fundamentally nondeductible personal consumption. To date, the Service has taken sometimes conflicting positions. Publication 502 specifically states, in pertinent part, that “the cost of the following procedures to overcome an inability to have children [are medical expenses]: procedures such as in vitro fertilization (including temporary storage of eggs or sperm).” In private letter rulings, the Service has allowed deductions for the costs of egg donation under the structure/function prong, Birth control may be used to treat diseases or conditions such as endometriosis, thereby qualifying as medical care under the disease prong. See Endometriosis, Mayo Clinic, https://www.mayoclinic.org/diseases-conditions/endometriosis/diagnosis-treatment/drc-20354661 [https://perma.cc/S6X5-94HY].


See Davis, supra note 8, at 35 (arguing that such care is qualifying medical care and that the Service’s inconsistencies in this area result from implicit bias); Pratt, supra note 10, at 1144-61 (arguing that that deductibility of fertility expenses is appropriate and supported by extant authority).

I personally do not find this analogy compelling. However, because it is the undercurrent of more recent precedent in the area and is highly relevant to the interpretation of § 213 and elective egg freezing, it is important to note.

See Pratt, supra note 7, at 1156-61 (discussing the Service’s position on surrogacy costs). Pratt goes on to further develop her position after the Magdalin case in, Pratt, supra note 10, at 1302-07.

recognizing fertility as a function of the body and egg donation as a means of affecting the recipient taxpayer's reproductive function.\textsuperscript{160}

Absent from these analyses is the sense that fertility care is personal consumption driven by individual choice. The Service seems uninterested in casting the decision that drove the care—to have a child—as personal choice. In its view, infertility compelled the care—a condition outside the individual's control—not the preceding choice to have a child. This approach is consistent with precedent outside the reproductive care context. Neither the Service nor the courts would hold that the setting of a broken leg was not medical care because the injury occurred skiing.\textsuperscript{161}

Yet the Service has taken a different view of the role of choice in the few cases at the intersection of § 213 and fertility care. Specifically, it advocates a restrictive view of the deductibility of assisted reproductive technologies (ARTs) without a diagnosis of infertility, retreating from a broad interpretation of the structure/function prong in reproductive care. In the most significant case prior to \textit{Morrissey}, the Service argued for and the court accepted, reading a disease requirement into the structure/function prong.\textsuperscript{162} The case, \textit{Magdalin v. Commissioner}, concerned the deductibility of surrogacy and ART expenses paid by a man.\textsuperscript{163} Denying a deduction, the Tax Court wrote:

\begin{quote}
The expenses at issue were not paid for medical care under the first portion of section 213(d)(1)(A) because the requisite causal relationship is absent. None of the expenses at issue was "incurred primarily for the prevention or alleviation of a physical or mental defect or illness." Sec. 1.213-1(e)(1)(ii), Income Tax Regs. In other words, petitioner had no medical condition or defect, such as, for example, infertility, that required treatment or mitigation through IVF procedures. We therefore need not answer lurking questions as to whether (and, if so, to what extent) expenditures for IVF procedures and associated costs (e.g., a taxpayer's legal fees and fees paid to, or on behalf of, a surrogate or gestational carrier) would be deductible in the presence of an underlying medical condition.\textsuperscript{164}
\end{quote}

By denying a deduction on the grounds that a disease must be present even for expenses that satisfy the structure/function prong, the court held that the limiting language so often used to deny preventative care applies \textit{even to care that is}

\begin{footnotes}
\footnotetext{161}{Setting aside likely insurance coverage, setting a broken leg fits well within both prongs of § 213 and nothing in the precedent suggests the Service or courts would look to the cause of the broken leg in their analysis. See Pratt, supra note 7, at 1168–69 (discussing the voluntary/involuntary nature of reproductive care).}
\footnotetext{162}{Magdalin v. Comm'r., 96 T.C.M. (CCH) 491 (2008); see also Davis, supra note 8, at 20–21; Pratt, supra note 10, at 1311–1344.}
\footnotetext{163}{See Magdalin, 96 T.C.M. (CCH) at 492.}
\footnotetext{164}{Id. at 493.}
\end{footnotes}
readily identifiable as medical.\textsuperscript{165} Though the court noted that § 213 is written in the disjunctive, it opined that the cosmetic surgery exception was evidence that Congress intended to narrow the scope of the structure/function prong.\textsuperscript{166}

There is much to criticize in the Magdalin opinion and the Service’s arguments in the case, and scholars have done so in prior work.\textsuperscript{167} The import of the case for this Article is that it signals that the Service seems to be narrowing its interpretation of the scope of § 213 by narrowing the structure/function prong.\textsuperscript{168} Courts, in turn, seem receptive to the Service’s position. The First Circuit affirmed the Magdalin case and, as the next part explores, the Eleventh Circuit added its support.\textsuperscript{169}


\textit{Morrissey v. U.S.} is the culmination of a line of argument the Service developed in an early, settled case\textsuperscript{170} and Magdalin.\textsuperscript{171} Specifically, it is a strong indicator that the Service is committed to (1) narrowing the scope of the structure/function prong and (2) casting reproductive care costs as too personal to be medical, injecting the analysis with the rhetoric of choice.\textsuperscript{172} If the Service persists in both positions, elective egg freezing is unlikely to qualify as medical care. More broadly, if the Service continues to narrow the structure/function prong, emerging medical technologies outside the reproductive realm are at risk of classification as personal consumption. A discussion of the facts of the case, the arguments made therein, and the lower and circuit court opinions lays the necessary foundation for understanding the potential impacts of the case.

In \textit{Morrissey v. United States}, Joseph Morrissey, a gay man, utilized egg donation, in vitro fertilization, and gestational surrogacy to have children.\textsuperscript{173} The eggs were fertilized with Mr. Morrissey’s sperm and he incurred over $100,000 in costs to become a parent.\textsuperscript{174} Amending his 2011 return, Mr. Morrissey sought to

\begin{footnotesize}
\begin{enumerate}
\item See id.
\item See id. at 492 & n.5.
\item See Pratt, supra note 10; Infanti, supra note 10 at 171–173; Davis, supra note 8 at 13.
\item See Longino v. Comm’r, 105 T.C.M. (CCH) 1491, aff’d, 593 Fed. Appx. 965 (11th Cir. 2014); Pratt, supra note 7.
\item Magdalin, 96 T.C.M. (CCH) at 492.
\item Morrissey has implications for tax, reproductive rights, and constitutional law. I began exploring these issues shortly after the opinion was handed down. Tessa Davis, Morrissey v. U.S. and the IRS’s Hostility to Reproductive Choice, PRAWFSBLAWG (October 18, 2017), http://prawfsblawg.blogs.com/prawfsblawg/2017/10/morrissey-v-us-and-the-irs-hostility-to-reproductive-choice.html [https://perma.cc/24WQ-9LKF].
\item Morrissey v. United States, 871 F.3d 1260, 1263 (11th Cir. 2017). Gestational surrogacy involves a woman carrying an embryo created by implantation of another woman’s egg with a man’s sperm. See id. It is distinguished from traditional surrogacy wherein the embryo the woman carries is a product of her own egg and a man’s sperm. See id. Mr. Morrissey provided the sperm for the procedure but pursued parenthood with his now husband. Id.
\item Id.
\end{enumerate}
\end{footnotesize}
deduct $36,538\textsuperscript{175} of the ART costs, which, if allowed, would have entitled Mr. Morrissey to a $9,539 refund.\textsuperscript{176} After the Service denied his § 213 deduction, Mr. Morrissey appealed to the Middle District of Florida.\textsuperscript{177}

The Middle District granted the Service's motion for summary judgment.\textsuperscript{178} In its opinion, the court asserted that because the "IVF process" was not performed on the taxpayer's body the costs were nondeductible.\textsuperscript{179} The court's analysis of Morrissey's argument—that use of a surrogate and IVF were necessary to realize his reproductive function—leaves much to be desired. The court repeatedly cited the canon of construction that tax deductions are to be narrowly construed, failing to address the fact that legislative history and existing precedent suggest that that familiar canon is not as influential in the § 213 context.\textsuperscript{180} It then reasserted that a plain reading of the statute establishes that the IVF processes do not affect a structure or function of Morrissey's body, without a particularly nuanced analysis of what an individual's reproductive function is.\textsuperscript{181} In brief, the Middle District asserted its conclusion with little support or analysis.\textsuperscript{182}

Writing for the Eleventh Circuit, Judge Newsom\textsuperscript{183} provides a clearer, though no less problematic, rationale for denial of the deduction. The opinion relies heavily upon dictionary definitions of the terms "function" and "affect" to reach its conclusions.\textsuperscript{184} Taking an atomized view of reproductive function, the court stated that:

"[F]unction' is defined as 'the action for which a person or thing is specifically fitted, used, or responsible, or for which a thing exists'; 'the activity appropriate to the nature or position of a person or thing'; or 'one of a group of related actions contributing to a larger action,' such as 'the normal and specific contribution of any bodily part (as a tissue, organ, or system) to the economy of a living organism.'\textsuperscript{185}

Adopting this definition of function, the court construed Mr. Morrissey's reproductive function as limited to the provision of sperm.\textsuperscript{186} Though the court

\textsuperscript{175} Id. In 2011, medical expenses had to exceed a 7.5% of AGI threshold. See supra note 96 and accompanying text. The $36,538 of costs Morrissey sought to deduct reflected the impact of that threshold.
\textsuperscript{176} Morrissey, 871 F.3d at 1263.
\textsuperscript{177} Id. at 1264.
\textsuperscript{178} Morrissey v. United States, 226 F. Supp. 3d 1338, 1346 (M.D. Fla. 2016).
\textsuperscript{179} Id at 1342.
\textsuperscript{180} See id. at 1341–42.
\textsuperscript{181} See id. at 1344 (rejecting Morrissey’s argument that the ART costs were all necessary and incidental to the fulfillment of his own reproductive function by using conclusory reasoning, stating “that simply is not the case and that position runs contrary to the line of reasoning in all the case law cited”).
\textsuperscript{182} Social context seems to inform the decisions in a manner similar to Magdalin.
\textsuperscript{183} The opinion generated a reasonable amount of interest for a tax case, likely due to its equal protection analysis and that fact that it was one of Judge Newsom's, a Trump appointee, first opinions at the Eleventh Circuit.
\textsuperscript{184} See Morrissey v. United States, 871 F.3d 1260, 1265 (11th Cir. 2017).
\textsuperscript{185} Id. at 1263 (quoting WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY 920–21 (2002)).
\textsuperscript{186} Id. at 1266 ("The male body's necessary function within the reproductive process is simply stated: it must produce and provide healthy sperm . . . .")
recognized a potential broader read of function in § 213, it stated that the "limiting modifier" of § 213(d)—that medical care must affect a structure or function "of the body"—required its narrower view.\footnote{187} This view ignores, however, the broader construction of the term "of the body" that the Service permitted in a line of precedent on the deductibility of kidney donor costs.\footnote{188} It also ignores the aggregation of bodies within the statute itself.\footnote{189} Thus, while the court’s construction is not untenable, it was also not required by existing precedent or the terms of the statute itself.

Because the Morrissey opinion is the most thorough circuit court opinion on reproductive care under § 213, the precedent it set is important. Had the court adopted a holistic view of reproduction—one which did not sever male and female reproductive functions but instead focused on the end result of successful reproduction, a child—§ 213 could operate to subsidize reproduction regardless of the individual’s gender, sexual orientation, or marital status. Instead, the court adopted the limited view of reproduction that the Service offered—focusing on the respective male and female contributions to the production of a child in isolation—that, when filtered through the lens of tax, casts reproduction outside the context of a heterosexual, married couple as a personal consumption decision.\footnote{190}

In Morrissey, the Service took a different track in arguing for disallowance than it did in Magdalin. Gone was the express argument that the structure/function prong had an implied disease requirement.\footnote{191} In its place was the argument that the structure/function prong itself is narrower than its terms.\footnote{192} Arguing that reproductive function in § 213 is limited to the unique contribution of the taxpayer’s body to the reproductive process allows the Service to narrow the structure/function prong and cast reproduction (of certain individuals) as wholly personal—and it does so in a manner that is less subject to criticism than its argument in Magdalin.

Because § 213 is written in the disjunctive, the Service’s argument that the structure/function prong still requires the presence of disease seems to be in obvious conflict with the statute (though the argument still persuaded the Tax Court in Magdalin). The argument in Morrissey is more sophisticated. In effect, the Service imported a disease requirement into the structure/function prong and its judgment that reproduction is a personal consumption decision via the backdoor by narrowing of the prong itself. An example clarifies this point.

\footnote{187}Id. at 1265.\footnote{188} See I.R.S. Priv. Ltr. Rul. 2003-18-017 (May 2, 2003). Professor Pratt connects this line of precedent to her analysis of fertility and surrogacy costs under § 213 in Pratt, supra note 7, at 1156–61 and Pratt, supra note 10, at 1297–1303.\footnote{189} Section 213 itself allows for aggregation of the taxpayer’s body with those of family members as it allows a deduction for qualifying medical expenses of the taxpayer and her spouse and dependents. §213(a).\footnote{190} For a thorough discussion of this point, see Davis, supra note 8 (analyzing how section 213 is not evenhandedly applied to allow the deduction), Pratt, supra note 10, and Infanti, supra note 10, at 161–63.\footnote{191} See supra notes 159–166 and accompanying text.\footnote{192} See supra notes 178–188 and accompanying text.
In earlier authority (albeit nonprecedential) the Service stated that reproduction is a function of the body.939 If the reproductive function means the end result of that function—a child—expenses incurred to enable an individual to have a child affect a function of that person’s body. Whether an individual has diagnosable infertility should be irrelevant, then, if the care satisfies the structure/function prong. If instead function is defined more narrowly to mean only the respective contributions of male and female bodies to reproduction, infertility must be present for care to be deductible. A male body can only produce sperm, so costs such as egg donor fees and surrogacy cannot be tied to his reproductive function. Such an argument is not untenable, but it is, as I and others have argued, unfair.94

It is unfair because it ends in § 213 subsidizing fertility care of certain bodies (heterosexual and married) more than that of others (single, LGBTQ, and male). Most importantly, in light of the history of the Service’s arguments in this area, the narrowing of the structure/function prong is consistent with the Service’s apparent goal of writing a disease requirement into the structure/function prong. Thus, rather than a principled construction of what the language of the Code says, narrowing the structure/function prong was the Service’s means of making the Code say what the Service thought it should.

In addition to the narrow construction of reproductive function, the Morrissey opinions adopt a potentially problematic frame of care that clearly involves the taxpayer’s body. Both opinions focus on the deductibility of the more expensive egg donor and surrogacy costs, rather than the costs of diagnostic tests for sperm collection from Mr. Morrissey.959 Because the latter costs only totaled $1,500 dollars, in isolation they fell under the then 7.5% AGI threshold of § 213, so the courts’ focus is appropriate.196 However, both courts do briefly consider the deductibility of such costs.97 The Eleventh Circuit makes the somewhat qualified statement that the sperm collection “could be said to have affected his reproductive function”98 while the district court properly asserts that “the collection of Plaintiff’s

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93 See supra note 150 and accompanying text.
94 See supra note 190 and accompanying text.
95 See Morrissey v. United States, 871 F.3d 1260, 1263, 1265 (11th Cir. 2017); Morrissey v. United States, 226 F. Supp. 3d 1338, 1344–45 (M.D. Fla. 2016).
96 Morrissey, 871 F.3d at 1263 (“All told, the IVF process cost Mr. Morrissey more than $100,000. In 2011 alone—the tax year at issue in this case—Mr. Morrissey paid nearly $57,000 out of pocket for IVF-related expenses. Of that total, only about $1,500 went toward procedures performed directly on Mr. Morrissey’s body—namely, blood tests and sperm collection. He spent the remaining $55,000 to identify and retain the women who served as the egg donor and the gestational surrogate, to compensate those women for their services, to reimburse their travel and other expenses, and to provide medical care for them.”).
97 See id. at 1267 (“To be sure, the aspects of the IVF process that related specifically to Mr. Morrissey’s provision of healthy sperm could be said to have affected his reproductive function. So, for instance, if the $1,500 that Mr. Morrissey spent on sperm collection and accompanying bloodwork had exceeded the applicable 7.5%-of-AGI threshold, it would have been deductible. But as already explained, it didn’t—by a long shot—and so it wasn’t.”); Morrissey, 226 F. Supp. 3d at 1342.
98 Morrissey, 871 F.3d at 1267.
sperm undeniably affected the structure and/or function of his body.” The Eleventh Circuit’s seeming skepticism of whether sperm collection is medical care is inconsistent with the language of § 213 itself. But it and the Middle District’s linking of the sperm collection to the overall IVF process is more problematic. Specifically, both courts imply that the sperm collection costs would be deductible when performed in the context of IVF process. Lumping the sperm collection into a broader process, rather than considering each procedure in its own right, runs counter to the Service and court’s historic approach. Doing so may not always run counter to the taxpayer’s interest, but, regardless of the impact on classification, improperly aggregating care increases the potential for misclassification and is inconsistent with long-running precedent.

Beyond these flawed approaches to § 213, the Service used and the courts embraced using the rhetoric of choice to frame interpreting § 213, thereby giving greater importance to the social context of care. As part of his rationale for disallowing a medical expense deduction to Mr. Morrissey, Revenue Agent Gary Shepard focused on Mr. Morrissey’s choice to use egg donation, in vitro fertilization, and surrogacy to have a child. Conveying his sense that disallowing the deduction was plainly supported by the language of the Code, Agent Shepard wrote: “The first reason [for disallowance] is because there is no Medical Condition. The Taxpayer does have the ability to have Children with a member of the opposite sex but, not the same sex. The Taxpayers [sic] decision not to have children with a member of the opposite sex is a personal choice and not a Medical Condition.”


200 See Morrissey, 226 F. Supp. 3d at 1342 (“As Defendant correctly asserts, although the collection of Plaintiff’s sperm undeniably affected the structure and/or function of his body, the process ultimately and necessarily only affected the structure and function of the bodies of the third-party donors or chosen surrogate, who Plaintiff admits were neither a spouse nor dependent. Therefore, Plaintiff simply is not entitled to a deduction for those expense under the plain language of § 213(a).”); Morrissey, 871 F.3d at 1267 (“To be sure, the aspects of the IVF process that related specifically to Mr. Morrissey’s provision of healthy sperm could be said to have affected his reproductive function.”).

201 For example, see O’Donnabain v. Comm’r, 134 T.C. 34 (2010), action on dec., 2011-47 (Nov. 21, 2011), acq., 2011-47 I.R.B. 773, where the court considered three aspects of the taxpayer’s treatment for gender identity disorder, in turn—hormone therapy, sex reassignment surgery, and breast augmentation surgery. For additional discussion of the lumping together that occurred in Morrissey, see Katherine Pratt, Morrissey Creates New Uncertainty Regarding Tax Deductions for IVF, Egg Donation, and Surrogacy, TAXPROF BLOG (October 26, 2017) (noting the potential confusion caused by the court’s improperly grouping multiple procedures into one aggregate procedure for § 213 analysis and stating that “[t]he most confusing aspect of the Morrissey opinion is the court’s use of the term “IVF-related expenses” to refer to an entire series of fertility treatment procedures.”) (emphasis added)).

202 Brief for Plaintiff-Appellant at 4, Morrissey v. United States, 871 F.3d 1260, (11th Cir. 2017) (No. 17-10685) (“During the course of the audit, Shephard stated that Morrissey was not entitled to the deduction because it was Morrissey’s “choice” not to pursue heterosexual intercourse to conceive.”).

203 Id. at 4–5.
explicit language of choice dropped away as the case progressed, the choice frame persisted.\textsuperscript{204}

But choice cannot be decisive. It is inconsistent to assert that Mr. Morrissey chose to use assisted reproductive technologies but not find the same choice when medically-infertile and married taxpayers use similar technologies to have a child. If, however, the Service continues to use the choice frame, elective egg freezing is at risk of disallowance because of the social context of its use.

The Morrissey opinions make clear the challenge of determining where medical care begins and nondeductible personal consumption ends. The district and circuit courts that considered the cases were correct in that § 213 represents a departure from the general rule that personal expenses are nondeductible and that, as such, § 213(d) guards against the potential of turning nondeductible costs into deductible costs by dressing them in the trappings of medical care.\textsuperscript{205} But the Service's arguments and the courts' opinions signal a marked narrowing of § 213. The key takeaways for this Article are: (1) that Morrissey reinforces the importance of the choice frame and social context in analyzing reproductive care under §213; and (2) that the Service may be able to effectively write a disease requirement into the structure/function prong by directly narrowing the prong itself.\textsuperscript{206} It is possible that the Service will stop at Morrissey—that it may not seek to further narrow the structure/function prong or classify all reproductive care nondeductible. But the uncertainty created by Morrissey is precisely what makes the application of § 213 to elective egg freezing a litmus test.

\textsuperscript{204} In its fundamental rights analysis, the Eleventh Circuit echoed the choice frame, describing the potential fundamental right at issue as the “fundamental right to procreate via an IVF process that necessarily entails the participation of an unrelated third-party egg donor and a gestational surrogate.” Morrissey, 871 F.3d at 1269. By using the word “necessarily”, the court makes clear that it understands that Mr. Morrisey required an egg donor and surrogate to have a child. Yet even as it recognizes that fact it casts Mr. Morrisey’s decision as one option of many. Implied in the court’s narrow framing of the fundamental right at issue is the idea that Mr. Morrissey had other options and instead chose to use assisted reproductive technologies.

\textsuperscript{205} See Treas. Reg. § 1.213-1(e)(1)(ii) (2012) (“However, an expenditure which is merely beneficial to the general health of an individual, such as an expenditure for a vacation, is not an expenditure for medical care.”).

\textsuperscript{206} In its fundamental rights analysis, the Eleventh Circuit described the potential fundamental right at issue as “the fundamental right to procreate via an IVF process that necessarily entails the participation of an unrelated third-party egg donor and a gestational surrogate.” Morrissey, 871 F.3d at 1269. The Service and the courts framed the care at issue similarly. In their view, Mr. Morrissey hadn’t made the decision to have a child and then sought the care necessary to effectuate that decision. Instead, he chose to use assisted reproductive technologies. Describing Mr. Morrissey’s choice in this way opens the door to casting his decision as one of a number of possible consumption decisions—not having a child, adopting a child, or having a child without the use of reproductive technologies. It is also in tension with the implied framing of precedent that allows a deduction for assisted reproductive care. When the taxpayers using assisted reproductive technologies are medically-infertile and married, the taxpayers did not choose to use assisted reproductive technologies but rather chose to have a child and their use of assisted reproductive technologies was not a choice but compelled by their infertility. These two descriptions of the relevant choice cannot coexist. I explore the characterization and role of choice in Taxing Choices (draft available with author).
III. CATEGORIZING ELECTIVE EGG FREEZING

Elective egg freezing embodies a fascinating combination of technology and the social context of its use that does not lend itself to easy interpretation under § 213, making it an opportunity to test the boundaries of the medical care definition and expose its shortcomings. As it hedges against inevitable but not necessarily imminent infertility, it tests the boundaries of qualifying preventative care. Because aspects of the procedure impact the structure and function of a woman’s body, it seemingly fits well within the structure/function prong. Yet Morrissey and prior precedent on § 213 are unclear as to whether reproductive care is too bound up with the general health and well-being of the individual to qualify as medical care. In short, elective egg freezing defies ready categorization. This Part considers each of the three possible approaches of § 213 that the Service may adopt: (1) Full classification as medical care; (2) Partial classification as medical care; or (3) Classification as personal consumption/non-medical care, highlighting the weaknesses of existing doctrine and the implications of the Service’s categorization for tax policy and doctrine.

A. Elective Egg Freezing Under Pre-Morrissey Precedent

Though not indisputable, the weight of pre-Morrissey precedent points toward at least partial classification of egg freezing as medical care. The following Part, consistent with pre-Morrissey precedent, considers each aspect of the egg freezing process and whether it satisfies § 213, in isolation.

i. The Argument for Full Classification as Medical Care

There is a tenable argument that the entire cost of the elective egg freezing process should qualify as medical care under the structure/function prong of § 213(d). The hormone treatments required to stimulate egg production affect both a structure—the woman’s ovaries—and function—the release of eggs by the body. Egg retrieval—the insertion of a needle through the woman’s vaginal wall to extract the eggs—at a minimum affects a structure of the woman’s body. Whether the retrieval process affects a function of the body is less clear. Because the number of a woman’s eggs is finite, it can be argued that egg retrieval impacts a woman’s reproductive function by reducing the number of eggs available for future ovulation.

207 Contra Erb, supra note 63, at 4 (arguing, without significant explanation, that elective egg freezing is not medical care under § 213.).
208 See 26 U.S.C. § 213(b) (2012); Treas. Reg. § 1.213-1(e) (2014) (including the cost of prescription drugs as medical care); Rev. Rul. 73-200, 1973-1 C.B. 140; Rev. Rul. 82-111, 1982-1 C.B. 48 (holding that the scalp is construed as a structure of the body); I.R.S. Priv. Ltr. Rul. 2003-18-017 (May 2, 2003) (holding that an egg donor’s medical costs were allowed as a deduction).
209 Cf. I.R.S. Priv. Ltr. Rul. 2001-40-017 (Oct. 5, 2001) (opining but not ruling that DNA collection is not medical care). DNA collection is readily distinguishable from egg retrieval, however, because the latter is significantly more invasive.
210 But see Morrissey v. United States, 871 F.3d 1260, 1263–66 (11th Cir. 2017).
cycles. That care, however, affects a structure but is not cosmetic surgery, and that should be sufficient to pull it into the category of medical care.

Classifying hormone treatment and egg retrieval as medical care is consistent with existing administrative pronouncements on elective reproductive care. The costs of prescription drugs readily satisfy the medical care definition. Thus the hormone treatments, like birth control, fit within § 213. Bloodwork and ultrasound tests tied to the egg retrieval process are similar to the care expressly identified as medical under Treasury Regulation 1.213-1. Further, the egg retrieval process is readily identifiable as medical, as it is a surgical procedure. The fact that it was undergone at the individual’s discretion—that it was not medically necessary—should not be determinative, just as it was not in the case of elective sterilization or abortion procedures. In brief, under pre-Morrissey precedent the structure/function prong should pull both the stimulation and retrieval aspects of elective egg freezing into the category of medical care.

Whether egg storage qualifies as medical care is harder to determine. The Service has stated that temporary storage of eggs or sperm qualifies as medical care. However, allowance of the deduction in that context seems dependent upon the individual suffering from an “inability to have children” and the storage being for a limited period of time. A woman who utilizes elective egg freezing has neither a diagnosis of infertility nor the intent to use her frozen eggs in the near future. Nevertheless, if the Service understood the egg storage process to be inherently medical and not a benefit to the general health of the woman, it could qualify the costs as deductible alongside the hormone treatment and egg retrieval processes.

Clinics use this point to sell their services. See La Ferla, supra note 22 (“[C]linics like Prelude, Pacific NW Fertility in Seattle, Shady Grove in Washington and Ova in Chicago began reminding their youngest target customers that fertility is finite and begins to wane as early as one’s 20s. Those clinics once catered almost exclusively to women at the older end of their childbearing years. Their messaging, generally friendly and fact based but in some cases alarmist in tone, varies from Ova’s invitations to ‘freeze for your future,’ to Extend’s more urgent ‘eggs are a nonrenewable resource.’”).


Id.; see also Rev. Rul. 73-200, 1973-1 C.B. 140.

See Treas. Reg. § 1.213-1 (2014) (“Thus, payments for the following are payments for medical care: hospital services, nursing services (including nurses’ board where paid by the taxpayer), medical, laboratory, surgical, dental and other diagnostic and healing services, X-rays.”). But see I.R.S. Priv. Ltr. Rul. 2001-40-017 (Oct. 5, 2001) (indicating that deductibility for tests seems to turn upon their diagnostic role).

See supra notes 151–155 and accompanying text.


Id.

This outcome seems unlikely, as will be addressed in the next example. See I.R.S. Priv. Ltr. Rul. 2001-40-017 (Oct. 5, 2001). One aspect of the DNA collection discussion weighs in favor of pulling the storage costs into classification as medical care because of its role as an essential element of broader, qualifying care. This view, however, was not part of the ruling which itself is nonbinding. Id. Consider, however, how the Eleventh Circuit’s grouping of separate aspects of care into one process could bootstrap storage into qualification. See supra Subsection II.C.iii.
ii. The Argument for Partial Classification as Medical Care

Partial classification of elective egg freezing as medical care is more likely than full classification. Even if the IRS classifies the hormone stimulation and egg retrieval phases of the elective egg freezing process as medical care, the storage costs are at significant risk of disallowance. A recent private letter ruling outside the reproductive context is instructive. In 2010, the Service addressed the question of whether the costs of banking umbilical cord blood, in case the blood would be required in the future, were deductible. Even if not determinative, the ruling is revealing. Relying upon the imminent probability standard requires viewing the care as not wholly medical. Indeed, to support its position in the donor cord blood ruling, the Service cited two cases—Jacobs v. Commissioner and Stringham v. Commissioner, neither of which dealt with care that is readily identifiable as medical. It considered whether legal fees for a divorce recommended by a psychiatrist were deductible as medical care: they were not. Stringham considered whether the costs of moving a child with a pulmonary disorder to, and educating her at, a school in a warmer climate satisfied the then new definition of medical care: they did in part. Arguably, storage of bodily materials, whether blood or eggs, is more clearly medical than legal, moving, or educational fees. By Stringham’s own guidance—wholly medical care has “no other legitimate function in everyday life” —it is difficult to envision the everyday function of frozen eggs. Nevertheless, the Service took the position that storage of cord blood was too tenuously connected to prevention or treatment of disease to satisfy the definition of medical care. Stated differently, storage of cord blood—an expense that is for a highly-medical, technical service necessary to the preservation of bodily tissue for future use—was a personal, rather than medical expense.

Invoking the “imminent probability” of disease standard, and the line of precedent of which it is a part, opens the door to disallowing the egg storage costs. With Stringham, Jacobs and related cases comes a set of factors for the court to

221 Id. ("Cord blood contains stem cells that doctors may use to treat disease. Thus, expenses for banking cord blood to treat an existing or imminently probable disease may qualify as deductible medical expenses. However, banking cord blood as a precaution to treat a disease that might possibly develop in the future does not satisfy the existing legal standard that at a minimum a disease must be imminently probable.").
222 Id.
225 Id. at 584 (discussing Congressional intent when enacting § 23 in 1949).
evaluate in determining whether care is medical. These factors include: whether the care was performed or recommended by a physician,\textsuperscript{226} the taxpayer’s motive in incurring the expense,\textsuperscript{227} the expected efficacy of the care\textsuperscript{228} and the time gap between the care and the condition to which it relates.\textsuperscript{229} Such factors could, if made applicable to elective egg freezing—and the class of highly medical preventative care of which it is a part—strongly push against classification as medical care.

In addition to challenging the relevance of the imminent probability standard and related case law, one can distinguish between banking cord blood in the face of unknown and potentially low probability diseases, and the freezing of eggs with an eye to the certainty of eventual infertility. Assuming, \textit{arguingo}, that the imminent probability standard is relevant, egg storage fairs better than cord blood storage. The child for whom the cord blood is stored may never develop any of the approximately eighty diseases for which the stem cells in cord blood may provide treatment.\textsuperscript{230} A woman is, however, guaranteed to become infertile at some point in her adult life.\textsuperscript{231} Elective egg freezing and the storage it requires is, then, arguably more strongly connected to prevention of a disease or disorder than is storage of cord blood. Nevertheless, because it is prospective rather than diagnosed infertility that drives a woman to freeze her eggs and because storage should be considered in isolation, the Service is likely to argue that the expense does not qualify as medical care.\textsuperscript{232}

Setting aside whether it is a proper interpretation of § 213, disallowing a deduction for the egg storage portion of elective egg freezing would have a relatively limited impact on the extent of § 213’s subsidy for elective egg freezing. With an average cost of annual storage of $500, if a taxpayer had no other medical expenses, she would need to have an \textit{AGI} of less than $4,999 for the first dollar of her egg storage costs to be deductible.\textsuperscript{233} Thus, because it is the least expensive portion of

\begin{itemize}
  \item \textsuperscript{226} Havey v. Comm’r, 12 T.C. 409, 412 (1949); see also Seymour v. Comm’r, 14 T.C. 1111, 1117 (1950).
  \item \textsuperscript{227} Havey, 12 T.C. at 412; Stringham, 12 T.C. at 585.
  \item \textsuperscript{228} Havey, 12 T.C. at 412.
  \item \textsuperscript{229} Id.
  \item \textsuperscript{231} The average age of menopause is 51, however, infertility declines significantly ahead of menopause. Menopause, MAYO CLINIC, https://www.mayoclinic.org/diseases-conditions/menopause/symptoms-causes/syc-20353397 [https://perma.cc/SXL4-ZBAK]; Infertility, MAYO CLINIC, https://www.mayoclinic.org/diseases-conditions/infertility/symptoms-causes/syc-20354317 [https://perma.cc/K553-DMME] (explaining that fertility declines significantly after age 37). Such age-related changes also raise the question of whether or when prevention of age-related changes qualifies as medical care. Pratt, \textit{supra} note 7, at 1124–25 (discussing Professor Joseph Dodge’s opinion on age-related changes under § 213).
  \item \textsuperscript{232} Such an argument would be consistent with the IRS’s arguments in \textit{Havey}. 12 T.C. at 412–13. Though the case did not involve inherently medical expenses, the Service has already demonstrated its view that storage is not an inherently medical expense. See IRS, PUB. 502: MEDICAL AND DENTAL EXPENSES 5–14 (2017), https://www.irs.gov/pub/irs-pdf/p502.pdf [https://perma.cc/4V65-XXHR]. Despite the inevitability of infertility, however, there is no certainty that the woman who stores her eggs will be infertile at the time she decides to become pregnant—a fact that cuts against deductibility.
\end{itemize}
the elective egg freezing process, a deduction for egg storage costs is the easiest cost with which to part.

B. A Narrower § 213: Elective Egg Freezing Post-Morrissey and the Argument Against Deductibility

A post-Morrissey Service is likely to argue that elective egg freezing is a wholly nondeductible, personal expense. Morrissey shifts the analysis of egg freezing under § 213 in two important ways. First, Morrissey may be read as signaling a trend toward, at its broadest, viewing all reproductive care or, more narrowly, assisted reproductive technologies, through a choice frame. Second, it signals a willingness to limit the structure/function prong as means of overriding the disjunctive nature of § 213 and imbuing the prong with a disease requirement.234

The social context of elective egg freezing does not fare well in a choice framework. If it adheres to a choice frame, the Service is likely to argue against elective egg freezing being qualifying medical care. As a means of preserving fertility by hedging against future infertility, elective egg freezing fits well within the realm of fertility care. With disallowance of the deduction as its end goal, the Service would argue that because the decision to have a child is a personal consumption decision, any costs incurred in pursuit of that goal run afoul of the legislative history and regulatory limiting language of § 213. The costs of having a child are “an expenditure which is merely beneficial to the general health of an individual.”235 It would caution that Congress warned against an overly-broad deduction as it wrote that: “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.”236 And for good measure, it would remind the taxpayer and the court that deductions are “matters of legislative grace,” thus § 213 should be construed as a narrow exception to the general disallowance of deductions for personal expenses in § 262.237 As a cost directly tied to preserving the ability to have a child, elective egg freezing is, in this view, just one more of a smattering of fertility costs, all of which are too personal to be medical.238

To succeed in disallowing the costs of elective egg freezing, the Service would have to establish that the care fails both the disease and structure/function prongs. If elective egg freezing can satisfy the disease prong, it must do so as preventative care. Analyzing elective egg freezing under the preventative care precedent brings its weaknesses to the fore, however.

Elective egg freezing does not fit well within the existing precedent on preventative care. Because it is readily identifiable as medical—elective egg freezing

234 See supra Subsection II.C.iii.
236 S. REP. NO. 77-1631, at 96 (1942).
238 This is an argument that the Service has made. See Pratt, supra note 10 at 1160–61.
requires prescription drugs, anesthesia, and the services of a physician—it is easily distinguished from dance lessons, a gym membership, or a move to a warm climate.\textsuperscript{239} Such preventative care frequently is "merely beneficial to the general health" of the individual.\textsuperscript{240} Rather than being compelled by medical exigency, it is the product of individual choice. And if it is committed to the choice frame for § 213, the Service could use the inadequacies of existing primary care precedent to bolster its argument that elective egg freezing is too personal to be medical—an argument that \textit{Morrissey} and the authority that preceded it suggest the Service is keen to make.\textsuperscript{241}

Part of the preventative care framing would rely upon the Service challenging the view that elective egg freezing qualifies as "wholly medical."\textsuperscript{242} It demonstrated a willingness to do so in opining that DNA collection and storage is subject to the "imminent probability" of disease standard (which should apply only to non-wholly medical care).\textsuperscript{243} In making this argument, the Service could assert that the "legitimate function[s]" process serves in daily life are in giving a woman peace of mind, allowing her to make the decision to delay childbearing, to devote more time to career, to take more time to find a partner—in brief, to make immensely personal lifestyle choices.\textsuperscript{244} If the Service succeeded in arguing that elective egg freezing is not "wholly medical" it would then have a slew of factors at its disposable to argue against deductibility. And because "wholly medical" is poorly-defined, the Service has the space to do so.

Under existing preventative care precedent, the woman’s motivation in using elective egg freezing is relevant, as is the temporal relationship between the care and the condition prevented.\textsuperscript{245} Because the motivations for using elective egg freezing are easily framed as lifestyle choices, the Service would argue that elective egg freezing is closer to a § 262 personal expense than § 213 medical care.\textsuperscript{246} It would emphasize the fact that the condition prevented (or delayed) is too far in the future to be construed as being tied to the current outlay for egg freezing. The Service could highlight that while infertility is inevitable, the woman who uses egg freezing may not actually be infertile when she decides to have a child—a fact that would render the care unnecessary. It may also emphasize that rates of using frozen eggs to have a child are variable and decline with age, to argue that the woman could not have a reasonable belief that the care would be "efficacious."\textsuperscript{247} In brief, if the Service could successfully frame elective egg freezing as speculative, not wholly-medical

\textsuperscript{239} See supra notes 136–137 and accompanying text.
\textsuperscript{240} Treas. Reg. 1.213-1(e) (2014); see also supra notes 120–132 and accompanying text (discussing the \textit{Havey and Stringham} line of precedent).
\textsuperscript{241} See supra Subsection II.C.iii.
\textsuperscript{242} See supra note 128 and accompanying text.
\textsuperscript{244} See infra Section IV.C.
\textsuperscript{245} See supra notes 227–229 and accompanying text.
\textsuperscript{246} See supra notes 90–95 and accompanying text.
\textsuperscript{247} See supra notes 144, 228 and accompanying text.
preventative care, it would have a greater chance of convincing a court that the care is more personal consumption than medical procedure.

An obvious objection to the Service's position is that elective egg freezing, unlike much preventative care, has a direct impact on structures and functions of the woman's body. *Morrissey*, however, seems to confirm what prior precedent suggested—that the Service is aiming to narrow the structure/function prong by binding it up with a disease requirement. The Service could dust off its argument in *Magdalin* that the structure/function prong expressly requires the presence of disease or dysfunction. Then, because the woman who uses elective egg freezing is not currently infertile, any impact on her reproductive function or her ovaries as a structure of her body is insufficient to make the process medical care.246 Alternately, the Service could take the tack it did in *Morrissey* and narrow the scope of the terms “affect” or “function.” To do so, the Service would draw upon the definition of “affect” articulated by the Eleventh Circuit, arguing that a mere acceleration of the production of eggs does not “materially influenc[e] or alter[]” her ovaries or her reproductive function.

Egg retrieval fares even worse under such a definition. Retrieving the eggs has no lasting effect on the woman's ovaries. Nor does the retrieval obviously materially affect the woman’s reproductive function. Because the efficacy of egg freezing is unclear, it may not significantly increase a woman’s chances of having child. Further, as the number of eggs retrieved is relatively low, retrieval would not seem to markedly decrease the woman’s future reproductive capacity. Because there is little clear precedent on the meaning of affect under § 213 and because it is, on its surface, consistent with the fact that § 213(d) is disjunctive, the latter argument gives the Service the space to do what it did in *Morrissey*: import a disease requirement into the structure/function prong by narrowing the terms of the prong itself so as to disallow a deduction for care it deems too driven by personal choice to be medical.

Pulling elective egg freezing, particularly the egg stimulation and retrieval costs, from the structure/function prong would require a departure from prior authority. But much of the relevant authority is, in fact, nonbinding. The General Counsel Memoranda in which the Service expressly stated that the structure/function prong cannot be limited by a disease requirement is over thirty years old and, by its nature, nonbinding. Though revenue rulings are binding upon the Service some of the

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246 See supra Subsection II.C.iii.
247 See supra notes 162–169 and accompanying text.
249 Morrissey v. United States, 871 F.3d 1260, 1265 (11th Cir. 2017).
250 Though it arguably does. See supra note 212 and accompanying text.
251 See supra notes 83–87 and accompanying text.
252 But see Mattes v. Comm'r, 77 T.C. 650 (1981), action on dec., 1982-46 (June 1, 1982), acq., 1982 C.B. 1. (focusing on the medical nature of the procedure). *Mattes* was decided before the addition of the cosmetic surgery exception, so its specific holding has been overruled by statute. Its approach to drawing the line between medical and personal expenses, however, could still be considered relevant.
253 See supra Subsection II.C.iii.
254 See supra note 147 and accompanying text.
most relevant—the 1973 revenue rulings qualifying birth control, vasectomies, and abortions as medical care under the structure/function prong\(^\text{257}\)—were drafted before the addition of the cosmetic surgery exception.\(^\text{258}\) Magdalin illustrated that the Service viewed the addition of § 213(d)(9) as a signal that Congress meant to narrow the structure/function prong.\(^\text{259}\) And though expressly arguing so seems unsupported by the language of the exception itself, the arguments in Morrissey suggest that the Service persists in learning the lesson of a narrower § 213,\(^\text{260}\) whether or not that was what Congress intended.\(^\text{261}\) Stated differently, it seems unlikely that the Service feels bound by increasingly outdated and, in some cases, nonbinding authority. Further, Magdalin and Morrissey illustrate that courts are receptive to the Service’s new, narrower construction.

Lastly, egg storage costs fare particularly poorly under post-Morrissey precedent. As discussed above, the Service has repeatedly asserted that storage of bodily materials does not qualify as medical care save the limited exception for short-term storage of eggs and sperm as part of the treatment for infertility.\(^\text{262}\) Storage already has a more tenuous connection to affecting a structure or function of the body. Under a narrower § 213, egg storage costs are easily relegated to personal consumption status.

The arguments articulated in this Section are necessarily speculative. The Service has not yet been presented with a claimed deduction for elective egg freezing. It is possible that the Service would adopt either the full or partial classification approach. If, however, Morrissey is, as this Article argues, an indicator of the Service’s view on reproductive care and its disinclination to feel bound by prior positions, elective egg freezing is likely to be classified as nondeductible, personal care. Stated simply, the precedent for preventative care, particularly wholly medical care, is thin and requires significant work to build into a coherent and consistent doctrine.

**C. Equity Impacts of Classification**

Elective egg freezing raises a host of policy concerns, including but not limited to how its availability will impact family formation, gender roles, women’s equality, and employer/employee relations. Each of these topics could be the subject of its own paper—and many have already been explored\(^\text{263}\)—but this Section focuses on a narrower equity concern: how the Service’s chosen classification will differentially impact women because of that classification’s interactions with other code provisions and the concept of income itself.

\(^{257}\) See supra note 152 and accompanying text.


\(^{259}\) See supra Subsection II.C.iii.

\(^{260}\) See Magdalin v. Comm’r, 96 T.C.M. (CCH) 491 (2008).

\(^{261}\) See supra Subsection III.A.ii.

\(^{262}\) See sources cited supra note 66.
Academics who have studied the role of reproductive technologies on family formation have highlighted the fact that such technologies, and the family planning they enable, are frequently the purview of financially secure individuals.\textsuperscript{264} If the Service attempts to and succeeds in classifying elective egg freezing as a nondeductible personal expense, its decision could further restrict reproductive choice. For the individual who pays for elective egg freezing out of her own pocket, classifying elective egg freezing as a nondeductible personal expense forecloses deductibility under § 213. Even a woman whose employer provides an elective egg freezing benefit may fare only marginally better than the woman who pays her own expenses. If an employer structures the benefit as a reimbursement program, such as an HRA, the reimbursement is only excludable from gross income if the cost would be deductible as medical care under § 213.\textsuperscript{265} If not, the reimbursement remains taxable compensation. If instead the employer structures the benefit as covered care under an employer-provided group health plan,\textsuperscript{266} but caps that coverage at a particular dollar amount, the woman who receives such a benefit will have, at best, a partial subsidy, as any amount she pays out of pocket remains nondeductible under § 213.\textsuperscript{267} Thus, if elective egg freezing fails to qualify as medical care under § 213, the only individuals who are likely to receive a full subsidy for such care are those whose employers provide uncapped coverage of elective egg freezing under an ERISA-qualified plan that is excluded from the employee’s income (and does not come onto the return as an itemized deduction).\textsuperscript{268} Most importantly, even if elective egg freezing qualifies as medical care, any employer-provided coverage is likely limited to higher-income individuals,\textsuperscript{269} a fact that only exacerbates existing inequities in access to healthcare broadly and reproductive care specifically.

\textsuperscript{264} See generally Carbone & Cahn, supra note 66.
\textsuperscript{266} 29 U.S.C. § 1167(1) (2012), defines group health plan with reference to the definition of medical care under § 213. The strength of influence of the Code on qualified plans is, however, unclear. See Health and Welfare Plans, 4 Emp. Benefit Plans & Issues for Small Employers (BNA) (2018) (“Like many other aspects of employee benefit plans, the interaction of tax attributes under the I.R.C. and mandates placed on the employer under ERISA is quite fuzzy. Technically, there is no definition of a group health plan under the I.R.C., and the only definition is found in ERISA; however, the ERISA definition contains cross-references to I.R.C. sections.”).
\textsuperscript{267} Partial because Treas. Reg. § 1.105-2 (2017) clarifies that reimbursement includes payments made, by the employer or by an insurance company, to the care provider, meaning the §213(e) definition of medical care applies to such payments. If, however, the Service failed to detect (likely) or challenged the care within the context of an already ERISA-approved employer provided plan, the partial subsidy could remain. See 26 U.S.C. §§ 105(b), 106(g) (2012); Rev. Rul. 2005-24, 2005-1 C.B. 892.
\textsuperscript{268} See The Tax Cuts and Jobs Act of 2017, Pub. L. No. 115-97, § 11027, 113 Stat. 2054, 2077 (2017) (granting greater standard deduction until 2026). There is some evidence that women may receive the funds necessary to pursue elective egg freezing as gifts from family. In such cases, the woman may be more likely to have the liquidity to purchase the services while also having an AGI low enough that getting over the §213 threshold is likely. La Ferla, supra note 22 (noting that parents or grandparents may gift the funds necessary to pay for elective egg freezing).
Consider two hypothetical taxpayers. Jennifer works for Facebook which structures its elective egg freezing benefit as coverage under its health insurance plan but caps the maximum payout at $20,000. In contrast, Aria’s employer provides no elective egg freezing coverage, so Aria pays all associated costs out of pocket. Assume both Jennifer and Aria’s care cost $35,000 and both have adjusted gross income of $75,000. Jennifer, however, has economic income of $95,000 because of the value of her employer-provided benefit. Under §213, Jennifer can deduct $9,375 of her out of pocket costs, a deduction that saves her $2,344 in federal income tax.\(^{270}\) Aria, in contrast, can deduct $29,375 of her $35,000 in out of pocket costs, resulting in a tax savings of $7,343.\(^{271}\) Though Aria’s tax savings are higher her after-tax cost is also greater. After the dust settles, Jennifer has spent only $12,656 while Aria has spent $27,657. This example illustrates the comparatively lower value of the medical expense deduction as compared to an exclusion from income of an employer-provided benefit. This problem is not unique to elective egg freezing, but it is a potentially troubling example of tax law failing to properly identify similarly and differently-situated taxpayers.

IV. INCUBATING ARGUMENTS: ELECTIVE EGG FREEZING AND THE FUTURE OF THE MEDICAL EXPENSE DEDUCTION

Having analyzed elective egg freezing under §213 and identified the doctrinal weaknesses it lays bare, this Part moves beyond considering elective egg freezing in isolation. How the Service applies §213 to elective egg freezing and, if contested, how a court rules, could set precedent that alters the scope of §213 and influences the tax treatment of emergent medical technologies. This Part explores the impacts of the Service’s potential rulings and, in doing so, reinforces the need for the Service to carefully consider its characterization of elective egg freezing and revisit its understanding of preventative care and the role of choice in tax.

A. Scope of §213 and Medical Care

Were the Service to classify elective egg freezing (in whole or part) as medical care, it would signal a retreat from the views advanced in Morrissey and the cases that preceded it. Recall that if elective egg freezing qualifies as medical care, it likely does so via the structure/function prong.\(^{272}\) Allowing a deduction for the costs would, then, affirm that the medical care definition should be read as disjunctive; that an expense need only satisfy one or the other prong to qualify as medical care. Doing so would also suggest that the Service does not view all reproductive care as inherently personal consumption. If care hedging against future infertility is deductible, then care provided to have a child cannot be wholly personal consumption. Where allowance of a deduction would at the least maintain the current scope of §213 and, at best, signal a modest expansion, disallowance would move precedent

\(^{270}\) $15,000 paid less 7.5% of her AGI at a 25% marginal rate.
\(^{271}\) $35,000 paid less 7.5% of her AGI at a 25% marginal rate.
\(^{272}\) See supra Subsection III.A.1.
toward a narrower § 213. The Service has three basic arguments to deny a deduction for elective egg freezing costs: (1) that all reproductive care is nonmedical, personal consumption, (2) that elective egg freezing is preventative care that is not wholly medical and that benefits only the general health of the taxpayer, or (3) that the care does not affect a structure or function of the woman’s body. As discussed above, each position requires the Service to retreat from prior, more expansive understandings of the scope of § 213. Both Magdalin and Morrissey represent such moves. A similar decision on elective egg freezing would bolster the narrowing trend.

B. Defining the Baseline Taxpayer

Determining what qualifies as a disease, disorder, or condition requires establishing a baseline. For a physical or mental state to be abnormal we must know what it means to be normal. The boundaries of the baseline healthy individual are not clearly-defined by § 213, but either full or partial classification of elective egg freezing as medical care could help clarify the concept. Elective egg freezing, if successful, counteracts natural, age-related infertility, in so far as it removes the undesired impact of infertility by artificially extending it. Consider the woman who successfully uses her frozen eggs to have a child at fifty-five. To do so, she would utilize IVF. Morrissey and Magdalin strongly suggest that such care qualifies as medical only if it follows a diagnosis of infertility. At forty-five, an overwhelming majority of women are unable to have a child without intervention but the question arises whether that inability is a disease or simply a normal consequence of aging. By increasing the possibility of women getting pregnant later in life, elective egg freezing may push the Service to decide if baseline health is relative or fixed. Stated differently, if the Service views the woman’s use of her frozen eggs and IVF at fifty-five as treatment for infertility, it implies that the baseline is reproductive age. If and when medical advances enable significant delay or reversal of the aging process, knowing the bounds of the baseline could influence whether policymakers consider a deduction appropriate. Categorizing elective egg freezing under § 213 plays a role in this discussion.

273 See supra Section III.B.
274 See supra Section III.B.
275 See infra Section II.C.
277 IVF already allows this, and elective egg freezing may increase the likelihood because its express goal is to buy time.
278 See Pratt, supra note 7 at 1125 (discussing Professor Joseph Dodge’s opinion on age-related changes under §213).
C. The Future of Preventative Care

Elective egg freezing is, at its core, highly-medicalized preventative care. Because elective egg freezing is readily identifiable as medical and because of its impact on the woman’s body, the costs should qualify as medical care. The Service, however, seems likely to argue that such care is nondeductible, personal consumption. It may rely upon the weakness of relevant precedent. Or it may utilize the rhetoric of choice. Or it may combine the two—casting the care as too speculative, too tied to lifestyle choices to fit within §213. Describing some preventative care such as dance lessons or a gym membership as “merely beneficial to the general health of an individual”\(^{279}\) and therefore nondeductible, is unsurprising and appropriate as a matter of policy.\(^{280}\) Regular exercise may prevent the development of a wide-range of diseases such as diabetes, cardiovascular disease, or Alzheimer’s, and it may even affect a structure or function of the body, but it is settled precedent that such costs are nondeductible, personal consumption.\(^{281}\) But emerging medical technologies suggest that future preventative care may be readily identifiable as medical, similar to elective egg freezing. They may also, like elective egg freezing, be separated by time or probability from the conditions they prevent.

This section considers two forms of preventative care—prophylactic surgery and CRISPR-Cas9 gene therapy—detailing how both put new pressure on the scope of preventative care under §213 and underscore the potentially wide-ranging impacts of the Service’s chosen approach to categorizing elective egg freezing.

i. Prophylactic Surgery

A prophylactic mastectomy is a surgery sometimes performed as means of attempting to prevent the development of breast cancer.\(^{282}\) Specifically, the surgery

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\(^{280}\) Allowing such costs would represent a significant preference for a particular type of consumption and would stand in stark conflict with 26 U.S.C. § 262 (2012).

\(^{281}\) IRS, PUB. 502: MEDICAL AND DENTAL EXPENSES 2 (2017), https://www.irs.gov/pub/irs-pdf/p502.pdf [https://perma.cc/4V65-XXHR]; see also Thoene v. Comm’r, 33 T.C. 62, 65 (1959) ("It is not at all unusual for doctors to recommend to a patient a course of personal conduct and personal activity which, if pursued, will result in health benefits to the patient, but the expenses therefor are generally to be considered ordinary personal expenses. There may be rare situations when such expenses would lose their identity as ordinary personal expenses and become properly classified as medical care expenses, but this record does not present such a case.").

\(^{282}\) Prophylactic removal of a woman’s uterus and fallopian tubes may also be performed. The surgery gained widespread attention when actress Angelina Jolie revealed that she had undergone the surgery absent a breast cancer diagnosis but because of her family history and the fact that she carried the BRCA1 gene. See Angelina Jolie, My Medical Choice, N.Y. TIMES (May 14, 2013), http://www.nytimes.com/2013/05/14/opinion/my-medical-choice.html?src=me&ref=general [https://perma.cc/J3C4-F5NM]; Stephanie Watson, Angelina Jolie’s Prophylactic Mastectomy a Difficult Decision, HARV. HEALTH BLOG (May 15, 2013, 11:50 AM), https://www.health.harvard.edu/blog/angelina-jolies-prophylactic-mastectomy-a-difficult-decision-201305156255 [https://perma.cc/C2HR-JTKV].
involves removing one or both breasts when the breasts are still healthy.\(^{283}\) The surgery may be performed in one of three contexts: (1) when a woman has genetic testing which reveals she carries the BRCA1 or BRCA2 genes and other risk factors, but no breast cancer diagnosis; (2) when she has the gene(s) and a breast cancer diagnosis in one breast (contralateral prophylactic mastectomy); or (3) when she does not have the gene but has a breast cancer diagnosis in one breast (contralateral prophylactic mastectomy).\(^{284}\) When the surgery is performed in the second scenario, the cost of care should easily satisfy § 213, as it is part of the treatment of the diagnosed breast cancer.\(^{285}\) But were the Service to succeed in categorizing elective egg freezing as nonmedical, the categorizations of (1) and (3) become less clear.

At first glance, either scenario (1) or (3) should satisfy the structure/function prong of § 213. A mastectomy affects a structure of the woman’s body and is not, in this context, motivated by a desired change in appearance.\(^{286}\) But if the Service narrows the structure/function prong to effectively require the presence of disease as a co-requirement, the deductibility of both scenarios (1) and (3) becomes more tenuous.

A woman with a family history of breast cancer and/or the BRCA1 or 2 genes has a significantly higher chance of developing breast cancer than does a woman without such risk factors.\(^{287}\) Assume, *arguendo*, that because the risk of developing breast cancer is so high for the woman in scenario (1), that the Service feels compelled or inclined to construe the surgery as treatment.\(^{288}\) It is not clear that scenario (3) could be categorized as treatment under a narrower § 213, however.

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\(^{285}\) Such care would likely be covered, at least in part, by insurance.

\(^{286}\) See 26 U.S.C. § 213(d)(9) (2012) ("Cosmetic surgery.—(A)In general.—The term 'medical care' does not include cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease. (B)Cosmetic surgery defined.—For purposes of this paragraph, the term "cosmetic surgery" means any procedure which is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.").

\(^{287}\) Data are somewhat conflicting but it appears that greater than 50% of women with these risk factors develop breast cancer at some point in their lives. *BRCA Mutations: Cancer Risk and Genetic Testing*, NAT'L CANCER INST. (January 30, 2018), [https://www.cancer.gov/about-cancer/causes-prevention/genetics/brca-fact-sheet][https://perma.cc/S5K9-3XTD].

\(^{288}\) Note that the likelihood of developing the disease should not matter where the care is wholly medical. However, it is reasonable to assume that the Service might view scenario (1) as a compelling, sympathetic case and therefore be more inclined to allow a deduction even if such care could be disallowed under a narrower § 213.
Though the woman in scenario (3) has a breast cancer diagnosis in one breast, her risk of developing cancer in the other breast is at or less than 1%, absent other risk factors.\textsuperscript{289} Further, data on the women who pursue the preventative surgery in this context “suggests that patient characteristics, such as age and education status, are stronger predictors of [the surgery] than tumor factors.”\textsuperscript{290} Indeed, a recent report stated that “women may opt for [the surgery] for psychological rather than clinical indications,” citing a survey study that found that “95% of [scenario (3)] patients reported ‘desire for peace of mind’ as an extremely or very important reason for choosing” to have the surgery performed.\textsuperscript{291}

Armed with these facts and favorable precedent from its prior disallowance of a deduction for elective egg freezing, the Service could argue for similar treatment for the woman in scenario (3). Though the care is preventative, the Service might concede, the fact that the risk of breast cancer is low, and that the woman’s motivation was “peace of mind” makes clear that the care was more for her general health and wellbeing than is required for care to be medical.\textsuperscript{292} To allow a deduction would, the Service would argue, subsidize an unnecessary surgery already utilized more heavily by a limited set of women. While it is accurate that surgery is listed in the regulations as medical care, the Service would assert that preventative surgery is distinct from surgery to treat a condition. It would reiterate the limiting language in the regulations that pulls from medical care “an expenditure which is merely beneficial to the general health of an individual.”\textsuperscript{293} The Service would, then, import factors from preventative care precedent—iniminent probability of disease, the taxpayer’s motivation, etc.\textsuperscript{294}—that should not apply when the care is wholly medical. And if it had successfully done so in its characterization of elective egg freezing, the Service could bolster its argument with such precedent.

Because the precedent on preventative care does not address care such as prophylactic surgery or elective egg freezing—care that is readily identifiable as medical, but which prevents conditions that could develop long after the care is provided—there is space for the Service to argue for a more restrictive § 213 if it chooses. Intuition suggests that if the prophylactic surgery scenario came in front of the Service before elective egg freezing, it might take a more taxpayer-favorable position on the classification of such care. Because the care is not for reproduction—a disfavored category of care that the Service views as wholly personal\textsuperscript{295}—the Service might be less skeptical and more inclined to permit a deduction. Stated differently, the social context of the care matters. But it is precisely that element of chance that makes considering how elective egg freezing should be treated so important and makes clear the need to better define preventative care.

\textsuperscript{289} Tracy et al., \textit{supra} note 284, at 448.
\textsuperscript{290} \textit{Id.} at 447.
\textsuperscript{291} \textit{Id.} at 448.
\textsuperscript{292} \textit{See supra} Section III.B (regarding how the Service might import the preventative care factors into even wholly medical care).
\textsuperscript{293} Treas. Reg. § 1.213-1(e) (2014).
\textsuperscript{294} \textit{See supra} notes 226–229 and accompanying text.
\textsuperscript{295} \textit{See supra} notes 157–158 and accompanying text.
Precedent on the tax treatment of highly-medicalized preventative care should not be unnecessarily narrowed because the Service views reproduction as a consumption decision, but rather should be the result of reasoned consideration of how such care fits within the § 213 framework. 296

ii. CRISPR-Cas9 Gene Editing

Whereas prophylactic surgery is already part of medical practice, CRISPR-Cas9 (Clustered Regularly Interspaced Short Palindromic Repeats) is a novel medical technology. 297 CRISPR-Cas9 is a means of editing DNA derived from bacterial immune systems that essentially enables scientists to make precise and stable changes to an individual’s genome. 298 CRISPR-Cas9 is part of a trend in research to develop what is known as precision medicine—highly individualized care. 299 Though not yet approved for use, the technology successfully repaired a genetic mutation in human embryos in a research context. 300 Stated simply, CRISPR-Cas9 may revolutionize both therapeutic and preventative care.

CRISPR-Cas9, like elective egg freezing and prophylactic surgery, tests the scope of § 213. Consider an example drawn from actual requests for the technology. A lead developer of the gene editing process reports that she has already been contacted by women wondering if CRISPR-Cas9 can prevent the passage of the BRCA genes to their children by editing their embryos’ DNA. 301 The regulations for § 213 would only permit a deduction for the medical care of the child if the child qualified as a dependent either at the time the care was provided or when the expenses were paid. 302 This restriction provides the ready, but wholly uninteresting

296 How insurance companies treat or are likely to treat such care is also important. The ACA expanded required coverage for preventative care. See 42 U.S.C. § 300gg–13 (2012). Interestingly, in April 2018, the Service issued Notice 2018-12, holding that vasectomies do not meet the § 223 definition of preventive care. I.R.S. Notice 2018-12, 2018-12 I.R.B. 441. Though it doesn’t bear directly on the § 213 analysis, it is a timely example of the Service struggling with the scope of preventative care. See I.R.S. Notice 2004-23, 2004-15 I.R.B. 725 (stating that “preventive care does not generally include any service or benefit intended to treat an existing illness, injury, or condition”).


298 See Rajat M. Gupta & Kiran Musunuru, Expanding the Genetic Editing Tool Kit: ZFNs, TALENs, and CRISPR-Cas9, 124 J. CLINICAL INVESTIGATION 4154, 4156 (2014).


301 See id.

302 Treas. Reg. § 1.213-1(e)(3) (2014) (“Status as spouse or dependent. In the case of medical expenses for the care of a person who is the taxpayer’s spouse or dependent, the deduction under section 213 is allowable if the status of such person as ‘spouse’ or ‘dependent’ of the taxpayer exists either at the time the medical services were rendered or at the time the expenses were paid.”); see also Kilpatrick v. Comm’r, 68 T.C. 469, 473 n.4 (1977).
answer, to whether gene editing of an embryo qualifies as medical care: no. To address the fascinating question of whether gene editing could qualify as medical care, this discussion sets aside that restriction. And because gene editing can be used as care for already living persons, the question remains relevant.

Gene editing could give rise to at least three types of medical care: (1) treatment of a current disease, (2) prevention of a disease, and (3) selection of traits. Under pre-Morrissey precedent, there is an argument that all three meet the § 213 definition of medical care. Assume an individual is diagnosed with cancer and CRISPR-Cas9 can edit the genes of her immune cells to empower them to combat the cancer. The use of CRISPR-Cas9 on these facts should readily satisfy the disease prong of § 213. Classifying the second use of CRISPR-Cas9 technology—prevention of a disease—is more challenging.

Recall from prior discussion that the Service has shown that when care is preventative, it considers the likely efficacy of the care in determining whether it qualifies as medical care. Not unlike the prophylactic surgery in scenario (3), CRISPR-Cas9 could be used to edit genes to prevent the development of a disease that the individual has a low probability of developing. Herein, the precedent the Service may set with elective egg freezing would be relevant. Elective egg freezing targets a condition—infertility—of the highest possible probability. Were the Service to disallow a deduction for elective egg freezing by appealing to the “imminent probability” standard, for example, the use of gene editing (or prophylactic surgery) to prevent development of a disease or condition with lower probability seems even less likely to qualify as medical care. The potential response to this assertion—that gene editing affects a structure or function of the body—seges into considering the last possible use of gene therapy: trait selection.

Trait selection is a complex and controversial potential application of gene editing. Scientists emphasize that the type of traits that parents are likely to select—hair or eye color, intelligence, etc.—are controlled by many genes and therefore difficult to engineer. Nevertheless, CRISPR-Cas9 brings medical technology one step closer to the possibility of trait selection. And assuming such care would not be covered by insurance and would be costly, an individual may attempt to deduct the costs of that care. In the absence of a disease to treat or

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303 See Kahn, supra note 297.
304 Such care is a focus of gene editing and the growing field of precision medicine of which it is a part. See Researchers Use CRISPR Gene-Editing Tool to Help Turn Immune Cells Against Tumors, NAT’L CANCER INST. (Mar. 20, 2017), https://www.cancer.gov/news-events/cancer-currents-blog/2017/crispr-immunotherapy [https://perma.cc/M548-LZSK].
305 See supra notes 226-229 and accompanying text.
308 Id. (“‘Allowing any form of human germline modification leaves the way open for all kinds — especially when fertility clinics start offering ‘genetic upgrades’ to those able to afford them,’” Marcy Darnovsky, executive director of the Center for Genetics and Society, said in a statement. “‘We
prevent, gene editing for trait selection would have to qualify as medical care under the structure/function prong. That fact, in turn, raises many questions including: Is the gene the relevant structure that gene editing affects, or should it be construed to be the bodily structure or function which the gene (or genes) influence? Answering that question is essential to determining whether the editing affects a structure/function within the meaning of § 213. Also influential would be precedent on what constitutes an affect—precedent that the Service’s decision on elective egg freezing may significantly shape.

If the gene is the relevant structure, is its modification significant enough to qualify as affecting a structure of the body? If instead the relevant structure or function is that which the gene influences, the argument for an effect is stronger. Enabling an individual’s body to produce more of a hormone that boosts muscle capacity (a possible application of CRISPR-Cas9) by editing a gene produces a change upon the individual’s bodily function of producing hormones. Stated differently, precedent on what qualifies as a structure, function, and/or affect influences the materiality of the argued affect itself. While how § 213 would or should apply to gene editing is not clear, the precedent the Service may set when it considers elective egg freezing will loom large.

If instead the Service continues to push to read a disease requirement into the structure/function prong, it could take the position that gene editing outside the treatment context is wholly personal consumption, even if it affects a structure or function of the body. Importantly, the Service would have many persuasive policy arguments with which to support its argument. Emerging technologies such as gene therapy and the highly-medicalized preventative care of elective egg freezing, and prophylactic surgery are expensive. To the extent such care is not covered by insurance (which is more likely, the more preventative the care), individuals do and will face high out of pocket costs. The high costs, particularly if no subsidy is available, give rise to equity concerns. Meaningful differences in access to and uptake of care that could be construed as medical, inject such care with a greater consumption element. The Service could marshal such arguments to support its

could all too easily find ourselves in a world where some people’s children are considered biologically superior to the rest of us.”)

309 There is an analogy here to the regulations for §263 that provide guidance on determining the relevant unit of property as a step in determining the materiality of a change to such property. See 26 CFR 1.263-3(e).

310 See Belluck, supra note 307.

311 See Preventative Surgery: Prophylactic Mastectomy, SUSAN G. KOMEN (Nov. 27, 2018), https://ww5.komen.org/BreastCancer/PreventiveSurgery.html [https://perma.cc/U4JT-7JB6] (“At this time, no federal laws require insurance providers to cover prophylactic mastectomy. Some state laws require coverage for prophylactic mastectomy, but coverage varies state to state. It’s best to check with your insurance provider to learn about your plan’s coverage.”).

312 The costs of elective egg freezing were addressed. See supra notes 36–40 and accompanying text. Costs of prophylactic mastectomy are difficult to determine but it is safe to assume they exceed $15,000. See K. Fanuko, Preventive Mastectomies Benefit a Select Few, CONSUMERS DIG. (June 10, 2013), http://www.consumersdigest.com/news/preventive-mastectomies-benefit-a-select-few [https://perma.cc/BZP4-3SAZ].

313 See generally Andrews, supra note 91; Colliton, supra note 161.
position that any of the technologies discussed in this Article or similar ones in development run afoul of § 262. Stated differently, that highly-medicalized preventative care may be medical in nature, but it is personal in tax.

CONCLUSION

At first blush, defining the boundaries of a deduction for medical care appears uncomplicated. One should be sure to include care that just seems medical—provided by a physician or other skilled care provider, performed in a hospital, involving scalpels, prescription drugs, respirators, and the like. Including care aimed at diagnosing, preventing, treating, or lessening the impact of a condition strikes one as appropriate as well. After all, an individual does not elect to receive such care in the same way she elects to travel to Paris. And despite the fact that both decisions can be viewed as personal—they both provide a personal benefit—because such care can be distinguished from the vacation, an argument can be made for subsidizing it without risk of violating the Code’s restriction on deducting personal expenses. In many instances, the definition of medical care in § 213 works without issue. Elective egg freezing is not one of those instances.

As an amalgamation of preventative and fertility care, elective egg freezing challenges the scope of § 213. Because it seems medical, unlike much of the preventative care which has been tested under the medical care definition, it does not fit well within such precedent. Because it is also bound up with fertility, it implicates a growing body of authority that seems to narrow the scope of § 213 beyond what its language would require. Both aspects of elective egg freezing make it challenging to classify and the recent case of Morrissey v. United States suggests that the Service may aim to categorize the process as wholly personal/nonmedical consumption. And analyzing elective egg freezing under § 213 exposes the cracks in the doctrine—a superficial understanding of preventative care and the role of choice in § 213.

Yet how the Service rules on elective egg freezing could influence the tax treatment of emerging medical technologies that share its characteristics: seemingly medical intervention motivated by concern for the eventual onset of a given condition that is either unlikely to develop in the near future or may not ever develop. Medicine is shifting toward developing such similarly if not more highly-medicalized preventative care—gene editing that reduces or eliminates your risk of developing a given condition—and how the Service rules on elective egg freezing will lay a foundation that influences the tax treatment of such care. Or even if the test case of elective egg freezing does not arise, other emergent technologies will face the challenges of an uncertain and unclear § 213. Considering elective egg freezing and the medical care definition allows us to address the doctrinal and policy concerns that such technology presents before issues arise, providing, therein, the best chance of advancing § 213 in a way that is consistent, coherent, and fair.