
OUR TAXES GET A DIET: THE CODE ATTACKS THE OVERWEIGHT & OBESITY EPIDEMIC*

I. INTRODUCTION

In 2010, twenty-four-year-old Melissa Moss experienced weight-loss success for the first time in her life.¹ After suffering through failed diet after failed diet since the age of fourteen, Melissa finally reshaped her unhealthy lifestyle and lost forty-five pounds in six months.² While Melissa's success might bring to mind common weight-loss rewards, such as lower cholesterol, decreased risk of cardiovascular disease, and better blood pressure,³ another dramatic effect of undergoing weight loss exists—debt. While Melissa Moss experiences many of the positive benefits of successful weight-loss treatment, she now also faces four thousand dollars' worth of credit-card debt.⁴

Despite only earning fifteen dollars per hour, Melissa enrolled in a collectively focused weight-loss plan run by George Washington University Weight Management Program, at a cost of about eight hundred dollars per month.⁵ She did so because she knew that she “needed intensive help.”⁶ Melissa was obese and her cholesterol levels were dangerously high, but despite her doctor's suggestion to lose weight, her insurance company refused to cover the program.⁷

Melissa Moss is not alone in her battle to overcome weight problems, or in her efforts to fund those efforts. Obesity and overweight have reached epidemic proportions in America.⁸ And while the United States has made great progress in the field of public health over recent decades, the obese and overweight conditions of millions of Americans run the risk of “wip[ing] out the gains we have made” in public

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1. Sandra G. Boodman, *Paying a High Price for Losing Pounds; Insurers Are Slow to Cover Treatments for Obesity: Insurers Slow to Cover Obesity Treatment, Patients Often Must Foot the Bill*, WASH. POST, Sept. 21, 2010, at HE1.

2. *Id.*

3. *E.g.*, NAT'L HEART, LUNG & BLOOD INST., CLINICAL GUIDELINES ON THE IDENTIFICATION, EVALUATION, AND TREATMENT OF OVERWEIGHT AND OBESITY IN ADULTS: THE EVIDENCE REPORT, at xiii (1998) [hereinafter CLINICAL GUIDELINES].

4. Boodman, *supra* note 1, at HE1.

5. *Id.*

6. *Id.*

7. *Id.*

8. David Satcher, *Foreword* to OFFICE OF THE SURGEON GEN., DEPT. OF HEALTH & HUMAN SERVS., THE SURGEON GENERAL'S CALL TO ACTION TO PREVENT AND DECREASE OVERWEIGHT AND OBESITY 2001, at xiii (2001), available at <http://www.surgeongeneral.gov/topics/obesity/calltoaction/message.htm>.

health.⁹ Those inflicted with obesity or overweight run the risk of suffering from conditions such as heart disease, diabetes, and cancer, to name only a few of the potential chronic health problems.¹⁰ As a result, the Surgeon General of the United States released the first ever “Call To Action” in 2001, in which he called upon “the close cooperation and collaboration of a variety of organizations and individuals,” to combat this public health crisis.¹¹

Acknowledging a change in the public health scenery, the Internal Revenue Service (IRS) responded to the Surgeon General’s Call to Action by allowing taxpayers to receive obesity-related treatment at a lower cost.¹² The IRS acknowledged obesity as a disease for the first time in 2002 and allowed a taxpayer to deduct obesity-related treatment expenses as medical expenses under § 213 of the Internal Revenue Code (the Code).¹³

Treating obesity is expensive,¹⁴ and millions of Americans are faced with the same ultimatum as Melissa Moss: choosing between significant debt or their health.¹⁵ Melissa chose the latter. And while she has finally found a solution to treating her obesity, she has incurred the new problem of debt.¹⁶ Because Melissa’s insurance provider refused to cover her treatment, Melissa was forced to take a second job as a waitress in order to try to pay back her surgery costs.¹⁷

This Comment sets out to analyze how providing a tax benefit for weight-loss expenses fits within the purview of tax law. It proposes that, in addition to obesity-related expenses, overweight individuals should receive a tax benefit for weight-loss expenses. Section 213 currently can be interpreted as allowing obesity- *and* overweight-related treatment expenses as deductible; however, this deduction only gets taxpayers and policymakers part of the way. This Comment argues that the most effective vehicle to implement the tax benefit is through a refundable tax credit. Because including a tax benefit for obesity- and overweight-related expenses can exist under the current § 213 framework, this Comment first analyzes this inclusion under the § 213 deduction, where there is no need for new legislation. Ideally, however, Congress would modify the tax benefit for certain medical expenses, using the same § 213 analysis, and recognize the need for a refundable tax credit for obesity- and overweight-related expenses with new legislation.

Section II of this Comment explains the historical evolution of the medical

9. *Id.*

10. *Id.*

11. *Id.* at xv.

12. Rev. Rul. 2002-19, 2002-1 C.B. 778. See *infra* Part II.E for an explanation of how the IRS’s deduction can be seen as a response to the Call to Action.

13. Rev. Rul. 2002-19, 2002-1 C.B. 778.

14. See Louis F. Martin et al., *Socioeconomic Issues Affecting the Treatment of Obesity in the New Millennium*, 4 PHARMACOECONOMICS 335, 335 (2000) (“[T]he healthcare and social security/disability system will accumulate direct and indirect costs related to obesity that will be more substantial than those for any other primary disease within this generation.”). See *infra* notes 287–90 and accompanying text for a discussion of common weight-loss expenses.

15. Boodman, *supra* note 1, at HE1.

16. *Id.*

17. *Id.*

expense deduction and discusses the technical aspect of expenses meeting the medical care definition. It focuses on the different interpretations of a proper tax base and whether or not medical expenses are a proper or improper inclusion in the tax base. Section II then highlights the ongoing debate associated with obesity in America as to whether or not obesity is truly a disease and notes the viewpoints associated with both sides of the tax benefit under the Code. Section II concludes with a description of the prevalence of overweight and obesity in the United States. Specifically, it reviews the dramatic rise in rates of overweight and obesity in recent decades, and explains how providing a tax benefit to those seeking treatment of their excessive weight represents a response to the current public health crisis.

Section III of this Comment addresses how allowing a tax benefit for obesity-related expenses is an appropriate response to the public health crisis. This Section also argues, however, that the IRS needs to expand the deduction to include treating overweight individuals as well. Section III argues that precedent, policy, and statutory reading all support treating overweight taxpayers, in addition to those who are obese, as eligible to receive a tax benefit for their treatment-related costs under the Code. It further proposes that a holistic treatment plan is the only way to ensure effective treatment. Section III acknowledges that though tax law is not the most common or perfect vehicle for implementing a public health policy, it can be seen as a foundational part of a holistic plan to aid in our nation's battle with obesity and overweight.

Section IV of this Comment argues that an ideal tax benefit for weight-loss treatment exists in the form of a refundable tax credit, and not the currently provided deduction. It explains how the current implementation through a deduction results in practical barriers for a taxpayer seeking a real tax benefit, thus reducing a taxpayer's incentive to engage in treatment, and reducing the deduction's effectiveness in addressing the public health crisis. Finally, Section V of this Comment emphasizes the seriousness of our nation's current public health crisis. It explains how allowing tax benefits in the form of a refundable tax credit to address public health concerns is a better method than what currently exists both in and out of the world of tax law.

II. OVERVIEW

A. The Lifespan of the Medical Expense Deduction

The medical expense deduction allows a taxpayer to decrease taxable income by deducting the cost of expenses paid for the medical care of the taxpayer, the taxpayer's spouse, or the taxpayer's dependent from adjusted gross income (AGI).¹⁸ Section 213 of the Code allows for the deduction of expenses for medical care, not compensated by insurance or otherwise,¹⁹ and has two separate prongs—either or both of which allow

18. I.R.C. § 213(a) (2012). Section 61 of the Code provides that net income is "all income from whatever source derived," *id.* § 61(a), while AGI, under § 62 of the Code, is the amount of gross income less certain specified deductions, *id.* § 62(a). Thus, a taxpayer's AGI is always equal to or less than the taxpayer's gross income.

19. *Id.* § 213(a). This Comment considers only out-of-pocket, unreimbursed, and expenses that are not covered. Therefore, any medical treatment covered by insurance, Medicare, Medicaid, or by a tortfeasor is not addressed in this Comment. Explanation and analysis of medical treatment reimbursed or paid by any of the

for a deduction.²⁰ The first prong allows a deduction for amounts paid for “the diagnosis, cure, mitigation, treatment, or prevention of disease”²¹—meaning a taxpayer must have the imminent probability or present existence of a disease to claim a deduction under this prong.²² The second prong provides a deduction for amounts paid for “the purpose of affecting any structure or function of the body,”²³ which may include such things as undergoing surgery to correct a personal physical injury.²⁴

1. The Original Version of the Medical Expense Deduction

Congress incorporated the medical expense deduction into the 1939 Internal Revenue Code in 1942 (the “1939 Code”).²⁵ Set against the backdrop of World War II, the Senate Finance Committee recommended the deduction “in consideration of the heavy tax burden that must be borne by individuals during the existing emergency (World War II) and of the desirability of maintaining the present high level of public health and morale.”²⁶

The original version of the medical expense deduction existed in a different form than what we have today.²⁷ The 1939 Code provided a “floor” of five percent of the taxpayer’s net income for the purpose of ensuring that taxpayers could only claim this deduction for incurring extraordinary medical expenses, while simultaneously saving the government a potential loss in revenue.²⁸ Congress settled on the five percent floor because the legislature believed that five percent of a taxpayer’s net income reflected the average medical expenditure for most taxpayers—only when expenses exceeded this average could a taxpayer claim the tax benefit.²⁹ Lawmakers presumed that the standard deduction, available to all taxpayers, would sufficiently cover medical expenses of the taxpayer that did not rise to the “extraordinary” level.³⁰

Congress also imposed a cap on the first version of the medical expense deduction, setting it at \$2,500 for a head of household or husband and wife filing joint

latter-mentioned methods, and how those provisions affect the medical expense deduction, is outside of the scope of this Comment and may be addressed in a separate paper.

20. *O’Donnabhain v. Comm’r*, 134 T.C. 34, 49 (2010) (describing the two prong approach).

21. I.R.C. § 213(d)(1)(A).

22. *See Daniels v. Comm’r*, 41 T.C. 324, 327–28 (1963) (stating that a mere possibility of acquiring a disease does not satisfy this prong).

23. I.R.C. § 213(d)(1)(A); *see also O’Donnabhain*, 134 T.C. at 49 (describing the two prong approach).

24. I.R.C. § 213(d)(9)(A).

25. S. REP. NO. 77-1631, at 95 (1942). When originally enacted, the medical expense deduction was under § 23 of the Code. *Id.*

26. *Id.* at 6.

27. *See infra* Parts II.A.1 and II.A.5 for explanations of the medical expense deduction’s original structure and its current structure, respectively.

28. James E. Jensen, *Rationale of the Medical Expense Deduction*, 7 NAT’L TAX J. 274, 282–83 (1954).

29. *Id.* at 283.

30. *Id.* The standard deduction is a dollar amount subtracted from a taxpayer’s adjusted gross income, along with personal exemptions, used to arrive at the taxpayer’s annual taxable income. I.R.C. § 63(b) (2012). It is available to all taxpayers, unless the taxpayer elects to itemize deductions for the year. *Id.* The dollar amount of the standard deduction depends on the taxpayer’s filing status. I.R.C. § 63(c)(1)–(2).

returns, and \$1,250 for all other cases.³¹ Two major reasons Congress capped the new deduction were (1) to limit confusion of what was a personal expenditure, like travel, versus a legitimate deductible medical expense, and (2) to attempt to limit an overuse of the deduction by people such as “hypochondriacs.”³²

2. Development of the Medical Expense Deduction

Not long after Congress incorporated the medical expense deduction into the 1939 Code, Congress and important contemporary political figures expressed a desire to alter its content in order to achieve the deduction’s intended purpose.³³ Just two years after the deduction’s enactment, Congress changed the floor from five percent of net income to five percent of AGI.³⁴ Congress further altered the deduction as part of the Revenue Act of 1948, and raised the upper limit to \$5,000 for joint returns with at least four exemptions.³⁵ Shortly after, in 1951, Congress removed the floor requirement entirely for taxpayers sixty-five years of age and older and their spouses.³⁶ The Senate Finance Committee cited decreased earnings and increased medical expenses in the years over sixty-five as the rationale.³⁷

Our nation’s leaders solidified both the primary role and the main concerns of the medical expense deduction a little over a decade after its inception. In 1954, President Eisenhower called for a liberalization of the medical expense deduction to alleviate taxpayers’ burden, and to “cover the many tragic emergencies which occur in too many families.”³⁸ To effectuate a broader reach for the medical expense deduction, he recommended the floor be reduced to three percent of AGI and that the upper limit be raised to \$2,500 per exemption, with a cap set at \$10,000 for joint returns.³⁹ Still concerned with abuse of the medical expense deduction, however, he explicitly sought to exclude ordinary household supplies and indirect travel expenses from the definition of “medical care,” regardless of their purported medical use.⁴⁰

The Undersecretary of the Treasury at the time, Marion B. Folsom, further stated that the deduction should extend to “real hardship situations” resulting from “heavy medical expense[s].”⁴¹ Such commentary clarified that the deduction’s purpose and

31. S. REP. NO. 77-1631, at 6.

32. Jensen, *supra* note 28, at 283.

33. *See id.* at 280–81 (explaining President Eisenhower’s desire to cover “tragic emergencies” while avoiding abuse).

34. *Id.* at 282–83.

35. *Id.* at 283. Under § 151 of the Code, exemptions include both personal exemptions, where the taxpayer is personally allowed a deduction, and a dependency exemption. I.R.C. § 151. Under the dependency exemption a taxpayer can deduct an amount for a “qualifying child” or “qualifying relative.” *Id.* § 152. Every taxpayer with taxable income is eligible to claim this deduction. *Id.* § 151.

36. Jensen, *supra* note 28, at 283.

37. *Id.*

38. *Text of President Eisenhower’s Budget Message to Congress for the Fiscal Year 1955*, N.Y. TIMES, Jan. 22, 1954, at 14 [hereinafter *Eisenhower Message*].

39. Jensen, *supra* note 28, at 281.

40. *Eisenhower Message*, *supra* note 38, at 14.

41. Jensen, *supra* note 28, at 282 (citing *Hearing on H.R. 8300 Before the S. Fin. Comm.*, 83d Cong. 24 (1954)).

unique structure were aimed at achieving a balance of allowing taxpayers to deduct extraordinary medical costs in times of need,⁴² while limiting deduction abuses for ordinary or luxury living expenses “in the guise of medical costs.”⁴³

3. Tax Expenditure Analysis: The Medical Expense Deduction Achieving Non-Tax Policy Goals

Before the 1942 adoption of the medical expense deduction, Congress regarded medical care expenses as “personal, living, or family expenses,” which are strictly non-deductible under the Code.⁴⁴ Congress chose to incorporate the medical expense deduction into the Code, however, to achieve the non-tax purpose of easing the “heavy tax burden” on individuals and “maintaining the present high level of public health and morale.”⁴⁵ When the government uses a tax subsidy as a vehicle to implement certain government policy without a corresponding tax purpose, the subsidy is classified as a tax expenditure.⁴⁶

Congress defines a tax expenditure as “revenue loss[] attributable to provisions of the Federal tax laws which allow a *special* exclusion, exemption, or deduction from gross income or which provide a *special* credit, a preferential rate of tax, or a deferral of tax liability.”⁴⁷ The Joint Committee on Taxation⁴⁸ characterizes the special income tax provisions as analogous to direct government outlay programs, implemented to achieve a certain budget policy objective not based in tax law.⁴⁹ Congress defines and estimates tax expenditures with reference to “normal income tax law,”⁵⁰ and the Joint Committee on Taxation has the responsibility to use its judgment in distinguishing between income tax provisions that can be viewed as part of the normal income tax law, and those that are tax expenditures.⁵¹

The Joint Committee on Taxation traditionally classifies the medical expense deduction as a tax expenditure because it is a departure from normal income tax law, which is aimed at taxing “all income from whatever source”⁵² in order to achieve a non-tax policy objective—a high level of public health—without a resulting economic

42. Jensen, *supra* note 28, at 282.

43. *See id.* (stating that the floor acts as a safeguard mechanism).

44. Stringham v. Comm’r, 12 T.C. 580, 583 (1949) *acq.*, 1950-2 C.B. 4, *aff’d per curiam*, 183 F.2d 579 (6th Cir. 1950).

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

46. STAFF OF J. COMM. ON TAXATION, 106TH CONG., ESTIMATES OF FEDERAL TAX EXPENDITURES FOR FISCAL YEARS 2000–2004 at 2 (Comm. Print 1999).

47. 2 U.S.C. § 622(3) (2012) (emphasis added).

48. The Joint Committee on Taxation is a nonpartisan committee of the United States Congress, empowered under the Revenue Act of 1926. *Overview*, JOINT COMMITTEE ON TAXATION, <http://www.jct.gov/about-us/overview.html> (last visited Oct. 22, 2013). The Joint Committee on Taxation is involved in every aspect of the tax legislative process, such as: assisting Congressional committees in development and analysis of legislative proposals, preparing revenue estimates of all tax legislation, drafting legislative history for tax-related bills, and investigating various aspects of the federal tax system. *Id.*

49. STAFF OF J. COMM. ON TAXATION, *supra* note 46, at 2.

50. *Id.*

51. *Id.*

52. I.R.C. § 61(a) (2012).

burden on the taxpayer.⁵³ These special tax provisions fall into one of two categories: “tax incentives” or “hardship relief.”⁵⁴ The medical expense deduction qualifies as a hardship relief provision because Congress designed the deduction with the intention of alleviating the burden of extraordinary medical expenses on taxpayers and achieving good public health.⁵⁵ The Joint Committee of Taxation regularly includes the medical expense deduction as part of its revenue loss estimates from tax expenditures.⁵⁶ And according to the *Estimates of Federal Tax Expenditures for Fiscal Years 2010–2014* prepared by the Joint Committee on Taxation, the deduction for medical expenses and long-term care expenses are projected to reach \$77.6 billion, which is one of the largest health expenditures provided for fiscal years 2010–2014.⁵⁷

4. Medical Expenses as a Proper Deduction From the Tax Base: An Alternative Rationale

Though the medical expense deduction is traditionally viewed as a tax expenditure meant to help promote public health policy, other legal commentators have argued that the current “normal” tax base is far from universally accepted,⁵⁸ and that the medical expense deduction serves an alternative purpose that is based in tax law.⁵⁹ A theory espoused by Professor William Andrews formulates a different tax base than the current income-focused base.⁶⁰ He argues that an ideal tax base is a combination of a taxpayer’s aggregate personal consumption and accumulation.⁶¹ This base, Andrews contends, more adequately reflects a taxpayer’s “material well-being,” and therefore, an individual’s relative ability to pay tax.⁶²

Andrews’ disagreement with the current tax base finds support from some of our nation’s leading tax experts.⁶³ For instance, the Joint Committee on Taxation’s former Chief of Staff, Edward Kleinbard, criticized the credence given to the current tax base

53. STAFF OF J. COMM. ON TAXATION, *supra* note 46, at 22 (including the medical expense deduction in a table listing tax expenditures); *see also* William D. Andrews, *Personal Deductions in an Ideal Income Tax*, 86 HARV. L. REV. 309, 309–10 (1972) (stating that the medical expense deduction is the equivalent to a direct expenditure program).

54. Thomas D. Griffith, *Theories of Personal Deductions in the Income Tax*, 40 HASTINGS L.J. 343, 347 (1989); *see also id.* (“A tax incentive seeks to change a taxpayer’s behavior, while hardship relief helps to reduce the impact of a taxpayer’s misfortune.”).

55. *Id.*

56. *See* MICHAEL J. GRAETZ & DEBORAH H. SCHENK, *FEDERAL INCOME TAXATION: PRINCIPLES AND POLICIES* 41–42 (Foundation Press, 6th ed. 2009) (providing an abbreviated version of the Joint Committee’s estimates for 2000).

57. STAFF OF J. COMM. ON TAXATION, 111TH CONG., *ESTIMATES OF FEDERAL TAX EXPENDITURES FOR FISCAL YEARS 2010–2014*, at 48 (2010).

58. Edward D. Kleinbard, Chief of Staff, Joint Comm. on Taxation, Address at Chicago-Kent College of Law Federal Tax Institute: Rethinking Tax Expenditures 7 (May 2, 2008), *available at* <https://www.jct.gov/publications.html?func=startdown&id=1197>.

59. *See generally* Andrews, *supra* note 53.

60. *Id.*

61. *Id.* at 313.

62. *Id.* at 335.

63. Kleinbard, *supra* note 58, at 6–7.

in tax expenditure analysis.⁶⁴ The current concept of our “normal” tax base, Kleinbard contended, is nothing more than “idiosyncratic or pragmatic choices,” rather than the analytical framework originally envisioned.⁶⁵ Thus, what is the “normal” tax base is still a subject of debate.⁶⁶

Andrews formulated an alternative tax base, which imposes a tax burden equivalent to an individual’s relative ability to pay tax, and argues that a deduction for medical expenses helps reflect this goal.⁶⁷ When deciding proper tax deductions with this base in mind, the “central question” becomes whether there is a necessary reason to exclude a particular good or service received by the taxpayer from the concept of personal consumption, which therefore should be excluded from the tax base.⁶⁸ In analyzing the medical expense deduction, his rationale is that “greater utilization of medical services by [a taxpayer] is likely not to reflect any greater material well-being or taxable capacity” as between two people otherwise similarly situated.⁶⁹ Rather, an increased expenditure only reflects a greater medical need.⁷⁰ More medical expenses are attributable to those with poorer health, thus reflecting a lower taxable capacity for these taxpayers.⁷¹ And one’s tax burden should therefore account for this disparity.⁷²

It is quite “impractical” to try to include good health directly into the tax base, but, according to Andrews, allowing a deduction for medical expenses at least partially reflects the difference between the haves and have-nots.⁷³ This theory does not put a speculative price on good health, but only accounts for health differences as they “manifest themselves in financial terms,” measured by quantifiable medical expenses.⁷⁴ Andrews asserts that expenditures for medical care are distinguishable from other personal expenses because the former reflect a need rather than choice of gratification.⁷⁵ Any medical expense deduction therefore requires the taxpayer’s condition to reflect a departure from good health. The related treatment expenses must

64. *Id.* at 6.

65. *Id.*

66. Compare Mark G. Kelman, *Personal Deductions Revisited: Why They Fit Poorly in an “Ideal” Income Tax and Why They Fit Worse in a Far from Ideal World*, 31 STAN. L. REV. 831, 834 (1979) (“My view is that a taxpayer’s net receipts, receipts minus the cost of obtaining the receipts, *tautologically* consists of consumption plus savings [and is the proper tax base.]”), with HENRY C. SIMONS, PERSONAL INCOME TAXATION: THE DEFINITION OF INCOME AS A PROBLEM OF FISCAL POLICY 50 (1938) (describing the proper tax base as the “(1) market value of rights exercised in consumption and (2) the change in the value of the store of property rights between the beginning and end of the period in question”).

67. Andrews, *supra* note 53, at 335–36.

68. *Id.* at 313–14.

69. *Id.* at 314.

70. *Id.*

71. See *id.* at 314 (explaining that good health does not vary in direct proportion to medical services utilized; rather those in poorer health usually require more medical services, thus incurring more medical expenses).

72. See *id.* (noting that between similarly situated taxpayers, a greater utilization of medical services likely only reflects greater medical need, and that the medical expense deduction should be primarily evaluated considering that fact).

73. *Id.* at 335.

74. *Id.* at 336.

75. *Id.*

not be for personal consumption, but rather *necessary* to get the taxpayer back to good health—thus negatively affecting the taxpayer’s material wealth and taxable capacity. As such, any medical expenses deductible under the Code are not personal consumption expenses, and reflect proper deductions from taxable income.

5. The Medical Expense Deduction in 2013

The most recent version of the medical expense deduction exists under § 213 of the Code and allows a deduction for medical expenses, which are not compensated by insurance or otherwise (e.g., a tortfeasor paying victim’s medical care) and are substantial: now defined as exceeding ten percent of the taxpayer’s AGI.⁷⁶ Certain medical expenses are explicitly stated in the Code, such as allowances for prescription drugs and insulin.⁷⁷ In other instances, the Code provides guidance by exclusion in defining medical expenses, like when it specifies that medical care *does not* include cosmetic surgery or other similar procedures.⁷⁸ The Code, however, does not provide an exhaustive list of deductible expenses.⁷⁹

When medical expenses are not specifically enumerated, the Code broadly defines such expenses as relating to “the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body.”⁸⁰ When applying this definition, courts and the IRS consider determinations of congressional intent.⁸¹ In certain cases they may also consult Supreme Court interpretations, scientific evidence, case law, and medical reference texts to ultimately determine if a medical expense is appropriately classified as a tax deduction.⁸² Examples of well-accepted medical expenses include in-patient hospital care,⁸³ doctor’s visits,⁸⁴ and dental care.⁸⁵ Common expenses denied as medical expense deductions include over-the-counter

76. I.R.C. § 213(a) (2012) (allowing a deduction for expenses exceeding 7.5% of a taxpayer’s AGI). The medical expense deduction recently underwent another revision pursuant to the recently enacted Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 9013, 124 Stat. 119, 868 (2010), *amended by* Pub. L. No. 111-152, 124 Stat. 1029 (2010). After December 31, 2012, the 7.5% floor in § 213 increased to 10%. *Id.* § 9013(a), (d). There is an exception to this new requirement if a taxpayer, or a taxpayer’s spouse, is sixty-five years old before the close of a taxable year. *Id.* § 9013(b). Those taxpayers are temporarily still subject to the 7.5% floor, not the 10% increase, but the special waiver expires for the taxable year starting January 1, 2017. *Id.*

77. I.R.C. § 213(b). Section 213(d)(1)(C) also allows a deduction for qualified long-term care services and § 213(d)(1)(D) allows a deduction for covering medical care referred to in subparagraphs (A) and (B) or for any qualified long-term care insurance contract. *Id.* § 213(d)(1)(C), (D).

78. I.R.C. § 213(d)(9).

79. *E.g., id.* § 213 (providing an allowable deduction for a broadly defined category of medical expenses but failing to include an exhaustive list of what expenses fall within that broad definition).

80. *Id.* § 213(d)(1)(A).

81. *E.g., Havey v. Comm’r*, 12 T.C. 409, 411 (1949) (“Whether a given deduction falls within the favor of the section is largely a matter of . . . Congressional intent.”).

82. *E.g., O’Donnabhain v. Comm’r*, 134 T.C. 34, 56–57, 60 (2010).

83. Treas. Reg. § 1.213-1(e)(1)(v) (2011).

84. *See id.* § 1.213-1(e)(1)(i) (“Expenses paid for ‘medical care’ shall include those paid for the purpose of affecting any structure or function of the body or for transportation primarily for and essential to medical care.”).

85. *See id.* § 1.213-1(e)(1)(ii) (allowing a deduction for artificial teeth).

medicine,⁸⁶ vacations and trips for general health improvement or health restorative purposes,⁸⁷ and dancing lessons.⁸⁸

The 10% floor in the medical expense deduction is a recent revision implemented under the Patient Protection and Affordable Care Act.⁸⁹ The prior floor was set at 7.5%, and 2013 is the first tax year in which the 10% floor will apply.⁹⁰ By raising the requisite AGI amount that medical expenses must surpass, a taxpayer now must either incur more medical care expenses, or have a lower AGI in order to claim the same deduction as compared to the 7.5% floor. While the ultimate effects remain unknown, an increase in the floor amount may make it more difficult for a taxpayer to benefit from the medical expense deduction than under the prior 7.5% floor.

B. *Obesity Is Now a Disease Under the Code*

1. Before Obesity Was Recognized as an Independent Disease Under the Medical Expense Deduction

Because no prior IRS ruling addressed whether deductions were allowable when a taxpayer suffered from obesity alone, the IRS decision in Revenue Ruling 2002-19 marked a milestone in medical care expenses under § 213.⁹¹ Traditionally, the IRS disallowed deductions for expenses incurred for participation in a weight-loss program and for purchasing exercise equipment because it found such expenses to normally be personal.⁹²

For instance, in 1979, the IRS denied a taxpayer's deduction for expenses associated with a weight-loss program when the taxpayer's doctor prescribed the weight-loss program as treatment to improve his health.⁹³ The taxpayer paid an initial fee to join a program and an additional fee to attend periodic meetings.⁹⁴ The participant developed a diet plan and received diet menus and instructional booklets, in addition to discussing problems encountered in dieting.⁹⁵ The IRS ruled that participation in the weight-loss program was "merely beneficial to the general health of [the] individual,"⁹⁶ and found that the taxpayer's treatment was not for the purpose of curing any specific disease, and therefore was a personal expense.⁹⁷ In coming to this

86. I.R.C. § 213(b) (2012).

87. Treas. Reg. § 1.213-1(e)(1)(iv).

88. *France v. Comm'r*, 40 T.C.M. (CCH) 508 (1980).

89. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 9013, 124 Stat. 119, 868 (2010), amended by Pub. L. No. 111-152, 124 Stat. 1029 (2010).

90. *Id.* § 9013(a), (c).

91. *Cf.* I.R.S. Priv. Ltr. Rul. 80-04-111 (Oct. 31, 1979) (allowing a deduction for participation in weight-loss program when the taxpayer suffered from hypertension, obesity, and had problems with his hearing, which were all directly related to the taxpayer's excessive weight).

92. *See* *Thoene v. Comm'r*, 33 T.C. 62, 65 (1959) (stating that weight-loss programs and purchasing exercise equipment did not "lose their identity as ordinary personal expenses").

93. Rev. Rul. 79-151, 1979-1 C.B. 116.

94. *Id.*

95. *Id.*

96. *Id.*

97. *Id.*

conclusion, the IRS did not address whether or not the taxpayer was normal weight, overweight, or obese, nor if the IRS would ever even consider obesity a disease.⁹⁸

In the same year, the IRS did permit a deduction for expenses associated with participation in a weight-loss program when the agency found that a taxpayer's excessive weight was directly responsible for "specific illnesses."⁹⁹ The taxpayer suffered from obesity, hypertension, and hearing problems, and two physicians found that the latter two diseases were a direct result of the taxpayer's excessive weight.¹⁰⁰ Each physician prescribed a weight-loss program as the taxpayer's treatment for all of the illnesses.¹⁰¹ The IRS found that the purpose of the taxpayer's participation in the weight-loss program was for the treatment and curing of "illnesses," not merely for the taxpayer's general health.¹⁰² However, the IRS did not address, whether, absent hypertension or a hearing problem, obesity alone would suffice as a "specific illness."¹⁰³ The IRS did not answer that question until 2002.¹⁰⁴

2. Revenue Ruling 2002-19

In 2002, the IRS issued Revenue Ruling 2002-19, and, for the first time, acknowledged obesity as a disease in its own right.¹⁰⁵ In its ruling, the IRS analyzed whether uncompensated amounts paid by taxpayers for participation in physician-prescribed weight-loss programs came within the definition of medical expenses and were therefore deductible.¹⁰⁶ The ruling considered two taxpayers, one diagnosed with hypertension and one diagnosed as obese, both of whom were directed to lose weight by their physicians.¹⁰⁷ Both taxpayers paid an initial fee to join a weight-loss program and an additional fee to attend periodic meetings.¹⁰⁸ They each developed a diet plan, received diet menus and additional literature, and discussed problems encountered in the process of dieting.¹⁰⁹

The IRS found for the first time that obesity was a "medically accepted" disease,

98. See *infra* Appendix for weight classification standards according to body mass index (BMI). BMI is the common method used to determine classification of overweight and obesity in adults. *E.g.*, *BMI Classification*, WORLD HEALTH ORGANIZATION, http://apps.who.int/bmi/index.jsp?introPage=intro_3.html (last visited Oct. 22, 2013). BMI is calculated by taking an individual's weight in kilograms and dividing that number by the square of the height in meters. *Id.* To classify as obese, an individual's BMI must be greater than or equal to thirty. *Id.*

99. I.R.S. Priv. Ltr. Rul. 80-04-111 (Oct. 31, 1979).

100. *Id.*

101. *Id.*

102. *Id.*

103. See *id.* (holding that the weight-loss program was deductible only because the program was for the treatment of hypertension, obesity, and hearing problems).

104. See Rev. Rul. 2002-19, 2002-1 C.B. 778 (holding that "[u]ncompensated amounts paid by individuals for participation in a weight-loss program as treatment for a specific disease or diseases (including obesity) diagnosed by a physician are expenses for medical care that are deductible under § 213").

105. *Id.*

106. *Id.*

107. *Id.*

108. *Id.*

109. *Id.*

just like hypertension, and as such, the taxpayer's cost of participation in the weight-loss program, as prescribed by a physician, was a medical expense within the meaning of § 213.¹¹⁰ The IRS supported its classification of obesity as a well-accepted disease because organizations such as The National Heart, Lung, and Blood Institute of the National Institute of Health (NIH), the Food and Drug Administration (FDA), and the World Health Organization (WHO) all acknowledge obesity as a disease.¹¹¹ The IRS allowed both participants to deduct their expenses under § 213 because the weight-loss program was the prescribed treatment for each taxpayer's disease—hypertension and obesity.¹¹²

The participants also requested a deduction under § 213 for the cost of their diet-food items.¹¹³ The IRS denied the deduction for the cost of purchasing the reduced-calorie food because the food was merely a substitute for what the taxpayers would normally have consumed to satisfy their nutritional requirements.¹¹⁴ Even though the reduced-calorie food was part of their treatment, the IRS followed precedent, which disallowed a food deduction, even if it was related to disease treatment, absent special circumstances.¹¹⁵

3. The Cost of Food is Generally Nondeductible as a Medical Care Expense

Generally, the cost of purchasing food or beverages does not qualify as a medical expense under § 213.¹¹⁶ The cost of any "special food" is nondeductible, unless the taxpayer can establish that particular circumstantial facts meet specific requirements.¹¹⁷ The cost of purchasing special food is for the purpose of medical care, and hence deductible, if: "(1) the food alleviates or treats an illness, (2) it is not part of the normal nutritional needs of the taxpayer, and (3) the need for the food is substantiated by a physician."¹¹⁸ Special foods that are a substitute for food the taxpayer normally consumes, and that satisfy the taxpayer's nutritional needs, are not for the purpose of medical care and thus nondeductible under § 213.¹¹⁹ If the taxpayer can meet all the requirements, the taxpayer may claim a deduction for the difference in cost between the amount of special foods purchased and the amount the taxpayer would normally pay for food.¹²⁰

110. *Id.*

111. *See id.* (noting that these various government and scientific entities all concluded after extensive research that obesity is a disease "in its own right").

112. *Id.*

113. *Id.*

114. *Id.*; *see also* Rev. Rul. 55-261, 1955-1 C.B. 307 (providing certain requirements for the cost of food to be classified as medical care).

115. *See* Rev. Rule. 55-261, 1955-1 C.B. 307 (explaining that the costs of special foods or beverages generally do not qualify as a medical expense); *cf.* *Von Kalb v. Comm'r.* 37 T.C.M. (CCH) 1511 (1979) (allowing a food deduction when taxpayer's hypoglycemia required her to consume more protein in a day than the average person).

116. Rev. Rul. 2002-19, 2002-1 C.B. 778 (citing Rev. Rul. 55-261, 1955-1 C.B. 307).

117. *Id.*

118. *Id.*

119. *Id.*

120. Rev. Rul. 55-261, 1955-1 C.B. 307.

The tax court, in *Flemming v. Commissioner*,¹²¹ denied a deduction for the costs of vitamins, mineral supplements, health foods, yogurt, and bottled water the taxpayer purchased for his spouse.¹²² The taxpayer's spouse was diagnosed with cancer, and the taxpayer purchased certain items based partially upon a booklet containing diet suggestions for cancer patients given to them from a doctor of dental surgery.¹²³ The taxpayer presented no evidence that any additional costs were incurred as a result of the food and supplement purchases: there was no evidence that the food and supplements alleviated the wife's cancer, the doctor was not a medical doctor, and the doctor never declared any of the purchases necessary.¹²⁴ Viewing all factors in totality, the tax court denied the taxpayer's deduction for all the expenses.¹²⁵

A taxpayer did receive a deduction for the purchase of special foods, however, when the taxpayer suffered from hypoglycemia, and two physicians found that the taxpayer had to consume extra protein to treat her disease.¹²⁶ The taxpayer consumed between six to eight servings of protein a day to mitigate her disease.¹²⁷ The tax court found that the diet of an average person did not include consuming as much as six to eight servings of protein a day, and that the primary purpose of the taxpayer's extra protein consumption was necessary to meet the "additional, 'abnormal' dietary needs caused by her disease."¹²⁸ As such, the additional costs to her normal food purchase amount, incurred as a result of her disease, were properly deductible under § 213.¹²⁹

4. The Future Impact of Obesity Under the Medical Expense Deduction

Since the IRS has acknowledged obesity as a disease in its own right, the agency has allowed taxpayers to deduct certain costs as medical care expenses that were previously disallowed as personal or living expenses.¹³⁰ For instance, when a physician recommended that a taxpayer purchase home-exercise equipment as part of the taxpayer's obesity treatment post-Revenue Ruling 2002-19, the IRS found that the cost of the home-exercise equipment was an acceptable nonpersonal deduction.¹³¹ Even though gym equipment is normally a nondeductible capital expenditure under § 263, the same expenditure incurred for medical care within the meaning of § 213 qualifies for an immediate deduction.¹³² The IRS explicitly disallowed these expenses before

121. 41 T.C.M. (CCH) 676 (1980).

122. *Flemming*, 41 T.C.M. (CCH) at 676.

123. *Id.*

124. *Id.* at 677.

125. *Id.* at 678.

126. *Von Kalb v. Comm'r*, 37 T.C.M. (CCH) 1511, 1512 (1978).

127. *Id.*

128. *Id.* at 1513 (quotation marks omitted).

129. *Id.* at 1514.

130. Rev. Rul. 2002-19, 2002-1 C.B. 778.

131. I.R.S. Priv. Ltr. Rul. 2003-0202 (April 8, 2003).

132. Treas. Reg. § 1.213-1(e)(iii) (1960); *see also* I.R.C. § 263 (2012) (providing that capital expenditures do not qualify for a tax deduction). The IRS allows for this exception in relation to § 213 by stating:

a capital expenditure made by the taxpayer may qualify as a medical expense, if it has as its primary purpose the medical care . . . of the taxpayer, his spouse, or his dependent. Thus, a [deductible]

Revenue Ruling 2002-19 because it held that exercise-related expenses were personal expenses, not medical expenses within the meaning of § 213.¹³³ The IRS's recognition of obesity as a disease could allow taxpayers to deduct the cost of home-exercise equipment if it is required to treat the illness—obesity—as prescribed by a physician.¹³⁴

A physician might also prescribe weight-loss medicine to treat obesity.¹³⁵ The costs of medicine or drugs are only deductible if the medicine or drug is prescribed for medical care to treat a disease.¹³⁶ Therefore, another new acceptable deduction, post-Revenue Ruling 2002-19, would be the cost of purchasing certain weight-loss drugs because obesity is now a § 213 disease.¹³⁷

Taxpayers must still establish that the obesity-related expenses are incurred for the purpose of treating the obesity, rather than promoting general health, and that the taxpayer would not have paid the expense but for this purpose.¹³⁸ Taxpayers who seek to deduct obesity-related fees as medical care expenses must meet certain objective factors to prove that the expenses are for medical care because many of these expenses have a personal component to them.¹³⁹ The IRS considers a list of objective factors, adopted from the Tax Court, when determining if an expense related to obesity treatment is a medical expense.¹⁴⁰ To sufficiently establish an expense as medical, rather than personal, the IRS looks to: (1) a taxpayer's motive or purpose for the expenditure, (2) a physician's diagnosis of a medical condition, (3) the physician's recommendation of the expense as treatment or mitigation, (4) the relationship between the treatment and the illness, (5) the treatment's effectiveness, and (6) the proximity in time to the onset or recurrence of a disease.¹⁴¹ Both the IRS and the tax court disallow medical expense deductions if a taxpayer would have paid the expense absent the medical condition.¹⁴²

capital expenditure . . . is related only to the sick person and is not related to permanent improvement or betterment of property, [and] otherwise [meets the other § 213 requirements].

Treas. Reg. § 1.213-1(e)(iii). Some examples include "eye glasses, a seeing eye dog, artificial teeth and limbs, a wheel chair, crutches, an inclinor or an air conditioner which is detachable from the property and purchased only for the use of a sick person, etc." *Id.*

133. *Thoene v. Comm'r*, 33 T.C. 62, 65 (1959).

134. *Cf.* Rev. Rul. 2002-19, 2002-1 C.B. 778 (holding that uncompensated amounts paid for a weight-loss program were deductible because they were specifically prescribed to treat a disease—obesity).

135. *See generally* NAT'L INST. OF DIABETES AND DIGESTIVE AND KIDNEY DISEASES, NAT'L INSTS. OF HEALTH, PRESCRIPTION MEDICATIONS FOR THE TREATMENT OF OBESITY (2010), available at <http://win.niddk.nih.gov/publications/prescription.htm>.

136. *See* I.R.C. § 213(a), (d) (2012) (generally authorizing the deduction of expenses incurred for medical care, defined as expenses incurred for the treatment or prevention of disease); *id.* § 213(b) (explicitly including amounts paid for prescription drugs within the allowance granted by subsection (a)). Insulin is deductible without a prescription. *Id.* § 213(b).

137. *Cf.* Rev. Rul. 2002-19, 2002-1 C.B. 778 (allowing deduction for uncompensated amounts paid for a weight-loss program primarily because they were specifically prescribed to treat a disease—obesity).

138. I.R.S. Priv. Ltr. Rul. 2003-0202 (April 8, 2003).

139. I.R.S. Priv. Ltr. Rul. 2010-0175 (June 25, 2010). Examples of medical care expenses that also have a personal component include gym membership and health-club fees. *Id.*

140. I.R.S. Priv. Ltr. Rul. 2010-0175; *Havey v. Comm'r*, 12 T.C. 409, 412 (1949).

141. I.R.S. Priv. Ltr. Rul. 2010-0175.

142. *Jacobs v. Comm'r*, 62 T.C. 813, 820 (1974); I.R.S. Priv. Ltr. Rul. 2010-0175.

A likely expense amongst obesity-related treatment includes health club and gym membership fees. The IRS established specific criteria to consider if any taxpayer seeks to deduct gym fees as part of disease treatment, not just those suffering from obesity. For gym membership fees to qualify as a deduction, a taxpayer must establish that: “[a] physician diagnosed the taxpayer with a specific disease, [t]he taxpayer uses the gym to treat the specific disease, [and t]he taxpayer would not incur the gym fees but for the specific disease.”¹⁴³

When seeking to deduct expenses for participation in a weight-loss program, gym fees, or home-exercise equipment, a taxpayer must further establish that there is a limited availability of alternatives to the taxpayer’s chosen weight-loss treatment, even when a doctor prescribes such treatment.¹⁴⁴ In each determination, the IRS considers the surrounding facts and circumstances particular to the taxpayer’s situation.¹⁴⁵ For instance, when the agency considers if health-club membership fees constitute medical treatment within § 213, the IRS will consider the health club’s location; if an alternative, less expensive health club is accessible from the taxpayer’s home; the types of activities available to the taxpayer; the type of services available at the health club facility; and if the taxpayer could safely fulfill the prescribed exercise treatment without joining a health club.¹⁴⁶ All factors taken in totality therefore satisfy the IRS that the costs were incurred for medical—not personal—care.

C. *Costs Incurred for Medical Care Under the Code*

1. Distinguishing Between Medical Care and Personal Expenses

In prior rulings and case law, the IRS and tax court laid foundational principles providing guidance on how to distinguish between expenses falling within the definition of medical expenses, and those that are nondeductible personal or living expenses.¹⁴⁷ Shortly after the inception of the medical expense deduction, *Havey v. Commissioner*¹⁴⁸ held that personal expenses may be “highly and directly beneficial to . . . general health,” but lack any relation to “diagnosis, cure, mitigation, treatment, or prevention of disease.”¹⁴⁹ The court found that the identifying factor that validates a medical expense deduction is whether the expenses were incurred *primarily* for medical care.¹⁵⁰ *Havey* found that expenses that were only helpful in treating a taxpayer’s disease, did not cross the dividing line into medical care and were thus personal expenses.¹⁵¹

143. I.R.S. Priv. Ltr. Rul. 2010-0175.

144. I.R.S. Priv. Ltr. Rul. 2002-0077 (June 28, 2002).

145. *Id.*

146. *Id.*

147. See generally *Flemming v. Comm’r*, 41 T.C.M. (CCH) 676 (1980); *Thoene v. Comm’r*, 33 T.C. 62 (1959); *Havey v. Comm’r*, 12 T.C. 409 (1949).

148. 12 T.C. 409 (1949).

149. *Havey*, 12 T.C. at 411–12 (stating that record does not link treatment of coronary occlusion with change of climate when taxpayer attempted to deduct expenses at New Jersey hotel and ranch in Arizona).

150. *Id.* at 413.

151. *Id.*

It is essential to keep in mind that not all expenditures prescribed by a physician are definitively medical expenses.¹⁵² Expenses must always be primarily for the prevention or alleviation of a physical or mental defect.¹⁵³ Where an expense merely serves the convenience of the taxpayer, it is not considered a medical expense.¹⁵⁴ Regardless of the presence of a prescription, an expense may be classified as a personal, living, or family expense, which is strictly nondeductible under § 262 of the Code, if it lacks relation to true medical care.¹⁵⁵

Many factors determine whether an expense qualifies primarily as a deductible medical expense or a nondeductible personal expense. Motive or purpose of the taxpayer is important, but not determinative, because giving motivation or purpose conclusive weight subsumes the disallowance for personal expenses.¹⁵⁶ The origin of the expense must also be considered.¹⁵⁷ This inquiry requires asking a number of questions such as: was it incurred by direction of a physician? Did the treatment directly bear on the physical condition at issue? Was the treatment close in time to the onset or reoccurrence of the disease or condition to substantiate a relationship between the two? Do the surrounding circumstances eliminate the inference that the expense was incurred for general, rather than physical, improvement?¹⁵⁸

When a taxpayer does not currently have a disease, and incurs expenses as a preventative measure, a deduction requires that the treatment have a proximate relationship to the “diagnosis, cure, mitigation, . . . or prevention of disease.”¹⁵⁹ To qualify as preventative, there must be a present existence or *imminent probability* of developing an identifiable disease, physical or mental defect, or illness.¹⁶⁰ An expense merely benefitting general health, meaning it does not decrease the likelihood of disease onset or proximately cure or mitigate an existing disease, is not an expenditure for medical care.¹⁶¹

The specific disallowance of cosmetic surgery from the definition of allowable medical expenses exemplifies the tax law principle against personal expense

152. *Seymour v. Comm’r*, 14 T.C. 1111, 1117 (1950).

153. *See Altman v. Comm’r*, 53 T.C. 487, 489 (1969) (finding that doctor’s recommendations of playing golf for exercise and increasing oxygen intake when taxpayer had pulmonary emphysema nondeductible because playing golf was not necessary to get proper treatment of light exercise).

154. *Worden v. Comm’r*, 42 T.C.M. (CCH) 399, 400 (1981). *Compare id.* (rejecting deduction for costs of constructing a pool when it contained no special equipment to aid taxpayer with physical therapy but was merely convenient to help taxpayer exercise), with *Mason v. United States*, 52 A.F.T.R. 1593 (D. Haw. 1957) (allowing a deduction for cost of constructing swimming pool because it was specially designed to provide hydrotherapy and included a ramp which allowed taxpayer access to the pool from a wheelchair).

155. I.R.C. § 262(a) (2012); *see also Haines v. Comm’r*, 71 T.C. 644, 646–47 (1979) (stating test to determine when medical care expenses are not personal is whether expenditures were incurred for the “primary purpose” of, and were “related directly to,” medical care).

156. *Havey*, 12 T.C. at 412.

157. *Id.*

158. *Id.*

159. I.R.C. § 213(d)(1)(A); *see also Havey*, 12 T.C. at 411–12 (rejecting deduction when it was shown that though a change in climate and vacations may be conducive to general health, the taxpayer did not show how a change in climate served to cure or alleviate existing heart condition).

160. *Daniels v. Comm’r*, 41 T.C. 324, 327–28 (1963).

161. Treas. Reg. § 1.213-1(e)(1)(ii).

deductions.¹⁶² The Code defines cosmetic surgery as any procedure meant to improve the patient's appearance, which does not meaningfully promote proper body functioning, or prevents or treats any illness or disease.¹⁶³ The only exception to the general bar against a cosmetic surgery deduction exists when "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."¹⁶⁴ As an example, a taxpayer who undergoes breast reconstructive surgery following a mastectomy that removed the breast as part of the taxpayer's cancer treatment would meet this exception.¹⁶⁵ The breast removal qualifies as a deformity directly related to a disease—cancer—and the breast reconstruction ameliorates the deformity; thus, related, reasonable costs incurred to correct the abnormality qualify as a medical care expense within the meaning of § 213(d).¹⁶⁶

2. Disease Determination For Purposes of § 213

For an expense to qualify as deductible medical care, there has to be the presence or imminent likelihood of the person developing a disease, defect, or illness.¹⁶⁷ It therefore follows that a condition must be classified as a disease, defect, or illness before any expenditure can be considered deductible under § 213. "Disease," as used in § 213, "must be resolved by the Court, using settled principles of statutory construction, including reference to the Commissioner's interpretive regulations, the legislative history, and case law precedent."¹⁶⁸

There are a variety of ways a condition is deemed to qualify as a "disease" within § 213. Such determinations include Supreme Court interpretations,¹⁶⁹ scientific evidence,¹⁷⁰ and case law.¹⁷¹ Further, all interpretative sources acknowledge that § 213 diseases include both physical and mental defects.¹⁷² A listing of the condition in a medical reference text may be sufficient to classify a condition as a disease, but a listing is not necessary.¹⁷³ Diseases need not have an "organic or physiological origin

162. I.R.C. § 213(d)(9)(A).

163. *Id.* § 213(d)(9)(B).

164. *Id.* § 213(d)(9)(A).

165. Rev. Rul. 2003-57, 2003-1 C.B. 959.

166. *Id.*

167. *Daniels v. Comm'r*, 41 T.C. 324, 327-28 (1963).

168. *O'Donnabhain v. Comm'r*, 134 T.C. 34, 56 (2010).

169. *E.g.*, Rev. Rul. 72-226, 1972-C.B. 96 (classifying an addiction to narcotics as a disease and allowing for related expenses for treatment because the Supreme Court held such in *Linder v. United States*, 268 U.S. 5 (1925)).

170. *E.g.*, Rev. Rul. 99-28, 1999-1 C.B. 1269 (classifying an addiction to nicotine as a disease and allowing for related treatment expenses when Surgeon General report and further scientific studies established nicotine as addictive and smoking as detrimental to health).

171. *E.g.*, *O'Donnabhain*, 134 T.C. at 56-57 (citing numerous tax court decisions finding that mental conditions are "diseases" where mental health professionals regarded the condition as creating a significant impairment to normal functioning and warranting treatment).

172. See Treas. Reg. § 1.213-1(e)(ii) (allowing deductions under § 213 for expenses resulting from both physical and mental illnesses).

173. *O'Donnabhain*, 134 T.C. at 59 (finding a disease in the context of mental conditions may be

or cause” to qualify as a disease for § 213 purposes.¹⁷⁴

Similar to the IRS’s determination of obesity as a new § 213 disease, the tax court had to recently analyze whether Gender Identity Disorder (GID) was a new § 213 disease for the first time in *O’Donnabhain v. Commissioner*.¹⁷⁵ The court held that GID was a § 213 disease and allowed the taxpayer to deduct the related expenses which satisfied other § 213 requirements, despite the IRS’s assertion that GID was not a disease.¹⁷⁶ As a result, the taxpayer deducted the cost of the taxpayer’s hormone therapy and sex-reassignment surgery.¹⁷⁷ In classifying GID as a recognizable disease for § 213 purposes, the tax court found it significant that: (1) “GID [was] is listed as a mental disorder in the DSM–IV–TR” and that all testifying experts agreed that the DSM–IV–TR “[was] the primary diagnostic tool of American psychiatry”;¹⁷⁸ (2) absent treatment, GID is sometimes associated with self-mutilation and suicide; and (3) seven federal circuit courts concluded that GID treatment “constitutes a serious medical need for purposes of the Eighth Amendment”—which proscribes the deliberate indifference to a prisoner’s serious medical needs—because indifference to GID constitutes unnecessary and wanton infliction of pain.¹⁷⁹ The court stated that even if “diagnosis [of GID] is subject to some debate in the psychiatric profession, the widespread recognition of the condition in medical literature persuade[d] the Court” that the prevailing view is acceptance of GID as a disease.¹⁸⁰

Further, the IRS recently issued an Action on Decision regarding *O’Donnabhain* and acquiesced in the tax court’s decision.¹⁸¹ Because the IRS acquiesced to the *O’Donnabhain* decision, it now not only accepts the court’s holding that GID is a § 213 disease, but it will follow the outcome in future cases with sufficiently similar facts.¹⁸² While acquiescence does not indicate approval or disapproval of the reasoning behind the decision, the court’s decision and IRS’s acquiescence allow for an expanded application of the medical expense deduction to a “new” disease.¹⁸³ This exemplifies the ability of the IRS and tax court to interpret “disease” broadly.

D. *The Argument Over Obesity as a Disease and Epidemic*

Though the IRS classified obesity as a disease, a debate still exists in terms of scientific and social facts as to its status,¹⁸⁴ which could potentially lead to a challenge

satisfied by either a determination of a mental health professional or a listing of the condition in a medical text, such as the DSM–IV–TR).

174. *Id.* at 56. To have an organic or physiological origin or cause would require a medically based etiology to classify a condition as disease. *Id.* at 58.

175. 134 T.C. 34 (2010).

176. *O’Donnabhain*, 134 T.C. at 59.

177. *Id.* at 34.

178. *Id.* at 60.

179. *Id.* at 60–62.

180. *Id.* at 60.

181. I.R.S. Action on Decision I.R.B. 2011-47 (Nov. 21, 2011).

182. *Id.*

183. *Id.*

184. Abigail C. Saguy & Kevin W. Riley, *Weighing Both Sides: Morality, Mortality, and Framing Contests over Obesity*, 30 J. HEALTH POL. POL’Y & L. 869, 869 (2005).

of the IRS's obesity classification. Two groups, loosely led by social activists and scientific researchers, are at the center of this debate: the "fat acceptance" group and the "antiobesity" group.¹⁸⁵ The antiobesity group frames obesity as an illness and epidemic, analogizing obesity with other high-risk behaviors, like smoking,¹⁸⁶ which supports the IRS's determination. They argue that body weight is within a person's control, and that people not only have a medical responsibility to treat their excessive weight, but a moral responsibility as well.¹⁸⁷ The fat acceptance group rejects obesity as an epidemic.¹⁸⁸ They view obesity as a natural and largely inevitable form of body diversity,¹⁸⁹ and contend that one can be healthy or fit at any size, and a fat body does not necessarily indicate ill health any more than a thin body.¹⁹⁰

The main points of contention in the debate are: What is an ideal weight and can one even exist? Why do people gain weight? Why do some people weigh more than others? Does weight loss really improve health?¹⁹¹ What is the accurate rate at which obesity is really increasing?¹⁹² While the two groups dispute over the same main issues, their call to action is different.

The fat acceptance group frames obesity as a form of body diversity, hoping to build on US tradition of antidiscrimination and equal rights.¹⁹³ Much of their research tries to show a genetic and biological basis for obesity.¹⁹⁴ So if one assumes that weight is a biological fact of life, and largely outside of one's personal control, then raising the issue of health risks associated with obesity has little practical effect; it may instead worsen the stigma and discrimination against fat people.¹⁹⁵ Fat acceptance camps demand equal rights and challenge different treatment of obese individuals as discriminatory, since they view obesity as a diverse and natural body form, analogous to a lack of choice in being black or gay.¹⁹⁶

Formally created fat acceptance organizations seek to combat everyday discrimination by advocating for specific changes, such as making seatbelt extenders mandatory in cars, finding alternative solutions for people too large to fit in one airline seat instead of charging a passenger for two, and making magnetic resonance imaging machines large enough for someone over 350 pounds.¹⁹⁷ According to this group's

185. *Id.* at 869–70.

186. *Id.* at 870.

187. *Id.*

188. *Id.* at 870; *see also* Rogan Kersh & James Morone, *How the Personal Becomes Political: Prohibitions, Public Health, and Obesity*, 16 *STUD. IN AM. POL. DEV.* 162, 170 (2002) (stating that various "body-acceptance movements" began in opposition to the social disapproval of obese individuals).

189. Saguy & Riley, *supra* note 184, at 869–70.

190. *Id.* at 896.

191. *Id.* at 874.

192. *Id.* at 882.

193. *Id.* at 882; *see also* Martin et al., *supra* note 14, at 336 ("Discrimination against the obese is rampant . . .").

194. Saguy & Riley, *supra* note 184, at 883.

195. *Id.*; *see also* Kersh & Morone, *supra* note 188, at 169 (acknowledging the overweight Americans face prejudice due to their weight).

196. Saguy & Riley, *supra* note 184, at 882.

197. *Id.* at 878.

viewpoint, the IRS's position would further stigmatize and discriminate against obese individuals, and any "treatment" costs simply cannot exist under this model because fat acceptance proponents do not view the condition of obesity as a disease.¹⁹⁸

The antiobesity group frames obesity as a "risky behavior,"¹⁹⁹ which espouses the idea that weight is under one's personal control and that fat people have an unhealthy lifestyle.²⁰⁰ The antiobesity group generally recognizes that body weight is not completely under one's personal control, but contends that remedies still exist for obese people.²⁰¹ For the antiobesity proponents, weight-loss studies showing any percentage of weight-loss success demonstrate that permanent weight loss is possible—it is just difficult.²⁰² Antiobesity proponents argue that weight-loss methods mainly fail because "people are not truly committed to them" and "most people do not monitor their weight at all."²⁰³

JoAnn Manson, a Harvard epidemiologist, put it this way, "people 'know if they were to get up off the couch and do some more walking . . . it would be helpful to them, but they just don't feel like it.'"²⁰⁴ Rather, every day "they *make a choice* to buy 'the Big Mac and French fries instead of a salad or roasted chicken.'"²⁰⁵ The antiobesity camps demand public intervention, research funding, and private action to help combat what they view as "an alarming health threat,"²⁰⁶ concluding that dietary intervention and increased exercise, are at least partial solutions to the epidemic.²⁰⁷

198. Fat acceptance groups do not view obesity as a disease, even with the presence of increased health risks. *Id.* at 870. Rather they view obesity as a product of genetics, and analogize it to the color of one's skin, and believe that the condition does not need to be treated. *Id.* at 870–72. Thus, according to this view, obesity fails to qualify under § 213. *Cf.* I.R.C. § 213(d)(1)(A) (2012) (requiring demonstration of costs incurred for the "diagnosis, cure, mitigation, treatment, or prevention" of the disease); Rev. Rul. 79-66, 1979-1 C.B. 114 (1979) (holding that § 213 requires "the present existence or the imminent probability of a disease" (quoting *Stringham v. Comm'r*, 12 T.C. 580 (1949), *acq.*, 1950-2 C.B. 4, *aff'd per curiam*, 183 F.2d 579 (6th Cir. 1950)). It can be argued, however, that obesity and overweight, as genetically based conditions, are no different than a disease such as cancer because many cancers have a genetically based origin and present increased health risks and complications; however, cancer treatment is a § 213 deduction, and where cancer patients have brought discrimination claims (for example, under the Americans with Disabilities Act (ADA)), those claims have been largely rejected. *See, e.g.*, *Treiber v. Lindbergh Sch. Dist.*, 199 F. Supp. 2d 949, 961 (E.D. Mo. 2002) (holding that stage II breast cancer was not a "disabling impairment" under the ADA); Jane Byeff Korn, *Cancer and the ADA: Rethinking Disability*, 74 S. CAL. L. REV. 399, 412–33 (2001) (discussing the difficulties cancer survivors face in bringing claims pursuant to the ADA's discrimination standard). *But see* *Haley v. Community Mercy Health Partners*, No. 3:11-cv-232 (WHR), 2013 WL 322493, at *10-12 (S.D. Ohio, Jan. 28, 2013) (failing to reject the fact that cancer substantially limits the major life activity of normal cell growth pursuant to the ADA Amendment Acts of 2008, and calling *Treiber* into question).

199. Saguy & Riley, *supra* note 184, at 883–84.

200. *Id.*

201. *Id.*

202. *Id.*

203. *Id.* Walter Willett, a Harvard epidemiologist and antiobesity researcher, says that mainly overweight people "are [not] seriously thinking of weight loss," but those that do take weight loss seriously "lose weight and keep it off." *Id.*

204. *Id.* at 884–85 (omission in original) (quoting JoAnn Manson).

205. *Id.* at 885.

206. *Id.* at 877.

207. *Id.* at 884.

Such proponents would support the IRS's recognition of obesity as a disease because joining a gym or weight-loss program can be effective in treating the disease—obesity.

E. A Nationwide Call to Action

Before 2002, the IRS ruled that taxpayers' weight-loss treatments were "merely beneficial to the general health" of taxpayers, and not acceptable medical expense deductions.²⁰⁸ Notably, the IRS never considered or even mentioned in its determinations whether or not the taxpayer was of normal weight, overweight, or obese.²⁰⁹ Revenue Ruling 2002-19 announced the IRS's stance on this issue when it allowed a deduction for a weight-loss program under the medical expense deduction when the taxpayer was obese, and the taxpayer's physician prescribed the weight-loss program as the treatment for the obesity.²¹⁰ Such a new and controversial stance begs the question: What changed?

When the IRS issued its 2002 ruling, the issue of weight-related health concerns reached across America and infiltrated modern-day society as an alarming problem nonexistent in prior decades.²¹¹ The Surgeon General issued the first ever Call to Action in 2001 to focus our country's attention on the fact that the rate of overweight and obesity amongst the US population officially reached "epidemic proportions."²¹² For an individual to be classified as overweight, he must have a body mass index (BMI) greater than or equal to twenty-five, and to be classified as obese, BMI must be equal to at least thirty.²¹³ In 2001, when the Surgeon General declared that our country had an epidemic of overweight and obesity on its hands, the US population had "nearly twice as many overweight children and almost three times as many overweight adolescents" as compared to figures from 1980.²¹⁴

Since the Surgeon General's Call to Action in 2001, incidents of overweight and obesity have maintained their prevalence.²¹⁵ As of 2006, approximately 65% of adults were overweight, and about 33% of adults were obese in the United States.²¹⁶ These alarmingly high numbers place America as the fattest economically advanced country

208. *E.g.*, Rev. Rul. 79-151, 1979-1 C.B. 116.

209. *Id.* See *infra* Appendix for a complete breakdown of BMI and weight classification.

210. Rev. Rul. 2002-19, 2002-1 C.B. 778.

211. U.S. DEP'T OF HEALTH & HUMAN SERVS., OFFICE OF THE SURGEON GEN., THE SURGEON GENERAL'S CALL TO ACTION TO PREVENT AND DECREASE OVERWEIGHT AND OBESITY, at v (2001), available at <http://www.surgeongeneral.gov/topics/obesity/calltoaction/message.htm> [hereinafter CALL TO ACTION].

212. Satcher, *supra* note 8, at xiii. The Surgeon General acknowledges that obesity and overweight are not infectious diseases, but nevertheless classifies them as an epidemic based on the surging rates of obesity and overweight amongst Americans. *Id.*

213. See *infra* Appendix for a complete listing of weight classifications based on BMI.

214. Satcher, *supra* note 8, at xiii.

215. See Press Release, U.S. Dept. of Health & Human Servs., HHS Secretary and Surgeon General Join First Lady to Announce Plans to Combat Overweight and Obesity and Support Healthy Choices (Jan. 28, 2010), available at <http://www.hhs.gov/news/press/2010pres/01/20100128c.html> ("The prevalence of obesity has more than doubled among adults and has tripled among children and adolescents from 1980 to 2004.")

216. Matthew D. McHugh, *Fit or Fat? A Review of the Debate of Deaths Attributable to Obesity*, 23 PUB. HEALTH NURSING 264, 264 (2006).

in the world.²¹⁷ From 1980 to 2005, the rate of obesity among adults, aged twenty to seventy-four, increased from 13% to 31%.²¹⁸ The most extreme category of BMI,²¹⁹ extreme obesity (or obese class III), quadrupled among adults from 1986 to 2000.²²⁰

Beyond the increase in overweight and obesity prevalence, the costs related to excessive weight in the United States are staggering.²²¹ In 2000 alone, the indirect and direct costs attributed to obesity amounted to \$117 billion.²²² As a result of such staggering health and economic figures, obesity and overweight came to the forefront of our nation's health concerns in the new millennium.²²³

In his Call to Action, the Surgeon General specifically called upon government agencies to assist in reducing the prevalence of overweight and obesity and help combat the US obesity epidemic.²²⁴ To achieve this goal, the Call to Action identified five overarching principles:

- Promote the recognition of overweight and obesity as major public health problems.
- Assist Americans in balancing healthful eating with regular physical activity to achieve and maintain a healthy or healthier body weight.
- Identify effective and culturally appropriate interventions to prevent and treat overweight and obesity.
- Encourage environmental changes that help prevent overweight and obesity.
- Develop and enhance public-private partnerships to help implement this vision.²²⁵

Revenue Ruling 2002-19 can be seen as a government response to the Call to Action, at least indirectly, because it addresses the IRS's acceptance of obesity as a disease for tax purposes, and provides a tax benefit to taxpayers seeking to treat their disease on the individual level. It is also significant that the IRS accepted obesity as a disease for the first time less than a year after the Call to Action was issued. Both government announcements discuss the alleviation of the disease of obesity, one calling for action and assistance from the government and citizens, and the other acting in

217. Nanci Hellmich, *Study: USA is Fattest Among Advanced Countries*, USA TODAY, Sept. 24, 2010, at 2A.

218. Edward W. Gregg et al., *Secular Trends in Cardiovascular Disease Risk Factors According to Body Mass Index in US Adults*, 293 J. AM. MED. ASS'N 1868, 1868 (2005).

219. See *infra* Appendix for classification.

220. Rogan Kersh & James A. Morone, *Obesity, Courts, and the New Politics of Public Health*, 30 J. HEALTH POL. POL'Y & L. 839, 842 n.3 (2005) (classifying a BMI of forty or higher as severe obesity).

221. See Sarah Sampsel & Jeanette May, *Assessment and Management of Obesity and Comorbid Conditions*, 10 DISEASE MGMT. 252, 253 (2007) (stating that obesity related costs amount to \$117 billion).

222. *Id.*

223. Tommy G. Thompson, *Message from the Secretary*, in U.S. DEP'T OF HEALTH & HUMAN SERVS., OFFICE OF THE SURGEON GEN., THE SURGEON GENERAL'S CALL TO ACTION TO PREVENT AND DECREASE OVERWEIGHT AND OBESITY, at xi (2001).

224. Satcher, *supra* note 8, at xiii-iv.

225. CALL TO ACTION, *supra* note 211, at v.

acknowledgement of the disease.

III. DISCUSSION

This Discussion begins by evaluating how, in light of the negative health factors now known to be associated with obesity and overweight conditions and their high rate of prevalence, obesity and overweight can and should be read as § 213 diseases. It explains that, in addition to being an independent disease, the Code can classify “pre-obese” treatment as preventative under § 213 as well.²²⁶ This Discussion establishes how the IRS has indicated its support for the treatment of public health concerns in the past, and how providing a tax benefit for overweight and obesity is merely an extension of the agency’s relationship with public health. This Discussion finds that the legislative policy and purpose of the medical expense deduction supports providing a tax benefit for obese and overweight treatment. It then proposes that under an alternative theory of a proper tax base, both overweight and obesity treatment reflect proper deductions from the tax base.

This Discussion explains that the classification of both overweight and obesity as diseases withstands even the most rigorous analysis of disease classification by the tax court. The Discussion continues to address why deductible medical treatment should include a nonexhaustive list of acceptable treatment expenses for pre-obesity and obesity, and how a holistic approach to disease treatment most adequately addresses the tax benefit’s intent and purpose. The tax benefit provided for obesity and overweight is well within the purview of well-established tax policies. The Discussion concludes by noting that using the Code as a vehicle for implementing public health policy is an effective and efficient response to the epidemic of obesity and overweight. It acknowledges that there are other routes to implement a national policy aimed at decreasing the prevalence of obesity and overweight, but explains how providing a tax benefit for taxpayers seeking treatment of their excessive weight provides a foundational piece of a holistic, national policy against the public health crisis.

A. *The Medical Expense Deduction Should Be Read to Include a Pre-Obese Condition*

The IRS ruling in 2002 may be seen as a direct response to the Surgeon General’s Call to Action in combating the obesity and overweight epidemic.²²⁷ While it is praiseworthy of the IRS to help promote public health policy by allowing a deduction for an obese taxpayer seeking treatment, the sad fact of the matter is that by the time a person becomes obese, it is extremely difficult to successfully lose weight and prevent the onset of other serious medical diseases.²²⁸ Therefore the line for deductions related

226. The terms pre-obese and overweight are used interchangeably, and have the same BMI criterion of 25.00–29.99 according to the WHO. *Global Database of Body Mass Index*, WORLD HEALTH ORG., <http://apps.who.int/bmi> (last updated Aug. 22, 2013).

227. See *supra* Part II.E for reasons why the IRS’s inclusion of obesity as a disease can be seen as responsive to the Surgeon General’s Call to Action.

228. See Priya Sumithran et al., *Long-Term Persistence of Hormonal Adaptations to Weight Loss*, 365 *NEW ENG. J. MED.* 1597, 1598 (2011) (describing the mechanisms that make it difficult for people to lose weight once obese).

to excessive weight needs to exist before obesity—for example, at overweight—which has not been allowed since the IRS issued its 2002 ruling. Just like obesity, overweight has reached epidemic proportions in the United States²²⁹ and is associated with a high level of comorbidities.²³⁰ By allowing taxpayers to deduct medical expenses, whether they are obese or overweight, the IRS will more successfully effectuate the policy aimed at combating obesity *and* overweight because it will encourage both obese and overweight taxpayers to take personal action against their condition.²³¹ In the alternative, even if it is questionable as to whether overweight is a § 213 disease, because obesity is a disease in its own right, § 213 can and should be read to include overweight as a condition indicating the “imminent probability of a disease”—obesity.²³² Under either method of acceptance, allowing this deduction is within the scope of tax policy and law, and further promotes all of the Surgeon General’s overarching principles.²³³

1. Overweight is a Disease in its Own Right

The IRS based its acceptance of obesity as a disease under the medical expense deduction by referring to the NIH’s classification of obesity as a disease, and the numerous negative consequences associated with obesity that are outlined in an NIH Publication.²³⁴ In that same publication, however, the NIH also included the condition of overweight as “pos[ing] a major public health challenge,” and noted that rates of both obesity and overweight have risen significantly in recent decades.²³⁵ In fact, both conditions substantially raise the risk of comorbidities and are major contributors to preventable death.²³⁶

Overweight and obesity are associated with increased rates of mortality, and as such, the NIH proposed the same form of treatment and reasons for treating both obese and overweight individuals.²³⁷ In referring to obesity and overweight, then-Secretary of the Department of Health and Human Services, Tommy G. Thompson, stated that our nation has “tremendous opportunities to prevent the unnecessary disease and disability that *they* portend for our future.”²³⁸ Further, the Surgeon General, in his Call to Action, announced that overweight, in addition to obesity, had reached epidemic proportions.²³⁹

Therefore, the very reasons that the IRS found conclusive enough to include

229. Satcher, *supra* note 8, at xiii.

230. Sampsel & May, *supra* note 221, at 253.

231. See *infra* Part III.G.3 for an explanation of how a tax benefit can incentivize taxpayers to seek treatment.

232. Stringham v. Comm’r, 12 T.C. 580, 584 (1949), *acq.*, 1950-2 C.B. 4, *aff’d per curiam*, 183 F.2d 579 (6th Cir. 1950).

233. See *supra* notes 224–25 for a discussion of the Surgeon General’s five overarching principles in the fight against obesity.

234. Rev. Rul. 2002-19, 2002-1 C.B. 778 (citing CLINICAL GUIDELINES, *supra* note 3, at xi).

235. CLINICAL GUIDELINES, *supra* note 3, at xi.

236. *Id.*

237. *Id.* at xi–xii.

238. Thompson, *supra* note 223, at xi (emphasis added).

239. Satcher, *supra* note 8, at xiii.

obesity as a § 213 disease equally apply to the condition of overweight. Both conditions are indicators of poor health, are preventable, and exist at epidemic proportions.²⁴⁰ Because overweight, in addition to obesity, currently exists at an alarmingly high rate, and is expected to remain at its currently high incidence rate unless action is taken, it should also be considered a disease in its own right under § 213. Allowing a deduction for overweight and obesity more accurately reflects the current public health crisis²⁴¹ and may more effectively combat the epidemic.²⁴² As such, both conditions should be classified as § 213 diseases.

2. Overweight is Indicative of an Imminent Probability of a Disease

If overweight is not considered an independent disease, the IRS and the tax court can and should expand the obesity-treatment deduction, and interpret the provision to include pre-obese treatment as preventative for the first time.²⁴³ A preventative approach would allow a taxpayer to deduct costs associated with losing weight, even before the taxpayer is in fact obese. This prevention-focused deduction would inhibit the onset of obesity and additional comorbidities associated with it.²⁴⁴ Comorbidities associated with obesity include a broad list of conditions and diseases such as cancer, hypertension, diabetes, joint disease, stroke, high cholesterol, breathing difficulties, sleep apnea, and gallbladder problems.²⁴⁵ This expanded interpretation finds justification in both the medical and tax field.²⁴⁶

In a study led by Dr. Albert Stunkard, an expert in the field of weight and eating disorders, no more than five percent of obese patients actually receiving weight-loss treatment succeeded at losing as many as fifty pounds, and only twenty-five percent of patients lost as many as twenty pounds.²⁴⁷ While these figures may be classified as mildly successful at best, it is important to note that they only include obese individuals who sought a treatment assistance plan and maintained a commitment to that program.²⁴⁸ It does not consider those individuals who quit the treatment plan or those who never sought a formal treatment plan, but instead attempted extreme weight loss alone.²⁴⁹ Stunkard further noted that most obese people do not even enter into treatment

240. See generally CALL TO ACTION, *supra* note 211.

241. See *supra* Part II.E for a discussion on how obesity and excess weight are part of the public health crisis.

242. See *infra* notes 243–46 and accompanying text for an explanation of how treating overweight, in addition to obesity, can be more effective than obesity treatment alone.

243. Rev. Rul. 2002-19, 2002-1 C.B. 778.

244. See Sampsel & May, *supra* note 221, at 253 (stating that common comorbidities are cancer, cardiovascular disease, and diabetes).

245. *Id.*

246. See *infra* notes 247–50 and accompanying text for an explanation of the low success of weight loss once a person is already obese and the inclusion of remedial treatment into the medical care expense deduction.

247. Albert J. Stunkard, *Presidential Address—1974: From Explanation to Action*, 37 PSYCHOSOMATIC MED. 195, 196 (1975).

248. *Id.*

249. *Id.*

for their obesity, and even when they do, most do not remain.²⁵⁰ Such expert opinion suggests that treatment aimed at obesity alone may be an uphill battle of success, with a low chance of actually overcoming the epidemic. Finding just the right line where treatment for excessive weight can result in successful weight loss is not one for tax law to decide. In the face of such medical data, however, it is reasonable to infer that the line exists somewhere before the onset of obesity, and setting the threshold at the point of pre-obesity is appropriate as both an effective and administrable tax policy.

Allowing a deduction for the costs incurred to prevent obesity, before its onset, is supported by other lines of IRS Rulings, which allow a deduction for preventative measures, not only remedial treatment.²⁵¹ In Revenue Ruling 79-66, the IRS allowed a medical expense deduction for a taxpayer to prevent lead poisoning when surfaces of the taxpayer's home had high-level lead-based paint readily accessible to children.²⁵² The IRS stated that lead poisoning was a disease of national concern, particularly prevalent in young children.²⁵³ It found that where a young child lived in a residence with lead-based surfaces, and the child has, or had, lead poisoning or undue lead absorption, certified by a doctor, "[a] present existence or the imminent probability of a disease" existed.²⁵⁴ Because a child need not have lead poisoning at the time the taxpayer incurs the expense, this particular application of the medical expense deduction has both a preventative and a remedial purpose, depending on the timing of the expense.

The same reasoning should apply to expenses incurred for the treatment of overweight and obese taxpayers. Deductions for the treatment of obesity and overweight, such as the cost of weight-loss programs and gym membership fees, should aim to serve both a remedial and preventative purpose. Thus, an overweight taxpayer should also be able to deduct weight-loss related expenses, since the treatment of an overweight condition may be classified as treating the "imminent probability of a disease"²⁵⁵—obesity. To encompass both a remedial and preventative purpose, the IRS should allow obese and overweight taxpayers to deduct these expenses so that they may not only cure and mitigate a current obese condition, but prevent the disease as well.

Further, preventative measures undertaken by the taxpayer to achieve a healthy weight can be even more impactful in terms of curbing the obesity epidemic. Some individuals may become overweight or obese because of a genetic predisposition; however, in most cases, the taxpayer's overweight or obesity results from societal and behavioral factors.²⁵⁶ The condition of excessive weight is largely preventable, and

250. *Id.*

251. *See, e.g.*, Rev. Rul. 79-66, 1979-1 C.B. 114 (holding that eliminating high level lead-based paint from surfaces of taxpayer's residence as an expense incurred primarily for the mitigation or prevention of a physical illness).

252. *Id.*

253. *Id.* The IRS defined "young children" as under the age of six. *Id.*

254. *Id.* (citing *Daniels v. Comm'r*, 41 T.C. 324 (1963); *Stringham v. Comm'r*, 12 T.C. 580 (1949)).

255. *Daniels v. Comm'r*, 41 T.C. 324, 328 (1963).

256. *See, e.g.*, Jeffrey Sobal & Albert J. Stunkard, *Socioeconomic Status and Obesity: A Review of the Literature*, 105 PSYCH. BULLETIN 260, 269-70 (1989) ("Attitudes toward obesity in developed and developing societies are one explanation of the association between [socioeconomic status] and obesity. These attitudes are congruent with the more robust associations between [socioeconomic status] an obesity: the positive

could significantly be reduced if individuals modify their behaviors through exercise, a change in eating patterns, and many other situationally appropriate treatments.²⁵⁷

If the IRS helps individuals avoid reaching the point of obesity, and further prevent comorbidities, a more immediate and impactful health benefit results to individuals and the public at large.²⁵⁸ All obese *and* overweight adults are considered at risk for developing comorbidity diseases,²⁵⁹ and both conditions exist at epidemic proportions in the United States.²⁶⁰ Therefore, overweight taxpayers and domestic public health can benefit just as much, if not more, from the inclusion of overweight treatment into the medical expense deduction.

B. The IRS and Public Health's Long Relationship

Allowing a medical expense deduction for public health problems is nothing new in tax law. As such, Revenue Ruling 2002-19 is merely an extension in a line of Rulings related to public health concerns such as alcoholism,²⁶¹ drug addiction,²⁶² and smoking.²⁶³ While the health risks and helpful nature of treatment plans for drug addiction, alcoholism, and smoking are commonly accepted in present day, it is important to remember that even these diseases were once “new” under the Code as well.

In 1979, the IRS initially disallowed a deduction for a taxpayer’s cost of completing a smoking cessation course, ruling that because the taxpayer did not have any specific disease at that time, the cost for completing the smoking cessation program was a personal expense.²⁶⁴ The IRS denied the deduction mainly on the basis that the taxpayer did not have the “present existence or imminent probability of a disease.”²⁶⁵ In a subsequent General Counsel Memo, the IRS fully explained the reasoning behind the disallowance, and provided guidance on when and how smoking cessation treatment could classify as a medical expense deduction.²⁶⁶ Significantly, because medical authorities at that time did not recognize smoking itself as a disease, and because no adequate support existed showing smoking resulted in an imminent probability of any disease, costs incurred to stop smoking were not medical

evaluations by almost all people in developing societies and the negative values about obesity affecting women in developed societies.”).

257. See *supra* notes 247–50 for a discussion of the difficulty associated with weight loss once a taxpayer is obese.

258. Sampsel & May, *supra* note 223, at 253.

259. CLINICAL GUIDELINES, *supra* note 3, at xii (listing disease such as hypertension, high blood cholesterol, type 2 diabetes, coronary heart disease, and other diseases).

260. Satcher, *supra* note 8, at xiii.

261. Rev. Rul. 73-325, 1973-2 C.B. 75.

262. Rev. Rul. 72-226, 1972-1 C.B. 96.

263. Rev. Rul. 99-28, 1999-1 C.B. 1269.

264. Rev. Rul. 79-162, 1979-1 C.B. 116.

265. *Id.*

266. I.R.S. Gen. Couns. Mem. 37,115 (May 10, 1977) (“If medical authorities should ever classify smoking itself as a disease or addiction, we believe the expense incurred in this case would probably qualify as a deduction for medical care.”).

expenses.²⁶⁷ The IRS stated that if medical research in the future showed that smoking was a disease, as research did for alcoholism and drug addiction, it was possible that a smoking cessation deduction would be allowed.²⁶⁸

Fast forward twenty years to 1999: the IRS ultimately revoked Revenue Ruling 79-162 and held that the costs for a smoking cessation program and for prescriptions drugs meant to aid in nicotine withdrawal were deductible as medical expenses.²⁶⁹ The IRS explicitly noted that since its initial ruling, scientific evidence established that not only is nicotine addictive, but that smoking is in fact detrimental to the health of the smoker.²⁷⁰ Finding support from Surgeon General reports, the IRS determined that deductions associated with smoking and nicotine addiction were acceptable medical expense deductions.²⁷¹

In classifying obesity and overweight treatment expenses as deductible, the IRS is paralleling its prior rationale when it recognized a “new” deduction for smoking cessation expenses, and revoked its prior ruling about smoking. Multiple medical authorities now recognize obesity and overweight as diseases in their own right.²⁷² And similar to the smoking context, the Surgeon General reported the extreme prevalence of overweight and obesity and classified both conditions as diseases.²⁷³ In classifying obesity as an appropriate § 213 disease, the agency also explicitly called attention to other prominent government and scientific entities, including the NIH, the FDA, and the WHO, who all in recent history further recognized obesity as a disease.²⁷⁴

Just as the majority of the public acknowledges smoking’s negative health consequences, it is equally well accepted that obesity and overweight have numerous negative health effects.²⁷⁵ The IRS found the act of smoking detrimental to one’s health because of the established link to several other serious diseases.²⁷⁶ Similarly, comorbid diseases are major risk factors of overweight and obesity.²⁷⁷ Well-known negative conditions associated with obesity, such as hypertension, congestive heart failure, and diabetes—to name a few²⁷⁸—all greatly increase one’s risk of death.²⁷⁹

The IRS’s position in allowing a deduction for smoking-related treatment shows the evolutionary ability of tax law as it relates to changing times in public health. A deduction for both overweight and obesity reflects the same necessary evolution of tax law, and will more accurately reflect the needs of the contemporary taxpayer and

267. *Id.*

268. *Id.*

269. Rev. Rul. 99-28, 1999-1 C.B. 1269.

270. *Id.*

271. *Id.* (citing U.S. DEP’T OF HEALTH & HUMAN SERVS., OFFICE OF SURGEON GEN., THE HEALTH CONSEQUENCES OF SMOKING: NICOTINE ADDICTION 6 (1988)).

272. See Rev. Rul. 2002-19, 2002-1 C.B. 778. (providing a list of sources the IRS used in deciding obesity is a disease, which include overweight).

273. See generally CALL TO ACTION, *supra* note 211.

274. Rev. Rul. 2002-19, 2002-1 C.B. 778.

275. Sampsel & May, *supra* note 221, at 253.

276. Rev. Rul. 99-28, 1999-1 C.B. 1269.

277. Sampsel & May, *supra* note 221, at 253.

278. *Id.* at 254.

279. Gregg et al., *supra* note 218, at 1868.

modern-day public health.

C. *A Deduction for Excessive Weight Treatment Helps Achieve Legislative Policy*

A deduction for obesity and overweight treatment is appropriately situated within the framework of the medical expense deduction as a tax expenditure because it helps achieve the greater policy aims of § 213: helping to reduce the burden of medical costs in real hardship situations and maintain a high level of public health.²⁸⁰ And no more immediate and burdensome health issues face our nation today than overweight and obesity.²⁸¹ Both prevention and treatment strategies of overweight and obesity are currently “national priorities.”²⁸² Just as Congress incorporated the medical expense deduction into the Code in reaction to the contemporaneous burdens of wartime expenses, recognizing obesity- and overweight-related deductions in § 213 are necessary because they alleviate the cost of our modern-day “war against obesity.”²⁸³ By allowing an obesity- and overweight-related deduction, the IRS is following through with the foundational policy of the medical expense deduction and appropriately applying it to the greatest threat to our current public health: excessive weight.²⁸⁴

This deduction also satisfies the policy aim of providing tax benefits through the medical expense deduction to those in real hardship situations, like taxpayers who incur heavy medical expenses to treat their excessive weight.²⁸⁵ The vast portion of those suffering from excessive weight are in the lowest socioeconomic class in the United States,²⁸⁶ and may not have the ability to afford the necessary treatment for overweight and obesity. Expenses, especially for those within the lowest socioeconomic class, can be quite burdensome.²⁸⁷ For instance, a taxpayer living in an urban area can expect to pay around \$500 for a yearly gym membership,²⁸⁸ \$750 for yearly participation in a Weight Watchers program,²⁸⁹ and bariatric surgery may cost upwards of \$30,000,

280. See *supra* Part II.A.1 for a discussion on the original purpose of the medical expense deduction.

281. CALL TO ACTION, *supra* note 211, at 1.

282. Satcher, *supra* note 8, at xv.

283. Press Release, Shape Up America!, In Spite of Diet Drug Withdrawal, the War on Obesity Must Continue Says Dr. C. Everett Koop! (Sept. 19, 1997), available at http://www.shapeup.org/about/arch_pr/091997.php (coining the term “war on obesity” when stating “[w]e can’t lose sight of this fact [that obesity is responsible for 300,000 deaths a year,] which is why the war on obesity must continue unabated”).

284. Satcher, *supra* note 8, at xiii–xv.

285. See *supra* Part II.A.1 discussion on the original purpose of the medical expense deduction.

286. Patricia F. Coogan et al., *Neighborhood Socioeconomic Status in Relation to 10-Year Weight Gain in the Black Women’s Health Study*, 18 OBESITY J. 2064, 2064 (2010); see also CLINICAL GUIDELINES, *supra* note 3, at xi (“Overweight and obesity are especially evident in some minority groups, as well as in those with lower incomes and less education.”); Sobal & Stunkard, *supra* note 256, at 261–65 (1989) (discussing the direct relationship between socioeconomic status and obesity among men, women, and children).

287. See Coogan et al., *supra* note 286, at 2064–65 (stating that lower neighborhood socioeconomic levels have higher environmental stress and limited access to healthy foods and exercise facilities, which can contribute to excessive weight).

288. Jeanine Skowronski, *The Best Gym Deals in America*, MAIN STREET (Jan. 5, 2011), <http://www.mainstreet.com/article/career/work/life-balance/best-gym-deals-america>.

289. *Membership & Fees*, WEIGHT WATCHERS OF PHILADELPHIA, <https://www.area12memberprocessing.com/newsite/membership.html> (last visited Sept. 29, 2013).

which does not include any lost wages due to undergoing surgery.²⁹⁰

The cost of incurring the latter-mentioned expenses, all unsubsidized by insurance or public assistance, results in a significant burden. By providing a reduction in a taxpayer's total expense outlay, the IRS is attempting to aid taxpayers in their pursuit of health, and thus effectuate a greater policy purpose.

D. Overweight and Obesity Are Adequate Deductions from Tax Base

If the medical expense deduction reflects an appropriate departure from the tax base as some scholars espouse,²⁹¹ a deduction for excessive weight is still a proper deduction in tax law. According to an alternative theory for a tax base, medical expenses reflect a need, rather than a personal consumption choice.²⁹² The threshold question under the alternate tax base in deciding if treatment for excessive weight constitutes need, and is therefore deductible, is: Does a taxpayer's pre-obese or obese condition reflect a departure from good health?²⁹³

Both pre-obesity and obesity are conditions departing from both ideal physical and mental health. Obesity and overweight are directly linked to numerous high-risk diseases such as heart disease, diabetes, stroke, infertility, and even some forms of cancer.²⁹⁴ Estimates of obesity-related deaths are upwards of 300,000 each year²⁹⁵ and are expected to rise,²⁹⁶ thus reflecting a significant departure from the ideal picture of physical health on the individual and national level. Excessive weight may also cause severe negative psychiatric reactions as well.²⁹⁷ Obese and pre-obese individuals can experience low self-esteem and severe depression, both of which are indicative of a departure from normal mental health.²⁹⁸

Because a pre-obese or obese condition is a departure from the baseline of both good mental and physical health, treatment-related costs merely reflect the taxpayer undertaking medically necessary treatment to achieve a healthy state. The more treatment expenses an overweight or obese taxpayer must incur, the less able the taxpayer is to pay taxes.²⁹⁹ To adequately reflect the taxpayer's decreased ability to pay

290. *6 Things to Consider Before Choosing Weight Loss Surgery for Your Obese Teen*, HEALTHNEWSDIGEST.COM (Nov. 3, 2011, 9:35 AM), http://www.healthnewsdigest.com/news/Teen_Health_290/6_Things_to_Consider_Before_Choosing_Weight_Loss_Surgery_for_Your_Obese_Teen_printer.shtml.

291. See *supra* Part II.A.4 for a discussion of the debate amongst scholars regarding a normative tax base.

292. Andrews, *supra* note 53, at 336.

293. See *infra* Appendix for weights that would be considered within the "normal range," or in good health.

294. Kersh & Morone, *supra* note 188, at 162.

295. Satcher, *supra* note 8, at xiii; see also David B. Allison et al., *Annual Deaths Attributable to Obesity in the United States*, 282 J. AM. MED. ASS'N 1530, 1533-36 (1999) (Table 4 showing estimated number of deaths attributed to obesity in 1991).

296. Satcher, *supra* note 8, at xiii.

297. Susan L. Megaard, *The Obesity Expense Rev. Rul.—Lots of Fuss but Maybe Not Much of a Real Long-Term Tax Benefit*, 97 J. TAX 34, 39 (2002).

298. *Id.*

299. See *supra* notes 69-71 for a discussion on how increased medical expenses reflect a lesser ability to pay taxes.

taxes, the medical expense deduction must include the treatment for overweight and obese taxpayers because these necessary expenses, incurred to achieve good health, diminish a taxpayer's ability to pay taxes, and lack the volitional and gratifying elements of personal consumption.

E. A Deduction for Excessive Weight Is Supported by the More Rigorous Analysis of the Tax Court

A deduction for both overweight and obesity is supported even under the tax court's more rigorous analysis standard of disease determination espoused in *O'Donnabhain*.³⁰⁰ In *O'Donnabhain*, the tax court addressed the question of whether the costs of sex-reassignment procedures are deductible § 213 expenses, requiring the tax court to preliminarily decide if GID was a disease within § 213.³⁰¹ The court held that GID is a disease within the meaning of § 213.³⁰² The court noted that disease classification under the Code does not rely exclusively on definitive scientific findings, but may also recognize a disease for purposes of the medical expense deduction based on many other sources.³⁰³ *O'Donnabhain* considered four specific factors in concluding that GID is a § 213 disease. These four factors, applied to overweight and obesity, support the classification of both conditions as a disease for purposes of § 213.

First, *O'Donnabhain* found that recognition of a disease in medical and diagnostic reference texts supported classifying GID as a disease.³⁰⁴ Similarly, medical and health references widely recognize obesity as a disease.³⁰⁵ The NIH acknowledges the seriousness of obesity and overweight, and published guidelines for overweight and obesity identification, evaluation, and treatment.³⁰⁶ The Centers for Disease Control and Prevention (CDC) also describes obesity as an epidemic and provides published information describing the disease, its health consequences, and the CDC's efforts at obesity prevention.³⁰⁷ Therefore, reference to materials published by the NIH and CDC, as the foremost health and disease prevention institutions in this country, support the first *O'Donnabhain* factor.

Second, the *O'Donnabhain* court found that GID is a seriously debilitating condition because GID has the ability to inflict "significant distress and

300. See *supra* notes 175–80 and accompanying text for a discussion of the tax court's reasoning in finding that GID is a § 213 disease.

301. *O'Donnabhain*, 134 T.C. at 52–53.

302. *Id.* at 63.

303. See *supra* Part II.C.2 for a discussion on interpretive sources for disease classification in § 213.

304. *O'Donnabhain*, 134 T.C. at 60.

305. *E.g.*, NAT. CTR. FOR CHRONIC DISEASE PREVENTION & HEALTH PROMOTION, OBESITY: HALTING THE EPIDEMIC BY MAKING HEALTH EASIER 1–2 (2011), available at <http://www.cdc.gov/chronicdisease/resources/publications/aag/obesity.htm> [hereinafter HALTING THE EPIDEMIC] (stating that obesity is an epidemic and listing obesity as one of its "Major Programs" under its "Chronic Disease Prevention and Health Promotion" programs, alongside arthritis, cancer, and diabetes); CLINICAL GUIDELINES, *supra* note 3, at xi (describing obesity and overweight as conditions that substantially increase the risk of morbidity).

306. CLINICAL GUIDELINES, *supra* note 3, at xi.

307. HALTING THE EPIDEMIC, *supra* note 305, at 2–4.

maladaptation.”³⁰⁸ The court relied on trustworthy reference texts in the field to support this finding.³⁰⁹ Further, three separate experts attested to the seriousness of GID and its effect, by noting that GID can result in sexual self-mutilation, and even suicide.³¹⁰

Similarly, obesity and overweight are infamous for producing significantly detrimental health consequences and can result in severe mental distress. The Surgeon General warned the entire nation that being overweight or obese substantially raises the risk of experiencing a number of severe physical adverse health outcomes including: “high blood pressure, high cholesterol, type 2 diabetes, heart disease and stroke, gallbladder disease, arthritis, sleep disturbances and problems breathing, and certain types of cancers.”³¹¹ According to the Surgeon General, the effect of excessive weight, coupled with the increased risk of comorbidities, could result in unprecedented death rates, potentially surpassing even tobacco as the chief cause of preventable death in the United States.³¹²

The adverse psychological interactions related to excessive weight are also well acknowledged. Many overweight and obese patients need to address the psychological underpinnings that contribute to their weight problems and impede their weight-loss success before successful weight loss is even possible.³¹³ Overweight or obese individuals are more susceptible to experience distressing factors such as low self-esteem, depression, cyclical eating disorders, and anxiety.³¹⁴ Thus, the tax court should adequately describe pre-obesity and obesity as a “debilitating condition,” because adverse physical and mental health consequences of an overweight or obese individual are well recognized.³¹⁵

Third, in *O’Donnabhain*, professionals in the field examined the taxpayer and found based on their professional evaluation that the GID did significantly impair the taxpayer.³¹⁶ An intensive evaluation and report of every taxpayer is certainly not an administrable option,³¹⁷ but requiring the taxpayer to provide a physician’s prescription, as Revenue Ruling 2002-19 already requires, offers sufficient certainty that the taxpayer truly has a disease. A physician can reasonably be expected to examine patients and determine, in the physician’s medical judgment, that a taxpayer’s overweight or obese status negatively affects the patient. In striking a workable balance between administrative resources and effective implementation of tax law, a physician’s prescription, stating that the taxpayer is in need of treatment, is substantive proof that the disease impairs the taxpayer.

308. *O’Donnabhain*, 134 T.C. at 61.

309. *Id.*

310. *Id.* at 76.

311. Press Release, U.S. Dept. of Health & Human Servs., Surgeon General Launches Effort to Develop Action Plan to Combat Overweight, Obesity (Jan. 8, 2001), available at www.surgeongeneral.gov/news/2001/01/obesity.html.

312. Satcher, *supra* note 8, at XIII.

313. Katherine Mayer, *An Unjust War: The Case Against the Government’s War on Obesity*, 92 GEO. L.J. 1001, 1015 (2004).

314. *Id.* at 1015–17.

315. *O’Donnabhain v. Comm’r*, 134 T.C. 34, 61 (2010).

316. *Id.*

317. See *infra* Part III.G.1 for a discussion on administrability in tax law.

Finally, *O'Donnabhain* found it persuasive that seven courts of appeal all found that GID was a “medical condition of sufficient seriousness.”³¹⁸ The weight of the other courts’ independent findings weighed heavily in the *O'Donnabhain* analysis, such that the court included this as one of the determinative four factors in deciding if a § 213 disease exists.³¹⁹ As such, the IRS, as an administrative agency, could benefit from looking to other administrative agencies’ disease classifications in determining if a § 213 disease is present.

When determining disease classification for obesity and overweight, the IRS should consult administrative determination and agency pronouncements such as the Notice of Social Security Ruling released by the Commissioner of Social Security in 2000.³²⁰ In the ruling, the Social Security office clarified the relevancy of obesity in determining disability claims, and provided that obesity is considered a “medical impairment.”³²¹ It further “remind[ed] adjudicators to consider” the effects of obesity when evaluating a disability because the combined effects of obesity can further exacerbate and worsen other impairments.³²² The Office of Social Security also indicated that obesity should be considered when determining an individual’s overall capacity.³²³

The IRS’s consideration of the Social Security Ruling would be analogous to the credence *O'Donnabhain* gave to multiple circuit court rulings regarding GID as a medical need.³²⁴ The Social Security Ruling is an explicit example of another government agency finding obesity as a disease, and choosing to consider a claimant’s weight when allocating precious governmental resources. Thus, the Social Security Ruling helps support the last factor of the *O'Donnabhain* analysis and the classification of overweight and obesity as diseases because a similar governmental body supported this finding.³²⁵

Importantly, the court emphasized that debate in the field as to GID’s character as a disease did not disqualify GID as a mental disease.³²⁶ The widespread acceptance of GID as a disease in the field outweighed the fact that some debate still existed.³²⁷ Regardless of the existing debate as to whether or not obesity is a disease in and of itself, a disease, for § 213 purposes, should include overweight and obesity because of their overwhelming acceptance as diseases in the health field.³²⁸ While an argument exists that one’s excessive weight is not a disease, but rather a predetermined body type, this view is not adopted and followed in the medical and public health fields.

318. *O'Donnabhain*, 134 T.C. at 61–63.

319. *Id.* at 62.

320. SSR 00-3p, 2000 WL 33952015 (May 15, 2000).

321. *Id.* at *4.

322. *Id.* at *1.

323. *Id.* at *6.

324. *O'Donnabhain*, 134 T.C. at 60–63.

325. *Id.*

326. *Id.* at 59–60.

327. *See id.* (stating that on a balance between the existing debate and evidence of widespread acceptance, GID is a disease in the field of psychiatry).

328. *See supra* Part II.D for a discussion about the two sides of the obesity debate.

Even if groups like fat acceptance proponents argue that excessive weight is merely a body diversity type,³²⁹ treating excessive weight still positively affects health. For instance, when considering whether obesity could properly be classified as a disease for government assistance purposes, Jyme Schafer, director of medical and surgical services at the Office of Clinical Standards and Quality for the Centers for Medicare and Medicaid Services said, “[w]e recognize that [relieving obesity] improves health outcomes And that’s the bottom line.”³³⁰ The mere existence of a debate did not trump the tax court’s decision in *O’Donnabhain*,³³¹ and there is no reason it should in the context of overweight and obesity. Overwhelming support indicates that treatment positively affects health regardless of semantics; thus, both overweight and obesity qualify as diseases in terms of the medical expense deduction.

F. *Treatment for Excessive Weight Is Holistic and Should Include Diet and Fitness Costs, Surgery Costs, and Psychiatric Costs*

The IRS should allow a taxpayer to deduct expenses associated with both the physical and mental aspects related to obesity and overweight treatment. Physical treatment often exists in the form of gym membership fees, exercise equipment, and bariatric surgery, while the mental component of treatment might be addressed in weight-loss programs or in receiving counseling from a dietitian or psychologist. The main treatable causes of excessive weight are sedentary lifestyles and dietary habits,³³² but that does not mean an obese or overweight taxpayer will not benefit from mental treatment as well.³³³ Treatment can be different for every taxpayer,³³⁴ and as such, the best determination of deductible treatment will exist on a case-by-case basis.

Scientific research shows that a poor diet and lack of exercise can result in excessive weight and increase the risk of death.³³⁵ Any treatment plan aimed at correcting diet or exercise is clearly related to the treatment of obesity and overweight, and is therefore acceptable treatment under § 213.³³⁶ As such, the IRS should continue to allow deductions for attending weight-loss groups and any exercise-related costs since they effectively treat excessive weight.

The medical expense deduction for obesity should also include the cost of bariatric surgery.³³⁷ Bariatric surgery is never the first method of weight loss, and is

329. Saguy & Riley, *supra* note 184, at 869–70.

330. Marianne English, *Is Obesity a Disease?*, DISCOVERY NEWS (Oct. 17, 2011, 3:00 AM), <http://news.discovery.com/human/obesity-disease-debate-111017.html> (second alteration in original).

331. *O’Donnabhain v. Comm’r*, 134 T.C. 34, 60–61 (2010).

332. See J. Michael McGinnis & William H. Foege, *Actual Causes of Death in the United States*, 270 J. AM. MED. ASS’N 2207–08 (1993) (stating that dietary and sedentary activity patterns account for at least 300,000 deaths each year and increase the risk of comorbidities).

333. See *infra* Part III.F for an explanation of the importance of mental and physical treatment in combating excessive weight.

334. See CLINICAL GUIDELINES, *supra* note 3, at xxi (describing cultural, social, and personal factors that should inform each overweight or obese patient’s treatment plan).

335. *Id.* at xii

336. I.R.C. § 213(d)(1)(A) (2012).

337. The term bariatric surgery encompasses many types of weight-loss surgery. These weight-loss surgeries make changes to a patient’s digestive system to help the patient lose weight by limiting how much

only used as a last-resort obesity treatment method.³³⁸ The stiff prerequisites a taxpayer already must meet before undergoing bariatric surgery demonstrate that the IRS should allow for a presumption of medical necessity whenever a taxpayer undergoes this surgery. It is significant that the average cost of bariatric surgery can be in excess of \$30,000.³³⁹ Therefore, a taxpayer, knowing that such expensive bariatric surgery costs are deductible, may be more likely to treat his or her obesity because of the decreased overall cost of undergoing the surgery.³⁴⁰ Further, bariatric surgery is proven to increase a patient's health, and even reverse incidences of Type 2 diabetes,³⁴¹ thus easily qualifying as the "diagnosis, cure, mitigation, treatment, or prevention of disease,"³⁴² and deductible for § 213 purposes.

The IRS should also allow a deduction for psychiatric costs incurred to help treat a taxpayer's excessive weight. The 1985 NIH Consensus on Obesity concluded that "obesity creates an enormous psychological burden [I]n terms of suffering, the [psychological] burden may be the greatest adverse effect of obesity."³⁴³ Psychological suffering and body dissatisfaction can contribute to low self-esteem and make losing weight difficult.³⁴⁴ The American Society for Metabolic and Bariatric Surgery provides certain suggestions for the psychological assessment of a bariatric patient before and after surgery.³⁴⁵ This professional suggestion evidences the vital role psychiatrics play in weight-loss treatment. As such, psychiatric treatment can provide real assistance in weight-loss treatment, and should be deductible as part of a successful weight-loss plan.

one can eat or by reducing the absorption of nutrients, or both. *Gastric Bypass Surgery*, MAYO CLINIC (Oct. 11, 2011), <http://www.mayoclinic.com/health/gastric-bypass/MY00825>.

338. See Henry Buchwald, *Consensus Conference Statement Bariatric Surgery for Morbid Obesity: Health Implications for Patients, Health Professionals, and Third-Party Payers*, 1 SURGERY FOR OBESITY & RELATED DISEASES 371, 373 (2005) (providing recommendations that first-time severely obese patients should try dietary modification, exercise, and behavioral changes and support before being considered for bariatric surgery).

339. *6 Things to Consider Before Choosing Weight Loss Surgery for Your Obese Teen*, *supra* note 290.

340. Due to the high costs of the surgery, providing a tax deduction for the procedure can have a profound impact a taxpayer's tax liability and savings, especially if this cost is not subsidized by insurance or public assistance. For example, if a taxpayer itemizes deductions and has a marginal tax rate of thirty-five percent, then allowing the taxpayer to deduct bariatric surgery costs under § 213 allows the taxpayer to save \$10,500 on the surgery. The surgery would therefore only cost the taxpayer \$19,500 instead of the full \$30,000. See *infra* Part III.G.3 for an explanation of how providing a tax benefit may incentivize a taxpayer to seek treatment.

341. E.L. Lim et al., *Reversal of Type 2 Diabetes: Normalisation of Beta Cell Function in Association with Decreased Pancreas and Liver Triacylglycerol*, 54 DIABETOLOGIA 2506, 2506 (2011) (explaining that "type 2 diabetes is clearly reversible following bariatric surgery").

342. I.R.C. § 213(d)(1)(A) (2012).

343. Albert J. Stunkard & Jeffrey Sobal, *Psychosocial Consequences of Obesity*, in *EATING DISORDERS AND OBESITY: A COMPREHENSIVE HANDBOOK* 417 (Kelly D. Brownell & Christopher G. Fairburn eds., 1995).

344. Mayer, *supra* note 313, at 1015.

345. See generally DIANE LEMONT ET AL., SUGGESTIONS FOR THE PRE-SURGICAL PSYCHOLOGICAL ASSESSMENT OF BARIATRIC SURGERY CANDIDATES (2004); Jeffrey I. Mechanick et al., *American Association of Clinical Endocrinologists, the Obesity Society, and American Society for Metabolic & Bariatric Surgery Medical Guidelines for Clinical Practice for the Perioperative Nutritional, Metabolic, and Nonsurgical Support of the Bariatric Surgery Patient*, 4 SURGERY FOR OBESITY & RELATED DISEASES 109 (2008).

One or all of the above treatment methods may be necessary as part of a holistic approach to an effective treatment plan for an overweight or obese taxpayer.³⁴⁶ In national guidelines set forth by the NIH, the organization went as far as recommending that “[a]n integrated program *must* be in place to provide guidance on diet, physical activity, and behavioral and social support both prior to and after the surgery.”³⁴⁷ Standard treatment for overweight and obese individuals must be tailored to meet each individual’s needs.³⁴⁸ With this framework in mind, the IRS should not categorically disallow deductions, but look to the necessity of the expenses to cure, treat, or mitigate the disease in its entirety.

G. Interpreting the Code to Include Pre-Obesity and Obesity Treatment Is Within the Purview of Tax Policies

1. Including Pre-Obese Treatment in the Medical Expense Deduction Is Administrable

Rather than only allow a medical expense deduction for obese taxpayers, the IRS can achieve the most successful end result by allowing those who are pre-obese to benefit from the deduction³⁴⁹ while still maintaining the current administrability of this deduction. As one of the main policy goals of the Code, administrability is an important consideration for the implementation of any tax provision.³⁵⁰ The IRS is an administrative agency with limited resources, and must therefore make difficult practical decisions regarding where to draw the line between taxable events and nontaxable events.³⁵¹ Here, the IRS chose to draw the line for weight-loss expenses at obesity.³⁵² This determination makes sense because eligibility is a bright-line rule and an objective, numbers-based decision—a taxpayer either is or is not obese depending on his or her BMI calculation.³⁵³ The obesity determination is easily ascertainable, and thus very administrable. Expanding the deduction to include the status of pre-obese does not alter the method of determination in any manner, but simply slides the scale to include lower BMI numbers into the § 213 disease. As such, it does not result in an increased use of any administrative resources because the method of determination would remain exactly the same.

In addition to the requisite BMI, necessitating a physician’s prescription for the treatment does not create more of an administrable burden on the IRS because it is only the taxpayer who is required to keep the prescription as part of his records for all § 213

346. CLINICAL GUIDELINES, *supra* note 3, at xxi–xx.

347. *Id.* at xxi (emphasis added).

348. *See id.* (describing cultural, social, and personal factors that should inform each overweight or obese patient’s treatment plan).

349. *See supra* Part III.A.2 for a discussion of how including pre-obese treatment into the medical expense deduction may help to prevent the onset of obesity.

350. GRAETZ & SCHENK, *supra* note 56, at 28.

351. *See Haverly v. United States*, 513 F.2d 224, 227 (7th Cir. 1975) (providing deference to the IRS decision to have a bright-line rule for taxing unsolicited book samples based on the agency’s chosen method of allocating its administrative resources).

352. Rev. Rul. 2002-19, 2002-1 C.B. 778.

353. *See infra* Appendix for BMI classifications.

expenses.³⁵⁴ The presence of a prescription acts as substantive proof that treatment of excessive weight is in fact necessary, rather than for “general health.”³⁵⁵ Merely requiring a taxpayer to retain a copy of a physician’s prescription in the same way as all other required medical treatment paperwork will not increase the IRS’s allocation of resources in any way.³⁵⁶ While not every expense prescribed by a doctor is in fact medical care,³⁵⁷ a prescription coupled with the taxpayer’s status as overweight or obese are two administrable methods which, taken together, ensure the taxpayer incurred an expense necessary to treat a disease.³⁵⁸ As such, an expansive incorporation of pre-obese treatment into § 213 should be allowed into the medical expense deduction to help fight the obesity epidemic.

2. Horizontal Inequity is Acceptable for Purposes of Implementing Other Policy Purposes

A deduction for obesity- and overweight-treatment expenses that results in horizontal inequity,³⁵⁹ yet helps incentivize healthy and active lifestyles, may be acceptable as a forgone by-product of a greater policy purpose. Congress has indicated through other Code provisions that horizontal inequity does not bar enacting tax provisions if those tax provisions can be said to support a separate policy purpose.³⁶⁰ There are well-established reasons why this deduction is appropriate even in the face of horizontal inequity.³⁶¹ Providing the tax benefit to overweight and obese taxpayers *only* when they are seeking to correct their excessive weight is allowable because the provision promotes a separate sought-after policy—combating the obesity and overweight epidemic.³⁶²

354. See INTERNAL REVENUE SERVICE, U.S. DEP’T OF TREASURY, PUB. 502: MEDICAL AND DENTAL EXPENSES (INCLUDING THE HEALTH CARE TAX CREDIT) 20–21 (2011) (providing the recommended method of what and how to keep records related to medical care, and stating not to send the records to the IRS).

355. *E.g.*, Rev. Rul. 79-151, 1979-1 C.B. 116.

356. INTERNAL REVENUE SERVICE, *supra* note 354, at 20–21.

357. *Seymour v. Comm’r*, 14 T.C. 1111, 1117 (1950).

358. In addition to administrability, the floor in the medical expense deduction helps reduce taxpayer abuse. Because a taxpayer cannot claim the medical expense deduction unless expenses exceed ten percent of AGI, a deduction will only be allowed when the taxpayer incurs extraordinary expenses. While including pre-obese expenses broadens the scope of allowable medical expense deductions, a stricter incorporation of the new ten percent floor into § 213 will make abuse that much less likely.

359. Allowing obese or overweight taxpayers to claim a deduction for their treatment does raise horizontal equity concerns because treatment plans for obesity or overweight may include expenses otherwise deemed “personal,” but for the presence of the condition. See *supra* Part II.B.1 for a discussion of how weight-loss treatments were treated before Revenue Ruling 2002-19 and how they are still treated absent an obese condition. Horizontal equity holds that similarly situated taxpayers should pay the same amount in taxes, and it is one of the main policy goals the Code aims to achieve. GRAETZ & SCHENK, *supra* note 56, at 28. The deduction results in an obese or overweight taxpayer receiving a tax benefit on the cost of such items and services, like gym-membership fees, while non-obese or overweight taxpayers are required to pay the entire gym-membership fee, with no corresponding tax deduction; thus resulting in horizontal inequity.

360. See William P. Kratzke, *The (Im)balance of Externalities in Employment-Based Exclusions from Gross Income*, 60 TAX L. 1, 1 (2007) (explaining how Congress uses the Code to shape the employer-employee relationship even though this use creates inequities).

361. See *infra* Part III.G.2 for an explanation of when policy concerns trump horizontal equity.

362. See *supra* Part II.E for a discussion of the tax benefit as a response to the *Call to Action*.

Under § 132 of the Code, for instance, Congress originally allowed the policy of energy conservation to trump horizontal inequity concerns when it provided an exemption from employee income and a business deduction for employers for a “qualified transportation fringe.”³⁶³ Under this tax provision, a “qualified transportation fringe” allows an employee to exclude from income a portion of expenses incurred in taking public transportation, using employer-provided parking premises, or commuting via bicycle to and from work and home.³⁶⁴ Normally, tax law presumes that employees incur commuting expenses for personal reasons.³⁶⁵ Congress’s aim in enacting this tax benefit, however, was to address the energy crisis of the 1970s by providing more generous tax treatment to those who opted for public transportation instead of the parking fringe.³⁶⁶ It was meant to incentivize taxpayers to drive less, and promote energy conservation policy.³⁶⁷

Providing certain taxpayers with a tax benefit for qualified transportation does result in horizontal inequity as compared to other taxpayers with similar earnings who must pay their commuting expenses from an after-tax salary.³⁶⁸ For example, if there are two taxpayers, both earning \$50,000 a year, and one is paying annual commuting costs of \$1,200, while the other is receiving \$1,200 worth of commuting expenses as a qualified fringe benefit under § 132(f), then horizontal inequity may exist. The latter taxpayer is able to receive \$1,200 worth of commuting expenses from his employer without having to include it in his income.³⁶⁹ The first taxpayer, however, is forced to pay \$1,200 to commute to and from work with after-tax dollars. Both are taxed on the same \$50,000 amount at the same marginal rate, even though the first taxpayer only has \$48,800 available to him to pay taxes, while the second taxpayer receives the benefit of commuting expenses tax free, and has the freedom to spend the full \$50,000 as he wants. If we presume that the taxpayers are otherwise similarly situated, then horizontal inequity results. Giving the qualified transportation fringe to an employee, however, was a congressional attempt to address the energy crisis of the 1970s in a controllable and administrable way.³⁷⁰ It is because of the greater policy purpose that this tax provision seeks—promoting energy conservation—that Congress allowed horizontal inequity.³⁷¹

363. I.R.C. § 132(a)(5) (2012); *see also* Kratzke, *supra* note 360, at 46 (stating that Congress provided more generous tax benefits to employees opting to take transit passes and travel in commuter highway vehicles rather than drive to work).

364. I.R.C. § 132(f)(1), (2), (5).

365. *Comm’r v. Flowers*, 326 U.S. 465, 473 (1946) (explaining that the “cost of maintaining [the taxpayer’s] home there and of commuting or driving to work concededly would be non-deductible living and personal expenses lacking the necessary direct relation to the prosecution of the business”).

366. Kratzke, *supra* note 360, at 47.

367. *Id.*

368. *See* STAFF OF JOINT COMM. ON TAXATION, 98TH CONG., GENERAL EXPLANATION OF THE REVENUE PROVISIONS OF THE DEFICIT REDUCTION ACT OF 1984, at 840–41 (1984). *See supra* Part III.G.2 for an explanation of horizontal equity.

369. I.R.C. § 132(a)(5).

370. Kratzke, *supra* note 360, at 47. *See supra* Part III.G.1 for an explanation of administrability in tax policy.

371. Kratzke, *supra* note 360, at 47.

Just like allowing an income exclusion and deduction for employees and employers, providing a tax benefit to obese and pre-obese taxpayers promotes a separate public health policy. Like the qualified transportation fringe benefit, providing the deduction for the obese and overweight will only benefit a certain subset of taxpayers, even though other taxpayers are taking the same actions, like going to the gym. Though the deduction results in horizontal inequity for what may be seen as personal expenses, the tax provision itself is not necessarily undesirable because it supports a greater public policy—reducing the incidence of obesity and overweight.³⁷²

3. The Tax Benefit for Obesity and Pre-Obesity Treatment Incentivizes Taxpayers and Rewards Those Perpetuating Public Health Goals

The deduction for seeking treatment when a taxpayer is obese or pre-obese should not be seen as rewarding those taxpayers for becoming obese or overweight. Instead it should be seen as providing a necessary incentive that might be lacking from the obese and pre-obese populations, and helping those who are actively seeking treatment now.³⁷³ Allowing a deduction for weight-loss related treatment reduces the taxpayer's total outlay costs, thereby providing taxpayers with an incentive to seek treatment when they otherwise may not. Being overweight or obese is expensive both for individuals and the public at large.³⁷⁴ And remaining overweight or obese essentially guarantees the taxpayer will have a more expensive or less prosperous life.³⁷⁵ Amazingly, many overweight and obese individuals still do not understand that their excessive weight is harmful to their health.³⁷⁶ With such a disconnect between Americans' weight and the negative consequences of their weight,³⁷⁷ providing a monetary benefit to taxpayers for treating their excessive weight might be just what the doctor ordered.

The immediate gratification of eating a cheeseburger or doughnut is “very powerful” and usually trumps a taxpayer's fear of eventually developing diabetes; however, providing countergratification that is more immediate than the idea of a long and healthy life, like a tax deduction, can counteract the immediate “cheeseburger

372. See *supra* Part II.E for a discussion of the public health crisis caused by obesity and overweight.

373. Further, because a deduction is only a partial tax benefit, dependent on a taxpayer's marginal tax rate, any deduction allowed for an incurred expense never makes a taxpayer whole.

374. AVI DOR ET AL., A HEAVY BURDEN: THE INDIVIDUAL COSTS OF BEING OVERWEIGHT AND OBESE IN THE UNITED STATES 3 (2010). The annual cost of being obese is \$8,365 for women and \$6,518 for men. *Id.* at 2. The report provided a systematic review regarding the types of costs that affect overweight or obese working-age adults and the overall cost estimates of being obese or overweight for individuals. *Id.* at 3. The costs it considered were: total direct medical costs, absenteeism from work, loss at work due to lower productivity while present, short-term disability, disability pension insurance, premature mortality, worker's compensation, personal costs (such as clothing and gasoline), and loss of life. *Id.* at 3.

375. See *id.* at 3–4 (estimating obesity-related costs stemming from comorbidities that are attributable to obesity and premature-mortality costs, such as lost wages, relative to normal-weight individuals).

376. Jenifer Goodwin, *Many Don't Believe Their Obesity Poses Health Risks: Study*, U.S. NEWS & WORLD REP. (Oct. 15, 2011), <http://health.usnews.com/health-news/managing-your-healthcare/treatment/articles/2011/10/15/many-dont-believe-their-obesity-poses-health-risks-study>. In a study of random patients seen in an emergency room, only forty-seven percent of obese and overweight men and sixty-two percent of obese and overweight women believed that their excessive weight was damaging their health. *Id.*

377. *Id.*

gratification.”³⁷⁸ Taxpayers can make irrational choices, such as eating a cheeseburger everyday even if they are overweight, and have high cholesterol or Type 2 diabetes.³⁷⁹ So, an important consideration when attempting to counteract the irrational and unhealthy choice is to provide a different kind of reward.³⁸⁰ By giving taxpayers a “deal” in allowing them to receive the necessary treatment at a lower cost, the Code is rewarding taxpayers seeking to correct their negative health.³⁸¹ The discounted access to gyms, weight-loss programs, and physical and mental health consultations could be the exact reward needed to motivate obese and overweight individuals to lose weight.

Taxpayers who are not obese or overweight, but still pay for gym membership, do not need the additional incentive that overweight and obese taxpayers do as evidenced by their maintaining a non-obese or overweight BMI level even without the additional incentive of a tax benefit. Their current level of health, as related to weight, is not in *need* of the treatment, and they are not in need of the extra incentivizing factor of maintaining it because their personal motivation is enough to effectuate the public health policy. So while the deduction is admittedly not perfect, it can be seen as foundational, and part of a holistic plan aiding in our nation’s battle with obesity and overweight.³⁸²

Since it is well acknowledged that the IRS must draw a line somewhere in enforcing tax laws,³⁸³ providing the deduction only to those who need it the most, the obese and overweight, is a more efficient balance of administrability, equity, and effectuation of a non-tax policy. Allowing the deduction for every taxpayer may be the most horizontally equitable answer, however, this response is not a realistic or administrable way to address the problem of excessive weight or promote active, healthy lifestyles.³⁸⁴ The deduction targets those individuals that need the weight-loss treatment the most, both in terms of health *and* motivation.

H. A Tax Deduction for Obesity and Pre-Obese Treatment Is an Efficient Government Action

With the rate of obesity and overweight increasing in our nation, despite public awareness of obesity and overweight’s prevalence and dangers, government assistance

378. Lenny Bernstein, *Do Programs That Pay People to Lose Weight Really Work?*, WASH. POST (Oct. 10, 2011), http://www.washingtonpost.com/lifestyle/wellness/do-programs-that-pay-people-to-lose-weight-really-work/2011/10/06/gIQAiIABbL_story_1.html.

379. *Id.*

380. *Id.*

381. *Id.* Providing the financial benefit of saving money for treatment fees, such as a gym membership, finds basis in traditional economic theory, which assumes that people make decisions rationally. *Id.*

382. See *supra* Part II.E for an explanation of how Revenue Ruling 2002-19 is part of a larger national effort to combat a public health concern.

383. See *Haverly v. United States*, 513 F.2d 224, 227 (1975) (providing deference to the IRS decision to have a bright-line rule for taxing unsolicited book samples based on the agency’s chosen method of allocating its administrative resources).

384. In addition to administrability, it should also be noted that the government needs to raise revenue through the Code, and allowing every taxpayer to deduct gym-membership fees or weight-loss programs from their taxes could severely limit the amount of capital the government raises.

is necessary.³⁸⁵ In releasing his Call to Action, the Surgeon General asked for the “close cooperation and collaboration of . . . organizations and individuals,” to develop national action plans targeting the obesity and overweight epidemic, and promoting healthy eating and physical activity habits.³⁸⁶ And the deduction for obesity and overweight expenses is merely one piece of a comprehensive solution to this public health crisis. While an ideal action plan would include involvement on the federal, state, and local government levels, community outreach, agribusiness input, and individuals, to name a few,³⁸⁷ such an alliance may be difficult, if not impossible, to collaborate. Given the number of actors involved, and the divergent interests amongst such a broad spectrum of parties, implementing a cohesive, efficient, and timely plan seems unlikely.

National health policy is traditionally implemented through Congress, executive agencies, and the judiciary.³⁸⁸ The obesity politicking involved in instituting traditional health policies through Congress,³⁸⁹ and the uncertainty and inadequate health policy understanding in the courts, have made such methods of implementation both unresponsive and inadequate. Government, however, is “the most important actor[] in reversing the obesity epidemic, because protection and promotion of public goods, including public health, is a core responsibility.”³⁹⁰ But, complicated by a variety of factors, congressional and judicial interventions at this point have proven inefficient and may even be unrealistic.³⁹¹ The IRS, as an executive agency, is an efficient way to initiate a timely government intervention thanks to the agency’s lack of partisanship and outside interest influence.

Legislators acknowledge that obesity currently presents a policy crisis.³⁹² The congressional division between Democrats and Republicans, however, is fiercely partisan, as the parties seek different methods to correct the problem.³⁹³ For instance, the “Cheeseburger Bill” was a Republican-supported bill that passed the United States House of Representatives in 2005, which sought to forbid obesity lawsuits against food manufacturers and restaurants.³⁹⁴ Wisconsin representative and chairman of the House

385. DOR ET AL., *supra* note 374, at 19.

386. Satcher, *supra* note 8, at xv.

387. JEFFREY LEVI ET AL., ROBERT WOOD JOHNSON FOUND., F AS IN FAT: HOW OBESITY POLICIES ARE FAILING IN AMERICA 2008, at 84–85 (2008) (stating that a national strategy combating obesity *must* include the federal government, state and local governments, community and faith-based organizations, schools, families and individuals, employers, insurers, food and beverage industries, agribusiness and farmers, and health researchers and evaluators).

388. Kersh & Morone, *supra* note 220, at 850–55.

389. See generally Kersh & Morone, *supra* note 220.

390. Steven L. Gortmaker et al., *Changing the Future of Obesity: Science, Policy, and Action*, 378 LANCET 838, 842 (2011).

391. See *infra* Part III.H for an explanation of the problems with legislative reform.

392. Kersh & Morone, *supra* note 220, at 850.

393. *Id.* at 850–52. Republican proposals focus more on individuals such as promoting nutrition education rather than broad policy intervention, while Democrats push for expansive legislation, like regulating public school meals. *Id.* at 850–51.

394. ‘Cheeseburger Bill’ Puts Bite on Lawsuits, CNN.COM (Oct. 20, 2005, 9:30 AM), http://articles.cnn.com/2005-10-20/politics/cheeseburger.bill_1_cheeseburger-bill-fast-food-chains-food-industry?_s=PM:POLITICS.

Judiciary Committee, James Sensenbrenner, supported the bill stating, “if a person knows or should know that eating copious orders of super-sized McDonald’s products is unhealthy and could result in weight gain, it is not the place of the law to protect them from their own excesses.”³⁹⁵ On the other hand, Democrat representative Bob Filner of California, found that the bill reflected “Congress[‘s] . . . allow[ing] the need[s] of big corporations before the need[s] of our children.”³⁹⁶ The Cheeseburger Bill never passed the Senate, however, as some legislators argued that fast-food companies needed to be held accountable.³⁹⁷ Political campaigning, food industry lobbyists, and different explanations for the obesity problem further exasperate the problem and have made health policy change in Congress “either halting or nonexistent.”³⁹⁸ Congress has consistently failed to pass health policies, and obesity can be expected to follow suit.³⁹⁹

The federal judicial system is an additional route for national health policy change, but, like Congress, courts provide an inefficient means to implement this change. While the judiciary is a passive lawmaking body,⁴⁰⁰ it has signaled a willingness to hear relevant cases regarding obesity-related lawsuits.⁴⁰¹ As seen in the wave of tobacco litigation in the 1990s, implementing health policy is nothing new to the judiciary, and the tobacco litigation framework provides a predictive model to critique the effectiveness of implementing obesity health policy through the courts.⁴⁰²

The aftermath of the tobacco litigation exemplifies why courts are inadequate mechanisms to provide a comprehensive and effective policy solution to public health issues, however. First, the lack of actual individual health benefits that resulted from the judicial activity in tobacco litigation foretells why a judicial decision is unlikely to curtail the obesity epidemic. Statistics calculated after the tobacco lawsuits showed only a slight decline in national smoking rates⁴⁰³ and tobacco use amongst adolescents.⁴⁰⁴ Hence, while the big tobacco companies might have suffered, no real

395. *Id.*

396. *Id.*

397. *Id.*; see also Kersh & Morone, *supra* note 220, at 851 (noting that as of early 2005, the Cheeseburger Bill had not passed the 108th Congress).

398. Kersh & Morone, *supra* note 220, 850–52.

399. Despite passing *health care* reform legislation in 2010, Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 9013, 124 Stat. 119, 868 (2010), amended by Pub. L. No. 111-152, 124 Stat. 1029 (2010), Congress has failed to address actual health policies.

400. Considering that federal courts are courts of limited jurisdiction, requiring a case or controversy, the judiciary may not issue advisory opinions or preemptively implement a health policy solution. Instead, judges are passive in their roles, and are forced to wait until the “perfect” plaintiff enters their courtroom to espouse their policy beliefs. See, e.g., Andrew M. Bickel, *The Supreme Court 1960 Term Foreword: The Passive Virtues*, 75 HARV. L. REV. 40, 42–43 (1961) (discussing the constitutional limitation of judicial power to deciding cases and controversies in front of it).

401. Kersh & Morone, *supra* note 220, at 862.

402. See *id.* at 857–58 (discussing the tobacco-litigation framework).

403. *Id.* at 860.

404. See Centers. for Disease Control and Prevention, *Tobacco Use, Access, and Exposure to Tobacco in Media Among Middle and High School Students—United States, 2004*, 54 MORBIDITY & MORTALITY WKLY. REP. 297 (2005), available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5412a1.htm> (discussing the lack of substantial decreases in the use of tobacco products amongst middle and high school student during the

health benefits resulted to the individuals whose private activities the litigation meant to correct.

Further, courts are unable to effectively monitor the implementation of their policies and ensure compliance with their new health policy.⁴⁰⁵ A case-by-case review of policy is an ineffective way to create a national solution to the obesity public health crisis. Limited by the stare decisis requirement, judges are constrained in “their inclination or ability to create policy innovations” to most effectively address the full gamut of solutions.⁴⁰⁶ And because stare decisis is only binding on courts within the given jurisdiction, unless the Supreme Court hears an obesity-related health policy case, any policy implemented by courts will be skewed and inconsistent throughout the nation.

A tax deduction for overweight- and obesity-related treatment is just one way the government can help consistently reduce the prevalence of obesity on a national level. Using the medical expense deduction as a policy vehicle allows the government to address the public health crisis immediately, rather than drag its feet, and at least lays a foundation from which further government policies can be built. And immediate government intervention is necessary, as more than fifty percent of US adults are expected to be obese in less than two decades if the government does not implement policies encouraging people to make healthier living choices.⁴⁰⁷ Therefore, a deduction for overweight- and obesity-related expenses addresses both obesity treatment and prevention as part of a successful holistic policy.

IV. POLICY PROPOSAL

While Congress implemented the medical expense deduction with the purpose of alleviating extraordinary expenses incurred by the taxpayer, in recent decades the medical expenses allowed as deductible by the IRS indicate a shift from this initial purpose. This Section proposes that the IRS’s more recent actions indicate its concern for taxpayers incurring medical expenses related to public health concerns (such as obesity and overweight),⁴⁰⁸ a concern that extends beyond its original purpose of protecting taxpayers who incurred involuntary, extraordinary medical expenses.⁴⁰⁹ Under the current scheme of the medical expenses deduction, however, problems surface when expenses do not rise to the level of being extraordinary—a problem Congress must correct before national public health can benefit.⁴¹⁰ This Section

2002–2004 school years).

405. Kersh & Morone, *supra* note 220, at 860.

406. *Id.* at 859.

407. Caroline Scott-Thomas, *Obesity Crisis Needs Government Action, Says Lancet Report*, FOOD NAVIGATOR-USA.COM (August 29, 2011), <http://www.foodnavigator-usa.com/Regulation/Obesity-crisis-needs-government-action-says-Lancet-report>.

408. See *supra* Part II.A.1 for an explanation of the original legislative purpose of the medical expense deduction.

409. See *supra* notes 285–90 and accompanying text for an explanation of the average cost of obesity and overweight treatment.

410. See *infra* Part IV.A for a discussion on reasons why the deduction might not result in a real tax benefit.

proposes that a tax benefit implemented through a refundable tax credit is the best method to address taxpayer problems and promote public health policy.⁴¹¹ A tax credit applied to tax liability results in a dollar-for-dollar subtraction directly from the taxpayer's tax liability.⁴¹² When the Code provides a refundable tax credit, however, a taxpayer is entitled to a refund in the form of cash even if the taxpayer owes no taxes for the year.⁴¹³ Therefore, regardless of one's tax liability, a taxpayer can be guaranteed to receive a tax benefit for seeking treatment, either in the form of reduced tax liability or cash.⁴¹⁴

A. *The Medical Expense Deduction and Public Health Expenses—Much Ado About Nothing?*

This shift in allowable medical expense deductions raises a problem, which heretofore has yet to be acknowledged: while the classification of obesity and overweight treatment as a medical expense deduction espouses a commendable recognition of a genuine health concern, these treatment expenses often do not result in any real tax benefit to taxpayers. Because the treatment expenses for weight-loss treatment are often not extraordinary, even if expensive, both the medical expense deduction itself and the Code, through other tax provisions, neutralize any potential tax benefits available in these instances for undergoing treatment of a medical disease.⁴¹⁵

As mentioned, in order for a taxpayer to deduct overweight- and obesity-related treatment expenses, those costs need to reach an "extraordinary" level. A problem with the type of treatment commonly sought to cure or mitigate excessive weight is that these expenses, even taken in the aggregate, often do not rise to the extraordinary level—expenses surpassing ten percent of AGI.⁴¹⁶ A similar problem exists under § 213 for other expenses associated with public health concerns, such as smoking, alcoholism, and drug addiction, because treatment costs for all the latter-mentioned diseases often do not total more than the § 213 floor.⁴¹⁷ And while treatment expenses for smoking, alcoholism, drug addiction, and obesity and overweight are properly classified as true medical expenses, they also indicate a policy of affirmative encouragement to engage in treatment for public health concerns. Further, two other tax provisions act as additional barriers in limiting a taxpayer's ability to actually take the deduction, and, even if the deduction is allowed, to benefit from the deduction.

First, a taxpayer may elect to take the standard deduction, instead of itemizing his

411. See *infra* Part IV.B for a discussion of providing a tax benefit through a refundable tax credit.

412. BLACK'S LAW DICTIONARY 1599 (9th ed. 2009). Therefore, the tax credit would entitle a taxpayer to tax deduction, which is an "amount subtracted from gross income when calculating" AGI. *Id.* at 475.

413. WEST'S TAX LAW DICTIONARY § R880 (2013). An example of a refundable tax credit is the Earned Income Credit (EIC). See BLACKS LAW DICTIONARY, *supra* note 412, at 1599 (stating that where the credit is paid to the taxpayer even if it exceeds the total tax liability).

414. WEST'S TAX LAW DICTIONARY, *supra* note 413, at § R880.

415. For example, the average cost of a full-course smoking-cessation program only amounts to anywhere from \$580 to \$1,865. KATE FITCH ET AL., COVERING SMOKING CESSATION AS A HEALTH BENEFIT: A CASE FOR EMPLOYERS 16 tbl.4 (2006).

416. See *supra* Part II.A.1 for an explanation of the purpose of the medical expense deduction to cover extraordinary expenses.

417. See *supra* note 415 for a cost estimate for a smoking-cessation program.

deductions, which has the effect of ignoring any expenses for tax purposes that would qualify under § 213.⁴¹⁸ Because the medical expense deduction is an itemized deduction,⁴¹⁹ before § 213 can reduce a taxpayer's tax liability, he must elect to itemize his deductions instead of taking the standard deduction that is automatically granted to every taxpayer.⁴²⁰ A taxpayer will itemize, rather than take the standard deduction, only if the monetary amount of the itemized deduction is greater than the standard deduction allowed for the taxpayer. For instance, the standard deduction for a taxpayer filing as single in 2011 was \$5,800.⁴²¹ Accordingly, a taxpayer's itemized deductions—including medical expenses—must surpass \$5,800 for the deduction to be economically beneficial for the taxpayer and result in any tax benefit. As mentioned, many of the expenses associated with overweight and obesity treatment are not extraordinary, and, barring uninsured bariatric surgery, it will often be the case that the standard deduction will provide a greater tax benefit than itemized deductions. Therefore, any potential assistance provided to the taxpayer through the overweight- and obesity-treatment deduction is moot when considered in conjunction with the standard deduction.

The second tax provision acting as a barrier to potential tax benefits provided under the medical expense deduction is the Earned Income Credit (EIC).⁴²² Many taxpayers who are overweight or obese are in our nation's lowest socioeconomic class.⁴²³ If these taxpayers are working and are low- to moderate-income earners, their tax liability may be totally offset by the EIC and may even result in a refundable tax credit—in the form of cold, hard cash.⁴²⁴ While a deduction for medical expenses coupled with the ability to take the EIC sounds like nothing more than a double tax benefit for a taxpayer, the practical result of this combination is receiving the EIC to the exclusion of any medical expense deduction benefit. A taxpayer qualifying for the EIC may have zero, or even negative, tax liability whether or not he deducts his medical expenses. In these scenarios, taking the medical expense deduction does not manifest into a noticeable tax benefit because the taxpayer would not have tax liability regardless of his taking the medical expense deduction. This combination again neutralizes any tax benefit the medical expense deduction might have provided for the

418. I.R.C. § 63(a), (b), (e) (2012).

419. I.R.C. § 213.

420. I.R.C. § 63(e).

421. Internal Revenue Service, *In 2011, Many Tax Benefits Increase Slightly Due to Inflation Adjustments*, IRS NEWSWIRE, Dec. 23, 2010, available at <http://www.irs.gov/uac/In-2011,-Many-Tax-Benefits-Increase-Slightly-Due-to-Inflation-Adjustments>.

422. See I.R.C. § 32 (outlining the different EICs that may be taken by individuals). The EIC is a refundable tax credit for low- to moderate-income working individuals and families, which can result in a tax refund even if the credit exceeds taxes owed. *EITC Home Page--It's Easier Than Ever to Find Out If You Qualify for EITC*, INTERNAL REVENUE SERVICE, <http://www.irs.gov/individuals/article/0,,id=96406,00.html> (last updated May 2, 2012). To claim the EIC for the 2011 tax year, a single taxpayer with no children would have to have an AGI less than \$13,660. *EITC Income Limits, Maximum Credit Amounts and Tax Law Updates*, <http://www.irs.gov/individuals/article/0,,id=150513,00.html> (last updated Jan. 23, 2013). The maximum credit amount for such a taxpayer in 2011 is \$464. *Id.*

423. See *supra* notes 286–87 and accompanying text for an explanation of how most obese and overweight taxpayers are in the lowest socioeconomic class.

424. See I.R.C. § 32 (outlining the ways in which an individual's tax liability may be totally offset by the EIC, thus resulting in a refund).

taxpayer.

B. A Shift in Medical Care Expenses: The Public Health Tax Credit

The IRS's policy shift, acknowledging certain public health problems as medical expense deductions even if such health concerns are not associated with extraordinary expenses, indicates that the time is ripe for the Code to provide a different delivery mechanism to continue to provide a tax benefit for certain treatment expenses. The mechanism that this Comment proposes is to implement a refundable tax credit as the appropriate tax vehicle to provide a tax benefit to taxpayers for expenses incurred for the treatment of public health concerns, as opposed to individualized health problems.⁴²⁵

Because inclusion of overweight- and obesity-related expenses under the umbrella of the medical expense deduction does not often result in a real tax benefit for taxpayers, a refundable tax credit gives taxpayers this benefit, while promoting the public health policy of alleviating the overweight and obesity epidemic. The "medical care" requisite for the credit need not differ from what § 213 requires. But because the government is choosing to support a different policy than what § 213 espouses, such general public health motivated expenses should not be required to pass the extraordinary ten percent floor. Instead, the floor requirement should be removed for public health motivated treatment so that all taxpayers can claim the credit for their expenses incurred for medical care. Allowing all obese and overweight taxpayers a refundable tax credit guarantees the taxpayer a tax benefit for undergoing treatment regardless of the monetary amount of the expense, or its interaction with other tax provisions that are unrelated to legitimate medical treatment, like AGI,⁴²⁶ EIC,⁴²⁷ or the standard deduction.⁴²⁸

Determination of the credit amount should take into account the usual factors in credit calculation, such as the taxpayer's filing status, income level, number of dependents, and marginal tax rate.⁴²⁹ Such incurred expenses, such as gym-membership fees and diet-plan fees, should require substantive proof (as is the case for many other tax allowances) in the form of receipts and doctors' prescriptions to verify that the expenses did occur and were part of a prescribed treatment plan.⁴³⁰ Ultimately, the analysis and administrative manner in which § 213 is applied should remain the same; however, eliminating the high floor and guaranteeing a tangible tax benefit to taxpayers

425. The Public Health Credit would apply to public health concerns such as obesity, instead of individual health problems like cancer.

426. See *supra* note 18 and accompanying text for a discussion on AGI as it relates to § 213.

427. See *supra* notes 422–24 and accompanying text for an explanation of how claiming the EIC can neutralize any tax benefit under § 213.

428. See *supra* notes 418–21 and accompanying text for an explanation of how under the current Code, taking the standard deduction may be more beneficial for the taxpayer, thus rendering any adequate medical expenses moot.

429. See, e.g., *Earned Income Tax Credit Rules for Everyone*, INTERNAL REVENUE SERVICE, <http://www.irs.gov/Individuals/Earned-Income-Tax-Credit-Rules-for-Everyone> (last updated Feb. 21, 2013) (listing the requirements and considerations for eligibility and amount of EIC).

430. See *supra* Part II.B.2 for a discussion on the requirements for taking a § 213 deduction for obesity-related treatment.

provides them with certainty when evaluating whether or not to seek treatment for their obese and overweight condition. Having certainty in an incentive may solidify a taxpayer's motivation and increase participation in seeking treatment,⁴³¹ thus promoting overall policy adherence and success.

V. CONCLUSION

With over two-thirds of Americans obese or overweight, this nation's weight-related public health problems are a national concern.⁴³² Overweight and obesity are both indicators of poor health and are associated with numerous comorbidities.⁴³³ The rate of excessive weight has skyrocketed and reached epidemic proportions in recent decades.⁴³⁴ The costs associated with the diseases for individuals, the government, and society are staggering. And both the epidemic itself and its associated costs will continue to grow without collaborative efforts from both the government and individuals.⁴³⁵ The IRS has properly reacted by allowing taxpayers to receive the necessary treatment for their obesity at more feasible costs.⁴³⁶ But the IRS's allowance falls short for two reasons: (1) a tax benefit needs to also include overweight taxpayers seeking weight-loss treatment in addition to obese taxpayers,⁴³⁷ and (2) it should exist in the form of a refundable tax credit.⁴³⁸

Because overweight can be seen as a § 213 disease in its own right, or at least as a condition indicating the "imminent probability" of a disease, there is no reason the IRS cannot expand the allowance to include the treatment-related costs of overweight taxpayers.⁴³⁹ Expanding a tax benefit for overweight- and obesity-treatment expenses can easily be seen as part of the collaborative effort in addressing the public health epidemic.⁴⁴⁰

Further, to adequately address the overweight and obesity epidemic through tax law, the Code should provide obese and overweight taxpayers with a guaranteed tax benefit in the form of a refundable tax credit. The current method—the deduction—used by the Code to address the public health concern is not the best method when

431. See *supra* Part III.G.3 for a discussion on how providing a tax benefit can incentivize weight loss.

432. See *supra* Part II.E for a discussion on the overweight and obesity public health crisis facing the United States today.

433. See *supra* Part III.A.1 for an explanation of how obesity and overweight are diseases for tax purposes.

434. See *supra* Part II.E for an explanation of how the numbers of obese and overweight individuals have reached epidemic proportions.

435. Satcher, *supra* note 8, at xiii–xiv.

436. See *supra* Part III.B for an explanation of how it is within the IRS's power to provide assistance for public health concerns.

437. See *supra* Part III.A for an explanation of why the deduction should properly include overweight as well as obesity.

438. See *supra* Part IV.B for an explanation of why a refundable tax credit is the best vehicle in tax law for addressing the obesity and overweight-related public health concern.

439. See *supra* Part IV.B for an explanation of why the IRS should expand the allowance under § 213 to include overweight-related expenses.

440. See *supra* Part III.H for a discussion on how the IRS's inclusion of obesity and overweight as a § 213 disease is part of a holistic plan aimed at addressing the current public health crisis.

considered in conjunction with other tax provisions because there is no guarantee that a taxpayer who seeks treatment will ever benefit from the deduction.⁴⁴¹

By using a refundable tax credit as the tax benefit delivery method, taxpayers like Melissa Moss would be ensured of a corresponding tax benefit to treating her excessive weight.⁴⁴² Melissa's \$4,000 of debt would be reduced if she had the ability to receive a refundable tax credit for her seeking a healthier life. She would be able to more fully enjoy the benefits of her weight loss instead of taking up a second job just to subsidize the cost of health. By providing the refundable tax credit for obese and overweight taxpayers, the IRS could help others like Melissa Moss fight back against the epidemic for both themselves and society.

Responding to the public health crisis of obesity and overweight is an exciting opportunity for tax law to use its foundational principles and policies to help our nation combat a modern-day health epidemic.⁴⁴³ This Comment encourages tax policymakers to take advantage of this opportunity by recognizing that both overweight and obesity are diseases, and that taxpayers deserve a guaranteed tax benefit in the form of a refundable tax credit when they seek to treat their disease, which further promotes public health policy.⁴⁴⁴

441. See *supra* Part IV.A for an explanation of how a taxpayer may not receive any tax benefit through a deduction for overweight and obesity treatment.

442. See *supra* Section I for an introduction to Melissa Moss and the debt she has as a result of treating her excessive weight.

443. See Press Release, *supra* note 283 (coining the term "war on obesity").

444. "Overweight and obesity must be approached as preventable and treatable problems with realistic and exciting opportunities to improve health and save lives. The challenge is to create a multifaceted public health approach capable of delivering long-term reductions in the prevalence of overweight and obesity." Satcher, *supra* note 8, at xiv.

APPENDIX

Table 1: The International Classification of adult underweight, overweight and obesity according to BMI.⁴⁴⁵

Classification	BMI(kg/m ²)	
	Principal Cut-Off Points	Additional Cut-Off Points
Underweight	<18.50	<18.50
Severe thinness	<16.00	<16.00
Moderate thinness	16.00–16.99	16.00–16.99
Mild thinness	17.00–18.49	17.00–18.49
Normal range	18.50–24.99	18.50–22.99
		23.00–24.99
Overweight	≥25.00	≥25.00
Pre-obese	25.00–29.99	25.00–27.49
		27.50–29.99
Obese	≥30.00	≥30.00
Obese class I	30.00–34.99	30.00–32.49
		32.50–34.99
Obese class II	35.00–39.99	35.00–37.49
		37.50–39.99
Obese class III	≥40.00	≥40.00

445. Data obtained from *BMI Classification*, *supra* note 98.