



OPINION POINT

The Case for Letting Taxpayers Buy Ivermectin with Health Savings Accounts

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Early in the pandemic, the internet brimmed with unproven remedies for COVID-19. Many were laughable. Others featured in impressive-looking “pre-prints.” Some found their way onto tax returns. Eventually, the tax court will have to decide which of these qualify as “medical care” under section 213(d). For the flimsiest treatments, the IRS may revive its position that there must be “scientific proof” that the regimen actually “treat[s] disease.” This idea has been adjudicated only once before, in *O’Donnabhain v. Commissioner*,¹ a case involving sex reassignment surgery. Judge Gale’s majority opinion² found that the petitioner’s surgery did treat her disease of gender identity disorder, and it implicitly accepted the IRS’s position that a regimen must be shown to treat disease. By contrast, Judge Holmes’s concurrence pointed to authority that taxpayers need only show that they relied on evidence sufficient to “justify a reasonable belief” that the regimen would help.

I argue that Judge Holmes’s view best reflects precedent. Admittedly, that interpretation opens the door to frivolous deductions, but that seems inevitable when there are new diseases with new treatments. If Congress wants to avoid these abuses, it should stop subsidizing medical care expenditures when scientists do not yet know what good medical care is. Until Congress makes this change, the biggest abuses will occur with over-the-counter (OTC) drugs. Congress has only itself to blame for that, as discussed in the final section.

Medical Care in the Code

Since 1918, the Code has denied deductions for “personal, living, [and] family expenses.”³ In 1942, Congress made an exception for medical care, “in consideration of the heavy tax burden that must be borne by individuals during the existing emergency and of the desirability of maintaining the present high level of public health and morale.”⁴ This describes medical care as activities “for the

Medical care consumption—like consumption entailed by employment, parenthood, religious/charitable obligation, poverty, casualty loss, etc.—follows this framework. We allow deductions when we feel the consumption was compelled, whether by pain, misery, duty, or fear. We question the deduction when the consumption also has a pretextual appeal. Often the line is blurry.

¹ *O’Donnabhain v. Commissioner*, 134 T.C. 34 (2010). The IRS ultimately acquiesced on the *O’Donnabhain* decision, rejecting the position announced in CCA 200603025. See AOD 2011-03.

² Although Judge Gale’s opinion was joined by only eight of sixteen judges, the Tax Court refers to it as the “majority.”

³ Pub. L. No. 65-254 § 215, 235; IRC 262.

⁴ S. Rept. No. 1631, 77th Cong., 2d sess., p. 6.

diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body.”⁵

The Haig-Simons definition of income⁶ says that income between two dates equals the sum of (1) “the change in the value of the store of property rights” and (2) “the market value of rights exercised in consumption.”⁷ As Simons acknowledged, this model fails to account for other variables which influence how a person benefits from consumption, including whether there is free choice, how personal tastes, allergies, or other traits affect the consumption experience; and moral or social taboos about the consumption. Simons famously illustrated the first two factors of constraint and taste using “Kleinwächter’s conundrum,”⁸ which describes a soldier who gets a plum assignment: instead of joining the infantry, he will serve as personal secretary to the Prince. While performing his duties, he will live royally at no expense to himself. In this hypothetical, the role of constraint is illustrated by the military and royal settings. That is, the aide’s daily consumption is completely dictated by the happenstance of his draft number and the Prince’s whims. In turn, the role of taste is illustrated by further assuming that he detests some of the Prince’s hobbies.

Medical care consumption—like consumption entailed by employment, parenthood, religious/charitable obligation, poverty, casualty loss, etc.—follows this framework. We allow deductions when we feel the consumption was compelled, whether by pain, misery, duty, or fear.⁹ We question the deduction when the consumption also has a pretextual appeal. Often the line is blurry. One commentator notes that “it is impossible to see a definitive boundary between the nondeductible expenses of healthful food and deductible expenses of special food needed to treat a medical condition.”¹⁰ Similarly, in the words of Bittker and Lokken: “In a nation obsessed by physical and mental health, many of whose people patronize health food stores as religiously as others worship at fitness centers, the borderline between personal living expenses and medical care constantly gets fuzzier.”¹¹

O’Donnabhain resembles a normal medical case, in that the IRS questioned whether the taxpayer pursued her therapy due to constraint or pretext. But it also falls outside this framework, because it implicates the other variables mentioned above: the therapy (at least in the views of some) also constitutes self-harm or violates taboos. To illustrate these forces at work, imagine a nicotine addict who seeks to deduct his cigarettes. Most of us would be skeptical. We might feel differently, however, if doctors could show that this particular taxpayer’s addiction was unbreakable and that nicotine with-

⁵ I.R.C. § 213(d)(1).

⁶ For differing explanations of the benefits of the medical care deduction, see James W. Colliton, *The Medical Expense Deduction*, 34 WAYNE L. REV. 1307 (1988) (contrasting the view of William Andrews, who applies a Haig-Simons analysis, with that of Stanley Surrey, who applies a tax expenditure analysis); L. Kaplow, *The income tax as insurance: The casualty loss and medical expense deductions and the exclusion of medical insurance premiums*, 79 CALIF. L. REV. 1485 (1991).

⁷ See HENRY SIMONS, *PERSONAL INCOME TAXATION* at 50, 61-62, 206 (Univ. of Chicago Press 1938).

⁸ See Wikipedia, https://en.wikipedia.org/wiki/Kleinwachter%27s_conundrum (an article about Austrian economist Friedrich Kleinwachter created by the author as a student in 2009).

⁹ See William D. Andrews, *Personal Deductions in an Ideal Income Tax*, 86 HARV. L. REV. 309, 336 (1972) (“What distinguishes medical expenses from other personal expenses at bottom is a sense that large differences in their magnitude between people in otherwise similar circumstances are apt to reflect differences in need rather than choices among gratifications”); Joel S. Newman, *The Deductibility of Nondiscretionary Personal Expenses*, 6 AM. J. TAX POL’Y 211 (1987).

¹⁰ Colliton, *supra* n. 6 at 1327. See also Andrews, *supra* n.9 at 336 (“we do not allow any deduction for food, presumably because we think substantial differences in expenditures for food mostly reflect differences in taste and means. ... It is impossible to make any generalization about whether a large appetite is a boon or a burden, let alone to assign it any monetary value.”)

¹¹ BORIS BITTKER AND LAWRENCE LOKKEN, *FEDERAL TAXATION OF EMPLOYEE COMPENSATION*, Ch. 7.

drawal was interfering with his ability to enjoy life. Nonetheless, some would never be comfortable calling a poison a medicine or subsidizing taboo behavior.

O'Donnabhain Is Not About What “Treats Disease”

As Judge Gustafson aptly noted in *O'Donnabhain*, the important issue in that case was not whether the procedure treated the disease.

Medical care that is given pursuant to medical consensus might later prove to have been unfortunate or even disastrous (such as thalidomide prescribed for morning sickness); but an eventual discovery that the care was ill advised would not affect the deductibility of that care for income tax purposes.¹²

Desperate people pursue nearly hopeless procedures all the time, and much legitimate medical care is unhelpful.

Before *O'Donnabhain*, no cases had even asked this question. Where the tax court has had a chance to weigh in on the question, it dodged it. For example, two different opinions in *O'Donnabhain* characterized prior tax court cases *Crain* and *Dickie*¹³ as cases defining medical care.¹⁴ In fact, these cases do not touch on these issues because both relied without analysis on *Tso*,¹⁵ a case which was really about substantiation of costs. Similarly, the *Tautolo* court¹⁶ denied a deduction for treatment by native Samoan doctors, including native herbs, massages, and calling upon spirits. Citing precedent that “the issue turns on the nature of the services rendered, not on the experience or qualifications or title of the person employed,” the court clarified that it denied the deduction not based on competence of the doctors or efficacy of the treatments, but because all patients, regardless of their individual needs, received the same treatments. That indicated that the treatments were not related to the individuals’ particular maladies. Further, the taxpayer’s personal circumstances suggested that he possessed only a hope rather than a “reasonable belief” in the probability of success. In other words, the *Tautolo* court did not consider whether the treatments were medicine, because the taxpayer effectively conceded that they were not. The same logic applied in another case to deny a medical care deduction for the cost of a trip to the Shrine of Our Lady of Lourdes in France.¹⁷ Although the record reflected the Catholic Church’s view that miracles had been performed at the shrine, the tax court similarly found that the visit was made for “spiritual aid,” with “no more than a hope that as a result some improvement would occur in a physical condition.” In short, the taxpayer himself did not view the visit as medical.

Colliton observed that cases of this kind demonstrate the lack of an effective definition of medical care for services based on uncommon individual beliefs. “Conceivably, most would not believe that Navajo medicine men, Christian Science practitioners, or Scientologists could treat illness, even though their patients have great faith in the treatment. The holdings do not indicate whether pop-

¹² *O'Donnabhain*, 134 T.C. at 110 (Judge Gustafson, concurring and dissenting in part).

¹³ *Crain v. Comm'r*, 51 T.C.M. (CCH) 806 (T.C. 1986) (holistic healing center for cancer) and *Dickie v. Comm'r*, 77 T.C.M. (CCH) 1916 (T.C. 1999) (naturopathic cancer treatments).

¹⁴ To the majority, they showed that “a complete consensus on the advisability or efficacy of a procedure is not necessary for a deduction under section 213.” To Judge Holmes’s concurrence, they showed that “Our precedent ...allows for the deductibility of treatments that are highly unlikely to survive rigorous scientific review.”

¹⁵ *Tso v. Comm'r*, 40 T.C.M. (CCH) 1277 (T.C. 1980) (allowing the deduction for traditional Navajo medical treatment performed by Navajo medicine men, where the IRS conceded without arguing that the treatments counted as medical).

¹⁶ *Tautolo v. Comm'r*, 34 T.C.M. (CCH) 1198 (T.C. 1975).

¹⁷ *Ring v. Comm'r*, 23 T.C. 950 (1955).

ular opinion defines medical care or whether the individual's belief controls the deductibility of the expenses.”¹⁸

***O'Donnabhain* Is About Who Decides What Treats Disease—Doctor, Patient, or Judge**

O'Donnabhain is the first and only case to address Colliton's question regarding who should be entrusted to *decide* whether a procedure treats the disease—doctor, patient, or judge. The opinions show a range of views on the matter. The majority deferred to medical consensus and further held that the doctors who approved the procedure had consensus behind them. Judge Holmes deferred to a reasonable person in the taxpayer's position, noting that once doctors show a condition is a disease, the court has no role in considering the standards of care or their effectiveness.¹⁹ For Judge Gustafson, judges have a more active role, because “Congress did not cede to doctors the authority to grant tax deductions” (and thus a doctor who treats a healthy male's body rather than the anomaly of his subjective sense of being female “has given up on the mental disease”).²⁰

James Colliton, writing before the 2010 *O'Donnabhain* case, had concluded that arguments like Gustafson's did not make sense.

[T]he logical trend is to allow the deduction if the patient believes the treatment may help his condition, even if others disagree. After all, there is no requirement that deductible medical care be effective. A patient can receive useless medical treatment from a medical doctor as well as from a Samoan native practitioner.²¹

I would go further. Since the 1949 *Havey* tax court case,²² it should be clear that a deduction is permitted for treatments that a reasonable person would pursue in the taxpayer's position. *Havey* involved an individual who traveled to the seashore during the summer, and to Arizona during the winter, purportedly on her cardiologist's recommendation. By the time of this travel, she was still convalescing but had mostly recovered. The “generally accepted” treatment was rest, yet she coaxed her doctor to recommend a travel regime that coincided with her vacation preferences. The heat and light in Arizona improved her general health (but no differently from other vacationers) and perhaps even her heart condition (but only incidentally).

Havey has a chameleon-like quality that appears to support opposing conclusions. For example, in *O'Donnabhain*, Judge Gustafson quotes the requirement that the treatment “bear directly on the ... condition in question” three times, including to support his view that the taxpayer should have treated her mental illness. Meanwhile, in its favorable discussion of the taxpayer's medical experts, the *O'Donnabhain* majority thrice cites the next clause in the same sentence in *Havey*, inquiring whether the treatment bore “such a direct or proximate therapeutic relation to the bodily condition as to justify a reasonable belief the same would be efficacious.” *Havey*'s influence can also be seen in the majority's repeated citations to the *Jacobs* case,²³ in which the taxpayer sought a medical deduction for legal expenses arising from his divorce, on the grounds that his psychiatrist

¹⁸ Colliton, *supra* n. 6, at 1345.

¹⁹ Although he refers to the “subjective” motives of the taxpayer, the “good faith” qualifier makes this a reasonableness test.

²⁰ Gustafson concurrence, *supra* n. 12.

²¹ Colliton, *supra* n. 6 at 1345.

²² *Havey v. Comm'r*, 12 T.C. 409, 411–13 (1949).

²³ *Jacobs v. Comm'r of Internal Revenue*, 62 T.C. 813 (1974).

“prescribed” the divorce to treat his depression. In finding that these medical factors were not the true cause of the divorce, the court cited *Havey* for its “direct or proximate therapeutic relation” language. It then held that, for an activity to be deductible, the taxpayer must show that it would not have been undertaken “if there had been no illness.” This, in turn, requires showing both that the activity would not have been undertaken for “nonmedical reasons” and also that the activity was “an essential element of the treatment.” This has become the standard articulation of the test for the medical deduction. In *O’Donnabhain*, the majority applied this “but for” test in finding that the medical evidence supported the taxpayer’s position.

Jacobs misconstrues *Havey*’s message in failing to mention *Havey*’s explanation of *why* the court cares about a treatment’s “direct or proximate therapeutic relation”: i.e., that it supports a reasonable belief of efficacy. Thus, the *Jacobs* case made *Havey* into a case about objective scientific truth, rather than a case about a taxpayer’s reasonable belief. Additionally, *Jacobs* deals with an entirely different issue than the one addressed in *O’Donnabhain*. Like the half-dozen cases it sought to restate, *Jacobs* involved the deductibility of a concededly non-medical expense (lawyer’s fees, school tuition, hotels and flights, etc.) when used in conjunction with other, concededly medical, treatments.²⁴ Because all these cases involved concededly non-medical activities, it made sense to ask whether they would have been undertaken “if there had been no illness.” That question makes

Until Congress takes these steps, the biggest source of abuse will be OTC drugs. While the medical care deduction is only available for expenses above 7.5% of AGI and is not available for most OTC drugs, the cost of these drugs is effectively deductible to persons with HSAs and other tax-favored medical accounts

no sense when the proposed treatment is medical in nature: if there were no illness, of course the taxpayer would not have undertaken the treatment. Thus, the *Jacobs* court could not have imagined that its test would be used to second-guess whether a purportedly medical treatment should qualify as medical.

When *Havey* is read in its entirety, it defines a reasonable person. A reasonable person would be influenced by the direction of a physician. A reasonable person would be influenced by whether the treatment bore “directly” on the condition from which the person suffered—or had a sufficiently “direct or proximate therapeutic relation” to the condition “as to justify a

reasonable belief the same would be efficacious.” A reasonable person would seek treatment “proximate[ly] in time to the onset or recurrence of the disease or condition.” This corresponds to the view expressed by Judge Holmes’s concurrence in *O’Donnabhain*.

COVID-19 and the Early Stages of Science

New diseases bring new treatments, and those new treatments bring novel claims for medical deductions. *O’Donnabhain* involved a new disease in the sense that public attitudes towards gender identity disorder have evolved. The COVID-19 pandemic brought a truly new disease on a mass scale and, with it, a potential wave of claims for tax benefits. If the tax court applies the majority’s rule in

²⁴ See *Havey*, *supra* n. 22 (travel to seashore and Arizona); *Atkinson v. Comm’r*, 44 T.C. 39 (1965) (deduction denied for attendance at a boarding school); *Stringham v. United States* (deduction permitted, where the taxpayer sent his sick child to Arizona to escape the cold winter weather that aggravated her respiratory ailments); *Carasso v. Comm’r*, 34 T.C. 1139 (1960) (trip to a resort area was undertaken “solely for medical reasons”); *Winderman v. United States* (deduction permitted for a California resident who traveled to New York to consult his personal physician); *Gerstacker v. Comm’r*, 414 F.2d 448 (6th Cir. 1969) (deduction allowed for the legal costs of the taxpayer’s guardianship proceedings, which were necessary to “put her under the continuing control of the doctors so that she could not leave and disrupt her therapy”).

O'Donnabhain, its job will be easier, especially if it uses hindsight. If, however, it defers to the views of a reasonable person in the taxpayer's shoes, the results might make many of us uncomfortable. Tax benefits may be permitted for controversial regimens like ivermectin, hydroxychloroquine, and other purported COVID-19 remedies that most medical doctors find unsubstantiated.²⁵ Further, the results might vary depending on the taxpayer's circumstances, such as his education, what he read, or with whom he consulted.

This is not a flaw in the legal rule; instead, it reflects the slow and ambiguous nature of medical progress. The state of science early in the pandemic is illustrated by a recent Washington Post essay by an emergency room doctor who explains the "standard thinking in the treatment of medical emergencies" as follows: "Might help. Won't hurt. Worth pursuing."²⁶ It is also illustrated by the recent popularity of "pre-prints," preliminary research papers that circulate on the internet before being accepted for publication.²⁷ Pre-prints have not been peer reviewed, yet they have the veneer of science. As such, they create a dilemma for the lay public, which is not capable of evaluating the claims.²⁸

If I were a judge, I would find it difficult to deny a deduction to a patient who took the advice of a pre-print—or, for that matter, a patient who relied on a chain email attributed to a doctor.²⁹ Yet when a disease is new and scientists do not yet agree what good medical care is, the medical care deduction becomes harder to justify as a public policy matter. Instead of subsidizing public health, it subsidizes panic shopping. A possible solution would be for Congress to delegate to Treasury the power to identify "novel diseases." Treasury, in turn, could delegate to the CDC the ability to include or exclude certain treatments for these diseases from the definition of "medical care" to be used for tax purposes.

Over-the-Counter Drugs: History of CARES Section 3702

Until Congress takes these steps, the biggest source of abuse will be OTC drugs. While the medical care deduction is only available for expenses above 7.5% of AGI and is not available for most OTC drugs, the cost of these drugs is effectively deductible to persons with HSAs and other tax-favored medical accounts, thanks to a provision in the CARES Act which has nothing to do with COVID-19 relief, the so-called "repeal of the medicine cabinet tax."

Between 1982 and 2010, OTC medicines have generally not been eligible for the medical care deduction, but they technically were eligible for purchase from HRAs, Health FSAs, Archer MSAs, and HSAs.³⁰ This is because these arrangements incorporated section 213(d)'s definition of "medical care," but not section 213(b)'s ban on claiming the medical care deduction for OTC medicines. The IRS did not draw this inference until 2003.³¹ The reason for this delay may be, in part, due to the con-

²⁵ Many of these are listed on the Wikipedia page, "[List of Unproven Methods Against Covid-19](#)."

²⁶ Farzon A. Nahvi, *Emergency situation. Might help. Won't hurt. Worth pursuing. In a pandemic, it's the right logic*, WASH. POST (Sept. 20, 2021).

²⁷ Nicholas Fraser et al., *The evolving role of preprints in the dissemination of COVID-19 research and their impact on the science communication landscape*, PLoS Biol. 19(4): e3000959 (2021), at <https://doi.org/10.1371/journal.pbio.3000959>.

²⁸ Stanford researchers discuss the benefits – and perils – of science without peer review, April 6, 2020, available at <https://news.stanford.edu/2020/04/06/open-science-era-covid-19/>.

²⁹ For example, see the widely circulated March 2020 letter falsely attributed to the Stanford Hospital Board, as discussed in Angelo Fichera, [Viral Social Media Posts Offer False Coronavirus Tips](#), FactCheck.org (Mar. 12, 2020).

³⁰ For more detail on these arrangements, see "[Tax-Advantaged Accounts for Health Care Expenses: Side-by-Side Comparison, 2013](#)," CRS Report (Nov. 8, 2013).

³¹ See Rev. Rul. 2003-102.

servative Bush Administration's desire to drive consumers towards Health MSAs and HSAs, forms of consumer-driven healthcare (CDHC) introduced in 1996 and 2003, respectively. This rule created a perverse incentive to purchase unneeded OTC drugs, arguably driving up their prices.³² To combat this, in 2010 the Affordable Care Act reversed the IRS.³³ In 2020, CARES Section 3702 then re-reversed this aspect of the Affordable Care Act, restoring the special treatment of purchases of OTC drugs using these tax-favored accounts.³⁴ For this reason, proponents of the 2020 provision loosely describe it as abolishing a tax—the “medicine cabinet tax.” Still, the provision *preserves* that tax for individuals without HSAs or similar arrangements, suggesting that the true motive was to restore the bias towards CDHC arrangements.

Despite its inclusion in a coronavirus relief bill, CARES Section 3702 has nothing to do with coronavirus relief. Its proponents clearly conceived of it as a permanent reform. Unlike another provision in the CARES Act targeted at the cash crunch (the new “coronavirus-related distribution” from retirement accounts), it is not expressly tied to coronavirus-related needs. Unlike other provisions tailored to the emergency at hand, it never sunsets. Like the other provision in Section 3702—the expansion of medical care to include feminine hygiene products³⁵—it was the subject of heated cultural debate before the pandemic.³⁶

Congress's decision to play partisan politics with the pandemic relief bill undermined pandemic relief. It took expert medical advice out of the equation exactly when patients needed expert help in formulating their “reasonable beliefs.” It gave a blessing to more affluent taxpayers with access to tax-favored medical savings arrangements to treat them as piggy banks for stocking up on nicotine gum, vitamin D,³⁷ or any other sundry with a legitimate-looking preprint to its name. If Congress is concerned about frivolous COVID-19-related deductions, it should set aside its grudge against Obamacare and repeal this CARES Act Section 3702 provision. ■

³² The expanded deduction reportedly led to increased spending, especially for FSAs and HRAs, where the unspent balance is forfeited at the end of the year. See Selena Simmons-Duffin, [Save Those Pharmacy Receipts! New Payment Flexibility, Courtesy Of COVID Rescue Act](#), NPR.org (Apr. 1, 2020) (“At the end of the year, you’d go and stock up on Band-Aids and Tylenol”). The Joint Committee on Taxation observed that “expenses for non-prescription drugs are more likely to represent expenses for ordinary consumption than ‘extraordinary’ medical costs,” and that allowing a deduction for non-extraordinary costs tends to lead to overutilization, driving up healthcare prices. Staff of Joint Comm. on Tax’n, 97th Cong., 2d Sess., General Explanation of the Revenue Provisions of the Tax Equity and Fiscal Responsibility Act of 1982, at 24 (Comm. Print 1982).

³³ See Rev. Rul. 2010-23. The ACA also added section 139D, which excludes Indian health care benefits from income. In CCA 201302021, the IRS held that the term “medical care” for this purpose does not include OTC drugs—even though it identifies no authority and even though the ACA took great pains to express its views on OTC drugs precisely. The CCA deserves to be challenged.

³⁴ Section 3702 also purports to affect section 106, in what is likely a typo. Also, while CARES Section 3853(a) appears to exclude homeopathic drugs from the expanded definition of medical care in CARES Section 3702, that appears to be a drafting mistake. The CARES Act and Families First Act both state that “any reference to ‘this Act’ contained in any division of this Act shall be treated as referring only to the provisions of that division.” This made sense in the Families First Act, where each Division corresponded to an “Act.” However, it is the Titles that correspond to separate “Acts.” Perhaps the drafters of CARES copied text from Families First but forgot they switched from Divisions to Titles.

³⁵ See [House Passes Meng Legislation Permitting Menstrual Hygiene Products to be Purchased with Health Flexible Spending Accounts](#), Press release, 07/27/2018; [letter from the American Medical Association to the IRS](#) (seeking clarification as to whether these products qualify under tax-qualified accounts); [IRS Info letter 2019-0005](#) (IRS’s response, suggesting they do not).

³⁶ See Americans for Tax Reform, [“Medicine Cabinet” Tax a Bitter Pill for Ordinary Americans](#), Blake Seitz, Aug. 3, 2012; [CARES Act Repeals Obamacare Medicine Cabinet Tax](#), Tom Hebert, March 26th, 2020.

³⁷ In Rev. Rul. 2003-102, the IRS held that vitamins do not constitute “medical care” when consumed for “general health.” In response, taxpayers could show that using Vitamin D for COVID-19 goes beyond “general health.” Or they could challenge the holding altogether (vitamin deficiencies are serious diseases).