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Tax Policy as a Lifeline:

Encouraging Blood and Organ Donation Through Tax Credits

Joseph B. Clamon, J.D.*

I. INTRODUCTION

Blood, organ, and tissue donation provide unique opportunities to assist others. Technology now exists to transfuse blood and transplant a plethora of organs including hearts, lungs, kidneys, livers, and intestines, among others. The ability to save a life through blood transfusions and organ transplants, however, has been significantly limited by a serious and chronic shortage of blood and organs suitable for infusion and transplantation.¹ Thousands of patients die awaiting transplants each year due to the lack of available organs.² The problem of blood shortages is equally significant, particularly after a major catastrophic event such as a terrorist attack or natural disaster.³

An inadequate supply of donors is the major reason for the shortage of transplantable blood and organs.⁴ Although estimates of the number of deaths that “occur each year under circumstances that would allow for removal and transplantation of cadaver organs vary widely, all such estimates reveal a substantial pool of potential organ donors who, for a

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¹ See generally Kathleen Kingsbury, Donor Deal, TIME, June 25, 2007, at 53 (“About 90% of Americans say they support organ donation, but only 30% have actually signed up to part with their parts after they die.”).

² The Organ Procurement and Transplantation Network, Data, http://www.optn.org/data/ (last visited Nov. 23, 2007). As of October 24, 97,910 people were awaiting an organ transplant of one or more organs. In comparison, only 19,249 transplants were performed nationwide between January and August 2007 from 9,759 donors. Id.


variety of reasons, fail to supply the needed organs.\(^\text{5}\) According to one estimate, only 49.8% of eligible cadaveric donors become actual donors.\(^\text{6}\) Other estimates suggest that the potential number of organ donors is at least double the existing number of actual donors.\(^\text{7}\) The shortage of potential organ donors is exacerbated by the fact that only two percent of donors meet the medical requirements to donate.\(^\text{8}\) Inefficient procurement practices further decrease the number of viable organ donors.\(^\text{9}\) Although the number of potential blood donors is not known for certain, most of the general public, with the exception of people with certain conditions or illnesses, possess the ability to donate blood.\(^\text{10}\) Many blood banks estimate that sixty percent of the United States population is eligible to donate blood, although only five percent of potential blood donors actually donate.\(^\text{11}\)

People choose not to donate for a vast array of reasons. The most prevalent reasons why people choose not to donate include moral opposition to the concept of organ donation, religious beliefs that oppose organ donation and/or blood transfusion, desire to keep the body intact posthumously, confusion about the process, fear of donation, reliance on myths about how organs are obtained (e.g., the urban myths of the person having their kidney stolen and being placed in a tub of ice), inability to control who will receive the organs, and failure by anyone to inquire about an individual's donative wishes.\(^\text{12}\)

In response to this critical shortage, scholars and legislators have proposed various mechanisms for increasing the amount of blood and


\(^\text{6}^\text{Carroll, supra note 4.}

\(^\text{7}^\text{Kaserman, supra note 5, at 568.}

\(^\text{8}^\text{HMS Researchers Address Transplant Organ Shortage, HARVARD UNIV. GAZETTE, October 2, 2003, http://www.hno.harvard.edu/gazette/2003/10.02/21-organs.html.}

\(^\text{9}^\text{Id.}


number of organs available. Many scholars have suggested adopting a commercial system in which donors are reimbursed in some manner for their donation. Proposals have included direct payment, death benefit, or the creation of a futures market in organs. Other scholars have proposed noncommercial solutions, including systems involving presumed consent, mandated choice, paired organ exchanges, or mutual insurance. Serious concerns accompany each of these proposals. For example, some argue that commercial systems offend traditional notions of giving, disrespect potential donors' wishes, and infuse financial considerations into a potential donor's decision-making process. An alternative proposal that addresses these concerns is to encourage donation through the establishment of more favorable tax treatment for blood and organ donations through the use of tax credits.

This article proposes the use of this type of alternative approach—to employ tax policy to encourage blood and organ donation. Section II discusses the current regulatory environment controlling donation and the tax code’s treatment of donation. Section III explores the possible development of commercial and noncommercial systems of blood, tissue, and organ donation, evaluates the problems with these systems, and explains why they are not the appropriate ways to encourage donation. Section IV analyzes alternative solutions based on tax policy and proposes an alternative solution that encourages blood and organ donation through the use of a tax credit. Section V concludes with the development of a model tax code statute that provides a tax credit for blood and organ donation that will encourage donation while eliminating the ethical and logistical problems posed by other proposals.

II. CURRENT REGULATION OF BLOOD AND ORGAN DONATION

The law addressing blood transfusion and organ transplantation is vast and complex. This section surveys the influential law that bears on the

14. See infra Section III.A.
15. See id.
16. See infra Section III.B.1-2.
17. See infra Section III.A.
various proposals for encouraging donation, including how current tax policy affects donation. Overall, the past and present state of the law shows continuous resistance to the notion of a market for organs or tax benefits for donating.

A. Regulation of Blood and Organ Donation

Regulation of blood and organ donation is based on society’s beliefs regarding the human body, in particular, society’s belief concerning whether a person possesses a property interest in his or her body and if so, what type of interest. By providing an overview of the historical development of the law regarding property interests in the human body and exploring current regulation of blood and organ donation, this section provides a basis for understanding and evaluating the potential for various proposals and their likelihood for success.

Early conceptions of property rights in the body were divided into views on property rights in cadavers and rights in living organs and tissue. This distinction had a significant impact on scholars’ views of whether a person held a property interest in his body, and whether a person had the ability to control the disposition of his body. Thus, this distinction frames the examination of the historical development of the law regarding property rights in the human body.

1. Early Conceptions of Property Rights in the Human Body

At common law, one could not hold a property interest in a cadaver. Lord Edward Coke “considered the property status of the cadaver implicit in its etymological derivation of the word cadaver, caro data vermibus, flesh given to worms, and, therefore, the property of no one.” Although the Catholic Church attempted to assert that it possessed temporal and jurisdictional power over human remains around 750 A.D. after the

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a survey of the most influential laws pertaining to the sale of human organs); DAVID PRICE, LEGAL AND ETHICAL ASPECTS OF ORGAN TRANSPLANTATION (Cambridge Univ. Press 2000) (providing a review of the ethical principles and positions underpinning organ transplant laws); THE ETHICS OF ORGAN TRANSPLANTS: THE CURRENT DEBATE (Arthur L. Caplan & Daniel H. Coelho eds., Prometheus Books 1998) (presenting a compilation of essays on the legal, ethical, medical, sociological, and political issues surrounding organ transplantation).


20. See generally id. at 9-20 (providing an overview of the development of perspectives on property rights in cadavers, living organs, and tissues).


22. Boyd, supra note 18, at 436.
beginning of burials in churchyards, the English courts stated in *Regina v. Sharpe* that no property rights in corpses existed. Early American courts similarly rejected the notion that absolute property rights existed in the human body. Today, American (and English) courts recognize a quasi-property right in corpses, for example, in the disposition of remains. However, even this right is limited by the rights of coroners and medical examiners to examine the body. As will be discussed in Sections II.A.2.d and e, a person’s property right in a cadaver is further limited today by the prohibition on purchasing or selling body parts for either transplantation or therapy.

Unlike at death, valid property rights have existed in living bodies. At common law, a creditor could force payment of a debt by court-ordered imprisonment of the debtor. A woman’s body was once considered the property of her husband. However, the most obvious example is the institution of slavery, under which an owner held an absolute ownership right in another human being, including the right to profit from a slave’s body. The Thirteenth Amendment to the United States Constitution, which outlawed slavery, implicitly affirmed that former slave owners previously held property rights in other human beings.

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26. Id.
29. Id.
30. Theoretically, a slave owner’s interest in a slave was not absolute because the murder of a slave by an owner constituted a crime. “In former times, the murder of a slave in most, if not all the slaveholding regions of this country, was, by law, punishable by a pecuniary fine only.” *William Goodell, The American Slave Code In Theory and Practice: Its Distinctive Features Shown By Its Statutes, Judicial Decisions, and Illustrative Facts* 178 (American and Foreign Anti-Slavery Society 1853). By 1853, murder of a slave was “punishable with death in every State.” *Id.* However, because of the “exclusion of all testimony of colored persons” and numerous exceptions to this rule of law (e.g., killing of slaves who resisted in any form was not murder, death of a slave because of harsh punishment was not murder), in reality an owner’s property interest in a slave was essentially absolute. *Id.* at 178-82.

More recently, courts have been inclined to hold that people have a limited property interest in their bodies.\(^{33}\) Today, some types of human tissues are legally traded. Bodily tissues and fluids, including blood, semen, and hair, are legally bought and sold.\(^{34}\) "However, jurisdictions are split over whether the sale of blood is the sale of a product or the provision of a service."\(^{35}\) The case law regarding whether an individual possesses a property interest in his or her body and its components is complex and inconsistent. Three notable cases dealing with the issue of property rights in biological specimens, including tissue and cells, extracted from a living person are Moore v. Regents of the University of California,\(^{36}\) Hecht v. Superior Court,\(^{37}\) and Washington University v. Catalona.\(^{38}\)

a. Moore v. Regents of the University of California

The issue in Moore was whether a person continued to own his tissue after it was removed from his body for research purposes without his consent.\(^{39}\) John Moore was diagnosed with hairy-cell leukemia and sought treatment at UCLA.\(^{40}\) During seven years of periodic visits, samples of blood, sperm, bone marrow, and skin were removed with Moore's consent.\(^{41}\) Moore was told that the removal of his body tissues and spleen was necessary for his health; however, they were also used by a researcher for commercial development.\(^{42}\) Moore was not informed that his physician was selling his cells for a substantial amount of compensation.\(^{43}\) Moore brought a claim of conversion, claiming a proprietary interest in each of the

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33. See, e.g., Hecht v. Superior Court, 59 Cal. Rptr. 2d 222 (Cal. Ct. App. 1996); Wash. Univ. v. Catalona, 490 F.3d 667 (8th Cir. 2007).
34. Gorsline & Johnson, supra note 13, at 11.
35. Id. at 12. See, e.g., Perlmutter v. Beth David Hosp. 123 N.E.2d 792, 794 (N.Y. 1954) (holding that blood transfusions were a service, not a sale of a product when determining whether to apply strict liability to a hospital for undiscoverable defects in blood). But see, e.g., Carter v. Inter-Faith Hosp. of Queens, 304 N.Y.S.2d 97, 100 (N.Y. Sup. Ct. 1969) (characterizing transaction with blood bank as a sales transaction).
38. Wash. Univ. v. Catalona, 490 F.3d 667 (8th Cir. 2007).
40. Id. at 480-81.
41. Id. at 481.
42. Id.
43. Id. at 482.
products created from his cells or the patented cell line. In response to Moore's claim for conversion, the California Supreme Court held that although Moore had a valid cause of action for breach of fiduciary duty for the doctor's failure to disclose his conflict of interest, Moore could not claim an ownership interest in the patented cell line and its resulting products. The court reasoned that Moore had no claim of ownership because the patented cell line was legally and factually distinct from Moore's cells. Through its decision, the court refused to "extend the existing law of conversion to Moore's tissues because his rights could be protected under [a theory of] breach of fiduciary duty and negligence. The court viewed the legislature as the more appropriate forum for making new policy regarding property interests in the human body.

In reaching its decision, the Moore court recognized the tremendous impact any other holding would have had on research because of researchers' need for access to tissue or cells for their work. Accordingly, the Moore decision attempted to strike a balance between protecting Moore and not impeding research. By basing its decision on lack of informed consent, the court protected both Moore and research, consequently refusing to recognize a property interest for Moore in the cells.

b. Hecht v. Superior Court

The issue in Hecht was whether a decedent's preserved sperm vials that remained after his suicide were the property of the decedent's estate and, by extension, whether he had a property interest in those vials and could direct their distribution. The court distinguished the facts in Hecht from those in Moore by explaining that there was an explicit contract with the sperm bank in Hecht that evidenced the decedent's intent. The court concluded that the "decedent had an interest, in the nature of ownership, to the extent that he had decision-making authority as to the use of his sperm for reproduction." Such interest was sufficient to constitute "property" within

44. Moore, 793 P.2d at 482-83.
45. Id. at 483, 492.
47. Gorsline & Johnson, supra note 13, at 13.
48. Id.
49. Jordan & Price, supra note 21, at 163-64.
50. Id.
51. Hecht v. Superior Court, 20 Cal. Rptr. 2d 275, 279 (Cal. Ct. App. 1993). In this case, two adult children sought to prevent the decedent's girlfriend from obtaining the vials. Id. at 278.
52. Id. at 281.
53. Id.
the meaning of the California Probate Code. Based on this property interest, the decedent's preserved sperm vials were the property of his estate, and therefore he could direct their distribution. The significance of the Hecht court finding such a property interest is that it permitted the donor decedent to direct the disposition of a part of his body, the sperm.

c. Washington University v. Catalona

The issue in Catalona was whether individuals who knowingly and voluntarily donate their biological materials for research retain an ownership interest that would allow that individual to direct the transfer of such material to a third party. Dr. William J. Catalona, a urologist employed by Washington University in St. Louis ("the University"), collected biological samples and associated clinical data during prostate cancer surgeries. He was instrumental in establishing the Genitor-Urinary Biorepository ("Biorepository") to house the samples used for genetic oncology research. The Biorepository housed 100,000 samples, only a small percentage of which came from Dr. Catalona's patients. In 2003 Dr. Catalona left the University, intending to continue his research at Northwestern University. Prior to his departure, Dr. Catalona sent a letter to his patients, their relatives, and other research participants requesting that the recipient sign a release form directing the University to release their samples to him. The University asserted that it owned the samples, and neither Dr. Catalona nor the individuals who provided the samples retained ownership of the samples.

54. Id.
55. See Davis v. Davis, 842 S.W.2d 588, 589 (Tenn. 1992) (holding that neither a husband or wife, who were getting a divorce, "had a true a property interest in... frozen pre-embryos, although they had an interest in the nature of ownership, including the control of the disposition of the pre-embryos."). The court permitted the donors to direct the disposition of the embryo but not because of a property interest. Id.
56. In a similar decision, an Iowa state court ruled that the parents of a critically ill man could donate the man's semen to his fiancée. In that case, the man did not have a will and did not expressly refuse to make the gift, and thus the court ruled that his parents could have discretion over his body and could donate the sperm to the fiancée. Kathryn Fiegen, Judge: Family Can Give Son's Semen to Fiancée, IOWA CITY PRESS CITIZEN, Sept. 14, 2007, at 1A. This case is notable because it did not require evidence of intent on the part of the donor.
57. Wash. Univ. v. Catalona, 490 F.3d 667, 673 (8th Cir. 2007).
58. Id. at 670.
59. Id.
60. Id. at 671-72.
61. Id. at 672.
62. Catalona, 490 F.3d at 672.
ownership rights.\textsuperscript{63} Dr. Catalona claimed that the research participants could direct the transfer of their samples to him.\textsuperscript{64}

The court held that "individuals who make an informed decision to contribute their biological materials voluntarily to a particular research institution for the purpose of medical research [do not] retain an ownership interest allowing the individuals to direct or authorize the transfer of such materials to a third party."\textsuperscript{65} The court based its decision on Missouri gift law, reasoning that the donors' actions constituted inter vivos gifts because the research participants who provided the samples possessed present donative intent to make the gift to the University, they delivered the samples, and the University accepted the gift.\textsuperscript{66}

The \textit{Catalona} and \textit{Hecht} courts were both substantially persuaded by the evidence of intent regarding the disposition of the tissue.\textsuperscript{67} Evidence of donative intent in \textit{Catalona} included signed informed consent documents on University stationary that characterized the transfer of tissue to the University as a voluntary "donation" for use in studies by "Dr. William J. Catalona and/or colleagues"; an accompanying brochure that characterized the donation as "free and generous gift[s] of [biological materials]"; previous research and material transfer agreements; University intellectual policies; and researchers' (including Catalona's) past practices.\textsuperscript{68} Further, the court concluded that the research participants "unquestionably delivered their biological materials" to the University, which "retained absolute possession."\textsuperscript{69} Although not discussed in the court's analysis, the court noted in its recitation of the facts that the University provides the majority of the funding to maintain and operate the Biorepository, with the remainder of the funding coming from public and private grants provided to the University as the grantee.\textsuperscript{70}

The previously discussed cases are at the center of the controversy regarding whether property rights exist in the human body, and if they do,
the extent to which such rights exist. Outside of cases like Moore, Hecht, Catalonia, and their progeny, the ability to possess a property interest in the human body, and thereby direct the disposition of body parts including blood and organs, is controlled by the National Organ Transplantation Act ("NOTA") and the Uniform Anatomical Gift Act ("UAGA"), which has been adopted in either its 2006, 1987, or 1968 form by all fifty states. These statutes prevent the sale of organs and determine the legal methods of procurement and distribution of organs.

d. National Organ Transplantation Act

NOTA regulates procurement, distribution, and transplantation of organs. NOTA explicitly prohibits the sale of human organs for valuable consideration. The definition of "human organ" does not include blood, sperm, or ova. However, NOTA permits donors to be legally compensated broadly for organ donation, including transplant cost, travel, and lost wages. Other than these exceptions, the prohibition is absolute. Any violation of NOTA is punishable by a fine of not more than $50,000 or imprisonment of not more than five years, or both.

To create a controlled environment in which organs could be transplanted in an ethical manner without the troubling questions of compensation, Congress established in NOTA the Organ Procurement and Transplantation Network ("OPTN"). The OPTN is a unified transplant

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71. The issue of property interests in the human body extends beyond debates about transplantation and blood transfusion. Most recently, the idea of explicitly recognizing a property interest in cells has been at the center of the controversy regarding the use of stem cells to cure a multitude of diseases.

72. See infra notes 89-91 and accompanying text.


75. 42 U.S.C. § 274e(a) (2000). The statute does not define valuable consideration, but states that it “does not include the reasonable payments associated with the removal, transportation, implantation, processing, preservation, quality control, and storage of a human organ or the expenses of travel, housing, and lost wages incurred by the donor of a human organ in connection with the donation of the organ.” 42 U.S.C. § 274e(c)(2) (2000).

76. A “human organ” is defined as “the human (including fetal) kidney, liver, heart, lung, pancreas, bone marrow, cornea, eye, bone, and skin or any subpart thereof and any other human organ (or any subpart thereof, including that derived from a fetus) specified by the Secretary of Health and Human Services by regulation.” 42 U.S.C. § 274e(c)(1) (2000).


network operated by a private, non-profit organization and overseen by the Department of Health and Human Services. The United Network for Organ Sharing ("UNOS") was awarded the initial contract to operate the OPTN and continues to operate the network today.

Under this system, statutorily regulated state or regional non-profit entities called Organ Procurement Organizations ("OPOs") are "paid acquisition fees to recover organs from donors." Hospitals pay OPOs for matched organs, while the patients are responsible for paying the hospital for the procedure, costs of organ procurement, and any other costs associated with the transplant. Given the regional nature of this system, a significant burden is placed on the states to regulate and encourage donation.

*e. Uniform Anatomical Gift Act*

Initially, states sought to protect patients and increase the supply of blood and organs by adopting the UAGA. Created almost sixteen years before NOTA, the UAGA was adopted as an effort by the National Commissioners of Uniform State Laws to "facilitate the transplantation of hearts and kidneys" and to protect transplant patients. The UAGA was intended to replace the "patchwork of [state] laws" that existed prior to its creation, which many people felt were "inadequate, confusing, and lacked uniformity," thereby making donation law difficult to understand for potential donors or recipients. As time passed, certain inadequacies were
identified in the original 1968 version of the model law. In response to these inadequacies, the National Conference of Commissioners on Uniform State Laws ("NCCUSL") revised the model law in 1987. The NCCUSL amended the model law again in 2006 to make the UAGA consistent with the organ procurement system developed under federal law and modern transplant practices.

The UAGA, in its 2006 form, has been adopted by twenty states. Eight states currently retain the 1987 version of the UAGA and twenty-two states still retain the 1968 version. The statute, in its 2006 form, allows

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90. Id.
adults to make an anatomical gift during the life of the donor for the purpose of transplantation, therapy, research, or education. It also sets forth guidelines and procedures that must be adhered to by those involved in the removal of organs and their use in research or transplantation. It “only applies to sales or parts intended to be recovered from a decedent after death for transplantation or therapy.” Similar to NOTA, the UAGA prohibits the sale of organs, although it only does so if “[the] removal of...[the body]...is intended to occur after the...[death of the decedent].” The UAGA does not discuss whether property rights exist in “replenishable tissues,” like blood, sperm, or ova. Thus, current law permits the sale of these types of tissues. In addition, when addressing the sale of replenishable body fluids, “most states have statutorily characterized such fluids as a type of service rather than as a sale of a good.” The reason for this characterization is not for tax purposes, but has implications for the tax treatment of organs and other tissues. It protects donors and suppliers from product liability for injuries that stem from blood or other fluid.

The UAGA recognizes corporeal property rights in the human body and authorizes individuals to make anatomical gifts of their bodies or parts and permits individuals other than donors, such as agents acting under a healthcare power of attorney, parents of unemancipated minors, and guardians, to make anatomical gifts on behalf of a donor during the donor’s lifetime. This view is consistent with the UAGA’s explicit prohibition on the sale of


96. Id. cmt.

97. UNIF. ANATOMICAL GIFT ACT § 16(a) (revised 2006), 8A U.L.A. 30 (Supp. 2007). However, the 2006 version does “allow certain individuals to make an anatomical gift for another individual during that individual’s lifetime. Health-care agents under a health-care power of attorney and, under certain circumstances, parents or a guardian, have this power. The donor must be incapacitated and the permission giver has to be the individual in charge of making health-care decisions during the donor’s life.” The National Conference of Commissioners on Uniform State Laws, Uniform Anatomical Gift Act, available at http://www.anatomicalgiftact.org/DesktopDefault.aspx?tabindex=1&tabid=67 (last visited Nov. 23, 2007) (explaining the changes made by the NCCUSL to UAGA in the 2006 version).

98. Jordan & Price, supra note 21, at 159.

99. Id.

100. Id.

101. Id.

a body part after death.\textsuperscript{103} Thus, the "UAGA applies to anatomical gifts which take effect on or after the death of the donor."\textsuperscript{104}

Both the UAGA and NOTA identify a quasi-property right in the human body and its parts, but neither law declares an absolute property right in them. The two statutes make a crucial distinction between selling and donating organs, but they blur this distinction by failing to address blood, sperm, and ova. During life, persons may donate non-vital organs, and at death they may donate any and all of their organs under these statutes, but people may never donate or sell life-necessary organs while alive. When combined with case law, these statutes create a highly controlled and limited property right in the human body. This regulatory environment substantially affects the ways in which society can encourage donation using traditional economic motivations.

\textbf{B. Tax Treatment of Blood and Organ Donation}

The current quasi-property right status of blood and organs significantly affects the ability of the government to encourage donation through tax policy. The classification of donations as property or a service is critical because under Section 170 of the Internal Revenue Code, "[n]o deduction is allowable \ldots for a contribution of services."\textsuperscript{105} The Internal Revenue Service ("IRS") "has long considered the donation of blood as more akin to the rendering of a nondeductible 'service' than the contribution of 'property.'"\textsuperscript{106} Thus, blood donations are not tax deductible.\textsuperscript{107} As a result

\begin{itemize}
\item \textsuperscript{103} \textit{UNIF. ANATOMICAL GIFT ACT} § 16(a) (revised 2006), 8A U.L.A. 30 (Supp. 2007).
\item \textsuperscript{104} Jordan & Price, \textit{supra} note 21, at 160.
\item \textsuperscript{105} Treas. Reg. § 1.170A-1(g). The regulation does permit reasonable expenditures for meals and lodging, but this provision amounts to a reimbursement for the indirect costs of donating, not a payment for donating or an indication of society's gratitude for the donor's gift.
\begin{quote}
The decision to disallow a charitable contributions deduction for a blood donation was controversial when it was made and we doubt whether the same decision would be made today. Rev. Rul. 162 focuses on and emphasizes the act of donating blood as a service in disregard of the substance donated. It followed the rationale that the donation of blood is more in the nature of a rendition of a personal service than a contribution of property because it involves the performance of an operation upon the person of the blood donor \ldots Such a position ignores the fact that today blood is a commodity with a commercial market and a value apart from its donor. To be consistent with the rationale for Rev. Rul. 162, one would have to say that where a taxpayer wants to donate clothes to the Salvation Army and is required to walk two
\end{quote}
\end{itemize}
of the classification of blood and perhaps organs\textsuperscript{108} as a service rather than property, an odd dichotomy exists in which a person who donates money or stock to a hospital will be entitled to a tax deduction, while a person who donates blood and an organ will not.

Another reason the current tax code prohibits a taxpayer from taking a tax deduction for donating blood is because it is not considered a long-term capital gain. As Frederick Parker and William Winslade explain in their article \textit{Tax Policy and the Blood Supply}, "[a]s a general rule, a charitable deduction is measured by the fair market value of the donated property . . . [but] only to the extent the property would have generated a ‘long-term capital gain’ had it been sold."\textsuperscript{109} If the donated property would not have created this type of gain, the deduction would be limited to the donor's basis in the property.\textsuperscript{110}

A sale of property generates a long-term capital gain if it is a capital asset and the owner held the property for more than one year.\textsuperscript{111} Assuming, that human blood would likely be considered a capital asset,\textsuperscript{112} the second requirement, that the owner hold the property for more than one year, effectively denies a charitable deduction for blood donors as “red blood cells have an average finite life of approximately four months.”\textsuperscript{113} Therefore, donors could not deduct the fair market value of their contribution, even if that value is determinable.\textsuperscript{114} Rather, donors can only deduct their basis in the blood, which is zero.\textsuperscript{115} It is likely, therefore, that even if the IRS considered blood to be property that qualified for a miles to a depository, the taxpayer is rendering the personal services of delivery and not contributing property. Permitting the blood to be withdrawn, and thereby delivering it to the donee, does not render the blood worthless as property donated. . . . Blood itself is undoubtedly property.

\textit{Id.} See generally Frederick R. Parker, Jr. & William J. Winslade, \textit{Organ Procurement and Tax Policy}, 2 Hous. J. Health L. & Pol’y 173, 179 (2002) [hereinafter Parker & Winslade, \textit{Organ Procurement and Tax Policy}] (suggesting that tax treatment of the sales and donations of blood and breast milk provide context such that one might anticipate that donation of organs might also be considered a service).


108. \textit{Id.} at 89-90.


112. The assumption that human blood would be included in the “inventory of the taxpayer” is reasonable given that it would seem odd not to consider something produced by, and coursing through, one’s body anything but a capital asset. 26 U.S.C. § 1221 (2000).

113. Lary v. United States, 787 F.2d 1538 n.3 (11th Cir. 1986).


115. \textit{Id.}
charitable deduction, the taxpayer would only be able to claim a deduction of zero. This problem would not be an obstacle, however, for organ donors.

In addition to not being considered property, another obstacle to implementing organ and blood donation tax deductions is that the ability to take a charitable deduction under current law is expressly limited to contributions made "to or for the use of" a qualified charitable organization.\textsuperscript{116} Organ donations and some blood donations are made directly to an individual because organ and blood donations must go to a compatible recipient. Thus, many donations would not likely satisfy the requirement.\textsuperscript{117}

A taxpayer could assert that the organ is donated to UNOS or the hospital, but this assertion is incorrect for two reasons. First, UNOS and the hospital are not the recipients; they are merely the vehicle through which the donation is made. Because the beneficiary of the gift is known at the time of the donation (or shortly thereafter), it would be incorrect to claim the gift was made to the hospital or UNOS. Second, the intent of the gift is not to benefit UNOS or the hospital. The intent is to benefit a specific individual who is ill, particularly in the case of gifts to relatives. A case could be made for completely anonymous gifts of organs at death, but these donations are still ultimately given to an individual. The argument is stronger for blood donation, specifically because typically blood from blood drives is sent to a blood bank rather than immediately given to a particular individual. This circumstance probably passes the charitable organization requirement, but would still fail the long-term criteria explained above. Thus, the current tax treatment of blood and organ donation denies any form of charitable deduction or other beneficial treatment for either blood or organ donation.

III. A CRITIQUE OF DONATION SYSTEMS

The reality of the regulatory and tax environment is that the demand for human organs considerably outweighs the supply.\textsuperscript{118} In response, several different proposals have been suggested. Some scholars advocate the creation of a market system for organs, such as a direct payment system,\textsuperscript{119} futures market,\textsuperscript{120} or a death benefit system.\textsuperscript{121} Other scholars have

\textsuperscript{116} 26 U.S.C. § 170(c) (2000).
\textsuperscript{117} Parker & Winslade, \textit{Tax Policy and the Blood Supply}, supra note 106, at 90.
\textsuperscript{118} See generally Kingsbury, \textit{supra} note 1 (discussing the severe shortage of organs and blood that is available for transplant and transfusion).
\textsuperscript{119} See Gorsline & Johnson, \textit{supra} note 13, at 25.
\textsuperscript{121} Id. at 1038.
proffered non-economic alternatives, such as systems based on presumed consent, mandated choice, paired organ exchange system, or mutual insurance. This section examines and critiques these proposals.

A. Commercial Donation Systems

Perhaps the most common suggestion to encourage blood and organ donation is the adoption of a commercial, or free market, system in which people would be permitted to buy, sell, and exchange blood and organs. The free market alternative comes in three main forms: direct payment, futures market, and a death benefit system.

1. Direct Payment

The idea of permitting sale and procurement of organs has been raised frequently since the very advent of blood transfusions and organ transplants. For example, H. Barry Jacobs formed the International Kidney Exchange Ltd. in 1983 to broker human kidneys, charging between $2000 and $5000 for its services, which excluded the actual acquisition and medical procedure costs. Jacobs’s plan involved procuring kidneys from indigent third-world residents.

Jacobs’s plan produced virulent opposition. The plan’s opponents included the American Society of Transplant Surgeons, the Association of Independent Organ Procurement Agencies, the American Society of Transplant Physicians, and the National Kidney Foundation. Opponents argued that “the selling of organs raises numerous ethical questions, including the possibility that transplant operations will be available only to the rich and that the organ donors will be poor.” Future Vice President, then U.S. Representative, Albert Gore said, “Putting organs on a market basis is abhorrent to our system of values. . . . It seems to be something inconsistent with our view of humanity. . . . Prostitution is illegal for reasons that are similar. So is slavery.” Jacobs admitted that many of the

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123. Id.
125. Siegel, supra note 122, at 949.
126. See Gorsline & Johnson, supra note 13, at 26.
127. Id.
128. Robinson, supra note 120, at 1036.
130. Id.
131. Id.
potential donors would be unable to read, but he argued that they "could give informed consent through tape recorded conversations."  

Although the idea of direct payment seems shocking, it remains an idea that has many advocates. Its advocates argue that with proper controls, a free market in organs will help people by enabling them to gain access to more organs at lower costs. They assert that some individuals who are otherwise unwilling to donate their organs may wish to sell them. Moreover, this system would allow both the donor and the recipient to benefit from the monetary reward and the much-needed organ. From an economic perspective, this system would create an efficient vehicle for transferring organs from person to person. In addition to these direct benefits to the donor/donee and the efficiency benefit to society, there is another argument in favor of a free market system: if blood and organs are the property of an individual, that individual should have the right to allocate his or her blood or organs in any manner that is not otherwise against the law.  

While the arguments in favor of a free market system emphasize the ability to increase the number of organs quickly and the rights of donors to direct the disposition of their blood and organs, critics state that such a system would have a disproportionately negative impact on the poor. Critics argue that the effect would be to create a market in which people sell out of need, essentially being coerced to sell their organs. It is not clear whether it is possible to obtain informed, voluntary consent from either the donor and/or his or her next-of-kin, as applicable, in the face of the possibility of immediate economic gain. A free market system would also "unfairly allocate organs: access to organ transplants should not be a function of the financial ability to buy organs." Beyond placing a social cost on those least able to bear them and favoring those most able in the allocation of organs, a commercial system would also discourage organ donations and altruistic values, perhaps ultimately causing people to "diminish [their] respect for themselves." Finally, as discussed in

132. Id.  
133. See id. at 28-29.  
135. Id. at 28.  
136. For example, it would not be permissible for a donor to direct the disposition of his or her blood or organs in such a manner that harmed himself or herself (e.g., killing oneself to sell organs) or that would pose a public health risk (e.g., selling blood that is contaminated with HIV).  
137. Gorsline & Johnson, supra note 13, at 37.  
138. Id.  
139. Id.  
140. Id. at 36.
Section II, it can be asserted that society does not view the human body as property in the traditional sense, in response to those who argue that individuals should have the right to allocate their blood or organs as they deem appropriate because it is property. Because the human body is not property in the traditional sense, the argument is that individuals do not have the same rights to direct the disposition of their blood or organs in any manner they desire because of a societal interest in that body.

2. Futures Market

Another proposal suggests compensating organ donors through the use of a futures market. Under this system, during a person’s lifetime he or she could sell the right to remove their organs at death, thereby creating a contractual relationship between the organ provider and buyer. A buyer could be an individual, a government agency, or other private entity. The advantage of this system, beyond an increased supply of organs, is that it would prevent the sale of organs by anyone but the decedent, thereby reaffirming personal autonomy. Proponents also argue that it would “prevent the reliance on live organ bearers.” However, many of the same concerns remain under this proposal, including coercion of the poor, inability to obtain informed consent, and the lack of an altruistic intent in their actions. In addition, the risk for family conflict is substantial under this system. The financial interest in a family member’s organs could appear when that person makes the contract to sell her organs, producing a situation in which an incentive would exist to murder that person or for that person to commit suicide. Just as in a direct payment system, the poor would be disproportionately impacted. A person might feel the need to sell their organs, in this case by ending their life, to provide for their family.

141. See infra Section II.A.
142. Robinson, supra note 120, at 1037. See, e.g., Lloyd R. Cohen, Increasing the Supply of Transplant Organs: The Virtues of a Futures Market, 58 GEO. WASH. L. REV. 1 (1989) (advocating the use of a futures market to increase the supply of transplantable organs).
143. Robinson, supra note 120, at 1037.
144. Id.
145. Id. at 1037-38.
146. Id. at 1038.
147. Id. at 1046.
148. Robinson, supra note 120, at 1046.
149. Id. at 1046-47.
3. Death Benefit System

Other commercial systems are non-market based. One example of this type of proposal is the death benefit system. A death benefit system compensates organ donors by providing financial incentives to the persons designated by the decedent, primarily the decedent’s family. Under this system, the incentive would not be offered until the donor was brain dead and would not be paid until the organs were harvested. Families or other persons would not be required under this system to accept compensation.

Although there is less concern for the issues of family conflict and coercion of the poor under this system, they are still present. Additionally, a death benefit system also poses the problems of inability to obtain informed consent and lack of altruistic purpose that are present in other commercial donation systems.

Thus, questions of altruism, coercion of the poor, inequitable allocation of organs, creation of family conflict, and basic morality plague each proposal. To a lesser extent, issues of wasted compensation for unusable organs, the difficulty of matching provider and recipient, poor quality of organs, abuse of the system, and the fair market value of an organ, cause many to question both the morality and practicality of compensation-based organ donation.

B. Noncommercial Donation Systems

In response to these moral and practical considerations facing compensation systems, noncommercial donation systems have been proposed. Three prominent types include presumed consent, mandated choice, and mutual insurance.

1. Presumed Consent

Presumed consent systems, which are common in Europe, “provide[] that organs will be automatically donated at death, unless stated otherwise.” This method is often called an “opt out” plan because if a person does not wish to donate his organs upon death, he must “opt out” during life. The advantages of this system are that it would increase the available supply of organs and “save hospital workers the difficult task of discussing organ

150. Id. at 1038.
151. Id.
152. Id.
153. Robinson, supra note 120, at 1038.
154. Id. at 1042-44.
155. Siegel, supra note 122, at 948.
156. Id.
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donation with grieving family members.”157 However, given the magnitude
of the decision to donate organs, many people find the notion of silence
serving as consent unsettling.158 In the eyes of many scholars who
emphasize the importance placed on personal autonomy by Americans,
“[t]he forced nature of presumed consent is antithetical to American
culture.”159

2. Mandated Choice

Mandated choice is very similar to presumed consent, except that under
mandated choice individuals must either “opt in” or “opt out”; there is no
presumption of “opting in.”160 Proponents argue that this increased
flexibility allows for more autonomy, the lack of which is the main
criticism of presumed consent.161 Similar to the presumed consent method,
it would relieve the hospital staff from the burden of having to discuss the
issue of donation with the grieving family, and instead place the burden on
individuals to think about and plan for death.162 The largest criticisms of
this proposal are that the costs of coordinating mandated choice would be
massive, because every citizen’s organ donation preference would have to
be recorded and followed, and that autonomy would still be sacrificed,
though to a lesser degree than with presumed consent.163

3. Paired Organ Exchange System

One of the most recent proposals is the creation of a paired organ
exchange system.164 Under this proposal, patients in need of organ
transplants would be paired with families and friends of patients also on the
waiting list to exchange non-vital organs.165 This system would “facilitate
transplantation in situations where a friend or family member of Patient A
is incompatible with him, but would be compatible with some other person
on the waiting list (Patient B), and a close friend or family member of
Patient B is incompatible with her, but compatible with Patient A.”166 The
friend or family member of Patient A would donate on the condition that

157. Id.
158. Id.
159. Id.
160. Siegel, supra note 122, at 948.
161. Id.
162. Id.
163. Id. at 949.
164. Morley, supra note 124, at 223.
165. See id.
166. Id. at 224.
the friend or family member of B donates a compatible nonvital organ to Patient A.\textsuperscript{167}

Proponents of this type of system argue that it preserves the altruistic nature of the current donation system.\textsuperscript{168} Also, paired organ exchange would prevent commodification of organs by basing the exchange not on a free-market system, but rather on the shared desire to offer the gift of life.\textsuperscript{169}

Opponents, however, offer four main criticisms. First, under this system only non-vital organs can be donated.\textsuperscript{170} Thus, the ability of this proposal to increase the number of organs will be limited to certain types of organs. Second, many commentators assert that it is immoral for a person to be able to donate to a direct recipient of their choosing rather than the next compatible person on the waiting list.\textsuperscript{171} These critics claim that donated organs are a communal resource to be allocated according to publicly established criteria, and not private property to be given or sold to another person.\textsuperscript{172} Third, many critics argue that this type of system is no different from any other commodification of the human body; just as trading a person is wrong, trading parts of a person is equally inappropriate.\textsuperscript{173}

Finally, opponents argue that this system amounts to coercion, because family and friends will pressure a potential donor into consenting to save the life of the other friend or family member.\textsuperscript{174} Proponents argue that coercing a compatible donor who refuses to donate is not immoral, but rather the appropriate and normal action of a concerned family member.\textsuperscript{175} In response, many scholars assert that coercion is intrinsically wrong and that the only choice the actor can reasonably make is to donate or else face "ex-communication" from his family and friends.\textsuperscript{176} This threat of coercion, along with the other criticisms, causes many people to have serious reservations about a paired organ exchange system.\textsuperscript{177}

4. Mutual Insurance

A mutual insurance pool operates by giving priority for transplants to persons who agree to make their organs available in the future to other

\textsuperscript{167} Id.
\textsuperscript{168} See id. at 260-61.
\textsuperscript{169} See Morley, supra note 124, at 258.
\textsuperscript{170} Id. at 252.
\textsuperscript{171} Id.
\textsuperscript{172} Id.
\textsuperscript{173} See id. at 257.
\textsuperscript{174} Morley, supra note 124, at 249.
\textsuperscript{175} Id. at 251.
\textsuperscript{176} Id.
\textsuperscript{177} See id.
members of the insurance pool.\textsuperscript{178} Within the insurance pool, standard matching procedures, like those used by UNOS, would be used to determine prioritization.\textsuperscript{179} An example of this type of system is LifeSharers, a no-fee network of approximately 9,000 organ donors.\textsuperscript{180} LifeSharers members sign a document expressing their wish that they want their organs to go to another LifeSharers member unless no member is a suitable match.\textsuperscript{181}

Mutual insurance provides a direct personal incentive to donate, thereby increasing the supply of organs.\textsuperscript{182} However, many ethicists have expressed grave concerns about this type of “gated community” for healthy organ donors.\textsuperscript{183} Principally, this type of system is ethically questionable because it requires patients to give something besides payment to receive the medical treatment they require.\textsuperscript{184} Furthermore, a mutual insurance system excludes any persons who are unwilling, such as for religious reasons, or unable, such as for medical reasons, from having access to any organs of mutual insurance pool participants.\textsuperscript{185} Another drawback to mutual insurance is that it would result in dividing individuals based on their level of risk, akin to any other type of insurance.\textsuperscript{186} Although not based on monetary incentives, this type of plan could lead to division based on ability to participate because the quality or usability of an individual’s organs, their age, or another factor could impact the ability to participate in the insurance pool.\textsuperscript{187} Finally, this type of system is hindered by the concept of adverse selection as “high-risk persons are the ones most likely to participate in the pool.”\textsuperscript{188} To address this concern, LifeSharers members must sign up at least one hundred eighty days before becoming ill.\textsuperscript{189} This issue could also be avoided by having people enroll early in life, such as in childhood.\textsuperscript{190}

\textsuperscript{178} Siegel, supra note 122, at 949.
\textsuperscript{179} See id.
\textsuperscript{180} Kingsbury, supra note 1, at 53. For specific information regarding how LifeSharers works, see Frequently Asked Questions, http://www.lifesharers.com/faq.asp (last visited Nov. 23, 2007).
\textsuperscript{182} Siegel, supra note 122, at 949.
\textsuperscript{183} Kingsbury, supra note 1, at 54.
\textsuperscript{184} See id.
\textsuperscript{185} Id.
\textsuperscript{186} Siegel, supra note 122, at 949-50.
\textsuperscript{187} Id. at 949. Mutual insurance inherently includes the problem of adverse selection because high risk persons with organs that are either less suitable or not suitable for transplantation are more likely to participate. Id.
\textsuperscript{188} Id.
\textsuperscript{189} Kingsbury, supra note 1, at 53.
\textsuperscript{190} Siegel, supra note 122, at 949.
Despite possible solutions to the adverse selection concerns, the larger ethical issues set forth above remain.

IV. POSSIBLE TAX POLICY ALTERNATIVES

An alternative to compensation or noncommercial systems, which raise serious ethical and practical concerns, is the use of tax policy to encourage blood and organ donation. As Parker and Winslade state in their article Tax Policy and the Blood Supply in which they advocate of the use of a charitable deduction for blood donations:

[T]ax incentive[s] would enhance a potential donor's willingness to give by reflecting the value society ascribes to the gift rather than by creating an economic incentive in and of itself... [the tax incentive would be] only a simple acknowledgement of generosity, a gesture of appreciation, or a token of esteem - not a financial incentive or reward. 191

This type of favorable tax treatment would accomplish four important objectives: “(1) provide an incentive designed to stimulate corporate sponsorship of blood drives;’ 192 (2) in some manner recognize the generosity of blood donors; (3) protect the safety of the blood supply; and (4) accommodate established ethical norms.” 193 To accomplish these goals, donations could be encouraged either by permitting a charitable deduction for donating either blood or organs or providing a tax credit. This section will explore both options, and explain why the tax credit is the stronger proposal.

A. Offering a Charitable Deduction for Donations

Allowing taxpayers to take a charitable deduction for donations of blood or organs offers numerous advantages. First, it would preserve the altruistic nature of donation. 194 Second, “it would not conflict with the ethical proscription against the exploitation of disadvantaged groups.” 195 Because the tax structure is progressive in nature, the value of the deduction would become greater the more income earned by the taxpayer, and conversely, its value would diminish the less income earned by the taxpayer. 196 At the lower levels of the income scale the deduction would be “swallowed” by

192. Providing an incentive to stimulate corporate blood drives is especially important because they are the greatest source of blood donation in the United States. Id.
193. Id.
194. Id.
195. Id. at 92.
the personal exemption and standard deduction. A charitable deduction would not serve as a disproportionate incentive to the poor, but rather, using a charitable deduction might actually "unfairly deprive the less affluent donor of a benefit." Third, it is unlikely that the tax incentive poses as significant threat to the safety of the blood supply as would a direct cash payment. Fourth, a tax incentive would not produce an inequitable allocation of organs, but rather would preserve the current allocation system under UNOS. Fifth, offering a charitable deduction would not undermine the basic ethics and morality that underlie the current foundation of our donation system.

Despite all of these advantages, implementing a charitable deduction for donation would require significant alterations to the tax code and would pose daunting administrative challenges. The tax code does not consider the human body to be property and does not permit deductions for contributions of services. To allow a deduction, the IRS would have to allow deductions for contributions of services or classify the human body as property. Either change would be a significant policy shift. If the body were to be considered property, the IRS would face many complicating issues, including: (1) whether "during life or upon death, [a person] could actually generate . . . additional income, gift, or estate tax liability"; (2) how to determine the fair market value of the human body, organs, and blood; (3) whether blood or organs constitute a long-term capital gain; (4) the basis in a human body; and (5) whether some blood and organs are worth more than others.

These questions are complex and controversial. A strict interpretation of the tax code would not make a distinction between a taxpayer who donates blood or an organ and any other commercial activity. For example, the Tax Court has found that income derived from the sale of blood plasma

199. Id. Parker and Winslade offer little support for this proposition. They reference general assumptions regarding the notion that the incidence of blood-borne disease is inversely related to the donor's income. Although this correlation is possible, without more evidence, it is not possible to be certain that a tax incentive could increase the safety of the nation's blood supply. Id.
200. Id. It could be asserted that the allocation system under UNOS is not equitable, but that question lies beyond the scope of this article.
201. See id.
204. Parker & Winslade, Organ Procurement and Tax Policy, supra note 106, at 181.
205. Id.
is conceptually the same as that generated by the sale of any other product, without regard to 'the sanctity of the human body.' Thus, "the excess of the fair market value of [blood or organs] received over the cost or other basis" of the transferred blood or organ constitutes taxable income.

If it is taxable income, fair market value would have to be determined. Courts have held that fair market value is "the price at which property would change hands between a willing buyer and a willing seller, neither being under any compulsion to buy or to sell..." Applying this notion to the human body is exceptionally complex. Parker and Winslade state, "[t]he very idea that a 'willing' buyer could act without 'compulsion' in a contract involving the exchange of a life-giving thing is an anomaly of thought." Furthermore, as discussed in Sections II.A.2.d and e, "the law precludes the existence of a legitimate market in which buyers and sellers may trade in these 'goods'..." This fact does not "render them without value, as the market in illicit drugs so readily attests," but it does make valuation difficult and would likely prompt substantial debate and increase the possibility of costly litigation.

To provide a charitable deduction for donation it would also be necessary to determine the basis in a human body. Parker and Winslade explain that:

Because we do not purchase our bodies or otherwise acquire them in a transaction from which we can derive any identifiable cost, it would appear that we have a basis of zero in these, our most physical of assets. Accordingly, a participant in [an organ] exchange would realize income in an amount equal to the full value of the organ received, which could be significant.

If the basis is not zero, would the basis in all bodies be equal? Since the fair market value of the donated organ or blood would have to be determined, would the blood or organ of a younger person be worth more than that of an older person? Would the blood or organ of a healthy person be worth more than that of a person who engaged in "unhealthy" activities such as smoking or drinking? Would someone whose blood type is O, the most common blood type, be worth more or less than type AB, the least

206. *Id.* at 182.
207. *Id.*
210. *Id.*
211. *Id.* at 182-83.
212. See *id.* at 183.
213. *Id.*
common type? How would such values be substantiated? These are just a few of many difficult questions that are created by such a system.

A charitable deduction for donation also has implications for the gift and estate tax provisions in the tax code. The IRS General Counsel stated:

If blood is property, then any part of the human body is property. Gift tax is imposed . . . on the transfer of property by gift. If any part of the body is property then a gift tax should be levied on the gift of a kidney for transplant if it is not given through a charitable organization. Likewise, a taxpayer's estate includes the value of all property in which he had an interest at death. The value of a decedent's body should therefore be includible in his estate. In today's world where transplants take place daily, these issues are not illusory.

Finally, the current tax code requires that a charitable deduction be made "to or for the use of" a qualified charitable organization. The IRS would likely have to either alter or clarify this regulation as well. Accordingly, the tax code would have to be significantly amended to provide a charitable deduction for blood or organ donation.

Implementing a charitable deduction poses other administrative challenges. One administrative challenge, especially for blood donors, is that donors would be subject to "the same substantiation requirements imposed on taxpayers who claim deductions for other forms of charitable contributions." Another administrative obstacle is that current FDA regulations require that blood be labeled as having been collected from either paid or volunteer donors. Permitting a charitable deduction would likely require either an alteration or clarification of these FDA rules. Accordingly, there are administrative obstacles in addition to tax law issues that would encumber implementation of a charitable deduction for blood or organ donation.

B. Granting a Tax Credit for Donations

The creation of a tax credit for donations is a less administratively complex means of reaching the same objectives without opening the Pandora's Box of deciding whether the human body is property and how to

214. This consideration is the most controversial because it involves factors over which the donor has no control, as opposed to smoking or taking illicit drugs.
215. Parker & Winslade, Organ Procurement and Tax Policy, supra note 106, at 183-84.
218. Id. at 91.
determine the fair market value of a donor's blood and organs. Under this proposal, a person would receive a tax credit for agreeing to be a donor.220

The tax credit system offers the same advantages as the charitable deduction, but does not require the IRS to change its interpretation that the human body is not property. Further, the tax credit would not require any fair market value analysis of blood or organs. The credit would also preserve the altruistic nature of the donation and would not exploit the disadvantaged.221 Additionally, a tax credit, like the deduction system, would not pose a threat to the safety of the blood supply and would not produce an inequitable allocation of organs. Similar to the charitable deduction, a tax credit would not undermine the basic ethics and morality that underlie the foundation of the current donation system.

As with almost all of the proposals made to date, the tax credit would incur the same substantiation problems, FDA regulation issues, and the question regarding the “to or for the use of” requirement as the charitable deduction. Yet, unlike the charitable deduction, a tax credit would not force significant changes to be made to the rest of the tax code. The IRS would not have to choose whether to allow deductions for services or classify the body as property. This problem is not created by a credit. A tax credit does not raise sensitive questions regarding the fair market value of body parts and fluids, or whether some people's organs and blood are worth more than another person's blood or organs. People would neither have to claim their bodies as assets upon their death nor would they have to determine their basis. Thus, a tax credit offers the same benefits as the charitable deduction without the statutory consistency problems created by a deduction. A tax credit creates an incentive to attract potential donors without creating a commercial market, changing the donation system to an "opt out" approach, defining the body as property, or imposing any other significant policy choices.

In almost all of the literature on methods of encouraging organ donation, five main concerns are consistently raised: (1) destroying the benefits of altruism; (2) coercion of the poor; (3) inequitable allocation of organs; (4) creating family conflict; and (5) concerns of basic morality.222 A tax credit for blood and organ donation does not raise any of these concerns, but rather protects the values they espouse.

220. For specific details as to how a tax credit would work, see Section V's model statutes.

221. It might, however, serve as a disproportionate incentive to the poor in the same manner as the charitable deduction. Parker & Winslade, Tax Policy and the Blood Supply, supra note 106, at 92.

222. Robinson, supra note 120, at 1044-47.
Moreover, the tax credit proposed would attain at least three of the four objectives set forth by Parker and Winslade in their charitable deduction proposal: (1) recognizing the generosity of donors; (2) not endangering the safety of the blood supply; and (3) accommodating established ethical norms. The fourth objective, encouraging corporate sponsorship of blood drives, could easily be accomplished by creating a provision in the proposed tax credit statute offering corporations a tax credit for organizing blood drives. Similar to the individual incentive in the model statute in this article, which gives incentives for donating more than once, the credit could increase for each additional blood drive, up to a defined limit.

Two issues that must be addressed to use a tax credit to encourage blood and organ donation are whether the tax credit should be refundable or nonrefundable and when the taxable event is realized and recognized such that the taxpayer may obtain the tax credit. Parker and Winslade propose the use of a refundable tax credit, which can reduce one’s tax liability below zero. “[A] refundable credit is applied first to reduce or eliminate one’s tax liability, with any unused amount being paid out to the taxpayer in cash; the amount of any credit in excess of the recipient’s tax liability would, in effect, represent a government subsidy to him.” A refundable tax credit would therefore not only cause the federal government to lose essential tax revenue, but would also force the government to spend money that could otherwise be allocated to address other significant public policy issues. Refundable tax credits are typically used only in circumstances where the government wishes to allocate money to achieve a fundamental societal objective, for example the earned income tax credit is intended to assist the poor.

Taking into consideration the economic implications of a refundable tax credit, in particular its impact on the availability of government resources for other public policy priorities, this article proposes the use of a nonrefundable tax credit, which would not permit taxpayers to receive a refund if their tax owed was reduced below zero. This type of credit would attain the objective of encouraging donation, but would not financially overburden the government. Blood and organ donation could effectively be encouraged through the use of a nonrefundable tax credit without requiring

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224. Id. at 91.
225. The use of a tax credit for individuals might reduce the need for a corporate incentive since individuals would be personally incentivized to donate.
226. See Parker & Winslade, Organ Procurement and Tax Policy, supra note 106, at 175-76.
227. Id. at 176.
the government to spend money that could be used for other public policy purposes. Further, if empirical data demonstrates after several years that the nonrefundable tax credit provides insufficient incentive, the tax credit could be transformed into a refundable tax credit if necessary.

The second issue concerning the timing of when the taxable event is realized and recognized has significant implications for organ donation. Should a person realize and recognize the tax credit when he or she pledges to donate blood or organs? Or should it be when a person actually makes the donation? For example, if a person promises to donate her organs at the time of death when she is twenty-five and she dies at eighty-five, may she obtain the benefit of the tax credit at twenty-five or at the time of her death? This issue is not as significant for blood donation, because blood donation can generally occur immediately within a given fiscal year in which the taxpayer seeks the tax credit. Parker and Winslade propose a refundable tax credit that is realized and recognized at the time when the taxpayer agrees to donate his organs irrespective of when death occurs.²²⁹

This article proposes the use of a tax credit that must be realized and recognized at the moment of donation, not upon a promise of future donation because it achieves the stated objective of encouraging donation while avoiding potential conflict that might arise under a system in which persons could take the tax credit prior to actual donation. The IRS does not treat a contribution as permanently set aside unless the chance that the contribution will not be applied to the donor's intended charitable purpose is so remote that it is negligible.²³⁰ As discussed earlier, the chance that a potential organ donor's contribution will not be applied is not remote, but rather substantial.²³¹

Parker and Winslade intelligently suggest that a database, akin to the National Practitioner Data Bank, could be used to document a taxpayer's promise to donate and that such a promise would thereafter make donation mandatory.²³² Further, Parker and Winslade pragmatically suggest immunizing providers from liability when they rely in good faith on the database when retrieving organs.²³³ These solutions, though beneficial, are insufficient. Given the history of conflict over donative intent, disputes between family members regarding organ donation, and questions of capacity of the donor, substantial controversy and costly litigation is likely

²²⁹. Parker & Winslade, Organ Procurement and Tax Policy, supra note 106, at 175.
²³¹. See supra note 5 and accompanying text.
²³². Parker & Winslade, Organ Procurement and Tax Policy, supra note 106, at 177-78.
²³³. Id. at 178.
to arise under such a system. This conflict is avoidable if the tax credit is permitted only at the time of donation. As discussed above, this position is consistent with current IRS guidance.\textsuperscript{234} Thus, a nonrefundable tax credit realized and recognized at the time of giving is a unique vehicle through which blood and organ donation can be encouraged, while guarding against the hazards of a commercial system and maintaining the current tax treatment of charitable giving and the human body.

The following are two model statutes that offer guidance as to how a nonrefundable tax credit section in the tax code might operate. These statutes are by no means the only way a tax credit could work. They are intended to be but one example of how donation could be encouraged through the use of a nonrefundable tax credit.

\section{Qualified Blood Donation Programs}
(a) Allowance of credit.

(1) In general. There shall be allowed as a credit against the tax imposed by this chapter for the taxable year with respect to each qualifying donation of blood products by the taxpayer an amount equal to the per donation amount.

(2) Per donation amount. For the purposes of paragraph (1), the per donation amount shall be determined as follows:

<table>
<thead>
<tr>
<th>In the case of any taxable year in which the taxpayer donated blood products:</th>
<th>The per donation amount is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Once in the taxable year</td>
<td>$500</td>
</tr>
<tr>
<td>Twice in the taxable year</td>
<td>$1000</td>
</tr>
<tr>
<td>Three to six times in the taxable year</td>
<td>$2000</td>
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</tbody>
</table>

(b) Limitation based on adjusted gross income –

(1) In general. The amount of the credit allowable under subsection (a) shall be reduced (but not below zero) by $50 for each $1000 (or fraction thereof) by which the taxpayer’s adjusted gross income exceeds the threshold amount.

(2) Threshold amount. For purposes of paragraph (1), the term “threshold amount” means –

(A) $110,000 in the case of a joint return


\textsuperscript{235}. Normally a person may safely donate blood every eight weeks. Thus, six times per taxable year is the maximum number of times that should count towards the tax credit.
(B) $75,000 in the case of an unmarried individual, and
(C) $55,000 in the case of a married individual filing a separate return.

(c) Qualifying blood product donation – For purposes of this section –
(1) In general – The term “qualifying blood production donation” means any donation of:
   (A) Blood products derived from human blood used for purposes of transfusion into another person or for federally-approved biomedical research.
   (B) Any other products formulated via removal of human blood used for purposes of transfusion into another person or for federally-approved biomedical research.

(d) Blood products – For purposes of this section –
(1) In general. The term “blood products” shall include human blood of any type, red blood cells, white blood cells, platelets, plasma, and any other federally-approved blood-derived product that may be legally donated under the National Organ Transplant Act.
(2) Sperm, ova, and hair are not covered by this section. 236

(e) Donation to self exception –
(1) In general. The term “qualifying blood product donation” shall not include the removal of human blood from one individual and replacement of that blood into the same individual at the same or a later time.

§ XXX. Qualified Organ Donation Programs
(a) Allowance of credit. -
(1) In general. – There shall be allowed as a credit against the tax imposed by this chapter for the taxable year with respect to each qualifying human organ donation(s) by the taxpayer an amount equal to the per donation amount.
(2) Per donation amount – For the purposes of paragraph (1), the per donation amount shall be-
   (A) $5,000 for the donation of at least one human organ to either another individual or individuals, a medical center for donation to an unspecified person(s), to the cause of science.
   (B) $10,000 for the donation of all of the taxpayer’s organs to either another individual or individuals, a medical center for donation to unspecified person(s), to the cause of science.

236. Sperm, ova, and hair are excluded because there are sufficient supplies to meet the demand for these items. This policy decision could always be reversed if more donations were ever required.
(b) Limitation based on adjusted gross income –
   (1) There shall be no limit on the amount of credit allowable under
       subsection (a) based on adjusted gross income.
(c) Qualifying organ donation(s) – For purposes of this section –
   (1) In general – The term “qualifying organ donation(s)” means any
donation of:
       (A) A part or structure of the human anatomy adapted for the
           purpose of some specific function or functions.
       (B) Sperm, ova, and hair are not covered by this section.237
(d) Donation to self exception –
   (1) In general. The term “qualifying organ donation” shall not
       include the removal of human organ(s) from one individual and
       replacement of the organ(s) into the same individual at the same or a
       later time.

V. CONCLUSION

The demand for blood and human organs will continue to grow as
society’s ability to save and improve lives by transplanting more parts of
the body increases. To have any chance of meeting the ever-increasing
level of demand for blood and organs, the current donation system must be
modified to encourage donation in order to substantially increase the
quantity of available healthy, compatible blood and organs. Some
individuals, such as pure altruists, “would donate without any external
stimulus,”238 while others would never donate regardless of the incentives
offered. Some may be attracted to a direct compensation system, but many
people vehemently object to such an outright offer of remuneration.239 A
reasonable alternative is the use of a tax credit as an incentive to “attract the
attention of those potential donors who wouldn’t be willing to sell their
blood in a purely commercial transaction” but who would accept favorable
tax treatment as a “token of public appreciation of their generosity.”240 It
may even “arouse existing but dormant inclinations toward altruism.”241
For these reasons, tax credits are an effective, ethically acceptable, and
perhaps even ethically preferable means of encouraging blood and organ
donation.

237. See supra note 236.
239. Id.
240. Id.
241. Id.