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Recognizing the Larger Sacrifice: Easing the Burdens Borne by Living Organ Donors through Federal Tax Deductions

I. INTRODUCTION

Organ transplant recipients are the beneficiaries of a modern medical miracle. The “gift of life” provided by an organ donor often allows the recipient to be transformed from a terminally ill patient into a healthy survivor.¹ One transplant surgeon described his feelings of witnessing this transformation as a “constant joy and thrill . . . to see a chronically, ill, debilitated patient, often full of pain from his fingertips to his toes . . . restored to normal within days after the [transplant] operation.”²

The limit on organ resources, however, prevents many patients, families, and physicians from feeling this type of thrill. Currently, an average of seventy-seven people receive an organ transplant each day in the United States.³ However, another nineteen people die due to a shortage of available organs for transplantation.⁴ This steady parade of deaths numbered approximately 6,400 in 2002, and has only increased since.⁵ Putting the 2002 yearly number in a more familiar context, it equals roughly twice the total amount of U.S. soldier deaths experienced in the current war in Iraq to date.⁶ These deaths affect all segments of American society; victims of organ shortage “are ethnically and geographically diverse, their deaths typically passing unnoticed” to the general population.⁷

1. For an interesting description of the kidney “Transplant Olympics,” which displayed to the world the ability of a transplant patient to recover, see RUSSELL SCOTT, *THE BODY AS PROPERTY* 30–31 (1981).

2. *Id.* at 31.

3. OrganDonor.Gov, Access to U.S. Government Information on Organ and Tissue Donation and Transplantation, <http://www.organdonor.gov> (last visited Feb. 27, 2007).

4. *Id.*

5. “More than 80,000 Americans are currently awaiting organ transplants, yet fewer than 25,000 people received a transplant in 2002. During that same year more than 6,400 people died while waiting for a transplant.” OFFICE OF INSPECTOR GEN., U.S. DEP’T OF HEALTH AND HUMAN SERV., *VARIATION IN ORGAN DONATION AMONG TRANSPLANT CENTERS 1* (2003), <http://oig.hhs.gov/oei/reports/oei-01-02-00210.pdf> [hereinafter OFFICE OF INSPECTOR GEN.] (citing United Network for Organ Sharing statistics). At the current average rate of 19 deaths per day, the expected total for 2007 would be over 6,900.

6. Operation Iraqi Freedom (OIF) U.S. Casualty Status: Fatalities as of January 12, 2007, <http://www.defenselink.mil/news/casualty.pdf> (last visited Feb. 27, 2007).

7. Sean Arthurs, Comment, *No More Circumventing the Dead: The Least-Cost Model*

The problem is worsening as the need for organs continues to increase at an alarming pace. At the beginning of 2007, there were approximately 94,800 candidates on the national patient waiting list.⁸ This is an increase of over 24,000 from June 2000.⁹ Thus, the demand for donor organs has skyrocketed while supply of cadaveric donors “remains stagnant at approximately 5,000 per year.”¹⁰ As a result of this shortage of cadaver organs, patients have been increasingly relying upon transplants from living donors. Organ donations from living donors doubled from 1995 to 2004.¹¹ Many courageous Americans have stepped in to fill the need on behalf of family, friends, and in some cases, complete strangers.

People on the waiting list for an available organ know that they have a good chance of dying before they are able to receive a transplant. Obviously, the longer they must wait, the more their health declines and thus the worse their odds of surviving become. But the consequences do not end there. Large economic costs are borne by American citizens and government as a result of organ shortage. Patients awaiting transplants incur large medical bills, at a catastrophic economic burden to themselves, and often at the expense of the government.¹² Thus, living organ donors not only provide the organ recipient with a life-saving gift, they also provide an economic benefit for the government. According to one expert, Medicare incurs approximately \$55,000 per year per patient in direct dialysis costs alone.¹³ Since “waiting time for a deceased donor kidney is approximately 4 years longer than a living donor kidney,” Medicare saves roughly \$220,000 on average for a living transplant.¹⁴

Further, this tragic shortage of organs persists in the face of public

Congress Should Adopt to Address the Abject Failure of Our National Organ Donation Regime, 73 U. CIN. L. REV. 1101, 1101 (2005).

8. OPTN.org, Organ Procurement and Transplantation Network, <http://www.optn.org> (last visited Jan. 23, 2007) (numbers as of that visit).

9. Laurel R. Siegel, Comment, *Re-engineering the Laws of Organ Transplantation*, 49 EMORY L.J. 917, 917 (2000) (citing United Network for Organ Sharing statistics).

10. Lynt B. Johnson, *Some of the Challenges of Encouraging Organ Donation Among Minority Populations*, 65 N.C. MED. J. 35, 35 (Jan./Feb. 2004), available at <http://www.ncmedicaljournal.com/jan-feb-04/ar010408.pdf>.

11. ORGAN PROCUREMENT AND TRANSPLANTATION NETWORK/SCIENTIFIC REGISTRY OF TRANSPLANT RECIPIENTS 2005 ANNUAL REPORT, TABLE 1.1, U.S. ORGAN DONORS BY ORGAN AND DONOR TYPE, 1995 TO 2004 (2005), http://www.optn.org/AR2005/101_dh.pdf [hereinafter OPTN/SRTR 2005 ANNUAL REPORT].

12. See Andrew MacDonald, *Organ Donation: The Time Has Come to Refocus the Ethical Spotlight*, 8 STAN. L. & POL'Y REV 177, 179 (1997).

13. Ginny Bumgardner, Testimony before Subcommittee on Labor, Health and Human Services, Education and Related Agencies 3 (Apr. 15, 2005), available at http://www.a-s-t.org/PublicPolicy/Library_pdfs/Roundtable%20L-HHS-EduWrittenTestimony41105%20_D0040522.pdf.

14. *Id.*

support for organ donation from the vast majority of Americans. A 1993 poll undertaken by Gallup and a 2004 study conducted by the Coalition for Donation put public approval for donating organs upon death at 85% and 91%, respectively.¹⁵ These poll numbers suggest that increasing the amounts of donated organs is not only life-saving and economically sensible, but also supported by the public.¹⁶

Several policy changes have been proposed through the years to alleviate the shortage of transplantable organs. Some of these proposals call for drastic overhaul of the American system, departing from the altruistic opt-in system currently in place.¹⁷ But until the shortage of cadaveric donors can be alleviated, patients will continue to rely on the brave generosity of these living organ donors, who place their life at risk and undergo great economic, physical and psychological expense to donate.

As we focus our efforts on the plight of patients desperately waiting for organ transplants by working to increase the organ supply, we must not lose sight of the sacrifice of living donors, and the difficulties they may face in donating. Indeed, a great inequity exists in the law. The United States Tax Code allows for charitable contributions to be deducted from taxable income.¹⁸ This encompasses not only simple cash contributions, but also programs that encourage citizens to donate used automobiles to organizations such as the Kidney Foundation, with the allure of getting a deduction from taxable income in the amount of the value of the donated car.¹⁹

These deductible contributions should be supported and admired, because they provide a necessary monetary boost to the organizations that promote organ donor programs. However, the sacrifice of cash or cars should not be given greater respect than that of the actual donors, whose sacrifice is deeper and far more worthy of our nation's recognition. Sadly, those who courageously undergo the economic,

15. The Gallup Organization, Inc., *The American Public's Attitudes Toward Organ Donation and Transplantation, Section I* (Feb. 1993), http://www.transweb.org/reference/articles/gallup_survey/gallup_chap1.html (last visited Mar. 18, 2007) [hereinafter Gallup Poll]; G. David Fleming, *Investigating the Relationship Between Commitment to the Concept of Donation & Compliance*, NATCO IN TOUCH (bi-monthly bulletin), available at http://www.natco1.org/members/pdfs/NATCOInTouch_May-Jun05.pdf (referring to cadaveric donation).

16. Moreover, most major religions have expressed that donating an organ does not violate their religious principles and doctrines. American Red Cross, *Tissue Donation: Statements from Various Religions*, <http://www.redcross.org/donate/tissue/relgstmt.html> (last visited Mar. 13, 2007).

17. The current system relies on donors to "opt-in" to the system, altruistically choosing to make their organs available posthumously. See *infra* Part II.A.

18. 26 U.S.C. § 170 (2000). See also National Kidney Foundation, *Kidney Cars*, <http://www.kidney.org/support/kidneycars/index.cfm>.

19. National Kidney Foundation, *supra* note 18.

physical and psychological hardship of donation do not receive the same treatment as those who donate their old car.

Recent legislation at the state level seeks to reimburse living donors to a certain extent by providing tax deductions in order to reduce the overall expense.²⁰ On the federal level, the Organ Donation and Recovery Improvement Act of 2004 (“ODRIA”) is also a step in the right direction.²¹ ODRIA does not address the tax code, but instead provides funds for reimbursement grants from the government to the organ donor.²² Thus, it is also a significant step in the right direction toward alleviating the financial burdens of donating. However, ODRIA is an incomplete remedy as it will only be applied in cases of low-income donors and low-income recipients; many donors will receive no financial relief at all.²³

This Comment argues that federal tax law should be changed to follow the legislative example displayed by states that have enacted deductions. Specifically, the Tax Code should be changed to allow living donors who provide an organ for transplant to deduct the expenses of travel, lodging, and lost wages attendant with donating an organ that are not covered by insurance. The deduction would only cover the *expense* of donating, and not the organ itself, in order to comport with the U.S. altruistic system.

A federal tax deduction would complement ODRIA by providing another level of assistance to the majority of donors, who are unable to benefit from the Act. It would help to ensure that every living organ donor receives financial assistance and is dealt with fairly. The changes would serve to further basic intuitive principles of fairness—to recognize the great sacrifice made by those who risk their lives to save the life of another, and to give a small measure of financial assistance to help them recover. Why should the citizen who donates his used-up car receive government recognition for his altruism in the form of a tax deduction, while the organ donor who gives of her time and risks her life, may receive nothing?

Clearly, resolving the organ shortage will take much more than a mere change in the Tax Code. Extensive proposals to that end are outside the scope of this Comment. Removing a part of the financial burden for living donors through a tax deduction may, in fact, remove some financial disincentives to some donors and slightly increase the organ supply. However, instead of justifying a tax deduction only as a means of

20. *See infra* Part III.C.

21. 42 U.S.C.A. § 274f (West 2005).

22. *Id.*

23. *See infra* Part III.B.2.

resolving the organ shortage, this Comment argues that the rationale for such change should also focus on providing recognition for the good that organ donors provide to society. This good should be recognized, and without betraying our altruistic system, should be reimbursed. Further, such a change would be a positive step in addressing the basic unfairness which currently exists in the Tax Code.

Part II of this Comment provides background on the organ shortage problem and describes the current donation system in the United States. Part III examines legislative action that has been taken on a state and federal level, including the recently-passed Organ Donation and Recovery Improvement Act's reimbursement authorization for living donors. Part IV proposes a federal tax deduction and discusses arguments for and against the implementation of such a tax deduction for living donors at the federal level. Part V offers a brief conclusion.

II. BACKGROUND

This section will provide an introduction to America's altruistic, opt-in organ donation system, and the legal framework in which the system works. In addition, this section will discuss the two methods of organ donation—living and cadaver—and present the advantages and challenges to procuring organs through each method.

A. America's System of Donation

Two systems for procuring organs from the deceased are in common usage around the world. Many European countries with histories of stronger state intervention use an opt-out, or "presumed consent" system, in which citizens are presumed to have chosen to donate their organs at death and instead must explicitly elect out of the system.²⁴ Meanwhile, other countries with "strong normative concepts of individual rights and property rights" including the United States use an opt-in organ donor system.²⁵ In these systems, prospective donors are given the opportunity to elect into the system. In the United States, this is typically done while obtaining a driver's license.²⁶

24. NORA MACHADO, USING THE BODIES OF THE DEAD 45 (1998); *See also* Monique C. Gorsline & Rachelle L.K. Johnson, Note, *The United States System of Organ Donation, the International Solution, and the Cadaveric Organ Donor Act: "And the Winner is . . ."*, 20 J. CORP. L. 5, 21 (1995).

25. MACHADO, *supra* note 24, at 44.

26. Another commonly suggested system is called "mandated choice," which would require citizens to choose whether they would be donors. The hope of such a system is that by being forced to choose, more citizens would elect to become organ donors, thus mitigating the shortage. *See*

The opt-in system is based, at least in part, on three principles. First is the idea that the altruism of citizens, not government compulsion, should provide the impetus for organ donation.²⁷ To promote this altruism, public relations campaigns have utilized spokespersons like Michael Jordan,²⁸ and feel-good stories that tell of patients eagerly awaiting transplants, and the prospect of the pain of a donor's tragic death being somewhat mitigated by the preserving of the donee's life.²⁹ Second, a close corollary is that commoditization of the body and its parts should be avoided. Proponents of an altruistic system contend that that life and the body are intrinsically sacred and immeasurably valuable, and that putting a price on them is repugnant.³⁰ Such proponents take the view that, "[t]o speak of personal attributes [that which 'has become identified with a person, with her self-constitution and self-development. . .'] as fungible objects — alienable "goods" — is intuitively wrong."³¹ Additionally, such proponents want to "prevent the poor from being exploited, and ensure that the wealthy [a]re not the only segment of society who [have] access to life-saving organs."³² Finally, proponents of the opt-in system contend that the method is preferable because it better effectuates the desires of the deceased, in that it ensures

Bernard T. Kwitowski, *Learning From Each Other: Combining Strategies to End the Organ Shortage*, 9 MICH. ST. J. MED. & L. 141, 152–53 (2005). See also COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, STRATEGIES FOR CADAVERIC ORGAN PROCUREMENT: MANDATED CHOICE AND PRESUMED CONSENT 2 (1994), http://www.ama-assn.org/ama1/pub/upload/mm/369/ceja_2i93.pdf [hereinafter COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS] (arguing that the objection to the coercion of mandated choice "holds little weight when the cost of mandated choice is compared to the social benefits of such a policy").

27. Proponents of altruistic systems may argue that altruism "foster[s] social integration, contributing to the sense of belonging and participation among members of a community. . . ." MACHADO, *supra* note 24, at 58.

28. Lara Wozniak, *Jordan Makes Pitch for Organ Donations*, ST. PETERSBURG TIMES, Apr. 18, 1996, at 1E.

29. See, e.g., *supra* note 3. Additionally, such campaigns also typically seek to dispel prevalent myths that abound regarding organ donation. Sadly, such public relations campaigns are hampered by stories—both true and false—that describe ostensibly unfair donor preferences given to celebrities or politicians. While many Americans like the idea of extending life to those in need of their donor organs, they may be put off when they see Mickey Mantle or David Crosby quickly acquiring a donor organ. See Phyllis Coleman, *Brother Can You Spare a Liver? Five Ways to Increase Organ Donation*, 31 VAL. U. L. REV. 1, 1–2 (1996).

30. See, Cynthia B. Cohen, *Selling Bits and Pieces to Make Babies: The Gift of the Magi Revisited*, 24 J. MED. & PHIL., 288, 291–92 (1999) ("The reason we are reluctant to exchange money for human kidneys is that this would deny something distinctly valuable about human beings—their human dignity and worth. . . . When we or our integral body parts are sold, our dignity as human beings is denied."). However, see generally Eric A. Posner & Cass S. Sunstein, *Dollars and Death*, 72 U. CHI. L. REV. 537 (2005) for a discussion of how the legal system and governmental institutions assign monetary values to human lives.

31. Cohen, *supra* note 30, at 293 (quoting Margaret Jane Radin, *Market-Inalienability*, 100 HARV. L. REV. 1849, 1880, 1880 n. 115 (1987)).

32. Steve P. Calandrillo, *Cash for Kidneys? Utilizing Incentives to End America's Organ Shortage*, 13 GEO. MASON L. REV. 69, 99 (2004).

that the wishes of those who object to donating their organs are respected.³³ As previously discussed, this argument can be criticized, among other reasons, because the intent of a would-be donor may be subverted under the current system by the desires of the family or the failure of the individual to express those desires.

A key aspect of the American opt-in system is the illegality of exploiting organ transplantation for monetary gain. This prohibition provides the legal boundaries of the opt-in system, delineated by the National Organ Transplantation Act of 1984 (“NOTA”).³⁴ NOTA was enacted in order to clear up uncertainty that existed in regards to organ sales and to ensure equitable distribution of donated organs (so that recipients of transplant organs were not limited to only the wealthy).³⁵ The Act prohibits the buying and selling of transplant organs for “valuable consideration” if the transfer “affects interstate commerce.”³⁶ The Committee believed that human bodies should not be made into commodities,³⁷ and sought to “prohibit the assignment of a monetary value to an organ.”³⁸

However, while NOTA sought to close the door on the sale of the organs, it left open a window to reimbursement for costs associated with donation.³⁹ It explicitly excluded from valuable consideration “reasonable payments associated with the removal, transportation,

33. See J. MICHAEL DENNIS ET AL., PRESUMED CONSENT SUBCOMMITTEE AND UNITED NETWORK FOR ORGAN SHARING ETHICS COMMITTEE, AN EVALUATION OF THE ETHICS OF PRESUMED CONSENT AND A PROPOSAL BASED ON REQUIRED RESPONSE (June 30, 1993), <http://www.unos.org/resources/bioethics.asp?index=1>. See also COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, *supra* note 26, at 3 (noting that “[t]he individual’s interest in controlling his or her own body, even after death, is a widely accepted value in organ transplantation and other medical contexts”).

34. 42 U.S.C. § 274e (2000).

35. S. REP. NO. 98-382, at 17 (1984). See Gail L. Daubert, Comment, *Politics, Policies, and Problems With Organ Transplantation: Government Regulation Needed to Ration Organs Equitably*, 50 ADMIN L. REV. 459, 464 (1998).

36. 42 U.S.C. § 274e(a).

37. NATIONAL ATTORNEYS’ COMMITTEE FOR TRANSPLANT AWARENESS, ORGAN AND TISSUE DONATION AND TRANSPLANTATION: A LEGAL PERSPECTIVE (1995), <http://www.transweb.org/reference/articles/donation/nacta.html>. (last visited Mar. 13, 2007) [hereinafter COMMITTEE FOR TRANSPLANT AWARENESS].

38. Francisco L. Delmonico et al., *Ethical Incentives—Not Payment—For Organ Donation*, 346 NEW ENG. J. MED. 25, 25 (2002). Since NOTA, efforts have been made to soften its prohibition. For instance, the American Medical Association lobbied Congress in 2003 to examine the possibility of softening NOTA’s ban on consideration, and “allowing financial incentives for the donation of cadaveric organs.” Daniel T. Stimson, *Private Solicitation of Organ Donors: A Threat to the Fairness of the U.S. Organ Transplant System, or a Solution to the National Organ Shortage?*, 10 MICH. ST. J. MED. & L. 349, 357 (citing Andis Robeznieks, *Bill Would Allow Studies on Organ Donation Incentives*, AM. MED. NEWS, Aug. 11, 2003, <http://www.ama-assn.org/amednews/2003/08/11/prsb0811.htm>).

39. 42 U.S.C. § 274e. See also Delmonico et al., *supra* note 38.

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.”⁴⁰

B. Cadaveric Shortage and the Increasing Demand for Living Donations

There are two types of organ donation: living and cadaver (procuring organs from the deceased). Each type has identifiable advantages and disadvantages.

1. The shortage of cadaveric organs

Cadaveric organ donation is advantageous in two key ways. The first is that unlike with living donors, there is obviously no health risk to a donor who is already deceased. To some scholars this advantage for cadaveric donations is paramount. One commentator has noted the difficulty of medical professionals in reconciling the risks posed by living organ donation with the Hippocratic Oath.⁴¹

The second obvious advantage to cadaveric donation is that one cadaver donor can yield a greater quantity and variety of organs than can a living donor. The amount of organs capable of procurement from living donors are obviously limited.⁴² Meanwhile, an estimated average of 3.53 organs can be recovered per cadaveric donor.⁴³

40. 42 U.S.C. § 274e(c)(2).

41. Arthurs, *supra* note 7, at 1126. In support of using cadaveric donors over living donors, Arthurs concluded:

Even if medical advances can reduce the post-operative casualty rate to a fraction of a percent, any mortality rate above zero becomes indefensible when compared to a viable alternative with a mortality rate of zero. Not surprisingly, neither doctors nor medical administrators are blind to this risk assessment yet they are hardly given a choice: in the absence of sufficient numbers of cadaveric organs and confronted with the ever-expanding organ transplant wait list, the risk associated with living organ donation pales in comparison to the eventuality associated with inaction.

Id. at 1126.

42. Limited to *one* of the following: kidneys, lung lobes, liver segments, pancreatic segments, and in rare cases, hearts and intestines. United Network for Organ Sharing, Living Donation Facts, <http://www.transplantliving.org/livingdonation/facts/organs.aspx> (last visited Jan. 4, 2006). Meanwhile, cadaver donors can simultaneously yield far more organs, along with corneas, skin, ligaments, tissues, and more, which cannot be given by a live donor. MACHADO, *supra* note 24, at 2. Of course, it is possible that a living donor could make more than one donation over the course of a lifetime.

43. This is the recovery rate as of 2005. The organs transplanted per donor, however, is 3.06. ORGAN PROCUREMENT AND TRANSPLANTATION NETWORK/SCIENTIFIC REGISTRY OF TRANSPLANT RECIPIENTS 2006 ANNUAL REPORT, TABLE 2.12, DECEASED DONOR ORGAN UTILIZATION, 1996-2005, available at http://www.optn.org/AR2006/212_dc.htm [hereinafter ORGAN UTILIZATION TABLE]. A cadaver donor can conceivably provide a heart, two lungs, a liver, two kidneys,

The downside to cadaveric donation stems from the significant constraints that exist on the supply of available, eligible organs from deceased donors. It is these constraints which contribute most to the organ shortage we now face. While there have been many proposals as to the ways in which these restraints can be lessened and cadaver donation can be maximized, they lie outside the scope of this Comment. Instead, my purpose with this discussion is to provide context to show why living organ donation has grown in frequency and importance, and to propose ways to deal with the difficulties encountered in the process for the donors.

The initial obstacle to a larger supply of cadaver organ donors is the natural ceiling on potential donor organs. Qualifying to donate requires that the donor's organs be viable—meaning the body must be free of serious disease and the organs are fully functioning and effective. Therefore, the cadaver donor must have died in such a way as to preserve the integrity of his or her bodily organs—most commonly due to severe head trauma or some sort of brain hemorrhaging.⁴⁴ This constraint drastically reduces the potential pool of donors. Estimates place the annual supply of potential cadaver donors between 12,000 and 15,000.⁴⁵ This constraint on the potential supply is, in practical terms, insurmountable. Doctors can only take organs from donors who meet these qualifications, and we cannot change the amount of such viable donors. Estimates further indicate that if we had a 100% recovery rate on donors—using organs from all 15,000 potential donors—a pool of over 50,000 organs would result, taking us much farther in fulfilling our organ donor needs, if not eventually resolving them.⁴⁶

Unfortunately, additional constraints prevent full usage of potential cadaveric donors. In America's system, the percentage of potential donors for whom consent can be obtained is a key factor. A Department of Health and Human Services 2001-2002 study evaluating variation in donation among transplant centers put the national average consent rate

intestines, stomach, pancreas, blood vessels, tissues, ligaments, bones, corneas, and more. For a detailed description, see MACHADO, *supra* note 24, at 2 (fig.1) (1998).

44. DAVID PRICE, LEGAL AND ETHICAL ASPECTS OF ORGAN TRANSPLANTATION 27 (2000).

45. OFFICE OF INSPECTOR GEN., *supra* note 5, at 1. Estimates on this statistic vary, however. See Edward Guadagnoli et al., *Potential Organ-Donor Supply and Efficiency of Organ Procurement Organizations*, HEALTH CARE FINANCING REV., 101 (Summer 2003).

46. See Leonard H. Bucklin, *Woe Unto Those Who Request Consent: Ethical and Legal Considerations in Rejecting a Deceased's Anatomical Gift Because There Is No Consent by the Survivors*, 78 N.D. L. REV. 323, 324 n.12 (2002) (noting that 50,000 "would be sufficient because approximately 5,000 new patients are added to the list each year. . . . Over time, if 50,000 more organs were available, the list would be whittled down to a point where supply could easily meet demand.").

for these centers at 51%.⁴⁷ This is a low number considering that public opinion polls report that 91% of Americans support the idea of donation after death,⁴⁸ and that 62% of Americans would want at least some of their organs donated if they died in an accident—a difference of over 10% above the consent rate.⁴⁹ An improvement to accurately reflect this preference would have profound results. Even an increase of 10% over current recovery rates could result in the availability of up to an estimated 4,600 additional organs.⁵⁰

With such high support for organ donation, why is organ recovery so much lower? First, many Americans have not expressed their organ commitment for a variety of reasons, including ignorance, apathy, concerns based on widely-held myths, worry that donating will make their death more difficult for loved ones, or an unwillingness to contemplate their own mortality.⁵¹ Instead, they may “prefer to avoid the stress or even the physical effort required to sign up.”⁵²

Second, recovery of cadaver organs typically involves the input and consent of family members who may refuse even if the deceased has previously indicated his or her intent to donate. A potential donor who has filled out an organ donation card is often refused if his or her next-of-kin declines.⁵³ Many organ procurement centers refuse to procure validly donated organs “unless consent is given by a next of kin and no other next of kin objects.”⁵⁴ The Uniform Anatomical Gift Act⁵⁵ deems the wallet-sized donor cards to be a legal instrument permitting physicians to remove the deceased’s organs,⁵⁶ yet few states take advantage of these cards and actually retrieve organs based only on the authority of a donor document.⁵⁷ Most states still consult the next-of-kin; by 1988, forty-four

47. OFFICE OF INSPECTOR GEN., *supra* note 5, at 1.

48. Fleming, *supra* note 15. *See generally*, Gallup Poll, *supra* note 15; Press Release, Living Legacy Foundation, National Survey: Support for Organ Donation Strong, Steps to Take are Mostly Unknown (Apr. 7, 2005), available at <http://www.lcnw.org/info/press/pages/pr-2005-04-07.html>.

49. Fleming, *supra* note 48. *See also*, *A Majority of Americans Say that if Killed in an Accident, They Would Want Their Organs Used for a Living Person Who Needed Them*, PR NEWSWIRE, Sept. 23, 2003, at 1 (citing a Wall Street Journal/Harris Interactive Health-Care poll).

50. The 4,600 approximation is calculated by taking 10% of 15,000 multiplied by the recovery rate from cadavers (3.06). The 3.06 average is taken from ORGAN UTILIZATION TABLE, *supra* note 43.

51. Mark S. Nadel & Carolina A. Nadel, *Using Reciprocity To Motivate Organ Donations*, 5 YALE J. HEALTH POL’Y L. & ETHICS 293, 296 (2005).

52. *Id.*

53. *See* Bucklin, *supra* note 46, at 324.

54. *Id.* *See* Louis J. Sirico, Jr., *A Primer on Organ Donation*, 17 J.L. & HEALTH 1, 8 (2002).

55. UNIF. ANATOMICAL GIFT ACT (1987), available at <http://www.law.upenn.edu/bll/ulc/fnact99/uaga87>.

56. COMMITTEE FOR TRANSPLANT AWARENESS, *supra* note 37.

57. Bucklin, *supra* note 46, at 324–25.

states had enacted “required request” legislation, which requires consent from the next-of-kin in order for procurement to take place.⁵⁸

Since the organs must be procured as soon as possible after death (including brain death),⁵⁹ physicians are often forced to request permission from family members at the worst of times—shortly after a loved one has been pronounced dead.⁶⁰ At such a traumatic time, a decision as to what to do with the deceased’s organs can be overwhelming. In many instances, the preferences of the deceased have not been discussed with family members,⁶¹ who may be dissuaded by concerns of disfigurement, a delayed funeral, poorer medical treatment, and more—even if such concerns are unfounded.⁶² Doctors often give in to the family’s wishes because they “fear upsetting families . . . [and the threat of] harmful publicity or litigation.”⁶³ In fact, in a survey of organ procurement organizations, only 12% ranked “priority of the deceased’s wishes” as their top consideration in deciding whether to use the deceased’s organs, whereas 48% ranked the impact on the deceased’s family as the top factor.⁶⁴ Worse yet, in some cases, doctors presume the next-of-kin will not give consent and do not even bother to ask.⁶⁵ These difficulties with consent have led to suggestions that the next-of-kin should not even have a say in the matter.⁶⁶

58. *Id.*

59. Maximum ischemic time (the time that the organs are outside the donor’s body and without blood circulation) varies by organ. For instance, a heart may only have up to four hours, while a kidney may have up to thirty-six. PRICE, *supra* note 44, at 25 (citing Paul J. Hauptman & Kevin J. O’Connor, *Procurement and Allocation of Solid Organs for Transplantation*, 336 NEW ENG. J. MED. 422, 428 (1997)).

60. News Release, University of Iowa, UI Study: Emotional Aspects of Organ Donation Need Attention, *available at* <http://www.uiowa.edu/~ournews/2004/february/021004organ-donation.html> (last visited Jan. 4, 2006).

61. See COALITION ON DONATION, TOPLINE SUMMARY REPORT FOR 2004 QUANTITATIVE RESEARCH STUDY 1 (2005), *available at* http://www.donatelifeamerica.org/downloadables/pdf/Topline_Summary_Report_Qualitative.pdf (reporting that only 49% surveyed had told a family member that they wished to have their organs donated); Gallup Poll, *supra* note 15 (52% surveyed had spoken with a family member). See also Amy Vandenbroucke, *HIV and Organ Donation: Illinois’ Solution to Organ Donation Shortages*, 9 DEPAUL J. HEALTH CARE L. 1285, 1294 (2006).

62. Nadel & Nadel, *supra* note 51, at 298; THE STATE OF ORGAN, EYE & TISSUE DONATION: COLORADO & WYOMING, April 2006, at 9-10.

63. Nadel & Nadel, *supra* note 51, at 298.

64. See Kwitowski, *supra* note 26, at 145.

65. Lior Jacob Strahilivetz, *The Right to Destroy*, 114 YALE L.J. 781, 808 (2005)

(In sixteen percent of all cases involving transplantable organs, families are never even asked whether they are willing to donate the organs. Here the law and prevailing practices are perplexing. A decedent’s unambiguous instructions to destroy a home are disregarded, but parents often are presumed to believe that their children’s valuable organs should be destroyed.)

(citing Ellen Sheehy et al., *Estimating the Number of Potential Organ Donors in the United States*, 349 NEW ENG. J. MED. 667, 671 (2003)).

66. One commentator noted:

Although a significant amount of families who know the wishes of the deceased still elect to withhold from donation,⁶⁷ one study suggested that significant gains are possible if more potential donors discuss their desires to donate with their loved ones and/or have those desires reinforced by a physician who is privy to their legal documentation.⁶⁸ Whereas a lack of surety over the deceased's wishes makes some families hesitant, a study conducted in Pennsylvania and Ohio concluded that the likelihood that they will choose donation is nearly seven times greater if informed of the deceased's preferences.⁶⁹

2. *Living donors*

With the worsening shortage of available cadaveric organs,⁷⁰ more and more patients are looking to living donors for transplant organs. From 1993 to 2003, the percentage of transplants coming from living donors rose from 16% to 27%.⁷¹ Put another way, the amount of living donors more than doubled from 1995 to 2004, from 3,493 to 7,002—an amount practically equal to the amount of cadaver donors.⁷² Because humans have two kidneys and can function normally with only one, the majority of organs donated from living donors are kidneys.⁷³

A primary advantage of living organ donation is the immediacy of

One estimate is that if all OPOs took all organs donated by decedents, without asking for consent of next of kin, the number of organs recovered would be more than doubled. What would two times as many transplants do for society? The answer is impressive. We would have a smaller transplant waiting list, Medicare would have a huge financial burden lifted from it, and more people would be able to work fully and lead better lives.

Bucklin, *supra* note 46, at 324.

67. See Laura A. Siminoff & Renee H. Lawrence, *Knowing Patients' Preferences about Organ Donation: Does It Make a Difference?*, 53 J. TRAUMA 754, 756 (2002).

68. See discussion below *infra* Part IV.

69. See Siminoff & Lawrence, *supra* note 67, at 754. See also Bumgardner, *supra* note 13, at 4 (“[O]ver 95% of families would consent to organ donation if they knew it was the wish of their loved one.”).

70. For instance, the Mayo Clinic states on its website that while 15,000 patients are registered on the waiting list for a new liver, only about 4,500 cadaver donor livers become available for transplant each year. Mayo Clinic, *Living Donor Liver Transplant at Mayo Clinic in Rochester and Arizona*, <http://www.mayoclinic.org/liver-transplant/livingdonorlivertransplant.html> (last visited Jan. 4, 2006).

71. Rachel Emma Silverman, *A Tax Break for Your Kidney; States Move to Allow Deductions for Expenses and Lost Wages Incurred During Organ Donation*, WALL ST. J., Dec. 1, 2004, at D1.

72. OPTN/SRTR 2005 ANNUAL REPORT, *supra* note 11. Despite equaling cadaveric donation in number of donors, the percentage is far less due to the amount of organs that can come from a cadaveric donor.

73. Approximately 95% of living donor transplant organs in 2004 were kidneys. *Id.* See also National Kidney Foundation, *Q&A on Living Donation*, <http://www.kidney.org/transplantation/livingDonors/infoQA.cfm#1d> (last visited Jan. 13, 2007).

treatment—the recipient need not wait for a suitable cadaver donor.⁷⁴ However, another advantage is the reduced risk of organ rejection.⁷⁵ The genetic similarities, organ size, and blood type compatibility are higher in organs procured from relatives of the patient.⁷⁶ Further, the environment in which the transplantation takes place is more controlled, and can be planned and optimally executed.⁷⁷ The survival and long-term success rates of kidneys are greater when procured from a living donor.⁷⁸ Finally, unlike with cadaveric donors, gaining consent for living donations is simpler from a legal standpoint, since potential donors are in complete legal control of their organs and may choose to give as they please.

On the other hand, there are downsides of living organ donation. First, the transplantation procedure poses a small attendant risk of medical complications⁷⁹ and even death for the donor.⁸⁰ The risks are minute, but real—with the odds of death in the donation process estimated at three out of every 10,000.⁸¹ There is also the attendant future risk for the donor of being left with only one kidney—which may present more risk than living with both.⁸² Donors also report that “ongoing medical and psychological problems, albeit mild, persist for many months after donation.”⁸³

Psychological risks are manifest in the form of depression or other psychological effects.⁸⁴ These difficulties naturally extend to—and may

74. Mayo Clinic, *supra* note 70.

75. United Network for Organ Sharing, Living Donation Q&A, <http://www.transplantliving.org/livingdonation/questions.aspx> (last visited Jan. 13, 2007).

76. *Id.* See also MACHADO, *supra* note 24, at 47.

77. MACHADO, *supra* note 24, at 47.

78. See Medical College of Wisconsin, First Major Kidney Transplant Study Shows Increased Organ Survival Rates (2000) <http://healthlink.mcw.edu/article/953057292.html> (last visited Jan. 22, 2007).

79. PRICE, *supra* note 44, at 220–24.

80. *Id.* at 220.

81. Robert S. Gaston, *Is it Safe to Donate a Kidney?*, 11 TRANSPLANT CHRONICLES Summer 2003, at 8, available at http://www.kidney.org/transplantation/livingDonors/pdf/safe_to_donate.pdf. See also PRICE, *supra* note 44 (noting that between 1980 and 1991, clinics reported five donor deaths out of 19,368 kidney donations).

82. MACHADO, *supra* note 24, at 47–48; Gaston, *supra* note 81, at 8 (“Potential long-term complications remain the greatest concern of professionals involved with live donor transplantation.”). *But see*, PRICE, *supra* note 44, at 220–21 (“Studies over a long period have failed to reveal any increased risk of renal failure following nephrectomy . . .”).

83. Abhinav Humar, *Living Donor Liver Transplants: Potential Disadvantages*, 19 J. GASTROENTEROLOGY & HEPATOLOGY S304, S304–S306 (2004).

84. Living Organ Donor Advocate Program, Living Organ Donor Issues, <http://www.lodap.com/id14.html> (last visited Mar. 13, 2007). See Eric M. Johnson et al., *Long-Term Follow-Up of Living Kidney Donors: Quality of Life After Donation*, 67 TRANSPLANTATION 717, 720–21 (1999). *But see*, PRICE, *supra* note 44, at 221 (noting that despite studies reporting psychosocial complications such as post-donation depression, the evidence is inconclusive).

even be exacerbated in—those cases where the donor’s organ is rejected by the recipient, or when the recipient dies shortly after.⁸⁵ Because of these concerns, psychological evaluations are sometimes added to the battery of tests prospective donors must go through.⁸⁶

Providing an organ transplant can be a significant drain on a donor economically as well as physically and psychologically. These drains come in the form of discomfort, extended physical recovery time,⁸⁷ expenses related to the surgery, and lost wages.⁸⁸ Before the donation, a potential donor must undergo numerous tests to ensure compatibility with the recipient, including blood, tissue and urine tests, x-rays, antibody screens, and—in the case of female donors—gynecological examinations and mammograms.⁸⁹ The time taken to undergo these pre-operative tests as well as the surgery procedure itself and recovery times that are typically two to six weeks⁹⁰ add up to a significant amount of time away from work for the donor. Although the recipient’s insurance typically covers the actual medical expenses,⁹¹ the costs associated with travel, lodging, child care, and lost wages can be daunting.⁹² The lost wages that add up can be especially difficult on low income families, and

85. Organ Procurement and Transplantation Network, Facts About Living Donation, <http://www.optn.org/about/donation/livingDonation.asp> (last visited Mar. 13, 2007). *See also* PRICE, *supra* note 44, at 222 (donors who expressed dissatisfaction or regrets regarding the donation were often donors in cases where the recipient had died within one year post-transplant) (citing Johnson et al., *supra* note 84).

86. Organ Procurement and Transplantation Network, *supra* note 85.

87. Mayo Clinic, *supra* note 70.

88. *See* discussion *infra* notes 91-92 and accompanying text.

89. United Network for Organ Sharing, Being a Living Donor: Tests Involved, <http://www.transplantliving.org/livingdonation/livingdonor/tests.aspx> (last visited Mar. 10, 2007). *See also* Mayo Clinic, The Transplant Process, <http://www.mayoclinic.org/liver-transplant/transplantprocess.html> (last visited Mar. 10, 2007).

90. *See* Hume-Lee Transplant Center, Kidney Transplant Program: Living Kidney Transplant Program, http://www.vcuhealth.org/transplant/transplant_kidney_living/transplant_kidney_living.htm (last visited Mar. 10, 2007); Laroscopic Living Kidney Donation, <http://www.rogosin.org/LaparoscopicDonorBrochure.pdf> (pointing out that time missed from work may depend on the physical nature of the donor’s employment) (last visited Mar. 10, 2007); Mayo Clinic, *supra* note 70; New York-Presbyterian Hospital, Liver Transplant, http://www.nyptransplant.org/liver/cli_ser/liv_don.html?name1=Living+Donor&type1=2Active (last visited Mar. 10, 2007).

91. United Network for Organ Sharing, Financial Aspects: Living Donation Costs, <http://www.transplantliving.org/livingdonation/financialaspects/costs.aspx> (last visited Mar. 10, 2007). There may be circumstances, however, where complications arise for donors that are not covered by insurance. Mark W. Russo & Robert S. Brown, Jr., *Financial Impact of Adult Living Donation*, 9 LIVER TRANSPLANTATION S12, S12–S15 (2003). In some instances, donors may be entitled to disability pay. *See* United Network for Organ Sharing, *supra* note 75.

92. *See* Bumgardner, *supra* note 13, at 3; Russo & Brown, *supra* note 90, at S12–S15; U.S. DEP’T OF HEALTH AND HUMAN SERV., PARTNERING WITH YOUR TRANSPLANT TEAM: THE PATIENT’S GUIDE TO TRANSPLANTATION, at 22 (2004), available at http://www.unos.org/SharedContentDocuments/Transplantation_Guide_Final-3-04-04.pdf.

in some cases living donors have even lost their job due to donating.⁹³ The sad case of employees losing their employment due to becoming living donors appears relatively rare, although it would, of course, be very serious.⁹⁴ The prospect of a donor losing his or her job for donating strikes almost anyone as patently unfair.

As for total financial setbacks, reliable numbers are very difficult to determine, and reliable studies scant.⁹⁵ One decade-old study placed the mean number for out-of-pocket donor expenses at \$579, but the numbers ranged from \$0 to \$20,000.⁹⁶ In addition, some donors have experienced difficulty obtaining health insurance, or face rising premiums as a result of donating.⁹⁷

Even if steps are taken to maximize recovery of cadaveric donations, living donors will still be called upon, as long as the natural constraint on qualifying cadavers (as discussed above) remains constant, and as long as there are still differences in the survival rates. As science works to further reduce the risk to the living donor, the law should similarly reduce the financial costs of donation. Society should send a message that it acknowledges and lends support to brave citizens who sacrifice to save others, and that organ donation qualifies as a social good that accrues to us all.

III. LEGISLATION AIMED AT REMOVING DISINCENTIVES FOR LIVING DONORS

The concept of using tax deductions as a means of addressing organ shortage is hardly novel. Various measures have recently been enacted on a state and federal level that have specifically addressed living donors. These measures have sought to facilitate donation from living donors and ease financial burdens. These recent measures, especially at the federal level, suggest that Congress may be prepared to further act on this issue and embrace tax relief for living organ donors.

More specifically, the state tax deductions for living donors provide an example of how to proceed and have introduced us to opposing arguments to such a federal tax deduction. This section describes not

93. See, e.g., Jonathan Maze, *Living Organ Donors Put More than Life on the Line: South Carolina Lawmakers Weigh Tax Break*, POST AND COURIER, May 16, 2004, at A1.

94. This author could not locate any studies on the subject.

95. See R.S. Gaston, *Limiting Financial Disincentives in Live Organ Donation: A Rational Solution to the Kidney Shortage*, 6 AM. J. TRANSPLANTATION 2548, 2548–55 (2006).

96. Johnson et al., *supra* note 84. These numbers would be higher due to inflation and rising medical costs.

97. Living Organ Donor Advocate Program, *supra* note 84. However, results vary: some insurance companies view the donor as a healthy person, since they could not donate otherwise. *Id.*

only the historical proposals (and the obstacles they faced), but also the recent legislation and the opportunity to improve on this legislation.

A. Historical Proposals

As the technology and understanding needed to make organ transplantation became increasingly viable, the demand for organs also increased. Therefore, a variety of solutions to the shortage have been proposed over the last three decades. An in-depth look at every proposal aimed at easing the organ supply shortage is outside the scope of this Comment. Instead, the focus will be on proposals regarding tax deductions.

The idea to use tax deductions has been proposed before, but never implemented. In 1981, a bill was introduced in the House of Representatives that would provide a tax deduction for decedents, not living donors.⁹⁸ This proposal provided for a \$25,000 tax deduction for qualified transplant donations.⁹⁹ The primary purpose for the bill was as an incentive to increase the cadaveric organ supply. In addition, bills have also been introduced which would allow tax credits for living organ donors.¹⁰⁰ However, none of these bills have been passed into law, either.

B. Recent Federal Legislation

Two pieces of legislation passed in the last decade have sought to address the financial difficulties of living organ donors. These two pieces of legislation are the Organ Donor Leave Act and the Organ Donation and Recovery Improvement Act. This Comment briefly discusses the first of these and more closely analyzes the second.

1. Organ Donor Leave Act

First, the federal government and some state governments have addressed the inherent conflict between organ donors and their employers by enacting legislation that provides government employees with paid donor leave. The federal government was first, enacting the Organ Donor Leave Act in 1994, with subsequent amendments in

98. H.R. 3774, 97th Cong. (1st Sess. 1981).

99. Howard S. Schwartz, *Bioethical and Legal Considerations in Increasing the Supply of Transplantable Organs*, 10 AM. J.L. & MED. 397, 409 (1985).

100. H.R. 2474, 109th Cong. (1st Sess. 2005). H.R. 2090, 107th Cong. (1st Sess. 2001). Rep. Jim Hansen (R-UT) introduced a similar bill for a \$10,000 credit applying to deceased donors, in 2001. See H.R. 1872, 107th Cong. (1st Sess. 2001).

1999.¹⁰¹ Various states have also enacted such measures.¹⁰² The federal legislation permits “[a]n employee in or under an Executive agency” to take leaves of absences without reduction in pay for up to seven workdays in the case of bone marrow donors and thirty workdays in the case of organ donors.¹⁰³ These paid leave programs have attracted very little in the way of comment or controversy, perhaps in part because other paid or unpaid leave programs have been in existence for years, including paternity and maternity programs.¹⁰⁴

2. *Organ Donation and Recovery Improvement Act*

Another recently passed federal initiative addresses the financial difficulties many donors face.¹⁰⁵ The Organ Donation and Recovery Improvement Act (“ODRIA”) was designed to increase organ donation and recovery.¹⁰⁶ ODRIA authorized federal spending of \$25 million in funding for “travel and subsistence expenses for living donors, organ donation education and awareness activities, grants for hospital organ coordinators, and other programs designed to increase organ donation rates and improve organ recovery rates.”¹⁰⁷ This included \$5 million per year to reimburse living donors for expenses incurred in donating.¹⁰⁸ ODRIA is “groundbreaking” as it is the first enacted federal legislation that provides reimbursement to living donors, and because it “opened the

101. Organ Donor Leave Act of 1994, Pub. L. No 103-329, 113 Stat. 407 (1994) (codified as amended at 5 U.S.C.S § 6327 (2005)); Memorandum from Janice R. Lachance, Dir. of the U.S. Office of Pers. Mgmt, to heads of executive departments and agencies (Nov. 2, 1999), <http://www.opm.gov/oca/compmemo/1999/organ.htm>.

102. Numerous other states have legislation permitting state employees to take unpaid leave to donate. Erin Madigan, *States Offer Tax Breaks to Spur Organ Donation*, STATELINE.ORG, Aug. 26, 2004, <http://www.stateline.org/live/ViewPage.action?siteNodeId=136&languageId=1&contentId=15749>.

103. 5 U.S.C.S. § 6327 (2005).

104. *See, e.g.*, Family and Medical Leave Act, 29 U.S.C. § 2601–2654 (2000).

105. Bumgardner, *supra* note 13, at 3.

106. Organ Donation and Recovery Improvement Act, Pub. L. No. 108-216, 118 Stat. 584 (1994) (codified as amended at 42 U.S.C.S. § 274f (2007)). The stated purpose of ODRIA as described by Sen. Frist, its sponsor:

[To] improve the overall process of organ donation and recovery, enhance our knowledge base in these fields, encourage novel approaches to this growing problem [of a critical shortage of transplantable organs] and increase the number of organs available for transplants each year. The bill also seeks to remove potential barriers to donation, while identifying and focusing on best practices in organ donation.

Margaret R. Sobota, Note, *The Price of Life: \$50,000 for an Egg, Why Not \$1,500 for a Kidney? An Argument to Establish a Market for Organ Procurement Similar to the Market for Human Egg Procurement*, 82 WASH. U. L.Q. 1225, 1234 n.71 (Fall 2004) (citing 149 CONG. REC. S3330 (daily ed. Mar. 6, 2003) (statement of Sen. Frist)).

107. Bumgardner, *supra* note 13, at 3. *See* 42 U.S.C.S. § 274f.

108. Bumgardner, *supra* note 13, at 3.

door to further financial incentives, such as payments to families of deceased donors to offset funeral costs.”¹⁰⁹

ODRIA provided for \$15 million in grants for programs that effectively promote education and awareness concerning organ donation.¹¹⁰ It also provided \$2 million for studies related to scientific advancement in procurement and transplantation, in order to “maximize existing donation practices,”¹¹¹ and \$3 million in grants to “organ coordinators” to increase donation and transplant success rates.¹¹²

Most pertinent to this Comment, ODRIA authorizes \$5 million in grants to “[s]tates, transplant centers, qualified organ procurement organizations . . . or other public or private entities for the purpose of . . . providing for the reimbursement of travel and subsistence expenses incurred by individuals toward making living donations of their organs”¹¹³ Under ODRIA, donors are ineligible to receive payment if their expenses are paid for by another source, such as the organ recipient, insurance provider, or from a state program.¹¹⁴ This provision is intended to ensure that the payment is a reimbursement, and not a financial compensation for the organ.¹¹⁵ ODRIA is a significant step in the right direction, as it provides some live donors with financial relief and mitigates some of the financial disincentives for the poorest donors. However, while this provision of the bill is an excellent start, it is an incomplete solution.

The political viability and popularity of ODRIA is evident. The measure was supported by the American Medical Association,¹¹⁶ it passed in both houses of Congress with near-unanimous consent, and on April 5, 2004, President Bush signed it into law.¹¹⁷ Indeed, one scholar noted the appearance of “widespread sentiment in this country that live donors should not personally bear any costs associated with donation.”¹¹⁸ That is not to say that it comes without the potential for objection. The

109. J. Alex Little, *The ANGEL Act: A Proposal to Encourage Organ Donation After Death*, 3 GEO. J.L. & PUB. POL’Y 685 (2005) (citing Jim Warren, *Financial Support for Live Donors, Organ Trafficking, Stem Cell Research Among Major News Events of 2004*, TRANSPLANT NEWS, Dec. 31, 2004).

110. See Bumgardner, *supra* note 13; 42 U.S.C.S. § 274f.

111. See Bumgardner, *supra* note 13, at 5. See Organ Donation and Recovery Improvement Act, Pub. L. No. 108-216, 118 Stat. 584 (1994) (codified as amended at 42 U.S.C.S. § 274f (2007)).

112. See Bumgardner, *supra* note 13, at 3. See 42 U.S.C.S. § 274f.

113. 42 U.S.C.S. § 274f.

114. 42 U.S.C.S. § 274f(d).

115. Sobota, *supra* note 106, at 1235.

116. Calandrillo, *supra* note 32, at 112.

117. See Bumgardner, *supra* note 13, at 1–3.

118. Francis L. Delmonico, *Financial Incentives for Organ Donation*, MEDSCAPE TRANSPLANTATION 5(1), Jan. 7, 2004.

law could be criticized if its interaction with NOTA is viewed as suspect due to its provision allowing the donor to be reimbursed for expenses incurred in bringing up to two travel companions.¹¹⁹ Detractors may argue that since NOTA “implicitly precludes payment to anyone other than the donor,” being reimbursed for expenses incurred by travel companions puts the two in conflict.¹²⁰

ODRIA is administered through the Health Resources and Services Administration (HRSA), a subdivision of the Department of Health and Human Services. In order to provide the authorized reimbursements, HRSA has partnered with the Regents of the University of Michigan in a four-year, \$8 million agreement, together creating a national mechanism for distribution of the funds to living organ donors.¹²¹ Living donors from across the United States will be able to receive reimbursement if they meet eligibility criteria that HRSA and University of Michigan have developed.¹²² The proposed criteria have been published in the Federal Register and are currently subject to public comment.¹²³ It must be noted that the reimbursement program is still in its infancy, and the eligibility criteria discussed here have yet to be finalized.¹²⁴

To be eligible for reimbursement, a donor must be a U.S. citizen with his or her primary residence in the U.S and must donate at a qualifying transplant center.¹²⁵ The donor must meet the requirements of informed consent, be in full compliance with NOTA, and must not be participating in any restricted exchange program.¹²⁶

In addition, applicants must meet the income eligibility requirements. ODRIA is constrained in the number of donors who can qualify. Funding is limited, so HRSA must prioritize reimbursement

119. 42 U.S.C.S. §274f(c)(2) (2007).

120. Alicia M. Markmann, Comment, *Organ Donation: Increasing Donations While Honoring Our Longstanding values*, 24 TEMP. J. SCI. TECH. & ENVTL. L. 499, 508–09 (2005). See 42 U.S.C.S. § 274e(c)(2)(2007).

121. E-mail from Mesmin Germain, Public Health Analyst, Health Resources and Services Administration, to M. Lane Molen (Jan. 26, 2007, 13:05:19 MST) (on file with author) [hereinafter Email from Mesmin Germain, Jan. 26, 2007]; see also, HEALTH RES. AND SERV. ADMIN., U.S. DEP’T OF HEALTH AND HUMAN SERV., <http://granteefind.hrsa.gov/searchbyprogram.aspx?select=U13&index=165> (last visited Mar. 22, 2007). See also, As of April 9, 2007. Reimbursement of Travel and Subsistence Expenses Toward Living Organ Donation Proposed Eligibility Guidelines, 72 Fed. Reg. 17,564, 17,565 (Apr. 9, 2007) [hereinafter Proposed Guidelines].

122. E-mail from Mesmin Germain, Jan. 26, 2007, *supra* note 121; E-mail from Mesmin Germain, Public Health Analyst, Health Resources and Services Administration, to M. Lane Molen (Jan. 29, 2007, 07:17:13) (on file with author).

123. As of April 9, 2007. Proposed Guidelines, *supra* note 121. “The final program eligibility criteria will be posted on the Reimbursement of Travel and Subsistence Expenses for Living Organ Donation Web site, <http://www.livingdonorassistance.org>.” *Id.*

124. *Id.*

125. *Id.* at 17,566.

126. *Id.*

grants in accordance with the donor's ability to pay for donor expenses. While HRSA seeks to assist as many qualified donors as possible, the Act provides that the Secretary must give preference "to those individuals that the Secretary determines are more likely than otherwise unable to meet such expenses."¹²⁷ An administrator for the program confirms that, indeed, the program is not designed to reimburse donors who can themselves "reasonably pay for the[] expenses."¹²⁸ Furthermore, ODRIA explicitly precludes payments where "a donor's eligible expenses have been, or reasonably can be expected to be, paid by the organ recipient."¹²⁹ Thus, the recipient's ability to pay is also a crucial factor.

Because of this statutory proscription (on paying for expenses a recipient could reasonably pay), the first major obstacle for a reimbursement applicant is whether the recipient is deemed to have the ability to pay.¹³⁰ According to the proposed guidelines in the Federal Register, the threshold of income eligibility for the recipient is 200% of the Health and Human Services poverty guidelines.¹³¹ According to HRSA, "[a]ny income above this measure, it can reasonably be expected that the recipient of the organ could pay for the donor's qualifying expenses."¹³² Under the 2006 HHS poverty guidelines, a donor in a single-person household would generally be ineligible if the recipient had an income above \$19,600 in the applicable year.¹³³ Exceptions to this rule may be made by the program's Review Committee on a case-by-case basis, focusing on the recipient's hardship.¹³⁴ Such exception can be made if the social worker or other appropriate personnel involved in the transplant "can provide a written justification that notwithstanding the potential transplant recipient's income level, significant financial hardship is likely be encountered by the potential transplant recipient of the organ for the payment of the donor's qualifying expenses in the course of the donation process."¹³⁵ It

127. 42 U.S.C.S. § 274f(b).

128. E-mail from Mesmin Germain, Public Health Analyst, Health Resources and Services Administration, to M. Lane Molen (Feb. 27, 2007, 05:28:30 MST) (on file with author) [hereinafter Email from Mesmin Germain, Feb. 27, 2007].

129. *Id.*

130. Proposed Guidelines, *supra* note 121, at 17,565. "The program's authorizing legislation explicitly states that funds 'will not be expended to pay the qualifying expenses of a donating individual to the extent that payment has been made, *or can reasonably be expected to be made.* . . . by the recipient of the organ.'" *Id.* (emphasis added).

131. *Id.*

132. *Id.*

133. Amounts for residents of Hawaii and Alaska differ.

134. Proposed Guidelines, *supra* note 121, at 17,565.

135. *Id.*

appears from the proposed eligibility criteria that if this exception is not met, and the recipient does not meet the income requirements, then the donor will not be eligible for reimbursement.¹³⁶

The guidelines' assumption that at 200% above the poverty level recipients can be reasonably expected to pay the donor's expenses seems misplaced. Given that the Act is "intended for individuals with end stage organ failure,"¹³⁷ the recipients have likely been undergoing extensive medical treatment and are financially strained. While some recipients may be in a financial position to pay the donor's expenses, ODRIA only allows for reimbursement if the recipient is less than 200% of the poverty level. For example, this means that, despite extensive personal medical and other related expenses, the ODRIA expects a recipient making \$20,000 per year to be in a position to pay the donor's expenses.

If the recipient is not deemed to be reasonably expected to pay for the donor's expenses, then the donor's income level is the next factor considered. When a donor's income level exceeds 200% of the HHS poverty level, priority will be given elsewhere.¹³⁸ While donors with higher incomes may have a chance to receive reimbursement, they are only reimbursed as funds allow. To summarize, HRSA provides an order of preference categories, as follows:

All live organ donors are eligible for reimbursement of qualifying expenses provided all the criteria for donor reimbursement are fulfilled. However, subject to availability of funds, preference will be given to donors who are more likely to be otherwise unable to meet the qualifying expenses, in the following proposed order of priority:

Preference Category 1: Donor income and recipient anticipated income each is $\leq 200\%$ of the HHS Poverty Guidelines in their respective States of primary residence.

Preference Category 2: Donor income is $\leq 200\%$ of the HHS Poverty Guidelines in the State of primary residence.

Preference Category 3: Recipient anticipated income is $\leq 200\%$ of the HHS Poverty Guidelines in the State of primary residence.

Preference Category 4: Donors who can demonstrate that notwithstanding their income level, significant financial hardship is

136. *See id.* at 17,565.

137. *Id.* at 17,564.

138. *Id.* at 17,565.

likely to be encountered for qualifying non-medical expenses in the course of the donation process.

Preference Category 5: Any live organ donor, notwithstanding income level or financial hardship, who meets the criteria for donor reimbursement.¹³⁹

These proposed guidelines illustrate the prioritized manner in which reimbursements will be allocated. While preferences for poorer donors and recipients are sensible, it is unfortunate that the Act cannot provide economic relief to a larger segment of donors. A tax deduction could act as a complimentary measure to increase the amount of donors who receive some measure of relief.

Next, ODRIA is also limited in the amount of relief it can provide with respect to each individual donor. The language of the statute provides for the reimbursement of “travel and subsistence expenses incurred by individuals toward making living donations of their organs” and “such incidental nonmedical expenses that are so incurred as the Secretary determines by regulation to be appropriate.”¹⁴⁰ The proposed guidelines define qualifying expenses as “only travel, lodging, and meals and incidental expenses incurred by the donor and/or accompanying person(s)” in the course of donor evaluation, the actual donor surgical procedure, and medical or surgical follow-up procedures.¹⁴¹ These reimbursement expenses are capped at \$6,000.¹⁴²

Further, lost wages will not be reimbursed under ODRIA. No explicit reimbursement is found in ODRIA or in the proposed guidelines for lost wages, which in some cases can be the most expensive burden on the donor. Thus, a tax deduction which addresses lost wages would provide an extra measure of assistance beyond ODRIA for working donors who lose wages, both those who qualify for ODRIA relief, and those who do not.

Finally, ODRIA is limited in funding and application, both in scope and in time. The first problem is that it is subject to continuing appropriations. Currently, it has authorization for \$5 million for each year through fiscal year 2009.¹⁴³ Given that appropriation could be

139. *Id.*

140. 42 U.S.C.S. §274f(a) (2007).

141. Proposed Guidelines, *supra* note 121, at 17,566. The guidelines go on to state that “[t]he Program will pay for up to five trips per donation or intended donation. Three of these trips may be for the potential living donor and up to two trips may be for any accompanying person(s).” *Id.*

142. *Id.*

143. 42 U.S.C.S. § 274f(f).

discontinued after that time, a tax deduction provides another level of protection against a future Congress that fails to reauthorize spending in this area.

This Comment argues that even those who can afford the expense of donation—including those in the middle class and above—should still be afforded some relief, given the tremendous good that they provide for society. A tax deduction would serve as a complementary measure to ensure basic principles of fairness: A tax code that rewards a wealthy person who donates her old jalopy but not a wealthy person who donates her kidney still lacks fairness.

C. State Measures

A developing trend in encouraging living organ donors is the state-by-state adoption of legislation to provide to living donors deductions from their state income taxes. These measures are intended to help living donors recover their costs and remove disincentives to donation. Such disincentives arise mainly out of the financial burdens placed on organ donors, as discussed above.

In 2004, Wisconsin was the first state to provide for a tax deduction for expenses incurred by living organ donors.¹⁴⁴ The enactment, which received overwhelming support in both houses of the Wisconsin legislature,¹⁴⁵ allows for a deduction of up to \$10,000 from adjusted gross income as applied to state income taxes.¹⁴⁶ This deduction may be claimed for expenses incurred in travel, lodging, and lost wages related to the organ donation.¹⁴⁷ Wisconsin's law attracted media attention,¹⁴⁸ and other states have already followed suit, including Arkansas, Georgia, Idaho, Iowa, Minnesota, Missouri, New Mexico, New York, North Dakota, and Utah.¹⁴⁹ Still others are considering similar legislation.¹⁵⁰ However, as it stands now, an organ donor in one state may receive tax relief, but other donors are left in the cold.

144. WIS. STAT. § 71.05(10)(i) (2005). See also Jo Napolitano, *Wisconsin Senate Approves Tax Deduction for Organ Donors*, N.Y. TIMES, Jan. 23, 2004, at A12.

145. Napolitano, *supra* note 133.

146. See *id.*; Madigan, *supra* note 102.

147. WIS. STAT. § 71.05(10)(i).

148. See Napolitano, *supra* note 144.

149. Idaho and Utah have statutes that provide tax credits—\$5,000 for Idahoans and \$10,000 for Utahans. IDAHO CODE ANN. § 63-3029K (2006); UTAH CODE ANN. § 59-10-1015 (2006). The other states provide tax deductions of up to \$10,000. See ARK. CODE ANN. § 26-51-2103 (2005); GA. CODE ANN. § 48-7-27 (2005); IOWA CODE § 422.7(44) (2005); MINN. STAT. § 290.01 Subd. 19b(13) (2006); N.M. Stat. Ann. § 7-2-36 (2005).

150. United Network for Organ Sharing, Financial Aspects: Legislation, <http://www.transplantliving.org/livingdonation/financialaspects/legislation.aspx> (last visited Feb. 22, 2007).

IV. EVALUATING THE ARGUMENTS FOR AND AGAINST A FEDERAL TAX DEDUCTION

A. *The Proposal*

This Comment proposes that the federal government follow the example of the States,¹⁵¹ by amending the tax code to provide a tax deduction similar to the Wisconsin statute. The tax deduction bill introduced in 2004 by Rep. Alcee Hastings (D-FL) is a great start,¹⁵² although unfortunately, Hastings' bill never made it out of committee.¹⁵³ Like Hastings' measure, this proposal would include medical care not otherwise covered and lost wages.¹⁵⁴ And like Wisconsin's statute, it would include travel and lodging expenses.¹⁵⁵

A limitation of \$20,000 on the deduction would be included (Hastings' bill imposed a limitation of \$15,000 on the deduction).¹⁵⁶ The bill should allow for the number to be adjusted for inflation. The deduction would also be limited only to expenses that had not been otherwise reimbursed or compensated. To the extent the taxpayer received partial reimbursement through ODRIA or compensation through any other government program, insurance policy, or payment from the recipient, he would not be able to claim those expenses. Thus, while a tax deduction and ODRIA would overlap, they could not be doubly exploited by the taxpayer. In addition, if the taxpayer resided in a state with an existing income tax deduction, he would have to elect between the two—the taxpayer could not receive deductions for both state and federal income taxes.

The bill would also borrow from the language of ODRIA in defining who qualifies as a "donating individual." As in ODRIA, a "donating individual" would include donors who incur expenses toward an intended donation in good faith, but for "appropriate" reasons, the donation never takes place.¹⁵⁷ This could be further qualified to include only prospective donors who were initially deemed healthy enough to donate.

151. United Network for Organ Sharing, Financial Aspects: State Tax Deductions and Donor Leave Laws, <http://www.transplantliving.org/livingdonation/financialaspects/statetax.aspx> (last visited Feb. 22, 2007).

152. H.R. 4042, 108th Cong. (2d Sess. 2004).

153. 108 Bill Tracking H.R. 4042.

154. *Id.*

155. WIS. STAT. § 71.05(10)(i)(2005).

156. H.R. 4042, 108th Cong. (2d Sess. 2004).

157. 42 U.S.C.A. § 274f(c)(1) (West 2005).

This proposal is not intended to replace the ODRIA, but rather to complement it by adding another layer of relief. Indeed, a tax deduction combined with the reimbursements provided by ODRIA is a much better solution than either on its own. This is because tax deductions are typically more beneficial to higher-income donors who receive relief from a higher tax rate. Naturally, most taxpayers would prefer a straight reimbursement over a deduction, as it amounts to more money in the donor's pocket. But since ODRIA gives preference to poorer donors and excludes reimbursement when recipients have income levels above 200% of the poverty level, those who are wealthier and do not receive the reimbursement through ODRIA are still honored and supported by society through a tax deduction—a deduction that their equally situated neighbors already receive from donating their used car. Of course, this is assuming that Congress will not take the preferable course of raising the amount of money for reimbursement to the point where it will cover all donors. But as long as less than 100% of donors are reimbursed, a tax deduction of this sort will be an improvement. Indeed, even if funding is raised for ODRIA, a tax deduction still provides a valuable safety net in the event that ODRIA's funding does not match the amount of living donors.

B. Objections/Opposing Arguments

Part III discussed various state and federal measures that have recently been enacted to help living donors. This section discusses the implications of such measures generally, and specifically will discuss the state tax deductions and the various arguments for and against implementing similar legislation at the federal level.

1. Legal concerns

The Wisconsin statute and similar tax deductions pose a “challenge [to] the extent of the NOTA's prohibition” on compensating organ donors.¹⁵⁸ This challenge proved politically fatal to Kansas' proposed statute; it fell by the wayside after the Kansas attorney general opined that the statute would conflict with NOTA's prohibition on valuable consideration.¹⁵⁹

However, the key distinction is that the Wisconsin law and this Comment's proposal allow deductions based on the expenses incurred in

158. Arthurs, *supra* note 7, at 1126.

159. Napolitano, *supra* note 144.

donating the organ, not for the expense of *the organ itself*. The fact that the deduction is for the expenses and not for the organs is important because NOTA contains a provision excluding compensation for such expenses.¹⁶⁰ Furthermore, the Senate Report accompanying NOTA explicitly stated that travel, lodging and wages were not “valuable consideration” for the purposes of the Act.¹⁶¹ Thus, a properly structured change in the Tax Code would not stand in conflict with existing law.¹⁶² Considering Congress’s adoption of the Federal Organ Donor Leave Act with its feature of paid leave, a strong argument could be made that Congress has already chosen to make use of this NOTA exclusion.

2. Normative objections

Critics of tax deductions often object on the grounds that they appear to be compensating organ donors. This raises ethical objections because compensation for organ donation runs contrary to what they believe should continue to be a purely altruistic system.¹⁶³ Opponents fear a “slippery slope to the subsequent development of payment for live donor organs.”¹⁶⁴

Supporters of such legislation may respond by pointing out first, that such a tax deduction would only cover the expenses of donating, and not the organ itself. No monetary value would be placed upon the actual organ. Further, the legislation does not so much reward the donor as it does merely mitigate the economic burdens placed on the donor—the donor is still losing overall, financially speaking. The sponsor of the Wisconsin bill, State Representative Steve Wieckert, argued that the bill did not provide an incentive to donate, but instead provided “simply [for] the removal of a financial disincentive.”¹⁶⁵ Further, he argued, “[n]o one, rich or poor, would receive any additional money for donating. All they would do is lose less money.”¹⁶⁶

Given that most living organ donors will only make one such

160. See Arthurs, *supra* note 7, at 1130, for analysis of the application of NOTA’s provisions to the Wisconsin bill.

161. *Id.* at 1130 (citing S. REP. NO. 98-382 (1984)).

162. See *supra* Part II.A.

163. See Calandrillo, *supra* note 32, at 111; Julie Deardorff, *Living Donors Deserve Payback for Great Gift*, CHI. TRIB., Apr. 23, 2004, at 9.

164. Delmonico, *supra* note 118.

165. Jeremy Wheelock, *Tax Breaks May Relieve Expenses of Organ Donation*, THE BADGER HERALD, Sept. 10, 2003, available at http://badgerherald.com/news/2003/09/10/tax_breaks_may_relie.php.

166. See Napolitano, *supra* note 144. In addition, scholars have argued that there are ways for society to “explicitly thank organ donors . . . without jeopardizing its altruistic basis.” Delmonico, et al., *supra* note 38, at 25.

donation in their lives (with the possible exception of bone marrow donors), and the other emotional and physical restraints on donating, there should not be much concern about taxpayers exploiting such legislation for personal gain.

Further, if the concern is that providing a tax deduction will improperly provide incentives for those who would not otherwise donate, lawmakers should also bear in mind that the altruistic standard embraced in America and embodied in the National Organ Transplant Act is not immune from attack by outside sources. As one scholar has pointed out, “the standard of uncompensated donation of organs from living donors is also being eroded by the opportunity to obtain organs outside the United States.”¹⁶⁷ This opportunity appears to be increasing. As a “global black market in human organs and a booming transplant tourism industry has emerged. . . . three hundred Americans travel abroad each year to buy a human organ.”¹⁶⁸ The proposal is only for the expenses incurred in donating—providing such a reimbursement simply removes monetary *disincentives* more than it provides new monetary *incentives*. The idea, then, is to make the donor no better off than they were, while attempting to make them less worse off. Indeed, if steps are not taken to effectively work within the altruistic system, it seems likely that even more people will begin to look to outside sources.

With the deduction, the average donor in Wisconsin would see an actual tax break of \$550.¹⁶⁹ It is extremely unlikely a tax deduction would encourage people who would not already be donating in the first place to undergo the hardships of donation, since the best they can do is break even financially under ODRIA. At best, a tax deduction would only lessen expenses, not improve their financial situation. They will likely continue to donate for other, more humanitarian reasons. This seems especially likely given that over ninety percent of living donors donate to family members.¹⁷⁰ The goal of a tax deduction, then, would be to help courageous donors recover a portion of their costs and help to remove financial barriers to donation.

Other commentators criticize tax deductions because they “seek[] to incentivize living organ donation without first exploring the effect of

167. Delmonico, et al., *supra* note 38, at 25.

168. Calandrillo, *supra* note 32, at 87 (citing Eamonn O’Neill, *The Cost of Living*, THE SCOTSMAN, Mar. 10, 2001, at 14, available at 2001 WL 14095051).

169. Jim Ritter, *Not Nearly Enough to Go Around; The Future of Organ Transplantation*, CHI. SUN-TIMES, Sept. 5, 2004, at 19.

170. RICHARD H. HAUBOLDT & NICKOLAS J. ORTNER, 2002 ORGAN AND TISSUE TRANSPLANT COSTS AND DISCUSSION, MILLIMAN RESEARCH REPORT 45 (2002), available at http://www.transplantliving.org/ContentDocuments/2002_Milliman_Report.pdf (last visited Mar. 13, 2007).

incentivized cadaveric organ donation.”¹⁷¹ They contend that cadaveric donation is superior to living donation because of the risk to the donor.¹⁷² One commentator declared that “although the post-donation mortality rate is very low for [living donors], even one unnecessary death is an unreasonable cost to bear. . . . any mortality rate above zero becomes indefensible when compared to a viable alternative with a mortality rate of zero.”¹⁷³ In a newspaper report, a medical ethicist was quoted as saying, “[b]y encouraging living donors, we’re putting healthy people at risk. . . . The whole thing is just going in the wrong direction.”¹⁷⁴ Some physicians oppose living organ donation altogether.¹⁷⁵

These are powerful arguments, as no one wants to see any donor lose his or her life trying to save another’s. However, until recovery rates for cadaver donors are maximized, living donors will be called upon to help fill the gap.

In response to criticisms, supporters of tax deductions for living donors may also argue that living donation is a rational and humane choice given the increased survival rates for recipients of living donor organs over those of cadaveric organs.¹⁷⁶ This is especially true with kidney transplants. While the gap between one-year survival rates is narrowing considerably,¹⁷⁷ the gap for long-term success rates is still significant.¹⁷⁸ For example, the five-year survival rate is reported as up to 8% higher for recipients of living donors.¹⁷⁹

171. Arthurs, *supra* note 7, at 1126.

172. *See id.* at 1125–26. Arthurs argues that such deductions should only be viewed as secondary options, and that we must first pursue “the introduction of financial incentives to promote cadaveric donation.” *Id.* at 1129.

173. *Id.* at 1126.

174. Chris Fusco, *Wisconsin Eases Financial Burden on Organ Donors*, CHI. SUN-TIMES, Jan. 23, 2004, at 18.

175. *Id.* *See also* Owen S. Surman et al., *Some Ethical and Psychiatric Aspects of Right-Lobe Liver Transplantation in the United States and Japan*, 43 PSYCHOSOMATICS 347, 348, 352 (Sept.-Oct. 2002).

176. *See* Medical College of Wisconsin, *supra* note 78 and accompanying text.

177. New York Organ Donor Network, *Survival Rates*, http://www.nyodn.org/organ/o_donationfacts_survival.html (last visited March 12, 2007); Medical College of Wisconsin, *supra* note 78.

178. This gap grows wider as time passes subsequent to surgery. International Association of Living Donors, Inc., *Living Donors Online*, <http://www.livingdonorsonline.org/HLADData.htm> (last visited Mar. 12, 2007).

179. Organ Procurement and Transplantation Network, *All Kaplan-Meier Survival Rates for Transplants Performed: 1997–2004*, <http://www.optn.org/latestData/rptStrat.asp> (last visited Mar. 13, 2007). *See also* Mayo Clinic, *Kidney Transplant: Regain Your Independence with a Donor Kidney*, <http://www.mayoclinic.com/health/kidney-transplant/DA00094> (last visited Mar. 12, 2007); Press Release, Neoral, Novartis Pharmaceuticals Corporation, *Press Release: Large Scale Registry Analysis Shows Long-Term Graft Survival is Significantly Improved in Living Donor Kidney Transplant Patients Receiving Neoral® (Cyclosporine USP) Modified (June 3, 2003)*, <http://www.pharma.us.novartis.com/newsroom/pressReleases/releaseDetail.jsp?PRID=803>.

Therefore, in certain cases, relying solely on cadaveric donors may preserve lives of those who would have been living donors, but may place at slightly greater risk the lives of the recipients. Obviously, in our world of organ shortages, many parents who are healthy and can donate would rather make such a donation than take the risk of their child facing discouraging odds on the waiting list. However, even with an available cadaveric donor organ, family members may still reasonably choose to use a living donor organ to increase the survival rate for the recipients. For example, two parents featured in a *Washington Post* article, Scott and Carolyn Johnson, made the choice to increase their child's chances for survival and a longer, healthier life by choosing to donate their own kidneys.¹⁸⁰ According to a Kidney Foundation official commenting on the Johnson family's decision, "[i]f you look at the statistics, the survival rate of a deceased-donor kidney is between 10 to 12 years, whereas a living-donor kidney can last for 25 to 30 years."¹⁸¹ While the survival rate for cadaveric organ recipients is improving,¹⁸² this disparity is still compelling.

Even disregarding such parental choices, while critics like Arthurs may be correct that cadaveric donation is preferable over living donation, we must not ignore the reality: until the shortage is resolved, living donors will continue to be called upon. While such a reality persists, we should endeavor to improve living donors' quality of life and remove disincentives for donation. These efforts should, of course, coincide with larger efforts to increase organ procurement. Even if such tax deductions are to be considered as only "secondary options,"¹⁸³ the failure to successfully make progress in the realm of cadaveric organ procurement should not constrain us from addressing secondary options, nor should it prevent us from improving the quality of life of courageous organ donors.

3. *Economic concerns and the automobile donor versus the organ donor*

Because tax deductions decrease revenue, objections may arise on fiscal grounds, especially at the state government level where budgets are smaller. For instance, the Wisconsin bill is projected to cost Wisconsin about \$115,000 in tax revenues annually.¹⁸⁴

180. Ellen Crosby, *Back From the Brink of a Medical Nightmare: Kidneys Donated, Parents Save Son, Daughter*, WASH. POST, Jan. 20, 2005, at T01.

181. *Id.*

182. Medical College of Wisconsin, *supra* note 78.

183. Arthurs, *supra* note 7, at 1129.

184. Dep't of Legislative Serv., Md. Gen. Assembly, 2005 Session, Fiscal and Policy Note to SB 443, *Income Tax - Subtraction Modification for Living Organ Donors* (estimating that

On a broader level, the first response to this objection is purely humanitarian. How much in lost revenue is one life worth? Many would agree that a \$550 loss on a state level is a small price to pay for another life. Given the amount the federal government spends to save lives in other spheres of its influence, \$550 seems like a bargain.

More to the point though, cost savings in other areas can recover many of the lost revenues. In short, living organ donors are an economic benefit to society. As donors give organs, patients recover more quickly. They can thus more quickly begin work and paying taxes back to the government. More importantly, they do not incur to themselves nor externalize to society the additional costs of medicine and being kept alive as they await a transplant. By increasing organ supply, the waiting list gets smaller for all recipients. Policymakers should remember that patients who are on the waiting list for a transplant are steadily accruing large medical bills and placing additional strain on our health care system, thus driving health care costs up.

Cost savings are also noteworthy in the argument for federal funding, as substantial amounts of such patients are on Medicare.¹⁸⁵ One doctor, testifying before Congress made this statement concerning covering the costs of the Organ Donation and Recovery Improvement Act:

This program could also offer substantial cost savings for the Medicare program.

Essentially, for every new transplanted kidney from a living donor, Medicare would avoid direct dialysis costs of approximately \$55,000 per year for each patient transplanted since the waiting time for a deceased donor kidney is approximately 4 years longer than a living donor kidney. Therefore, for every new donor facilitated by this program, Medicare would save approximately \$220,000 over four years, minus the cost of immunosuppressive drugs.¹⁸⁶

Maryland's similar measure would decrease general fund revenues by \$64,000 annually). *See also Organ Donation; Wisconsin Organ Donors May See Tax Deductions*, HEALTH & MEDICINE WEEK, Feb 16, 2004, at 639. Missouri, meanwhile, estimated that loss of revenue would not exceed \$36,900 annually. Mo. Comm. on Legislative Research Oversight Div., Fiscal Note, L.R. No. 3725-01, available at <http://www.moga.state.mo.us/oversight/OVER06/fispdf/3725-01N.ORG.PDF> (last visited January 25, 2007).

185. *See Assessing Initiatives to Increase Organ Donations Before the Subcomm. on Oversight and Investigations*, 108th Cong. 61 (2003) (written statement of Richard M. Devos, a heart transplant recipient) ("Each kidney transplanted alone saves between \$200,000 and \$400,000 to the insurers paying to keep these patients alive on the waiting list. Medicare pays 60% of these bills.") [hereinafter *Devos*].

186. Bumgardner, *supra* note 13, at 3. *See also Devos, supra* note 185, at 61 ("Each kidney transplanted alone saves between \$200,000 and \$400,000 to the insurers paying to keep these patients alive on the waiting list. Medicare pays 60% of these bills.").

These costs do not include the economic ripple effect waiting for a transplant can have. Such calculations cannot take into account the lost economic production of the patient on the waiting list. Further, lawmakers would do well to consider the economic consequences endured by the patient's family, especially when that patient is the primary "breadwinner." Patients that are a primary income source for their household have a greater economic effect, and being left untreated leaves dependents to drain resources from private charities or government programs. In the absence of a breadwinner, reliance on government services naturally will increase.

Further, criticism focused on lost revenue also seems misplaced when considering these tax deductions alongside others that are obtained by donating used automobiles to charitable institutions, which raise large amounts of money for organizations such as the National Kidney Foundation.¹⁸⁷ By way of illustration, consider a hypothetical situation of a man who desperately seeks a kidney transplant. Imagine this man has two sisters, both equally committed to helping their sibling. Both undergo screening in order to determine if they are a possible kidney donor for their brother. One sister qualifies to be a donor, and the other does not. The qualifying donor then goes through a battery of tests, as described above, and the physical trauma of making the donation. She incurs great expenses in the process—expenses which her brother's insurance will not, nor can he afford to pay out of his own pocket. She looks for relief under ODRIA, but is rejected.

The other sister, determined to contribute in some way, looks for ways to help. She visits the website of the National Kidney Foundation. There she learns that its "Kidney Cars" program facilitates the donation of cars by citizens to the Foundation, with the Foundation using the proceeds to fund "public health education, organ donation programs and medical research to prevent kidney disease."¹⁸⁸ She learns that people like her who donate their car to the National Kidney Foundation—or a myriad of others that qualify as a tax-exempt 501(c)(3) organization—are eligible to receive a deduction from their federal taxable income.¹⁸⁹

While it seems doubtful that anyone would argue the tax code is typically fair, the inequities here are stark. Two sisters, both equally committed to their sick brother, both equally altruistic. One puts her life in danger, undergoes the expenses of travel and of missing valuable work

187. See Stacey Singer, *Tax, Not Charity, Drives People to Donate Cars*, TIMES-PICAYUNE, Apr. 19, 1998, at A26; *Top Ten Reasons to Donate Your Used Car to the National Kidney Foundation of Georgia*, U.S. NEWSWIRE, Aug. 14, 2003, at 1.

188. National Kidney Foundation, *supra* note 18.

189. 26 U.S.C.S. § 501(c)3 (2006); 26 U.S.C.S § 170 (2006).

time (and in rare cases may even risk losing her job), undergoes economic hardship, physical and psychological trauma; the other, donates her old Ford Taurus and takes a tax deduction. The inequities seem more intuitively unfair when the situation involves a typical automobile donor—who is probably more motivated by the tax break than altruism.

Is it fair that individuals who risk the most by undergoing surgery be placed at a relative disadvantage to those who simply drop their jalopy off at the local charity? Tax deductions for living donors may be justified because they introduce greater fairness into the system by placing those who sacrifice the most on similar footing to those who receive similar tax benefits by simply donating their used car or cash.¹⁹⁰

Indeed, the inequities do not end there. Even if the donor lives in a state that allows for deductions from state income tax, those who donate an organ are still at a disadvantage compared to those who donate their used automobile, since those donating the car benefit from the deduction within the federal code, which taxes at a much higher rate than do states.¹⁹¹ Further, some states do not even have a state income tax system,¹⁹² and those that do, tax income at different rates.¹⁹³ Introducing a tax deduction at the federal level would be the great equalizer among all American living donors.

In addition, such a tax deduction on a federal level would make more sense for states as it more fairly accords with “matching principles.” In other words, a donor may currently receive the benefit of a tax deduction in Wisconsin despite the fact that the donor who is benefited with the organ lives in another state. By allowing for federal deductions, this would eliminate such inequities to a large degree. The federalist counterargument would likely be that each state should be free to experiment with its own system. However, it should be countered that there would be nothing to prevent states from having unique systems of their own. Indeed, a prudent federal tax provision would require a taxpayer in a state with its own deduction to choose between the two.

190. See Phil Brinkman, *Organ Donor Deduction Advances; Budget Committee Backs Effort to Spur Donations by Living Donors*, WIS. ST. J., Oct. 29, 2003, at B1.

191. The lowest marginal tax rate at the federal level is 15%. 26 U.S.C.A. § 1(c) (West 2005). The highest state income tax marginal rate in 2006 was 9.3%, in California. TAX POLICY CENTER, STATE INDIVIDUAL INCOME TAX RATES 2000–2006 (2007) http://www.taxpolicycenter.org/TaxFacts/TFDB/Content/PDF/state_income_rates.pdf.

192. Alaska, Florida, Nevada, South Dakota, Texas, Washington, and Wyoming do not have state income taxes. New Hampshire and Tennessee levy an income tax on dividend and interest income only.

193. Even though other states have modeled Wisconsin and gone with a \$10,000 deduction, tax rates vary. Further, some states, like Washington, do not have state income taxes. Calandrillo, *supra* note 32, at 112.

More to the point, charitable contributions are already squarely in the realm of the Federal Tax Code. Failing to recognize the contribution of an organ as being as a “charitable contribution” seems absurd. What more can a person give than of her own body?

Again, it is not an in-kind donation of the organ that is being deducted, but rather it is the expense of donating it, which can be more closely analogized to a charitable cash deduction.

4. *Other objections*

If a tax deduction for living donors is seen primarily as a move to provide incentives to donate, and not as a move to compensate, other arguments may arise. Since statistics indicate that women are more likely to donate organs but less likely to be recipients than men are, feminist arguments may be implicated.¹⁹⁴ Many reasons have been suggested to explain the greater-than-expected disproportion regarding gender in donation, both medical¹⁹⁵ and practical.¹⁹⁶ Some scholars suggest greater ambivalence about donation for males, while others suggest that “men may be less available or less able to donate.”¹⁹⁷ However, policymakers concerned with this disproportion may actually favor systems of reimbursement for living donors, as scholars have suggested that “the absence of a guaranteed system of reimbursement for lost wages for donors may impact both the recipient’s and the donor’s interest in having a primary breadwinner (statistically more often male in the USA) undergo [the donation].”¹⁹⁸

Finally, and perhaps most powerfully, naysayers may argue that providing economic relief to living donors undermines their sacrifice and cheapens the most courageous of gifts. This argument is not easily dismissed. We are reminded that it is the altruistic, selfless sacrifices of family members, friends, and fellow citizens that point to who the real heroes are in society. The argument follows that we should strive to avoid tainting these heroic sacrifices with any hint of monetary inducement.

194. In 1999, 57.3% of U.S. organ donors were female. *See also* MACHADO, *supra* note 24, at 56–57; Nikola Biller-Andorno, *Gender Imbalance in Living Organ Donation*, MED., HEALTH CARE, AND PHIL. 5, 199 (2002). *See also* Liise K. Kayler et al., *Gender Imbalance and Outcomes in Living Donor Renal Transplantation in the United States*, AM. J. TRANSPLANTATION, 452 (Apr. 2003).

195. One explanation is that females may be less biologically able to accept kidney transplants, while their typically smaller kidneys are more amenable of donation. Kayler, *supra* note 194, at 455–57.

196. *Id.*

197. *Id.* at 455.

198. *Id.* at 456.

However, a response to these naysayers is that we must, as a society, choose to recognize and honor such heroes. While such donors probably would say they are more honored by the lives of those they save, our government can further honor their sacrifices by simply elevating it to the same level as cash contributors.

A federal tax deduction for expenses would not trivialize the gift because it does not place any cash value on a kidney or a liver to he who has given an organ up for the benefit of another. Indeed, the out-of-pocket monetary expenses may in fact be the smallest part of the donor's sacrifice and/or the least significant. But in assisting with those expenses, we are symbolically proclaiming—yes, even through the tax code—that in our nation we do not value a gift of life less than a gift of cash. Thus, in providing cash relief, we paradoxically demonstrate that cash is not the only important thing in our society, and that it is the smallest recognition and repayment we can offer to organ donors.

V. CONCLUSION

A tragic shortage of donor organs persists¹⁹⁹ despite its devastating physical and economic consequences, and despite overwhelming public support in favor of both types of donation.²⁰⁰ Living donors have stepped in to save the lives of family members, friends, and complete strangers. In doing so, these donors not only give the gift of life and lighten the financial burdens of organ recipients, but they also make a positive economic impact on society as they free up resources and reduce medical expenses. Society, in turn, should recognize these sacrifices by pursuing policy that lightens the financial burdens borne by donors. Society already recognizes charitable sacrifices; the Federal Tax Code provides tax deductions for those who contribute cash or a used car to a charitable organization such as the National Kidney Foundation, yet turns a blind eye to a deeper and more serious kind of sacrifice—the courageous sacrifice of the living donor.

In 2004, Congress took a step in the right direction with the Organ Donation and Recovery Improvement Act. However, this step was not complete and leaves the door open for some organ donors to bear alone the financial burden of giving the gift of life. Given that such sacrifices contribute to the common welfare and economic good of society, they should never be left unnoticed.

Living donor tax deductions should be adopted on a federal level to

199. See *supra* notes 3–11 and accompanying text.

200. See *supra* note 15 and accompanying text.

compliment the ODRIA and to bring a greater measure of fairness into a tax code that rewards those who donate cash or used cars to charity, but ignores those who actually go under the knife. Further, deductions may help mitigate or remove obstacles standing in the way of those who wish to give the “gift of life.” The limited economic compensation does not violate altruistic principles, because it merely reduces or eliminates donors’ losses and does not provide them with gains. Rather, by collectively supporting donors through U.S. government reimbursements and federal tax deductions, the altruism of the system is merely spread over the taxpayer base.

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