

# The Kindest (Tax) Cut:

## A Federal Tax Credit for Organ Donations



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## The Kindest (Tax) Cut: A Federal Tax Credit for Organ Donations

by Sally Satel and Alan D. Viard



Sally Satel



Alan D. Viard

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In this article, Satel and Viard discuss how to design a federal tax credit for organ donations that would help ease the pressing shortage of donated kidneys, saving thousands of lives and sparing many from dialysis.

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For one of us, Sally Satel, the issue of organ donation is more than academic. Last summer Satel's wonderful friend, Kim Hendrickson, gave her one of her kidneys. She was actually the second earthbound saint to rescue Satel from premature death: The first was the magnificent Virginia Postrel, who gave Satel a kidney in 2006 when she was desperately searching for a donor and had no prospects in sight. Satel considers herself immensely lucky.

Not everyone is so lucky. By tomorrow at this time, 12 people will have died waiting for a kidney transplant. There are 500,000 people with end-stage renal failure, and about 100,000 people are on the waiting list for kidneys. About 20,000 people are waiting for hearts, livers, and lungs.<sup>1</sup> Kidney transplants performed in 2016 numbered 19,061.<sup>2</sup> The numbers queued for kidneys are so high because patients with renal failure can live for years on dialysis — a thrice-weekly process that cleanses the blood of toxins for four hours per session — while those with liver and lung failure die relatively quickly without a transplant.

The organ shortage has existed since the national organ procurement and distribution system established by the National Organ Transplant Act of 1984 (NOTA) became operational.<sup>3</sup> The problem is simply that there are not enough donors. Kidneys can be donated by living friends, relatives, and the occasional good Samaritan donor, but they must be given for free.

NOTA permits reimbursement for donor expenses, and some states allow income tax deductions and credits for those expenses, but those measures have been insufficient to generate the necessary donations.

We do not propose any change to the ban on buying and selling organs in private exchanges between donors and recipients but we believe that the lack of financial compensation for donors is almost surely responsible for tens of thousands of needless deaths. We therefore propose a \$50,000 federal tax credit for individuals who are willing to save the life of a stranger by donating a kidney

<sup>1</sup> United Network for Organ Sharing, "Transplant Trends" (2017).

<sup>2</sup> Department of Health and Human Services, "Organ Procurement and Transplantation Network, National Data" (2017).

<sup>3</sup> P.L. 98-507 (enacted Oct. 19, 1984).

and a \$5,000 federal tax credit for deceased donors of kidneys, intestines, pancreases, livers, and lungs. The availability of the credit would be conditioned on stringent safeguards and would not (at least initially) apply to directed donations to specific individuals. By encouraging organ donation and thereby reducing expenditures on dialysis, the credit would save the government money — perhaps \$10 billion per year.

## I. Current System

### A. NOTA's Ban on Donor Compensation

Under section 301(a) of NOTA, codified at 42 U.S.C. section 274c, it is unlawful for “any person to knowingly acquire, receive, or otherwise transfer any human organ for valuable consideration for use in human transplantation if the transfer affects interstate commerce.”<sup>4</sup> Section 301(c)(2) of NOTA allows “reasonable payments associated with the removal, transportation, implantation, processing, preservation, quality control, and storage of a human organ or the expenses of travel, housing, and lost wages incurred by the donor of a human organ in connection with the donation of the organ.”

As enacted in 1984, NOTA section 301(c)(1) defined human organs as “the human kidney, liver, heart, lung, pancreas, bone marrow, cornea, eye, bone, and skin, and any other human organ specified by the Secretary of Health and Human Services by regulation.” In 1988 Congress amended NOTA to specify that the prohibition applied to fetal organs.<sup>5</sup> On March 9, 2007, the Health and Human Services secretary adopted 42 CFR section 121.13 to add the “intestine, including the esophagus, stomach, small and/or large intestine, or any portion of the gastrointestinal tract” to NOTA’s definition of human organs. On July 3, 2013, the secretary

amended the regulation to cover vascularized composite allografts.<sup>6</sup>

In 2007 Congress amended NOTA section 301(a) to state that the ban on valuable consideration “does not apply with respect to human paired organ donation” and added a definition of that term in section 301(c)(4).<sup>7</sup> Paired organ donations include swaps and chains. A swap can be used when willing donors do not match with their intended recipients: The donors are swapped to make a match, with each donor providing a kidney to the other donor’s desired recipient, so that both patients end up with a kidney. A chain is essentially a series of swaps and can involve complicated logistics. The economist Alvin E. Roth won the 2012 Nobel Prize in economics partly for his work on this issue. The congressional decision to allow paired donations was a step toward approving donations in which the donor received something in exchange (a kidney for his intended, but unmatched recipient).

Under NOTA section 301(b), a violation of the law’s provisions is a felony punishable by up to five years’ imprisonment, a fine of up to \$50,000, or both. There is no mandatory minimum sentence. Only one person has ever been prosecuted under NOTA: Levy Itzhak Rosenbaum was arrested on July 23, 2009, after being swept up in a five-year investigation of corruption and international money laundering, in which 43 other individuals were arrested on charges unrelated to organ trafficking.<sup>8</sup> Rosenbaum was charged with arranging for three donors in Israel to donate kidneys to recipients in New Jersey, with one recipient paying Rosenbaum \$120,000 in December 2006, another recipient paying him \$150,000 in September 2008, and the third paying him \$140,000 in February 2009. On October 27, 2011, Rosenbaum pleaded guilty in the U.S. District Court for New Jersey to

<sup>6</sup> On October 2, 2013, the secretary proposed a further amendment to the regulation to include “other hematopoietic stem/progenitor cells without regard to the method of their collection” within the definition. The proposed regulation was open for public comment through December 2, 2013. The secretary has not finalized the proposed regulation.

<sup>7</sup> Charlie W. Norwood Living Organ Donation Act, P.L. 110-144 (enacted Dec. 21, 2007).

<sup>8</sup> David M. Halbfinger, “44 Charged by U.S. in New Jersey Corruption Sweep,” *The New York Times*, July 23, 2009.

<sup>4</sup> Other countries also outlaw donor enrichment, except Iran, which has a legal system of cash payments to donors from both recipients and the government.

<sup>5</sup> P.L. 100-607 (enacted Nov. 4, 1988).



three counts of violating NOTA and one count of conspiring to violate NOTA. On July 11, 2012, Judge Anne E. Thompson sentenced Rosenbaum to thirty months' imprisonment, three years' supervised release, a \$5,000 fine, and forfeiture of \$420,000.<sup>9</sup> Rosenbaum, who is a citizen of Israel, was not removed from the United States because the Department of Homeland Security concluded that a conviction for a violation of NOTA does not trigger removability under the Immigration and Nationality Act.<sup>10</sup>

## B. Effects of NOTA

NOTA was adopted with noble intentions. The goal was to prevent a situation in which only wealthier patients could afford to buy organs and in which poor donors might become "suppliers" to the well-off. Notably, the congressman who spearheaded NOTA in 1983, Rep. Al Gore spoke of using "a voucher system or a tax credit to a donor's estate" if "efforts to improve voluntary donation are unsuccessful."<sup>11</sup> However, his wise words have been long forgotten by lawmakers.

More than enough time has elapsed to conclude that an altruism-only system is sorely inadequate. The greatest harms have fallen on poor individuals needing a kidney, especially poor minorities. They are less likely to be listed for transplant<sup>12</sup> and less likely to receive an organ from a living donor<sup>13</sup> or the national pool, even when they are referred.<sup>14</sup>

<sup>9</sup>The charges, plea agreement, sentencing order, forfeiture order, and other documents are available through the Public Access to Court Electronic Records system, *United States v. Rosenbaum*, No. 3:11-cr-00741-AET (D.N.J. 2009).

<sup>10</sup>Ted Sherman, "Released From Federal Prison, Black Market Kidney Broker in NJ Sting Avoids Deportation" (Dec. 18, 2014). DHS's conclusion appears to be correct. Because a violation of NOTA is a regulatory offense defined by statute, it is probably not a crime involving moral turpitude that could trigger removability under 8 U.S.C. section 1227(a)(2)(A).

<sup>11</sup>A Bill to Amend the Public Health Service Act to Authorize Financial Assistance for Organ Procurement Organizations and for Other Purposes: Hearing on H.R. 4080, before the Subcommittee on Health and Environment of the House Committee on Energy and Commerce, 98th Cong. 10 (1983).

<sup>12</sup>Sayeed K. Malek et al., "Racial and Ethnic Disparities in Kidney Transplantation," 24 *Transplant Int'l* 419 (July 2010).

<sup>13</sup>Erin C. Hall et al., "Center-Level Factors and Racial Disparities in Living Donor Kidney Transplantation," 59 *Am. J. Kidney Diseases* 849 (June 2012).

<sup>14</sup>Jesse D. Schold et al., "Barriers to Evaluation and Wait Listing for Kidney Transplantation," 6 *Clinical J. of the Am. Soc'y of Nephrology* 1760 (Jul. 2011).

For decades, the transplant community has mounted educational efforts, improved its procurement efforts at the time of death of potential donors, and tried various other approaches, yet the number of living and deceased donors has not risen significantly.

The number of kidney transplants rose from 17,878 in 2015 to 19,061 in 2016, a 6.6 percent increase. The number of kidney transplants involving deceased donors increased from 12,250 to 13,431. The number of living-donor kidney transplants changed little, inching up from 5,628 in 2015 to 5,630 in 2016. According to Dr. David Klassen, the chief medical officer for the United Network for Organ Sharing, the narcotics overdose epidemic probably accounted for about a third of the increase from 2015 to 2016. He also cited the increased use of organs harvested from patients following cardiac death (not just from those who suffer brain death) and the willingness of organ procurement organizations to broaden the population of donors that they are willing to consider.<sup>15</sup>

One bright spot has been the recent growth in organ swaps and chains. As discussed above, legislation adopted in 2007 expressly exempted those arrangements from NOTA's prohibitions. Swaps and chains together accounted for 590 transplants in 2015 and 642 in 2016 — an exciting innovation, but modest given the total number of people in need.<sup>16</sup>

Other imperatives, in addition to alleviating needless suffering and death, compel reform. The fiscal burden of dialysis is enormous, costing Medicare about \$90,000 per person per year.<sup>17</sup> With a census of about 468,000 dialysis patients in the country, the total expenditure represents roughly 7 percent of the entire Medicare budget.<sup>18</sup>

## II. Donors Receive Limited Financial Relief

Evidence suggests that living donors in the United States experience significant financial costs. Studies report that up to 96 percent of living

<sup>15</sup>Jody A. Charnow, "Record Number of Transplants in 2016 Reported," *Renal & Urology News* (Feb. 6, 2017).

<sup>16</sup>National Data, *supra* note 2.

<sup>17</sup>United States Renal Data System, "Costs of ESRD," chapter 11.

<sup>18</sup>National Data, *supra* note 2.

donors experienced financial consequences, including 47 percent who lost wages.<sup>19</sup> Living donors incur \$3,268 in expenses on average, with some reporting up to \$8,000 of costs.<sup>20</sup> Generally, costs were higher for living donors who traveled greater distances, had lower household incomes, and had more unpaid work hours. Donors' expenses vary widely because of differences in resources to offset costs, physical demands of the donor's job (and associated expected recovery time), employer-provided benefits, and the recipient's ability to provide financial assistance to the donor.

Efforts to reduce the financial burdens on living donors are fragmented and incomplete, leaving many living donors without assistance. Sources of funding include the federal National Living Donor Assistance Program, administered by the Department of Health and Human Services; hospital-based funds; and private foundations, such as the American Transplant Foundation. Although the National Living Donor Assistance Center travel grant has been a valuable resource to some living donors, not all donors meet the eligibility requirements (such as recipient financial means testing), and less than 10 percent of living donors receive grants.<sup>21</sup>

Under 5 U.S.C. section 6327, employees of executive agencies of the federal government are entitled to paid leave "for the time necessary to permit such employee to serve as a bone-marrow or organ donor," with an upper limit of seven days for bone marrow donors and 30 days for organ donors.<sup>22</sup> Some state and local governments

also offer employees paid leave for recovery from organ donation, but paid leave is unavailable to most living donors.<sup>23</sup>

## A. Federal Tax Relief

The IRC does not provide tax relief targeted to organ donors, but they can benefit from some general provisions. Donors who experience lost earnings automatically receive an implicit deduction under the individual income tax and the payroll and self-employment tax. The implicit deduction arises because donors do not pay taxes on the earnings they do not receive.

Although some organ donors can deduct some of their medical costs, the tax relief is severely limited because the deduction is available only to itemizers and applies only to expenses above a high threshold. Section 213(a) allows a deduction for "expenses paid during the tax year, not compensated for by insurance or otherwise, for medical care of the taxpayer, his spouse, or a dependent." Under section 213(d)(1)(B), deductible medical expenses include the cost of "transportation primarily for and essential to medical care." Under section 213(d)(2), deductible medical expenses include "amounts paid for lodging (not lavish or extravagant under the circumstances) while away from home primarily for and essential to medical care" if the medical care is provided at a hospital or other specified medical care facilities, and if "there is no significant element of personal pleasure, recreation, or vacation in the travel away from home." The amount of deductible lodging expenses is limited to \$50 per night per individual, a cap that is not automatically adjusted for inflation.

Expenses incurred by organ donors qualify as deductible medical expenses. The relevant IRS publication states, "You can include in medical expenses amounts paid for medical care you receive because you are a donor or a possible donor of a kidney or other organ. This includes transportation. You can include any expenses you pay for the medical care of a donor in connection

<sup>19</sup> S. Klarenbach et al., "Economic Consequences Incurred by Living Kidney Donors: A Canadian Multi-Center Prospective Study," 14 *Am. J. Transplantation* 916 (Mar. 2014); J.R. Rodrigue et al., "Direct and Indirect Costs Following Living Kidney Donation: Findings From the KDOC Study," 16 *Am. J. Transplantation* 869 (Feb. 2016).

<sup>20</sup> Klarenbach et al., *supra* note 19.

<sup>21</sup> P.H. Warren et al., "Development of the National Living Donor Assistance Center: Reducing Financial Disincentives to Living Organ Donation" 24 *Progress in Transplantation* 76 (Mar. 2014).

<sup>22</sup> The original version of the provision, which was adopted by section 629(a)(1) of P.L. 103-329 (enacted Sept. 30, 1994), limited employees' leave to seven days for both organ and bone marrow donations. The provision was amended by section 1(b) of P.L. 106-56, the Organ Donor Leave Act (enacted Sept. 24, 1999), to increase the limit to 30 days for organ donors.

<sup>23</sup> Rodrigue et al., "Predonation Direct and Indirect Costs Incurred by Adults Who Donated a Kidney: Findings From the KDOC Study," 15 *Am. J. Transplantation* 2387 (Sept. 2015).

with the donating of an organ. This includes transportation.”<sup>24</sup>

However, the medical expense deduction has several significant limitations. It is of no value to households with too little income to owe individual income tax, and it is unavailable to taxpayers who claim the standard deduction because it is an itemized deduction under section 62. Also, under section 213(a)(1), medical expenses are deductible only to the extent that they exceed 10 percent of the taxpayer’s adjusted gross income.

House Republicans appear to be undecided about whether to eliminate or expand the medical expense deduction. The House Republican leadership is backing the Brady-Ryan tax reform plan, which would eliminate the medical expense deduction. However, the House Republican leadership is also backing H.R. 1628, the proposed American Health Care Act, which would expand the deduction by lowering the 10 percent threshold. The version of H.R. 1628 reported by the House Ways and Means Committee on March 20, 2017, would have lowered the threshold to 7.5 percent of adjusted gross income, and the version passed by the House on May 4 would have further lowered the threshold to 5.8 percent.<sup>25</sup>

## B. State Tax Relief

Donors automatically receive implicit deductions for lost wages under state income taxes, in the same manner as under the federal income tax. The National Kidney Foundation reports that 19 states offer other tax deductions or credits to living donors or their employers.<sup>26</sup> Unfortunately, only three states provide significant tax relief.

Two states offer credits to the donor’s employer. Pennsylvania provides a 100 percent credit for wages that the employer paid to an

employee on leave for organ and bone marrow donation and wages paid to any temporary employees hired to fill in for the employee. Louisiana provides employers an 18 percent credit for wages paid to the employee on leave for a bone marrow donation. The credit also applies to other costs of operating an employee bone marrow donation program. The credit rate is scheduled to increase to 25 percent on July 1, 2018.

Fifteen states offer above-the-line deductions to living donors. Thirteen of those states (Arkansas, Georgia, Iowa, Massachusetts, Minnesota, Mississippi, New Mexico, New York, North Dakota, Ohio, Oklahoma, Rhode Island, and Wisconsin) follow a single template, with minor variations. In general, each state allows the taxpayer to deduct the first \$10,000 of costs related to the donation by the taxpayer, or a dependent of the taxpayer, of all or part of a liver, pancreas, kidney, intestine, lung, or bone marrow.

Most of the states define deductible costs as unreimbursed costs of travel, lodging, and lost wages. However, Arkansas’s deduction also covers medical costs; North Dakota’s deduction covers medical costs and does not cover travel and lodging costs; and Oklahoma left the definition of deductible costs to regulations. The provision of a deduction for lost wages is apparently in addition to the implicit deduction already provided under general income tax principles. Massachusetts applies the \$10,000 limit only to lost wages. Arkansas, Iowa, Mississippi, Ohio, Oklahoma, Rhode Island, and Wisconsin specify that a taxpayer may claim the deduction only once in his or her lifetime. The two other states offering deductions follow a somewhat different approach: Kansas allows a deduction for the first \$5,000 of unreimbursed travel, lodging, and medical expenses; and Virginia provides a deduction for the first \$5,000 of “unreimbursed out-of-pocket expenses directly related to the donation.”

Unfortunately, the tax savings from the state-level deductions are small because of low state marginal income tax rates. For example, a taxpayer in a 6 percent state income tax bracket would reap only \$600 of tax savings from a \$10,000 deduction.

Three states offer relief that is much more generous. Idaho provides a 100 percent credit for

<sup>24</sup> IRS Publication 502, “Medical and Dental Expenses (Including the Health Coverage Tax Credit),” at 14 (Nov. 11, 2016).

<sup>25</sup> For further discussion of the House Republicans’ discordant plans for the medical expense deduction, see Cody Kallen, “Republicans Need to Get Their Story Straight on the Medical Expense Deduction,” *Inside Sources* (Apr. 3, 2017).

<sup>26</sup> National Kidney Foundation, “Donor Leave Laws and Tax Deductions/Credits for Living Donors.” See also Shivam Joshi, Sheela Joshi, and Warren Kupin, “Reciprocating Living Kidney Donor Generosity: Tax Credits, Health Insurance, and an Outcome Registry,” 9 *Clinical Kidney J.* 166 (Feb. 2016).



the first \$5,000 of unreimbursed travel and lodging costs and lost wages. The credit is nonrefundable, but any excess credit can be carried forward for five years. Louisiana provides a 72 percent credit for the first \$10,000 of unreimbursed costs of travel, lodging, and lost wages, but not medical expenses. The credit rate is slated to increase to 100 percent, effective July 1, 2018. The credit is nonrefundable, but any excess credit can be carried forward for 10 years. Utah provides a 100 percent credit for the first \$10,000 of unreimbursed travel and lodging costs and lost wages. The credit is nonrefundable, but any excess credit can be carried forward for five years. The maximum tax savings under those credits — \$5,000 in Idaho, \$7,200 (slated to increase to \$10,000) in Louisiana, and \$10,000 in Utah — are an order of magnitude larger than the maximum savings offered by other states' deductions.

### III. The Need for Greater Donor Compensation

The existing state tax provisions appear to be too small and too poorly publicized to significantly increase donations. In a 2012 study, Atheendar S. Venkataramani and colleagues compared the pre- and post-legislation change in living donations in the 15 states that offered tax relief between 2004 and 2008 against the same change in those states that did not. They found no statistically significant contemporaneous or lagged effects of tax policy on donation rates. The authors concluded that the small size of most states' incentives might have impeded their effectiveness. They also found a striking lack of awareness of the provisions among potential donors, and even among Donor for Life campaigns.<sup>27</sup>

A 2015 paper assessed the effects of six policies designed to improve organ donation from 1988 to 2010. These included first-person consent laws, public education programs, tax benefits, donor registries, public education programs, and paid leave. The authors found no statistically significant effect on donations by living donors.<sup>28</sup>

<sup>27</sup>Venkataramani et al., "The Impact of Tax Policies on Living Organ Donations in the United States," 12 *Am. J. Transplantation* 2133 (Aug. 2012).

<sup>28</sup>Paula Chatterjee et al., "The Effect of State Policies on Organ Donation and Transplantation in the United States," 175 *JAMA Internal Med.* 1323 (Aug. 2015).

A 2015 paper by Firat Bilgel and Brian Galle obtained conflicting results. The authors' application of standard econometric techniques similar to those used in the previous studies failed to find significant effects of state tax provisions. However, they estimated a statistically significant, but modest, effect from New York's tax deduction when using a technique called the synthetic control method (which they could not apply to the other states because of data limitations). They estimated that New York's tax deduction increased living donations to unrelated donors by about three donations per year per million adults. The result suggests that, if the tax deduction were adopted nationwide, it would yield 700 to 800 additional donations per year.<sup>29</sup> However, the finding's fragility prevents definitive conclusions.

Although state tax provisions appear to have had little impact on donations, it is likely that better-publicized policies that offered financial gains to donors (rather than merely reimbursing them) would have significant effects. In a 2014 survey by an international polling firm, 59 percent of respondents stated that \$50,000 compensation would make them more likely to be a living donor.<sup>30</sup> A cost-benefit analysis published in the *American Journal of Transplantation* in 2016 concluded that it was reasonable to assume that payment of \$45,000 compensation would be sufficient to eliminate the waiting list for kidneys.<sup>31</sup> Based on these studies, we believe that a \$50,000 tax credit would significantly increase organ donations.

Congress could take the bold step of revising NOTA to permit individuals who are willing to save the life of a stranger through kidney

<sup>29</sup>Bilgel and Galle, "Financial Incentives for Kidney Donations: A Comparative Case Study Using Synthetic Controls," 43 *J. Health Econ.* 103 (July 2015).

<sup>30</sup>Thomas G. Peters et al., "Views of US Voters on Compensating Living Kidney Donors," 151 *JAMA Surgery* 710 (Aug. 2016).

<sup>31</sup>Philip J. Held et al., "A Cost-Benefit Analysis of Government Compensation of Kidney Donors," 16 *Am. J. Transplantation* 877 (Mar. 2016). Gary S. Becker and Julio Jorge Elias, "Introducing Incentives in the Market for Live and Cadaveric Organ Donations," 21 *J. Econ. Persp.* 3 (Summer 2007), estimated that a \$15,200 payment would generate an unlimited supply of kidney donations, and that a \$37,600 payment would generate an unlimited supply of liver donations, with values expressed in 2005 prices. Because those estimates assume that everyone would be willing to donate if their medical expenses, foregone earnings, and possible loss of quality of life were compensated, they are likely to understate the necessary payments.

donation to receive valuable consideration from governments or nonprofit organizations. Alternatively, lawmakers could take the intermediate step of establishing a pilot program allowing researchers to study the effects of such measures. In May 2016, Rep. Matt Cartwright, D-Pa., introduced H.R. 5344, the proposed Organ Donor Clarification Act of 2016, in the 114th Congress. The bill would have permitted federal, state, local, and tribal governments to conduct pilot programs offering noncash benefits. The programs would require approval from the Health and Human Services secretary, would be subject to an ethical review board process, and could last for up to five years. Although the bill did not define noncash benefit, it would seem reasonable to consider tuition vouchers for the donor and the donor's dependents, lifetime health insurance (perhaps with a cap on its value), contributions to a charity of the donor's choice, or loan forgiveness.

Here, we explore a related option: a \$50,000 federal tax credit for living kidney donors<sup>32</sup> and a \$5,000 credit for deceased donors of various organs. There would be no change in NOTA's restriction on payments by organ recipients and other private individuals and organizations, but NOTA would be amended to clarify that it does not prohibit receipt of the tax credit. If enactment of a tax credit is not politically feasible, it should at least be included in a pilot program of the type proposed in the Cartwright bill.

#### IV. A Federal Tax Credit

Tax benefits for organ donation should be universally available.<sup>33</sup> Accordingly, we propose a credit rather than a deduction to allow the tax benefit to be made refundable and to ensure that the size of the tax savings would be independent

of the donor's tax bracket. The credit would not have an income-based phaseout and would be available under the alternative minimum tax.

Because other provisions, described below, would protect low-income donors from being exploited, there is no reason to deny the credit to donors too poor to pay individual income tax. With 44 percent of households not paying individual income tax,<sup>34</sup> it would be a mistake to exclude such a large group of potential donors. The credit would therefore be fully refundable.

The credit would not have an income-based phaseout. Although the credit might have little effect on the donation decisions of high-income taxpayers, phasing out the credit would add complexity and create disincentives to earn income while saving little revenue. Moreover, a credit is already more progressive than a deduction, limiting the need for an income-based phaseout.<sup>35</sup>

With one exception noted below, the credit would be a fixed amount, independent of the donor's actual costs. Limiting the credit to donors' pecuniary costs would likely be insufficient to induce an adequate number of donations. Moreover, setting the credit at a fixed amount reduces administration and compliance costs by avoiding the need for taxpayers and the IRS to track and substantiate costs. We propose that the fixed amount be set at \$50,000 for kidney donations by living donors in 2018 and that it be adjusted for inflation in accordance with section 1(f).

We propose an additional credit equal to 100 percent of any out-of-pocket costs for follow-up medical care for any complications related to the transplant incurred within three years of the transplant. Costs for which the credit was claimed could not be deducted under section 213 or receive any other federal income tax benefit. Health insurers would be prohibited from free riding on the credit by denying coverage to organ donors or excluding transplant-related costs from

<sup>32</sup>We propose limiting the tax credit for living donors to kidney donors. Although a segment of liver can be retrieved from a living person, doing so is risky, and it is done only rarely (there were 345 donations in 2016). In informal discussions with several transplant surgeons, few of them expressed willingness to perform surgery on a compensated liver donor at this time. They generally indicated that they would first like to see a compensation system for living kidney donors succeed.

<sup>33</sup>If a tax incentive is designed to encourage a specific behavior, and if the social benefits of that behavior do not depend on who engages in it, the appropriate design of the tax incentive is a universal tax credit. For further discussion, see Brian H. Jenn, "The Case for Tax Credits," 61 *The Tax Lawyer* 549 (Winter 2008).

<sup>34</sup>The Urban-Brookings Tax Policy Center estimated in July 2016 that 43.9 percent of tax units would have no individual income tax liability in 2017, "Tax Units With Zero or Negative Income Tax in 2016-2026 Under Current Law," at Table T16-0211 (July 11, 2016).

<sup>35</sup>See Jeffrey H. Anderson, "Why Tax Credits Should Never Be Income-Tested," Hudson Institute (Mar. 3, 2017).



coverage. The additional credit would guarantee the availability of follow-up care for all donors.

The credit would be available only for a qualified donation. In a qualified donation, donors' kidneys would be distributed to people on the waiting list maintained by the Organ Procurement and Transplantation Network, which is administered by the United Network for Organ Sharing, according to the rules now in place. People who want to donate a kidney to a relative or any other specific person would still be able to do so and could claim any tax benefits offered by their state, but they would not receive the federal tax credit. We would, however, be open to revisiting this issue if the credit failed to attract sufficient donations from unrelated donors.

A qualified organ donation would involve a waiting period of at least six months before people donate, ensuring that donors did not act impulsively and that they had offered fully informed consent. Prospective compensated donors would be carefully screened for physical and emotional health, as all donors are now. The minimum six-month waiting period would filter out individuals who made an impulsive decision as well as financially desperate individuals who might otherwise rush to donate for a large sum of instant cash and later regret it.

As an additional safeguard against ill-considered donations by financially desperate individuals, the first disbursement of the credit would be only \$5,000 and would occur in the tax year following the year in which the organ donation occurred. Another \$5,000 would be allowed in each of the next four years, with the remaining \$25,000 allowed in the following year. If the taxpayer dies before the full credit is claimed, the remainder of the credit would be claimed on the decedent's individual income tax return for the year of death.<sup>36</sup> We are open to other possible payment schedules. There is precedent for allowing a credit over several years; the low-income housing tax credit is disbursed over a 15-year period under section 42(f). The credit for follow-up medical expenses would be claimed in

the year in which the expenses were paid or incurred.

A fixed credit, equal to \$5,000 in 2018 and adjusted for inflation, would be available for deceased donations of one or more of the following organs: hearts, livers, kidneys, lungs, intestines, and pancreases. The credit would be claimed on the decedent's individual income tax return for the year of death.

The Joint Committee on Taxation would undoubtedly, and appropriately, classify the credit as a tax expenditure. The JCT has said, "Special income tax provisions are referred to as tax expenditures because they may be analogous to direct outlay programs and may be considered alternative means of accomplishing similar budget policy objectives. Tax expenditures are similar to direct spending programs that function as entitlements to those who meet the established statutory criteria."<sup>37</sup> The credit would be the functional equivalent of a spending program.

Yet, the income tax system is likely to be a good delivery mechanism for donor compensation. Because most organ donors would file an individual income tax return in any case (either to pay tax, recover withheld taxes, or claim refundable credits), administering the credit through the tax system avoids the need for donors to apply for benefits at an agency with which they would otherwise have no contact. Although there are legitimate concerns about tasking the IRS with the administration of social welfare programs, those concerns have little application to this credit. The administration of the credits would primarily require confirmation that the organ donation took place and that the requirements of a qualified donation were satisfied. The latter issue could be addressed by requiring a certification by the hospital performing the operation. The IRS could publicize the availability of the credit in the income tax instructions.

## V. Fiscal Consequences

The credit has a direct budgetary cost of \$50,000 for each live organ donation and \$5,000 for each deceased donation. There would be some

<sup>36</sup> Under section 6012(b)(1), the decedent's individual income tax return for the year of death is filed by the executor, administrator, or other person charged with the decedent's property.

<sup>37</sup> JCT, "Estimates of Federal Tax Expenditures for Fiscal Years 2016-2020," JCX-3-17, at 2 (Jan. 30, 2017).

additional costs from the credit for out-of-pocket follow-up medical costs, which are not included in the calculations below. In 2016, 5,630 living donors donated a kidney. There were 9,971 deceased donors, who provided a total of 35,360 organs, including 18,132 kidneys.<sup>38</sup>

A purely static estimate (that assumes no change in organ donations) indicates that about \$331 million of credits would accrue per year. Even based on the static estimate, the credit's cost would be small. The \$350 million cost would be 30 times smaller than the fiscal 2017 tax expenditure estimate for the section 41 research tax credit and 180 times smaller than the estimate for the mortgage interest deduction.<sup>39</sup>

Incorporating behavioral changes suggests that the credit would save the government money. Although additional donations spurred by the credit would increase the credit's direct costs, they would yield budgetary savings that would more than offset those costs. That finding is supported by a cost-benefit analysis published by Frank McCormick, Philip Held, and two other authors in the *American Journal of Transplantation* in 2016. The estimates presented below differ slightly from those in the published study, based on updated estimates received from McCormick and Held.

McCormick, Held, and their co-authors considered a compensation program offering \$45,000 for living donors and \$10,000 for deceased donors. They noted that dialysis is almost four times more expensive per quality-adjusted life-year saved than a transplant. They estimate that taxpayers bear about 85 percent (up from their original estimate of 75 percent) of the costs of both dialysis and transplants, indicating that taxpayers

save a great deal of money when a kidney failure patient receives a transplant. While transplant surgery adds substantial expense initially, overall dollar savings come as soon as two years after transplant and continue for the patient's lifetime. Dialysis patients would no longer need expensive treatments now costing \$1.45 million for each patient's lifetime.

The authors' updated estimates, like their original estimates, indicate that the compensation program would save taxpayers money in the steady state. Taxpayers would incur \$2.6 billion per year in compensation payments, as well as \$4.9 billion of costs of making the additional transplants and \$12.2 billion of medical costs after the transplants — a total of \$19.7 billion. However, they would spend \$32.3 billion less on dialysis, yielding net savings of \$12.6 billion per year.<sup>40</sup>

Although our compensation parameters are slightly different from those considered in the study, the study's results suggest that our tax credit would likely have favorable effects on the federal budget. That conclusion would continue to hold even if the increase in organ donations was somewhat smaller than that assumed in the analysis.

## VI. Other Policy Implications

Of course, budgetary savings are not the most important reason to increase organ donations. The ultimate benefit is that transplant recipients would enjoy longer and healthier lives. The Held-McCormick cost-benefit analysis valued those gains at \$30.3 billion per year.<sup>41</sup>

The tax credit would be a constructive response to the dire organ shortage in both the United States and globally, where a black market flourishes. The World Health Organization estimates that at least 5 percent of transplanted organs worldwide are obtained on the black market.<sup>42</sup> The provision of a tax credit would reduce the need for Americans to patronize

<sup>38</sup> National Data, *supra* note 2. A significant number of organs recovered from deceased donors are discarded. In 2016, 27,622 organs from deceased donors were transplanted, including 13,431 kidneys. The significant number of discarded kidneys arises because transplant regulators (in an effort to obtain more kidneys) have allowed the procurement of suboptimal kidneys from deceased donors, but surgeons are effectively penalized for the bad outcomes that result from the transplantation of suboptimal organs. In a personal communication, nephrologist Benjamin Hippen said, "Organ discard is a way of avoiding unadjusted risk. A responsible leader of a transplant program now has to think about the center's ongoing ability to serve its entire patient catchment, as well as the ongoing financial stability of the center, if they take too much risk in accepting organs." See also Hippen, "Contemporary Debates Over the Acceptability of Kidneys for Donation," 14 *Virtual Mentor* 237 (Mar. 2012).

<sup>39</sup> JCX-3-17, *supra* note 37, at 29, 32.

<sup>40</sup> Held et al., *supra* note 31; personal communication from Frank McCormick, Mar. 9, 2017.

<sup>41</sup> Held et al., *supra* note 31.

<sup>42</sup> Yosuke Shimazono, "The State of the International Organ Trade: A Provisional Picture Based on Integration of Available Information," 85 *Bulletin of the World Health Organization* 955 (Dec. 2007).

unauthorized markets. Moreover, a workable example of a tax credit here could be a model for other countries.

The general notion of incentivizing organ donations is gaining traction. A 2009 poll of the membership of the American Society of Transplant Surgeons revealed that 80 percent supported or were neutral toward the provision of tax credits for donors.<sup>43</sup> In 2014 the American Society of Transplantation and the American Society of Transplant Surgeons published the results of a workshop in which the societies expressed approval of testing third-party, in-kind incentives.<sup>44</sup> The American Medical Association recently passed a resolution in favor of testing the effects of incentives on living and deceased donation.<sup>45</sup> As discussed above, Congress recognized a role for incentives when it amended NOTA in 2007 to allow paired organ donations.

Some have objected that a tax credit for donors “commodifies the body,” but those concerns are misplaced. Recipients would not be allowed to buy organs; instead, donors would receive financial recognition from the government for contributing to the public good. When a transplant is performed, surgeons and hospitals are paid, as are the agencies that obtain and transport the organs. Why would we now object to Treasury making a payment to the donor — the sole individual in this entire scenario who gives the precious item in question and assumes all the risk?

At the heart of the “commodification” claim is the concern that donors will not be treated with dignity. But dignity is affirmed when we respect the capacity of individuals to make decisions in their own best interest, protect their health, and express gratitude for their sacrifice. Material gain in itself is not inconsistent with this. The true indignity is to stand by while thousands of people

die each year for want of an organ and proclaim that it is the “moral” thing to do.

## VII. Conclusion

Within 20 to 30 years, it is highly plausible that technology will be adequate to solve the organ shortage. Three-dimensional organ printing (wherein a cartilaginous organ “skeleton” is seeded with the patient’s own stem cells to form an intact organ) and genetic engineering permitting the transplantation of a pig organ into a human are two areas of intensive and exciting work. But until then, we must consider incentives.

Although organs should not be bought and sold, government compensation of donors has the potential to save thousands of lives each year. A federal tax credit would be a straightforward way to provide the needed compensation. ■

<sup>43</sup> Rodrigue et al., “Stimulus for Organ Donation: A Survey of the American Society of Transplant Surgeons Membership,” 9 *Am. J. Transplantation* 2172 (May 2009).

<sup>44</sup> D. R. Salomon et al., “AST/ASTS Workshop on Increasing Organ Donation in the United States: Creating an ‘Arc of Change’ From Removing Disincentives to Testing Incentives,” 15 *Am. J. Transplantation* 1173 (Dec. 2015).

<sup>45</sup> The American Medical Association, House of Delegates, Res. No. 002 (I-16) (Sept. 2016).