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OBESITY AND THE INTERNAL REVENUE CODE: DEDUCTING COSTS OF DIET FOOD ITEMS INCORPORATED IN PHYSICIAN-PRESCRIBED WEIGHT-LOSS PROGRAMS

Ryan A. Bailey[*]

INTRODUCTION

The pandemic of obesity has reached alarming proportions and has become a nationwide health concern.[1] Continued increase in the prevalence of obesity over the last decade, coupled with its link to significant ailments and mortality,[2] has led some researchers to conclude that obesity should be considered a chronic disease requiring chronic medical management.[3] More than ever, it is clear that diet is an essential component to medical obesity management.[4] As a result, physicians now refer or prescribe to patients a variety of diet programs to treat obesity.[5]

Although some diet programs may result in only a small divergence from a typical, everyday-fare diet, others, such as the OPTIFAST Program, require a complete overhaul of a patient's diet.[6] In such cases,

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1. "Obesity is defined as a body mass index (BMI) of 30 or greater. BMI is calculated from a person's weight and height and provides a reasonable indicator of body fatness and weight categories that may lead to health problems. Obesity is a major risk factor for cardiovascular disease, certain types of cancer, and type 2 diabetes." CENTERS FOR DISEASE CONTROL AND PREVENTION, *New CDC Study Finds No Increase in Obesity Among Adults; But Levels Still High* (Nov. 28, 2007), *available at* http://www.cdc.gov/nchs/pressroom/07newsreleases/obesity.htm (last updated June 11, 2009).

2. *See* Aviva Must et al., *The Disease Burden Associated With Overweight and Obesity*, 282 JAMA 1523 (1999); *see also* David B. Allison et al., *Annual Deaths Attributable to Obesity in the United States*, 282 JAMA 1530 (1999).

3. *See* James O. Hill, *Dealing With Obesity as a Chronic Disease*, 6 OBESITY RES. 24 (1998).

4. Poor diet has been proven to proximately cause many physical and mental medical ailments in patients. These ailments include diabetes, digestive diseases and disorders, eating disorders, poor heart health, osteoporosis, and obesity. UNITED STATES DEPARTMENT OF AGRICULTURE: NATIONAL AGRICULTURE LIBRARY, *Food and Nutrition Information Center: Diet and Disease*, *available at* http://fnic.nal.usda.gov/nal_display/index.php?info_center=4&tax_level=1&tax_subject=278 (last modified Aug. 24, 2010).

5. Kristellar and Hoerr reported that on average, across all specialty groups, 34% of physicians would treat obese patients themselves, 29% would make direct referrals for other physicians and counselors to treat obese patients, and about 25% would provide recommendations for obesity management without specific referrals. Jean L. Kristellar & Robert A. Hoerr, *Physician Attitudes toward Managing Obesity: Differences among Six Specialty Groups*, 26 PREVENTATIVE MED. 542, 545 (1997).

6. The OPTIFAST weight-loss program has been the leader in commercial weight-loss programs for over

the cost of a diet program can be exceedingly high and often becomes a limitation preventing an obese patient from undergoing this avenue of treatment.[7] Finding a way to help patients afford physician-prescribed weight-loss programs such as the OPTIFAST Program would open the door for more patients to undergo diet treatment, thereby providing a sociomedical benefit in America.[8]

The IRS has already taken steps to help patients afford diet programs. Since April 2002, the IRS has allowed patients who have been diagnosed as obese by physicians to deduct some costs associated with programs such as OPTIFAST pursuant to section 213 of the Internal Revenue Code (Tax Code) through Revenue Ruling 2002-19.[9] The IRS approves personal deductions for the fees related to services, *e.g.*, membership fees and nutrition education meetings, for physician-prescribed weight-loss programs.[10] The IRS, however, does not allow a deduction for the cost of diet food items, *e.g.*, OPTIFAST liquids or nutrition bars, associated with such programs.[11] The high expense of these diet food items often blocks patients from seeking treatment for obesity.[12]

While many patients cannot afford treatment, the nonmonetary costs of obesity in America continue to rise. Data reflecting the national growth of obesity shows the ever-increasing prevalence of the disease in America. As stated by the Centers for Disease Control and Prevention, "Type 2 diabetes and obesity are major public health priorities because of their high prevalence and incidence nationwide and their long-term health

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thirty years. The program offers meal replacement formulas. Although each product is slightly different, OPTIFAST generally provides 100% of the Daily Value for twenty-four vitamins and minerals in five servings. A medically monitored weight-loss program, OPTIFAST combines the expertise of physicians, registered dietitians and behavioral counselors with a calorie-controlled, nutritional formula in a program. More than eighty peer-reviewed studies and a clinical database of over 80,000 participants illustrate the efficacy of the OPTIFAST program. One study of 20,000 patients completing twenty-two weeks of OPTIFAST treatment documented an average weight-loss of fifty-two pounds, an average decrease in cholesterol of fifteen percent, an average decrease in blood glucose of twenty-nine percent, and an average decrease in blood pressure of ten percent. *See* OPTIFAST, *at* www.optifast.com.

7. *See* OPTIFAST, www.optifast.com; *see also* Barbara Witherspoon & Margaret Rosenzweig, *Industry-Sponsored Weight Loss Programs: Description, Cost, and Effectiveness*, 16 CLINICAL PRACTICE 198, 199 (2004) (noting that two of "[t]he limitations" to many weight-loss programs are "the cost [and] the requirement for initial prepayment"); *see generally* Adam Drewnowski, *Obesity and the Food Environment: Diet Energy Density and Diet Costs*, 27 AM. J. PREVENTIVE MED. 154 (2004) (explaining that healthy choice foods and diet foods cost much more than foods associated with poor diets, such as high energy foods and foods with high sugar contents).

8. Merriam-Webster defines "sociomedical" as "relating to the interrelations of medicine and social welfare." Merriam-Webster.com, http://www.merriam-webster.com/medical/sociomedical.

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

10. *Id.*

11. *Id.*

12. Barbara Witherspoon & Margaret Rosenzweig, *supra* note 7.

implications for the U.S. population."[13] The Center also presented the following statistics:

During the past 20 years there has been a dramatic increase in obesity in the United States. In 2009, only Colorado and the District of Columbia had a prevalence of obesity less than 20%. Thirty-three states had a prevalence equal to or greater than 25%; nine of these states (Alabama, Arkansas, Kentucky, Louisiana, Mississippi, Missouri, Oklahoma, Tennessee, and West Virginia) had a prevalence of obesity equal to or greater than 30% of the State's population. [14]

The government has funded national campaigns to increase public awareness of obesity due to these trends. It declared the month of September 2010 "National Childhood Obesity Awareness Month" and the month of November 2010 "National Diabetes Awareness Month."[15] These actions illustrate the increasingly prevalent public policy in America of helping prevent and treat obesity.

Although Revenue Ruling 2002-19 noted above is a step in the right direction, more can be done through the Tax Code to help slow the obesity pandemic. The IRS should extend the tax deduction for services related to physician-prescribed weight-loss programs to include costs of diet food items related to the same programs. This extension of Revenue Ruling 2002-19 would not only be consistent with the prevalent public policy of helping treat and prevent obesity, it would also provide a sociomedical benefit to Americans.[16] Further, allowing a tax deduction for diet foods is

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13. CENTERS FOR DISEASE CONTROL AND PREVENTION, *Estimated County-Level Prevalence of Diabetes and Obesity -- United States, 2007*, Nov. 20, 2009, *available at* http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5845a2.htm.

14. CENTERS FOR DISEASE CONTROL AND PREVENTION, *U.S. Obesity Trends*, *available at* http://www.cdc.gov/obesity/data/trends.html.

15. OFFICE OF THE PRESS SECRETARY, *Presidential Proclamation -- National Childhood Obesity Awareness Month*, Sept. 01, 2010, *available at* http://www.whitehouse.gov/the-press-office/2010/09/01/presidential-proclamation-national-childhood-obesity-awareness-month; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, National Diabetes Education Program, *National Diabetes Awareness Month -- November 2010*, *available at* http://ndep.nih.gov/partners-community-organization/campaigns/family-history/campaign-materials.aspx.

16. With 65% of Americans overweight and nearly 1-in-3 clinically obese, employers pay a heavy price in direct health care costs, life and disability insurance outlays, and reduced productivity. The cost of obesity has resulted in: $93 billion in direct medical costs, $3.4 billion annually in sick leave costs, $2.5 billion annually in obesity-related life insurance spending, and $1.1 billion spent annually on disability insurance spending. *See* OPTIFAST.com, *Cost of Obesity for Employers*, www.optifast.com/Pages/cost_of_obesity_for_employers.aspx. Obesity-related healthcare costs can double an employer's annual healthcare expenditures from an average outlay of $4,016 for a normal weight employee to $8,359 for a Grade III (BMI greater than 40) obese employee. *Id.* Further, obese people are at greater risk of developing type-2 diabetes; they suffer more heart attacks and strokes and are also more vulnerable to depression, arthritis and certain types of cancer. *Id.* They are also less productive than normal weight employees and more prone to absenteeism. *Id.* Programs such as the OPTIFAST Program address the cost of obesity by helping to reduce the incidence and severity of obesity-related illness through

consistent with United States Tax Court decisions that have defined deductible medical expenses under section 213 of the Tax Code.[17]

Section I of this Article will analyze the general framework of the medical expense deduction in section 213 of the Tax Code. Section II will demonstrate how diet food items incorporated in physician-prescribed weight-loss programs fit within this general framework. Section III will argue that where a taxpayer can prove a *prima facie* case quantifying the excess cost of her physician-prescribed diet food items over her normal foods,[18] the excess cost should be deductible.

I. THE GENERAL FRAMEWORK OF SECTION 213

The Tax Code gives taxpayers preferential treatment for a plethora of medical expenses per section 213.[19] As one of the federal tax provisions that subsidize personal expenses,[20] section 213 states, "There shall be allowed as a deduction the expenses paid during the taxable year, not compensated for by insurance or otherwise, for medical care of the taxpayer, his spouse, or a dependent . . . to the extent that such expenses exceed 7.5 percent of adjusted gross income."[21] "Medical care" is defined in part as amounts paid "for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body."[22]

A deduction is primarily defined as the "act or process of subtracting or taking away."[23] In the tax sense, a deduction is defined as an "amount

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weight-loss. *Id.* In so doing, these programs improve employee productivity, reduce obese employees' absenteeism, and enhance participants' quality of life. *Id.* These sociomedical benefits are also financially quantifiable. Recent data suggests that by getting 50 obese employees to a healthy weight, a company can reduce annual health care costs by an average of $84,750. *Id.*

17. *See What Constitutes Medical Expenses Deductible for Federal Income Tax Purposes*, 37 A.L.R.2d 551 (outlining the test applied to section 213 deductions).

18. "Excess cost" in this Article refers to the difference in a taxpayer's food costs when she purchases weight-loss food products over her "normal" food costs.

19. Cohen v. Comm'r, T.C.M. (1951) (stating that amounts paid for eyeglasses, elastic stockings are deductible per § 213); Hammons v. Comm'r, T.C.M. (1953) (stating that the cost of a hearing aid is a medical expense per 213); BUREAU OF INTERNAL REVENUE PUBL'N, *Your Federal Income Tax*, Ed. 84 (1952) (stating that the cost of a "seeing-eye" dog and the expense of its maintenance enter into the medical deduction).

20. *See generally* Bernard Wolfman, *Tax Expenditures: From Idea to Ideology*, 99 Harv. L. Rev. 491 (1985).

21. IRC § 213. "Adjusted gross income" is defined as "gross income minus allowable deductions specified in the tax code." BLACK'S LAW DICTIONARY 347 (9th ed. 2009). "Gross income" is defined as "total income from all sources before deductions, exemptions, or other tax reductions." *Id.*

22. *Id.* The provision also includes other aspects of "medical care," such as "transportation primarily for and essential to medical care," "qualified long-term care services," and "insurance . . . covering medical care . . . or for any qualified long-term care insurance contract." *Id.*

23. BLACK'S LAW DICTIONARY 185 (9th ed. 2009).

subtracted from gross income, or from adjusted gross income, when calculating taxable income."[24] In the section 213 context, a taxpayer can only deduct her medical expenses to the extent that their value exceeds 7.5 percent of her adjusted gross income.[25] This limitation allows taxpayers to access the medical expense deduction only in extreme and limited circumstances.[26]

Since the incorporation of section 213 into the Tax Code, taxpayers "have presented many interesting and difficult questions concerning borderline deductions;" however, the general framework of the 1942 provision remains steadfast.[27] A fundamental principle provides a foundation for the framework. The tax court has stated:

> The Congressional intent [of IRC section 213] is sufficiently evident to require the showing of the present existence or the imminent probability of a disease, physical or mental defect, or illness as the initial step in qualifying an expenditure as a medical expense. In other words, the language used . . . is sufficiently specific to exclude, except as to diagnosis, amounts expended for the preservation of general health or for the alleviation of physical or mental discomfort which is unrelated to some particular disease or defect.[28]

Therefore, an expense incurred to improve a patient's *overall general health*, as opposed to some *specific condition*, is not deductible.[29]

Keeping this principle in mind, the tax court developed the test for determining the deductibility of medical expenses.[30] First, the expense must have "incurred at the direction or suggestion of a physician."[31] Second, the expense must have incurred "primarily" for the prevention or mitigation of a particular physical or mental defect or illness.[32] Third, an expense must relate directly and proximately to the "diagnosis, cure, mitigation, treatment, or prevention of disease," or it must be incurred "for the purpose of affecting some structure or function of the body."[33] Fourth,

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24. *Id.*
25. IRC § 213.
26. *See generally supra* note 17.
27. IRC § 213.
28. Stringham v. Comm'r, 12 T. Ct. 580 (1949), *aff'd* 183 F.2d 579 (6th Cir. 1950).
29. *Id. See also* Havey v. Comm'r, 12 T. Ct. 409 (1949); Dobkin v. Comm'r, 15 T. Ct. 886 (1950).
30. *See supra* note 17.
31. *Id.*; Havey v. Comm'r, 12 T. Ct. 409 (1949).
32. Treas. Regs. § 39.23(x)-1(d)(1) (1954) (wherein it is said that deductions will be confined strictly to expenses incurred primarily for the prevention or alleviation of a physical or mental defect or illness).
33. *See supra* notes 18, 22; Havey v. Commissioner, 12 T. Ct. 409, 412 (1949).

the taxpayer must pay the expenditure within the taxable year in which the deduction is claimed.[34] Fifth, as noted, only medical expenses exceeding 7.5 percent of the taxpayer's adjusted gross income shall be deductible.[35]

The general framework of section 213 also provides some limitations. No deduction shall be allowed for expenses (1) of such nature that the personal or other benefits realized are greater than the medical benefits, (2) that are solely for the preservation of general health, or (3) that alleviate some physical or mental discomfort unrelated to a particular disease or defect.[36]

It is important to note that section 213 must be read in conjunction with section 262, which provides that no deduction shall in any case be allowed for "personal, living, or family expenses."[37] However, the tax court has extended the medical expense deduction to personal expenses in the past. For example, a taxpayer is allowed a tax deduction for smoking cessation programs pursuant to section 213.[38]

II. DIET FOOD ITEMS FIT THE SECTION 213 FRAMEWORK AND SHOULD BE DEDUCTIBLE

Diet food items are not currently deductible as a medical expense due to a judicially created limitation. However, diet food items should be deductible because they satisfy the test for deductibility of medical expenses under the section 213 framework. The judicially created limitation blocking the deduction should be removed in order to provide a sociomedical benefit to America.

The court blocked the deduction of diet food items beginning over 50 years ago. The tax court held in 1955 that the costs of "special food[s] and beverages prescribed [by a physician] for specific ailments" do not qualify as medical expenses unless "the prescribed food or beverage is taken solely for the alleviation or treatment of an illness [and] is in no way a part of the nutritional needs of the patient."[39] More recently, in Revenue Ruling 2002-19, it was held that although the cost of services associated with physician-prescribed weight-loss programs is deductible, "[t]he cost of purchasing diet food items [that have been prescribed to a patient by a

34. IRC § 213; Estate of Borden v. Comm'r, 19 T.C.M. 583, 586 (1950); Estate of Triplett v. Comm'r, 19 T.C.M. 626, 631 (1950).
35. IRC § 213.
36. Rev. Rul. 55-261, 1955-1 C.B. 307..
37. IRC § 262.
38. Rev. Rul. 99-28, 1999-1 C.B. 1269.
39. Rev. Rul. 55-261, 1955-1 C.B. 307.

physician] is not deductible under section 213."[40] However, in coming to this conclusion, an inconsistency was ignored.

As stated above, a medical expense is "any expense paid and properly substantiated as being primarily" for "the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body."[41] In Revenue Ruling 2002-19, the IRS concluded that services provided in weight-loss programs fit this description but held that diet food items do not.[42] However, just as services provided in weight-loss programs affect "the structure and function of the body" by removing excess weight and decreasing body mass index, diet food items directly affect the body in a similar manner.[43] As noted, poor diet causes a myriad of diseases that alter the function of the body.[44] Further, obesity is treated by weight-loss and weight-loss is often achieved through diet programs that incorporate diet foods.[45] Weight-loss, in turn, affects the structure and function of the body. Diet food items, then, like services in weight-loss programs, logically qualify as a medical expense.[46] Despite this, Revenue Ruling 2002-19 excludes diet food expenses from preferential tax treatment.[47]

An application of the test for deductibility under section 213 to the facts of Revenue Ruling 2002-19 further evidences this inconsistency.[48] Under the general framework of section 213, medical expenses are deductible when they are: (1) prescribed by a doctor; (2) primarily for the treatment of disease; (3) meant to specifically treat that disease; (4) paid in the year incurred; and (5) only deducted to the extent exceeding 7.5 percent of the taxpayer's adjusted gross income.[49] In Revenue Ruling 2002-19, a physician diagnosed Patient *A* as obese while Patient *B* suffered from hypertension.[50] The IRS concluded that both patients could deduct the costs of services related to her physician-suggested weight-loss program but neither could deduct the cost of diet food items related to the same program.[51] The ruling stated that the physician-prescribed weight-

40. Rev. Rul. 2002-19, 2002-1 C.B. 778.
41. Rev. Rul. 55-261, 1955-1 C.B. 307.
42. Rev. Rul. 2002-19, 2002-1 C.B. 778.
43. Rev. Rul. 55-261, 1955-1 C.B. 307.
44. *See supra* note 4.
45. *See supra* note 5.
46. *See supra* note 39.
47. *See supra* note 40.
48. *See generally* Section I.
49. *See supra* note 17, at 553.
50. *See supra* note 40.
51. *Id.*

loss programs were designed primarily to treat obesity and hypertension through weight-loss.[52] The ruling also assumed that the expenses were paid in the year incurred and that the patients would only deduct expenses exceeding 7.5 percent of their adjusted gross income.[53] The ruling also cited a source that noted "dietary therapy," which incorporates the use of diet food items, is used to cure, mitigate, treat, or prevent obesity and other diseases.[54] The facts of Revenue Ruling 2002-19 therefore demonstrate that diet food items, just like weight-loss services, meet the five factors necessary for a medical expense deduction under section 213 of the Tax Code.[55]

In order for the ruling in 2002-19 to be legally sound, then, the diet food items must fall within one of the exceptions previously iterated by the tax court.[56] However, none of these limitations apply under the facts of 2002-19. The ruling did not state that the diet food items were solely for personal benefit or for the preservation of general health.[57] Rather, the ruling distinguished the facts presented in 2002-19 from other cases in which diet programs were used solely for personal benefits and general health.[58] Further, the ruling stated that weight-loss treatment, which incorporated the use of diet food items, was meant to specifically treat obesity and hypertension.[59] Therefore, none of the section 213 limitations apply to the diet food items excluded from preferential treatment in Revenue Ruling 2002-19.

Instead of applying the deductibility test as designed by the tax court, the IRS in Revenue Ruling 2002-19 reaffirmed the judicially created limitation that diet food items are not deductible "because the foods are substitutes for the food [the patients] normally consume and satisfy their nutritional requirements."[60] Concededly, it is impossible for diet foods to be "in no way a part of the nutritional needs" of a patient and most diet foods are substitutes for normal nutritional requirements.[61] However, this

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52. *Id.*

53. *Id.*

54. *Id.*

55. *See supra* note 17.

56. No deduction is allowed for expenses (1) of such nature that the personal or other benefits realized are greater than the medical benefits, (2) that are solely for the preservation of general health, or (3) that alleviate some physical or mental discomfort unrelated to a particular disease or defect. Rev. Rul. 55-261, 1955-1 C.B. 307.

57. *See supra* note 40.

58. *Id.*

59. *Id.*

60. *Id.*

61. *See supra* notes 6 and 39.

judicially created limitation on section 213 should be removed because it does not logically fit within the general framework of section 213. Also, this limitation was created over 50 years ago. Today, obesity is growing faster than ever before and has reached the state where researchers consider it a pandemic.[62] Therefore, because the removal of this limitation will help slow the rate of obesity in a small but measurable manner,[63] it will provide a quantifiable, sociomedical benefit to America.[64]

Further, it can be argued that allowing a deduction for diet foods should not be allowed under section 262 of the Tax Code;[65] however, section 213, as noted, already subsidizes other personal expenses. For example, Revenue Ruling 99-28 allows a deduction for smoking cessation programs.[66] There, the tax court stated that "a strong causal link exists between smoking and several diseases."[67] Also, by helping cut employee health care costs, smoking cessation by employees provides a long-term financial benefit to employers.[68] Therefore, allowing a deduction for smoking cessation programs creates a sociomedical benefit to society. In the context of obesity, the same logic applies. Reducing the rate of obesity, which like smoking has a strong causal link to several other diseases,[69] will create a quantifiable financial benefit for employers by helping cut employee health care costs.[70] This creates a sociomedical benefit for society. As with smoking cessation programs, then, the section 213 deduction should be extended to include the full cost of physician-prescribed weight-loss programs that incorporate the use of diet food items.

III. HOW TO DEDUCT DIET FOOD ITEMS PURSUANT TO SECTION 213

The IRS would not have to design any new standards in order to allow a medical expense deduction for diet food items used in physician-prescribed weight-loss programs. The tax court has dealt with similar

62. *See supra* notes 1-5.

63. *See supra* note 17. Due to the 7.5 percent of adjusted gross income limitation built into the medical expense provision, it is important to note that this deduction will only be provided to patients who require an extreme overhaul of their diet in order to treat their obesity. IRC § 213.

64. *See supra* note 16.

65. *See supra* note 37.

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

67. *Id.*

68. *See generally* Nicolaas P. Pronk et al., *Relationship Between Modifiable Health Risk and Short-Term Health Care Charges,* 306 JAMA 1407 (2011);

69. *See supra* note 2.

70. *See supra* note 16.

situations arising under section 213 and already created a workable framework.[71] In numerous cases, the tax court allowed as a medical expense deduction the "excess of the cost of specially prepared foods designed to treat a medical condition over the cost of ordinary foods which would have been consumed but for the condition."[72] Further, in Flemming v. Commissioner, the Court stated that when food items provide for a taxpayer's nutritional needs "only such excess costs [over more plain, everyday fare] would be deductible."[73] The tax court has explained that only the excess cost of diet food items can be deductible pursuant to section 213.[74] The IRS should use this standard when dealing with physician-prescribed weight-loss programs and the necessarily included diet food items.

Taxpayers have the burden in tax court proceedings of proving that they are deserving of the medical expense deduction.[75] Therefore, in order for an extension of the section 213 deduction to apply, a taxpayer must be able to quantify "normal" food costs with demonstrable evidence, *like* grocery store receipts or bank statements. The taxpayer must then quantify the "excess cost" of her diet food items.[76] If the taxpayer can present a *prima facia* case showing the excess cost of her diet food items, which were purchased in accordance with a physician-prescribed weight-loss plan designed to treat obesity, then that "excess cost" should be deductible as a medical expense pursuant to section 213 of the Tax Code.[77]

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71. *See, e.g.*, Cohn v. Comm'r, 38 T.C. 387, 391 (1962) (allowing the deduction of additional charge made by restaurants for preparing salt-free foods required on account of taxpayer's heart condition); Randolph v. Comm'r, 67 T.C. 481, 487 (1976) (allowing the deduction of excess costs of foods produced without herbicides and pesticides).

72. *See id.*

73. Flemming v. Comm'r, 41 T.C.M. (CCH) 676, 1 (1980).

74. IRC § 213.

75. Crawford v. Comm'r, 65 T.C.M. (CCH), 10-11 (1993).

76. "Excess Cost," *supra* note 18. *Cf.* Crawford v. Comm'r, 65 T.C.M. (CCH), 10-11 (1993) (stating that evidence of the cost of the special diet in the form of notations in a spiral notebook kept by taxpayer, which documented the amount of checks written to purchase special diet foods, but did not indicate the amount the special diet cost exceeded the cost spent on normal dietary needs, was insufficient to determine the excess cost of the diet foods).

77. *Id.*