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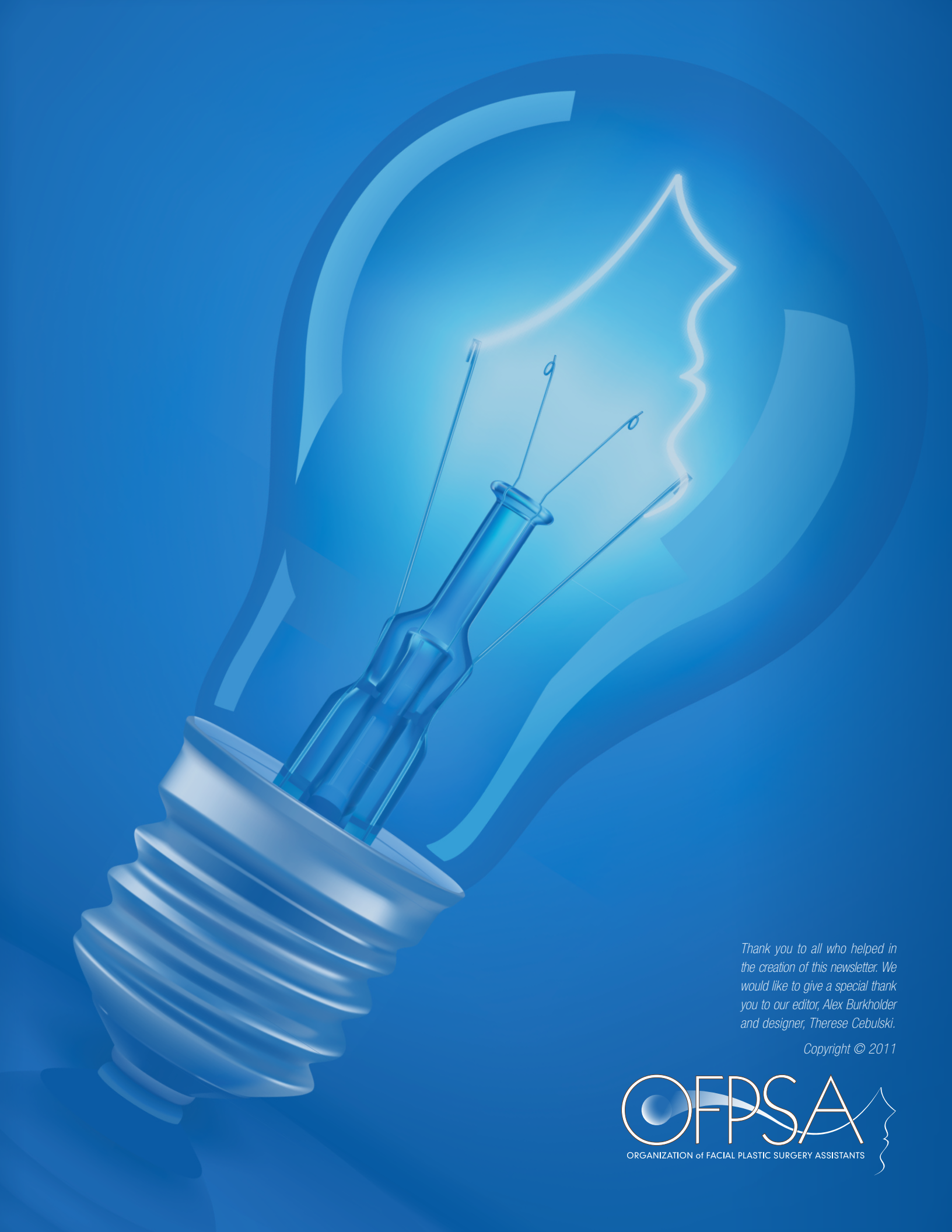
ORGANIZATION of FACIAL PLASTIC SURGERY ASSISTANTS

INNOVATION & IMPLEMENTATION

JUNE 2011 • ISSUE 1
OFPSA NEWSLETTER



Thank you to all who helped in the creation of this newsletter. We would like to give a special thank you to our editor, Alex Burkholder and designer, Therese Cebulski.

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FACIAL PLASTIC SURGERY
AMERICAN ACADEMY OF FACIAL PLASTIC AND RECONSTRUCTIVE SURGERY, INC.

A NOTE FROM THE AAFPRS PRESIDENT

Cos

A number of states have attempted to enact a cosmetic tax, originally designed to boost state revenues in troubled economic times. The initial knee-jerk reaction by facial plastic surgeons and other potential affected practitioners is to object to this tax. As our economy continues to have strong headwinds, many states with increasing debt and inability to balance their budgets are considering implementing "cosmetic" taxes. An in depth view at the history and success of cosmetic and similar taxes allows a perspective to argue for or against such a proposed tax.

Historically, New Jersey was the first state to pass legislation that requires patients to pay a special tax on cosmetic surgery. The tax was imposed to increase revenues that theoretically would be redirected to help provide care for uninsured New Jersey residents.

The New Jersey law was passed by the legislature and enacted on June 29, 2004 and first implemented on September 1, 2004. This law imposed a 6% tax on the purchase of certain "cosmetic medical procedures." Cosmetic Medical Procedures are medical procedures performed in order to improve the human subject's appearance without significantly serving to prevent or treat illness or disease or to promote proper functioning of the body. The law included procedures such as rhinoplasty, blepharoplasty, chemical peels, sclerotherapy, and cosmetic dentistry. It did not include reconstructive surgery or dentistry to correct or minimize abnormal structures caused by congenital anomalies, trauma, infection, or tumor. The tax applied to professional fees including anesthesia, and charges related to the facility or hospital. Additionally, this tax applied to in-office cosmetic services such as injectable fillers and neurotoxins.

New Jersey Governor John McGreevy signed the bill into law that marked the first time that a tax had been imposed on any medical operation in the United States. The original law required the provider of the service (e.g. surgeon, anesthesiologist, etc.) to collect a 6% tax on cosmetic medical procedures performed on or after 9/1/2004, and to report and remit the collected tax quarterly.

For obvious reasons, all medical specialties that perform cosmetic procedures vehemently objected to the New Jersey cosmetic tax as unjust. It is rare that people vote for increases in existing taxes or new tariffs which potentially impact business. Are their objections warranted, or do the revenues generated outweigh the negatives?

The NJ tax was intended to raise a large amount of funds for the state. This tax was expected bring in at least $25 million in its first year. However, tax revenues generated in the first 12 months after the law was enacted only amounted to approximately $7 million. The tax was, of course, politically controversial, and proved rather cumbersome to implement. New Jersey Assemblyman Joseph Cryan (D), the bill's original sponsor, introduced a new bill to repeal the original cosmetic tax. He stated that he thought that the cosmetic tax was "a creative approach to line item deficits in our state's budget." Cryan noted that the revenue stream was unfortunately untested and produced a 72% shortfall of expected revenues. The revenue generated primarily was used to pay the administrative costs associated with implementing the complicated tax system, and there was not enough additional revenue to provide funds for health care for the uninsured (as originally intended).

Hidden in the original national health care reform bill of 2009 was a 5% tax on cosmetic surgery. This federal mandate (Section 9017 of the health care reform bill) would clearly be associated with large administrative and implementation costs. The 5% cosmetic surgery tax in the federal health care reform bill was overturned at the 11th hour. Ironically, it was replaced at the last minute with a 10% tax on tanning salons in the U.S. At least legislators can reason that the ultraviolet radiation from tanning beds is unhealthy and can lead to an increase in skin cancers. No such argument can be made for cosmetic procedures. Since removing the cosmetic tax from the federal health care bill, many states have since proposed legislation introducing cosmetic taxes. These have included Connecticut, Minnesota (6.5%), Georgia (1.45% on ambulatory surgery centers), Texas, and Ohio.

metic Tax: Who's next?

Is the cosmetic tax fair? The critics of the NJ cosmetic tax argue that this tax unfairly discriminates against women (women receive 92% of cosmetic services). Other dissenters note that this tax is disproportionately imposed on people making less than $100,000 per year. (An ASPS study showed that 71% of plastic surgery procedures were performed on people making less than $60,000 per year.)

Are these sufficient arguments against a cosmetic tax? No clear-thinking citizen would advocate a tax discriminating against women. Enacting a tax which targets lower income individuals violates Obama's promise not to raise taxes on Americans making less than $250,000 a year. However, these are not the most important reasons to object to the proposed cosmetic tax. The major objection to the tax is that it is based on bias that cosmetic surgery is not good for people, and forces the physician to draw an artificial line between cosmetic and reconstructive procedures. This line will cause physicians to blur the distinction in cases such as nasal surgery, which may have both a functional and aesthetic indication, or cleft lip revision, which is certainly a congenital deformity at birth, but may have purely aesthetic reasons later in life. Physicians, like most humans, want to do the right thing. The cosmetic tax forces the plastic surgery specialist to decide whether every procedure is aesthetic and taxed, or reconstructive, and thus not taxed. Physicians will always choose what benefits them.

The other obvious argument against the cosmetic tax is the potential HIPAA (Health Insurance Portability and Accountability Act of 1996) violation that can be associated with implementation of the tax. The HIPAA laws are intended to protect individuals and their medical information. Implementation of cosmetic taxes requires the physician to self-regulate, and the government to trust this honor system. Alternatively, the state government could have access to patient records, including financial disclosures. Physicians are constantly required to increase protection of patient records, but federal and state laws such as the proposed cosmetic tax put at risk this protection. Additionally, implementation of these taxes will increase administrative costs to the physician.

Naturally, these increased costs are passed on to the patient. It seems that the goal of health care reform is to lower, rather than increase costs, and cosmetic taxes clearly will increase patient costs.

Does a cosmetic tax make moral and philosophical sense? State and federal governments are using these proposed taxes to create revenues to help balance budgets in flailing economies. In the wake of these laws are physicians' practices and patients' pocketbooks. The rationale for these taxes is that cosmetic surgery is an unnecessary excess, and that taxing is therefore justified. This was a similar philosophy used several years ago when a "luxury" tax was levied (in addition to the existing state sales tax) on expensive cars and boats. The luxury tax was clearly unfair, and the revenues generated were offset by decreased "luxury" items sold. The luxury tax law was subsequently overturned. Cosmetic surgery and related procedures are still medicine, and to arbitrarily tax certain medical services, while sparing others, makes no moral sense. Perhaps the designers of these laws, often lawyers, should consider an excise tax on "unnecessary" attorney fees.

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A NOTE FROM THE OFPSA PRESIDENT

In life we are undoubtedly faced with challenges and obstacles. Success is ultimately defined by how we respond to these daily "fires" we are confronted with. During a particularly taxing clinic day, I often recall Albert Einstein's declaration that "in the middle of every difficulty lies opportunity." Over the past seven years, I have learned that the OFPSA is an organization that shares Einstein's view. To me, this organization has represented a tremendous chance to not only turn difficult times into opportunities for individual growth, but to share, educate, and strengthen our industry as a whole. It is by offering guidance to our neighbors that we truly become a community.

I am excited to send our first digital newsletter for 2011 and I look forward to providing more tips and pearls from those who have donated their time and wisdom to our members. I encourage you to spread the word about the OFPSA network and invite your peers to join. To paraphrase Margaret Mead, "never doubt that a small group of thoughtful committed people can effect change - indeed, it is the only thing that ever has."

Along with the other officers, I would like to conclude by thanking a few individuals who are responsible for ensuring this great organization continues to thrive. Steve Duffy, Rita Magness, Ann Holton and ReGina Simo have passionately dedicated many years of support to the OFPSA. Without your efforts, this network wouldn't be what it is today. We thank you for your continued support. Additionally, Richard Linder and Dr. Jennifer Linder of PCA Skin have graciously sponsored the fall OFPSA meeting scheduled for September 8th-9th in San Francisco, CA. The support of PCA Skin is truly an honor.

Please look for our next e-newsletter scheduled to arrive in early August.

Warm wishes,

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