Allure of Cosmetic Surgery Tax Attracts States

Is it a hated luxury tax or a way to pay for uncompensated care? Depends on where you stand.

BY JOYCE FRIEDEN
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A tax on cosmetic procedures, already a reality in New Jersey, is causing concern among physicians in Illinois who fear their state may be next.

Late last year, Illinois State Comptroller Dan Hynes proposed a 6% tax on cosmetic procedures; revenues from the tax would be used to fund stem cell research. "Stem cell research promises to revolutionize the practice of medicine and spark treatment advances that could eventually improve the quality and duration of life for millions of Americans," Mr. Hynes said in a statement. "I intend for the medical community of Illinois to be on the front lines of that revolution."

Mr. Hynes noted that the state already faced "great financial difficulties" but added, "I want to be very clear here: What I am proposing is self-funded by this very narrowly defined luxury tax that is applicable to less than 2% of the population."

He estimated that the tax could raise enough money to fund both the initial $15 million needed for the research as well as debt service on a $1 billion bond issued for ongoing funding. The comptroller's office is planning to present a full proposal to the state legislature "in the spring," according to a spokesman for Mr. Hynes, who added that it "won't be a problem" to get a legislator to sponsor the bill.

The American Society of Plastic Surgeons blasted the proposal. "This is not the 'luxury tax' that Mr. Hynes would like the public to believe," ASPS President Scott Spear, M.D., said in a statement. "Plastic surgery, as the statistics illustrate, has become more mainstream. It is not just an indulgence of celebrities and rich people. It is a reasonable option for anyone who wants to look or feel better about their appearance."

Elvin Zook, M.D., past president of the ASPS, called the proposal "a grandstand play by the state comptroller, who's politically motivated."

He warned that taxing one kind of surgery could lead to other surgery taxes. "So you have an artificial knee; why not tax that?" asked Dr. Zook, who is professor of plastic surgery at Southern Illinois University, Springfield.

In New Jersey, where a similar tax—also at 6%—went into effect last September, physicians are seeing the results.

"An hour ago I had a patient call in who had seen me in consultation, and wanted to go ahead with significant surgery, but she is going to see someone in New York because she doesn't want to pay the tax," said Richard D'Amico, M.D., chief of plastic surgery at Englewood (N.J.) Hospital and Medical Center. "When you're talking about a $10,000 or $20,000 surgical bill, that's some real money." For example, a 6% tax on a $20,000 procedure would amount to an extra $1,200.

The New Jersey tax includes both less invasive procedures such as Botox injections and facial peels, and more invasive procedures such as liposuction and facelifts. Legislators expect the tax to bring in $26 million to help cover uncompensated hospital care in the state, but it may not work out that way since many doctors who also have offices in nearby New York or Philadelphia are simply switching their procedures over to those states instead of doing them at New Jersey facilities, Dr. D'Amico said. "It's very ironic that [the hospitals] will be hurt the most by this."

But officials at the New Jersey Hospital Association aren't worried. "I don't think it would put a dent into the $26 million, unless everybody fled," said NJHA spokesman Ron Czajkowski, in Princeton.

In addition to the cosmetic surgery tax, the state legislature also enacted a 3.5% gross receipts tax on freestanding ambulatory surgery centers (ASCs); that tax is capped at an annual maximum of $200,000 per facility. Physicians who perform cosmetic procedures and who have an ownership interest in an ASC are affected by both taxes.

The cosmetic procedure tax is fraught with other problems besides lost business, according to Peter Hetzler, M.D., president of the New Jersey Society of Plastic Surgeons. For example, "there are a huge number of procedures that have both functional and cosmetic components to them, and how do you determine what gets taxed and what doesn't?" said Dr. Hetzler, who is in private practice in Little Silver, N.J.

He cited the example of a patient who has significant airway obstruction and gets a rhinoplasty to fix the sinuses, septum, and turbinates; the surgery may also affect the look of the nose. "We have to find a way to divide that up."

Using CPT codes to designate which services will be taxed is not necessarily a solution, Dr. D'Amico said. "The code for a cosmetic breast lift is also the code for [restoring] symmetry in a woman who has had a mastectomy, but one is reconstructive and shouldn't be taxed," he said. "None of that has been worked out."

Dr. Hetzler has formed the Coalition of New Jersey Medical Professionals, a group of medical providers affected by the tax. The coalition is working with state taxation officials to figure out how to implement various aspects of the regulation, including the issue of how to tax procedures that are only partly cosmetic.

The coalition has little hope that the tax will be repealed, especially in the face of the state's large budget deficit, Dr. Hetzler said. But he is pleased that taxation officials have been cooperative and are willing to work with the coalition "to make sure that they don't indiscriminately audit physicians who may be at the mercy of patients paying this tax."

Naomi Lawrence, M.D., a spokeswoman for the American Academy of Dermatology, said that she was concerned that the tax idea may spread to other states.

"Everybody's looking for a way to cover charity care; they are desperate to find some way to do it," said Dr. Lawrence, chief of procedural dermatology at Cooper University Hospital, Marlton, N.J. "It's one of those ideas that's very popular with hospital associations across the country."

Dr. D'Amico agreed, noting that New Jersey's tax, which was passed without any input from affected providers, should serve as a warning to providers in other states. "They should be careful in whatever state they're in that this doesn't come up," he said. ■

Medicare Advisors Call for National Standards on Imaging

BY JENNIFER SILVERMAN
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WASHINGTON — A federal advisory panel wants to raise the bar on quality and use of imaging services.

In a series of recommendations, the Medicare Payment Advisory Commission called for national standards for physicians who bill Medicare for interpreting diagnostic imaging services, and for any provider who bills Medicare for performing such services. MedPAC advises Congress on Medicare payment issues.

There is evidence of variations in the quality of physician interpretations and reports, MedPAC analyst Ariel Winter said at a recent commission meeting. "Ensuring that only qualified physicians are paid for interpreting imaging studies should improve diagnostic accuracy and treatment," he said.

Standards for physicians would be based on education, training, and experience required to properly interpret studies. Private organizations would be charged with administering the standards, Mr. Winter said.

Several MedPAC commissioners questioned whether Medicare should get involved in the business of credentialing or accrediting physicians for interpreting imaging studies. Whether in cardiology or another specialty, Medicare would be taking on responsibilities that previously fell to licensing boards, specialty society certification, or other private sector organizations, said MedPAC commissioner Sheila Burke, R.N., of the Smithsonian Institution. "It is a new area and it's not entirely clear to me that Medicare may be the right place for that to occur."

Mr. Winter acknowledged that some providers might not be able to meet these standards, or incur costs to meet them. For example, they might have to invest in newer equipment or higher credentialed technicians, or they might have to obtain additional education, he said.

Measuring physicians' use of imaging services should be part of MedPAC's broader effort to profile fee-for-service physicians on their use of all services, Mr. Winter said. Radiologists can influence which tests physicians order, but physicians are important to the analysis on imaging because "they determine whether a test is appropriate," he said.

Under the MedPAC recommendations, CMS could develop measures of imaging volume for a patient seen by a physician, and could compare these measures to peer benchmarks or clinical guidelines, Mr. Winter said. The agency could then provide this information to the physician in confidence.

"The goal is to encourage physicians who order significantly more tests than their peers to reconsider their practice patterns," Mr. Winter said.

On other recommendations related to imaging, the panel voted that the Department of Health and Human Services improve Medicare's coding edits that detect unbundled diagnostic imaging services, and reduce the technical component payment for multiple imaging services performed on contiguous body parts.

Better coding will help Medicare pay more accurately for imaging services and help to control rapid spending growth, Mr. Winter said. Providers who bill for unbundled or multiple imaging procedures would experience a decrease in Medicare payments, though it's not anticipated that this would affect their willingness and ability to provide quality care to beneficiaries, Mr. Winter said.

MedPAC also proposed to strengthen the rules in the Ethics in Patient Referral Act (Stark law), which restrict physicians' investment in the imaging centers to which they refer Medicare or Medicaid patients. The restrictions already apply to radiology and certain other imaging services, but it's unclear whether nuclear medicine is a radiology service, Mr. Winter said.

The panel ultimately voted to include nuclear medicine and positron emission tomography procedures as designated health services under the Stark law. Investment in facilities that provide nuclear medicine services is associated with higher use, creating financial incentives to order additional services and to refer patients to facilities in which the physician is an investor. This undermines fair competition, Mr. Winter said.

Not according to Michael J. Wolk, M.D., president of the American College of Cardiology, who criticized MedPAC for recommending "restrictive tactics" to ratchet down the use of PET scans, CT, and MRI.

Studies that support these recommendations are biased, and specifically exclude examination of these procedures, Dr. Wolk said.

In a statement, he asked that policy makers take more time to look at this issue and evaluate the long-term health benefits of this technology, in addition to the immediate costs. ■