he or she stands at times of challenge and controversy. He stood up and fought for what was just in a world of controversy. I ask you all to stand up on the shoulders of Dr. King and fight for the elimination of hate and discrimination. Dr. Martin Luther King, Jr., will always be remembered for his courage, elegance and tireless endurance for the fight of equality in America.

PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2009

Mr. COBURN. Mr. President, I ask unanimous consent that these letters commenting on the Patient Protection and Affordable Care Act of 2009—the majority's ''health reform bill''—be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

PHYSICIAN ORGANIZATIONS THAT OPPOSE SENATE'S PATIENT PROTECTION AND AFFORDABLE CARE ACT

To date 43 state, county and national medical societies, representing nearly one-half million physicians, have stated their public opposition to the Senate healthcare overhaul bill, the Patient Protection and Affordable Care Act (H.R. 3590).

NATIONAL MEDICAL ASSOCIATIONS

American Academy of Cosmetic Surgery, American Academy of Dermatology Association, American Academy of Facial Plastic and Reconstructive Surgery, American Academy of Otolaryngology Head and Neck Surgery, American Association of Neurological Surgeons, American Association of Orthopaedic Surgeons, American College of Obstetricians and Gynecologists, American College of Osteopathic Surgeons, American College of Surgeons, and American Osteopathic Academy of Orthopaedics.

American Society for Metabolic & Bariatric Surgery, American Society of Anesthesiologists, American Society of Breast Surgeons, American Society of Cataract and Refractive Surgery, American Society of Colon and Rectal Surgeons, American Society of General Surgeons, American Society of Plastic Surgeons, and American Urological Association.

Association of American Physicians and Surgeons, Coalition of State Rheumatology Organizations, Congress of Neurological Surgeons, Heart Rhythm Society, National Association of Spine Specialists, Society for Vascular Surgeons, Society of American Gastrointestinal and Endoscopic Surgeons, Society for Cardiovascular Angiography and Interventions, and Society of Gynecologic Oncologists.

STATE AND COUNTY MEDICAL ASSOCIATIONS

Medical Association of the State of Alabama, Arizona Osteopathic Medical Association, California Medical Association, Medical Society of Delaware, Medical Society of the District of Columbia, Florida Medical Association, Medical Association of Georgia, and Kansas Medical Association.

Louisiana State Medical Society, Missouri State Medical Association, Nebraska Medical Association, Medical Society of New Jersey, Ohio State Medical Association, South Carolina Medical Association, Texas Medical Association, and Westchester (NY) County Medical Society.

DECEMBER 7, 2009.

Hon. HARRY REID,
Majority Leader, U.S. Senate,
Washington, DC.

DEAR SENATOR REID: The undersigned state and national specialty medical societies are writing you on behalf of more than 92,000 physicians in opposition to passage of the ''Patient Protection and Affordable Care Act'' (H.R. 3590) and to urge you to draft a more targeted bill that will reform the country's flawed system for financing healthcare, while preserving the best healthcare in the world. While continuance of the status quo is not acceptable, the shifting to the federal government of so much control over medical decisions is not justified. We are therefore united in our resolve to achieve health system reform that empowers patients and preserves the practice of medicine—without creating a huge government bureaucracy.

H.R. 3590 creates a number of problematic provisions, including:

The bill undermines the patient-physician relationship and empowers the federal government with even greater authority. Under the bill, 1) employers would be required to provide health insurance or face financial penalties; 2) health insurance packages with government prescribed benefits will be mandatory; 3) doctors would be forced to participate in the flawed Physician Quality Reporting Initiative (PQRI) or face penalties for nonparticipation; and 4) physicians would have to comply with extensive new reporting requirements related to quality improvement, case management, care coordination, chronic disease management, and use of health information technology.

The bill is unsustainable from a financial standpoint. It significantly expands Medicaid eligibility, shifting healthcare costs to physicians who are paid below the cost of delivering care and to the states that are already operating under severe budget constraints. It also postpones the start of subsidies for the uninsured long after the government levies new user fees and new taxes to cover expanded coverage and benefits. This ''back-loading'' of new spending makes the long-term costs appear deceptively low.

The government run community health insurance option eventually will lead to a single-payer, government run healthcare system. Despite the state opt-out provision, the community health insurance option contains the same liabilities (i.e. government-run healthcare) as the public option that was passed by the House of Representatives. Such a system will ultimately limit patient choice and put the government between the doctor and the patient, interfering with patient care decisions.

Largely unchecked by Congress or the courts, the federal government would have unprecedented authority to change the Medicare program through the new Independent Medicare Advisory Board and the new Center for Medicare & Medicaid Innovation. Specifically, these entities could arbitrarily reduce payments to physicians for valuable, life-saving care for elderly patients, reducing treatment options in a dramatic way.

The bill is devoid of real medical liability reform measures that reduce costs in proven demonstrable ways. Instead, it contains a ''Sense of the Senate'' encouraging states to develop and test alternatives to the current civil litigation system as a way of addressing the medical liability problem. Given the fact that costs remain a significant concern, Congress should enact reasonable measures to reduce costs. The Congressional Budget Office (CBO) recently confirmed that enacting a comprehensive set of tort reforms will save the federal government $54 billion over 10 years. These savings could help offset increased health insurance premiums (which, according to the CBO, are expected to increase under the bill) or other costs of the bill.

The temporary one-year SGR ''patch'' to replace the 21.2 percent payment cut in 2010 with a 0.5 percent payment increase fails to address the serious underlying problems with the current Medicare physician payment system and compounds the accumulated SGR debt, causing payment cuts of nearly 25 percent in 2011. The CBO has confirmed that a significant reduction in physicians' Medicare payments will reduce beneficiaries' access to services.

The excise tax on elective cosmetic medical procedures in the bill will not produce the revenue projected. Experience at the state level has demonstrated that this is a failed policy. In addition, this provision is arbitrary, difficult to administer, unfairly puts the physician in the role of tax collector, and raises serious patient confidentiality issues. Physicians strongly oppose the use of provider taxes or fees of any kind to fund healthcare programs or to finance health system reform.

Our concerns about this legislation also extend to what is not in the bill. The right to privately contract is a touchstone of American freedom and liberty. Patients should have the right to choose their doctor and enter into agreements for the fees for those services without penalty. Current Medicare patients are denied that right. By guaranteeing all patients the right to privately contract with their physicians, without penalty, patients will have greater access to physicians and the government will have budget certainty. Nothing in the Patient Protection and Affordable Care Act addresses these fundamental tenets, which we believe are essential components of real health system reform.

Senator Reid, we are at a critical moment in history. America's physicians deliver the best medical care in the world, yet the systems that have been developed to finance the delivery of that care to patients have failed. With congressional action upon us, we are at a crossroads. One path accepts as ''necessary'' a substantial increase in federal government control over how medical care is delivered and financed. We believe the better path is one that allows patients and physicians to take a more direct role in their healthcare decisions. By encouraging patients to own their health insurance policies and by allowing them to freely exercise their right to privately contract with the physician of their choice, healthcare decisions will be made by patients and physicians and not by the government or other third party payers.

We urge you to slow down, take a step back, and change the direction of current reform efforts so we get it right for our patients and our profession. We have a prescription for reform that will work for all Americans, and we are happy to share these solutions with you to improve our nation's healthcare system.

Thank you for considering our views.

Sincerely,
Medical Association of the State of Alabama,
Medical Society of Delaware,
Medical Society of the District of Columbia,
Florida Medical Association,
Medical Association of Georgia,
Kansas Medical Society,
Louisiana State Medical Society,
Missouri State Medical Association,
Nebraska Medical Association,
Medical Society of New Jersey,
South Carolina Medical Association,
American Academy of Cosmetic Surgery,
American Academy of Facial Plastic and Reconstructive Surgery,

American Association of Neurological Surgeons,
American Society of Breast Surgeons,
American Society of General Surgeons, and
Congress of Neurological Surgeons.

Past Presidents of the American Medical Association: Daniel H. Johnson, Jr., MD, AMA President 1996–1997. Donald J. Palmisano, MD, JD, FACS, AMA President 2003–2004. William G. Plested, III, MD, FACS, AMA President 2006–2007.

DECEMBER 1, 2009.

Hon. HARRY REID,
Majority Leader, U.S. Senate,
Washington, DC.

DEAR LEADER REID: On behalf of the over 240,000 surgeons and anesthesiologists we represent and the millions of surgical patients we treat each year, the undersigned 19 organizations strongly support the need for national health care reform and share the Senate's commitment to make affordable quality health care more accessible to all Americans. As you know, we have been working diligently and in good faith with the Senate during the past year and have provided input at various stages in the process of drafting the Senate's health care reform bill. To this end, we have reviewed the Patient Protection and Affordable Care Act of 2009.

As you may recall, on November 4 our coalition sent you a letter outlining a number of serious concerns that needed to be addressed to ensure that any final health care reform package would be built on a solid foundation in the best interest of our patients. Since those concerns have not been adequately addressed, as detailed below, we must oppose the legislation as currently written.

We oppose:

Establishment and proposed implementation of an Independent Medicare Advisory Board whose recommendations could become law without congressional action;

Mandatory participation in a seriously flawed Physician Quality Reporting Initiative (PQRI) program with penalties for nonparticipation;

Budget-neutral bonus payments to primary care physicians and rural general surgeons;

Creation of a budget-neutral value-based payment modifier which CMS does not have the capability to implement and places the provision on an unrealistic and unachievable timeline;

Requirement that physicians pay an application fee to cover a background check for participation in Medicare despite already being obligated to meet considerable requirements of training, licensure, and board certification;

Relying solely on the limited recommendations of the United States Preventive Services Task Force (USPSTF) in determining a minimum coverage standard for preventive services and associated cost-sharing protections;

The so-called ''non-discrimination in health care'' provision that would create patient confusion over greatly differing levels of education, skills and training among health care professionals while inappropriately interjecting civil rights concepts into state scope of practice laws;

The absence of a permanent fix to Medicare's broken physician payment system and any meaningful proven medical liability reforms; and

The last-minute addition of the excise tax on elective cosmetic medical procedures. This tax discriminates against women and the middle class. Experience at the state level has demonstrated that it is a failed policy which will not result in the projected revenue. Furthermore, this provision is arbitrary, difficult to administer, unfairly puts the physician in the role of tax collector, and raises serious patient confidentiality issues.

This bill goes a long way towards realizing the goal of expanding health insurance coverage and takes important steps to improve quality and explore innovative systems for health care delivery. Despite serious concerns, there are several provisions in the Patient Protection and Affordable Care Act of 2009 that the surgical community supports, strongly believes are in the best interest of the surgical patients, and should be maintained in any final package. Specifically these include: health insurance market reforms, including the elimination of coverage denials based on preexisting medical conditions and guaranteed availability and renewability of health insurance coverage; strengthening patient access to emergency and trauma care by ensuring the survival of trauma centers, developing regionalized systems of care to optimize patient outcomes, and improving emergency care for children; well-designed clinical comparative effectiveness research, conducted through an independent institute and not used for determining medical necessity or making coverage and payment decisions or recommendations; and the exclusion of ultrasound from the increase in the utilization rate for calculating the payment for imaging services.

Further, while redistribution of unused residency positions to general surgery is a positive step in addressing the predicted shortage in the surgical workforce, we believe that the Senate should look more broadly at the issue of limits on residency positions for all specialties that work in the surgical setting that are also facing severe workforce problems.

Finally, we are pleased that you have accepted our suggestion and removed language which would reduce payments to physicians who are found to have the highest utilization of resources—without regard to the acuity of the patient's physical condition or the complexity of the care being provided. We thank you for making this important change.

While we must oppose the Patient Protection and Affordable Care Act as currently written, the surgical coalition is committed to the passage of meaningful and comprehensive health care reform that is in the best interest of our patients. We are committed to working with you to make critical changes that are vital to ensuring that this legislation is based on sound policy, and that it will have a long-term positive impact on patient access to safe and effective high-quality surgical care.

Sincerely,

American Academy of Facial Plastic and Reconstructive Surgery, American Academy of Otolaryngology-Head and Neck Surgery, American Association of Neurological Surgeons, American Association of Orthopaedic Surgeons, American College of Obstetricians and Gynecologists, American College of Osteopathic Surgeons, American College of Surgeons, American Osteopathic Academy of Orthopedics, American Society of Anesthesiologists, American Society of Breast Surgeons, American Society of Cataract and Refractive Surgery, American Society of Colon and Rectal Surgeons, American Society for Metabolic & Bariatric Surgery, American Society of Plastic Surgeons, American Urological Association, Congress of Neurological Surgeons, Society for Vascular Surgery, Society of American Gastrointestinal and Endoscopic Surgeons, Society of Gynecologic Oncologists.

ALLIANCE OF SPECIALTY MEDICINE,
December 2, 2009.

Hon. HARRY REID,
Majority Leader, U.S. Senate, Washington, DC.

DEAR MAJORITY LEADER REID: As the Alliance of Specialty Medicine (Alliance), our mission is to advocate for sound federal health care policy that fosters patient access to the highest quality specialty care and improves timely access to high quality medical care for all Americans. As patient and physician advocates, the Alliance believes that true health reform should be enacted through a responsible and transparent process. Over the past year, the Alliance has provided substantive comments on those health reform provisions that concern specialty physicians and patients in their care. We are extremely concerned that your substitute amendment, the ''Patient Protection and Affordable Care Act,'' to H.R. 3590, fails to address our previously mentioned concerns. Therefore, we oppose the substitute amendment in its current form. We stand ready to work with you to address the issues, outlined below, that continue to concern us.

PHYSICIAN PAYMENT UPDATE (SECTION 3101)

Medicare's sustainable growth rate (SGR) formula needs to be replaced with a permanent, stable mechanism for updating Medicare fees to continue to assure Medicare beneficiary access to high quality care. Rather than come back year after year, providing a short-term fix to this large problem, we must stop utilizing band-aid solutions and establish a new baseline for physician reimbursement. President Obama agreed with that proposal when he sent this year's budget to the Congress. The cost of interim updates to the physician fee schedule should not be shifted to out years, making permanent SGR reform even more difficult, and costly, to achieve. Already, as a result of previous interim updates, physicians currently face a 21% fee reduction beginning in January 2010. Medicare physician payment rates already are below market rates. Therefore, any long-term solution should, at the very least, recognize reasonable inflationary cost increases.

VALUE-BASED PHYSICIAN PAYMENT MODIFIER (SECTION 3007)

Rather than create a stable physician payment schedule, Section 3007 would dramatically alter the current payment system by adding a new, untested payment modifier that would redistribute Medicare payments based on quality and geographic cost variation, without a more systematic review of the potential consequences. While the Center for Medicare and Medicaid Services (CMS) has been testing various models in this area, CMS does not have the current capability to implement such a proposal and no valid methodology that incorporates appropriate risk adjustment factors and outcome measures even exists. Furthermore, there are many reasons for geographic cost variation, including differences in population demographics that merit significantly more study before such a measure could be implemented. Therefore, rather than add stability to the physician payment mechanism, the proposal would create yet more instability with an unrealistic and unachievable timeline.

CMS should be allowed to fully test models for value-based payment and determine which system would achieve maximum benefit before further modification of a flawed Medicare physician payment formula. There is widespread agreement that the current SGR process results in arbitrary and damaging cuts to Medicare physician payment. We cannot achieve a reliable or stable incentive for quality care by modifying arbitrarily—and arbitrarily changing—reimbursement rates. And because this new modifier in Section 3007 would be budget neutral,

some providers would face the dual blow of arbitrary SGR cuts and neutrality-imposed value-based purchasing cuts.

PAYMENT CUTS FOR SPECIALTY CARE (SECTION 5101)

While we understand the potential need to increase the payment rates of primary care physicians, many surgical and specialty medicine disciplines have faced significant cuts over the years while primary care fees have increased. As Medicare payments have continued their steady decline over the past few years, reimbursement for primary care services has actually increased. For example, CMS recently approved a more than $4 billion increase in the fee schedule for primary care services, as well as a 37 percent increase in one key code used by primary care physicians. In its March 2009 report, MedPAC noted that Medicare payments for primary care have increased 10.6 percent between 2006 and 2009. And these changes will continue in the future. Indeed, under the 2010 Medicare Physician Fee Schedule, reimbursement for primary care physicians will increase between 2–4 percent.

While primary care payments have been increasing, specialty care payments have been decreasing. Since 1992, specialists have seen significant reductions in the fees they receive for procedural services. Although modest increases may have been provided for physician services in recent years, they have not kept up with the rate of inflation nor have all physicians seen increases. In fact, many surgical services were cut again in 2008 and a number of specialties are facing additional cuts in 2010 as a result of changes CMS has made in the fee schedule. Specialists continue to lose more ground in the fees they receive for serving Medicare beneficiaries while their practice costs continue to steadily rise. This is particularly troubling because much of the funding for this health care reform proposal already relies on cuts to Medicare and to the physicians that provide those key services. Additional cuts will likely result in decreased patient access to critical health care services. With a shortfall of 49,000 surgeons and other specialists predicted by the year 2025, we can ill-afford to further exacerbate the access to care problem.

INDEPENDENT MEDICARE ADVISORY BOARD (SECTION 3403)

Congress should retain proper oversight of the process that determines how services are provided under Medicare and not relegate it to another entity. If the goal of a new Advisory Board is to find new ways to eliminate spending in the Medicare program, the end result may well be detrimental to patient care for our nation's elderly. Already, Medicare reimbursement rates are well below market rates for similar services. And yet, the solution seems to be to further ratchet down the costs, without oversight, without care to ensure that our seniors receive the care that they deserve. Further, the construct of the Board seems to selectively exempt certain providers from its purview—placing more pressure to cut Medicare in those areas under its jurisdiction. There is no question we need to improve the Medicare program to make it sustainable well into the future. However, Medicare cannot be ''fixed'' when we do not look at the whole program, but rather, chop it up and force program savings into specific areas, such as provider reimbursement. We certainly understand and appreciate concerns with the rising costs of health care. But this is not the way to approach this problem. Rather than develop a coherent proposal to appropriately address the issue, the proposal contained in the substitute amendment abdicates Congress' fundamental responsibility and instead hopes that others can develop additional solutions and then allows them to be implemented. If we go forward with this process, there will be myriad unintended consequences, including restricting access to important interventions and services for Medicare patients. You should not allow important health care decisions to be made with little clinical expertise, resources or oversight required to ensure that seniors are not placed in jeopardy.

MEDICAL LIABILITY REFORM (SECTION 6801)

We remain concerned that the current health care proposal before us does not address our broken medical liability system. Medical liability reform will help achieve health system savings by reducing the incentives for defensive medicine and it will also protect physicians from unaffordable liability premiums. Last fall, President Obama stated in the New England Journal of Medicine that he would be ''open to additional measures to curb malpractice suits and reduce the cost of malpractice insurance.'' Earlier this year, at the American Medical Association's Annual Meeting, the President also noted that we will not be able to implement changes in our health care delivery system that reflect best practices, incentivize excellence and close cost disparities ''if doctors feel like they are constantly looking over their shoulder for fear of lawsuits.'' With a President that understands the need for medical liability reform, we do not understand why your proposal only includes a Sense of the Senate on the topic.

We would prefer a more comprehensive approach to this dire problem, such as federal medical liability reform based on the California or Texas models, which include, among other things, reasonable limits on non-economic damages. As you are aware the Congressional Budget Office recently scored comprehensive and proven medical liability reforms, similar to those above, as saving the federal government $54 billion over the next decade. In addition to this savings, these reforms will also improve patient access to specialty care, particularly in rural and underserved areas. However, at the very least, we should do something in this area, and there are several bipartisan proposals which we should debate, consider, and then include within a comprehensive health care reform package.

EXCISE TAX ON CERTAIN ELECTIVE MEDICAL PROCEDURES (SECTION 9017)

Physicians strongly oppose taxes on distinctive physician services to fund health care programs or to pay for health care reform and we therefore are extremely concerned by the last minute addition of the tax on elective cosmetic surgery and medical procedures. This is a dangerous precedent to set as it places physicians in the role of tax collector, compromises patient safety by encouraging individuals to circumvent the tax by seeking procedures from non-medical personnel or providers in other countries, and jeopardizes patient privacy by opening physician practices up to IRS audits. Furthermore, once in place, we fear that this tax could easily be expanded to other health care services. As demonstrated by New Jersey's experience with a similar tax, the application of such a tax is arbitrary and confusing to administer.

PROVISIONS IMPORTANT TO MAINTAIN IN ANY HEALTH CARE REFORM

We applaud many of the provisions in your substitute amendment that improve access to health insurance and believe a number of provisions must be included in any meaningful health reform package to improve access to affordable health insurance and assure access to specialty medicine. Those provisions included in your substitute amendment that we believe should be maintained include eliminating pre-existing condition exclusions, providing adequate access to specialty care through the benefit package, addressing rescission of health coverage, ensuring continuity in Medicaid coverage for children who go in and out of the system, and prohibiting annual and lifetime coverage limits.

In addition, the Alliance is pleased that your legislation includes a provision to expand comparative effectiveness research (CER). Like you, the Alliance believes appropriately designed CER conducted by an independent entity with full participation of all relevant stakeholders should enhance information about treatment options and outcomes for patients and physicians, helping them to choose the care that best meets the individual needs of the patient. CER needs to recognize the diversity, including racial and ethnic diversity, of patient populations and subpopulations and communicate results in ways that reflect the differences in individual patient needs. It should not be a vehicle for making centralized coverage and payment decisions or recommendations.

The Alliance also appreciates the elimination of a provision which would automatically reduce payment rates by 5% for physician services if they are deemed ''outliers'', regardless of patient acuity or other key factors.

Finally, we appreciate that you addressed our concerns related to imaging services and clarified that the definition of advanced imaging does not include ultrasound as it relates to the increase in the utilization rate for imaging services.

Thank you for commitment and leadership on this issue. Physicians are an integral part of the health care system and are on the front lines of patient care. The Alliance hopes you will work with us to improve the Senate health reform package.

Sincerely,

American Association of Neurological Surgeons; American Association of Orthopaedic Surgeons; American Society of Cataract and Refractive Surgery; American Urological Association; Coalition of State Rheumatology Organizations; Congress of Neurological Surgeons; Heart Rhythm Society; National Association of Spine Specialists; Society for Cardiovascular Angiography and Interventions.

AMERICAN ACADEMY OF DERMATOLOGY AND AAD ASSOCIATION,
Washington, DC, Nov. 20, 2009.

Hon. HARRY REID,
Majority Leader, U.S. Senate,
Washington, DC.
Hon. MAX BAUCUS,
Chairman, Senate Finance Committee,
U.S. Senate, Washington, DC.
Hon. TOM HARKIN,
Chairman, Senate HELP Committee,
U.S. Senate, Washington, DC.

DEAR LEADER REID, CHAIRMAN BAUCUS, AND CHAIRMAN HARKIN: On behalf of the American Academy of Dermatology Association (AADA), which represents nearly 12,000 dermatologists and our patients across the country, I am writing to state that we are opposed to S. 3590, the Patient Protection and Affordable Care Act (PPACA), in its current form. This legislation simply contains too many flawed provisions and policies that will harm vulnerable patient populations, undermine ongoing quality improvement efforts, leave in place an unstable physician payment system, and exacerbate physician workforce shortages—jeopardizing access to quality health care.

We are extremely disappointed to have reached this decision, because AADA fully supports meaningful and comprehensive

health system reform that achieves our shared goals of improving the health care delivery system and providing coverage for more Americans. We are serious about achieving reform—after working closely with leadership on the House side and finding that H.R. 3961 and H.R. 3962 comport with most of our principles for reform, we indeed issued letters supporting the key provisions of those bills. Early this year, AADA readily embraced the Senate's offer to work as constructive partners in finding the common ground that would serve as the foundation of meaningful health system reform. On several occasions, AADA submitted thoughtful, constructive comments on numerous proposed reform components, and subsequent legislative provisions, in an effort to work in a collaborative fashion. However, PPACA has made it clear that the majority of our input has been dismissed.

AADA is on record with the Senate in opposition to the following key provisions:

The Independent Medicare Commission—This commission removes public accountability and Congressional oversight of Medicare payment policy. Even more troubling is the exemption of hospitals from the Commission's jurisdiction, forcing physicians to bear the costs of Medicare Part A inefficiencies. It is unreasonable to expect that the cost curve can be bent solely within the Medicare part B silo.

Misvalued Relative Value Units—This provision creates an unnecessary, duplicative bureaucratic layer. CMS and the RUC are already engaged in extensive efforts to review and correct RVUs that no longer reflect practice realities, and this existing process continues to bring about substantial changes without the need for a duplicative and new panel.

Failure to Address Physician Payment—This legislation seeks to ''transform the health care delivery system,'' which would require physicians to make substantial changes in their practices. However, the bill offers yet another short term solution to a fundamentally flawed physician payment system. Without a stable payment system, physicians will be unable to make the long-term investments required to implement health system reform and continue to modernize their practices. The abject failure to recognize the need for real long- term reform demonstrates a misunderstanding of physician practice costs, including the employment of millions of Americans in these small businesses, and will inhibit transformation in the health care delivery system. We hope that the Senate will follow the House's lead and pass a complete repeal of the Sustainable Growth Rate formula.

While we are appreciative of changes made to the resource use and PQRI provisions, that positive movement was negated by the inclusion of new provisions in PPACA that have the potential to harm patients and conflict with several of our principles for reform.

Tax on Cosmetic Surgical and Medical Procedures—In an effort to offset the cost of this legislation, PPACA would impose a cosmetic procedure tax that disproportionately affects women and the middle class. Furthermore, this tax inserts the federal government into the physician-patient relationship in a new way—specifically, the Internal Revenue Service will become an arbiter of what is cosmetic and what is medically necessary. Under the proposed language, an HIV-infected patient with severe and stigmatizing lipoatrophy (loss of facial fat) resulting from their antiviral medications might be taxed for seeking to reduce their social stigmatization and return their face to a normal shape.

Public Reporting—We have extensively participated in quality measure development and supported incentives for physician participation. However, several unresolved problems still make public reporting of performance results premature. Our ability to assess comparative quality from claims data and to risk-adjust any measures to reflect different patient populations is still in its infancy. Releasing performance measures to the public before physicians have had the opportunity to advance this science and build trust in a system to properly account for variations in patient populations has substantial risk. In particular, the physician profiling that will result from such a premature data release will discourage physicians from taking on the sickest, most vulnerable patients and those with complex medical and social conditions. This can only serve to exacerbate health care disparities and create new barriers to care for those patients who are most in need.

AADA has previously submitted comments related to additional policies, including the value-based physician payment modifier, the lack of any meaningful provision related to the reform of our nation's unbalanced medical liability system, and others in its prior communications.

Our nation's doctors and patients are in need of health care system reform—reform that can happen if we work together to create a system that embraces the principles of quality care, efficient use of resources, and a patient-centered approach to practicing medicine. We are deeply disappointed to find ourselves with a Senate bill which fails to address several of the concerns we have raised, and it is regrettable that our efforts at collaborative dialogue have not resulted in a bill that we can support.

We urge you to work with us to arrive at a legislative proposal that is consistent with our specialty's principles for health system reform—principles which are widely shared by the physician community. AADA believes it is incumbent upon every health care provider to commit to being responsible stewards of the nation's health care resources. The challenge is finding the balance between fiscal prudence, delivering high quality care, and preserving the trusted physician-patient relationship. Please feel free to contact John Hedstrom (jhedstrom@.aad.org) in the Academy's Washington office at (202) 842–3555.

Sincerely,

DAVID M. PARISER, MD, FAAD,
President.

Mr. COBURN. Mr. President. I ask unanimous consent to have printed in the RECORD the following letter I sent to Mr. Alan Frumin, Parliamentarian of the U.S. Senate, on January 8, 2010, regarding the ruling that occurred in the Senate on December 16, 2009, during consideration of the health care reform bill that permitted Senator SANDERS to unilaterally withdraw his amendment during its reading.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

U.S. SENATE,
Washington, DC, January 8, 2010.

ALAN FRUMIN,
Parliamentarian of the Senate, U.S. Senate, Washington, DC.

DEAR MR. FRUMIN: I write to express my dismay with the situation that occurred in the Senate on Wednesday, December, 16th, 2009, regarding Sanders Amendment No. 2837. Specifically, I refer to the ruling that permitted Senator Sanders to unilaterally withdraw his amendment during its reading. This ruling had immediate, untoward, and severe ramifications for consideration of highly consequential legislation.

After thorough research into the matter, I firmly believe the Chair incorrectly applied Senate rules and precedents to permit Senator Sanders to withdraw the amendment. In doing so, the Chair cited a 1992 circumstance in which Senator Adams was allowed to withdraw an amendment during its reading, without unanimous consent. While this particular precedent has generated a significant amount of controversy in its own right, in this case it has only served to distract from the central issue at hand: even if the 1992 procedure were a proper precedent, it cannot be used to justify the withdrawal of the Sanders amendment.

Unlike the situation in 1992, consideration of Senator Sanders' amendment was governed by a unanimous consent order. The order not only sequenced the amendment but provided that no further amendments could be proposed to the Sanders amendment. In calling up his amendment, Senator Sanders expressly stated that he was doing so pursuant to the order. A 1971 precedent reflects well-established Senate practice: ''when the Senate is operating under a unanimous consent agreement or setting time for debate of a specific amendment that is action by the Senate on said amendment and subsequently it would take unanimous consent to withdraw the same.'' If this practice had been followed, Senator Sanders would not have been able to withdraw the amendment as a matter of right. Instead, he needed to propound a unanimous consent request, which he did not. Be assured, consent would not have been granted.

Following the ruling on December 16, your office justified Senator Sanders' unilateral withdrawal of his amendment, even in the face of the order, by claiming that the restrictions under a UC agreement for withdrawing an amendment are not imposed until after an amendment is pending. And you assert that the Sanders amendment could not be considered pending until the reading had been completed. I cannot find a basis for this explanation in Senate rules or precedents.

The assertion that the Sanders amendment was somehow not pending is illogical. A well-established practice, as expressed in a 1943 precedent, states ''the amendment must be before the Senate to be withdrawn.'' Thus, for the Sanders amendment to be withdrawn, it had to have been pending. If the amendment were not pending, and thus not subject to the order, it should not have been in order to withdraw it.

A 1979 precedent definitively demonstrates when an amendment must be considered pending. On December 10, 1979, Senator Roth of Delaware offered a second degree amendment to an amendment from Senator Stevens of Alaska. Objection was entered to dispensing with the reading of the Roth amendment. Upon a parliamentary inquiry during the reading, the Chair twice affirmatively stated that the amendment being read was the ''pending amendment'' and the ''pending order of business.''

Specifically, the Chair expressed the following: ''The Chair would advise that the amendment offered by the Senator from Delaware is the pending order of business. A unanimous consent request that the reading of the amendment be dispensed with was objected to. Therefore, the amendment is in the process of being read and now will be read.''

One can clearly draw two inferences from this ruling that demonstrate once an amendment is offered, it is pending:

1. If the amendment were not pending, the Chair would have stated that the order of business would be the reading of the amendment, not the amendment itself. Instead, the Chair stated that the pending order of business was the amendment, which was being read.

2. Furthermore, if the Roth amendment were not yet pending, the Chair would have stated the pending amendment was the underlying Stevens amendment. However, the Chair announced that the pending amendment was the Roth amendment.

Based on this precedent, which is directly on point and controlling, I believe it is conclusive that the Sanders amendment was, in fact, pending, thereby triggering the limitations imposed by a consent order. Because an order applied, ''action'' had been taken on the amendment. Therefore, Senator Sanders should have needed unanimous consent to withdraw his amendment.

If the amendment had been fully read, its disposition would have carried over until the next calendar day. That is what should have happened if Senate procedures were properly applied. Senators from both parties vividly understand that the Parliamentarian's advice in this matter may have been greatly consequential for the consideration of health care legislation.

Finally, it is disturbing to know that the only entities privy to the operative considerations underlying the ruling were your office and the majority party. Senator Cardin, who presided at the time of the ruling, submitted into the Record on December 21, 2009 a statement that mentioned the 1992 and 1950 precedents, supplied by your office, to attempt to justify his ruling.

Unfortunately, at the time of the ruling, I had no way of knowing about the 1992 Adams precedent since it occurred after the latest edition of Riddick's Senate Procedure was published. Furthermore, the 1950 precedent was inaccurately depicted in Riddick's, with the text of Riddick's contradicting the actual precedent cited. Had all the precedents been commonly available in a reliable and updated form, Senators could have had a basis to challenge the Sanders ruling in real time. By the time the dust had settled after the ruling, as Senators struggled to parse what had happened, such a challenge was long moot. In any event, neither of these precedents arose in the context of a consent order. I therefore believe the precedents were off-point and inapplicable.

You are a man of integrity, are a dedicated public servant, and hold the rules and precedents of the Senate in high regard. However, I believe this ruling was incorrect, and that it had a major adverse impact on a monumental piece of legislation.

Sincerely,

TOM A. COBURN, M.D.,
U.S. Senator.

TRIBUTE TO RICHARD GAUTHIER

Mr. LEAHY. Mr. President, today I would like to recognize Richard Gauthier, Chief of Police in Bennington, VT. Mr. Gauthier has been saving lives and protecting Vermont communities for nearly 30 years.

Chief Gauthier began his career with the Bennington Police Department in 1980 after graduating from the Vermont Police Academy in Pittsford. Six years later, he was promoted to detective, and in 1998, he was named chief of the department, a position he has held for the past 12 years.

Chief Gauthier received his bachelor's degree from Southern Vermont College in 1991, and later attended the FBI National Academy. He also holds a master's degree in criminal justice administration from Norwich University. As chief, he has led by example and consistently sought to improve the department, encouraging officers to seek additional education, improve their training and better their performance. He currently teaches courses in criminal justice at Southern Vermont College, his alma mater, where one former student described him as ''a phenomenal educator.''

During his time as chief, he has overseen a number of positive changes in the department and in the community including the formation of the Bennington County Child Advocacy Center/Special Victims Unit, of which he is a founding member. He also led efforts to specialize police investigation into drugs and gangs, and managed the department's move to a new police headquarters. A celebrated law enforcement officer, Chief Gauthier received the Vermont VFW Law Enforcement Officer of the Year in 2005 and the Vermont Commissioner's Award for Service to Children and Families.

Chief Gauthier will celebrate 30 years of service in September, and plans to step down as Chief of Police. I commend Chief Gauthier for his dedication to the city of Bennington and the State of Vermont. He has selflessly given so much to his community.

I ask unanimous consent that a story from The Bennington Banner about Chief Gauthier's career be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From the Bennington Banner, Jan. 6, 2010]

BPD'S CHIEF GAUTHIER RETIRING: 30-YEAR VETERAN OF FORCE PLANS TO STEP DOWN IN SEPTEMBER

(By Neal P. Goswami)

BENNINGTON.—Bennington Police Chief Richard Gauthier, a longtime member of the town police force, has informed officials of his decision to retire in the fall.

The 54-year-old Gauthier, appointed to the post in 1998, will reach the age of 55 and his 30th anniversary with the Bennington Police Department in September.

''I do have other goals that I want to achieve, and that would be a good time to start that,'' Gauthier said Wednesday in his downtown office. ''When I came on 30 years ago when I was 25, I made up my mind at that point that I was going to finish here if at all possible, and that's what happened.''

Gauthier joined the force two days after his 25th birthday, as a patrol officer. Six years later, he joined the Bureau of Criminal Investigations. After 12 years, and having reached the rank of sergeant, Gauthier was tapped by Town Manager Stuart A. Hurd to replace former Chief David Wooden.

''He was, I think, in the end, an excellent appointment. It was one of my first major appointments I had to face as town manager and, believe me, I was very, very nervous about it,'' Hurd said Wednesday.

''I say, more power to him. I certainly hate to lose him, and I think it's going to be an interesting process to try and replace him,'' he said. ''Overall, there isn't anything bad you can say about Rick Gauthier.''

Gauthier said his initial goal in police work was to become a detective, but his ambitions grew as he ascended the ranks of the department.

''That was as far forward as I was thinking at the time,'' Gauthier said. ''Later on, after I had been at (the Bureau of Criminal Investigation) for a while, I began entertaining the potential, but I was still surprised when I was actually chosen.''

Hurd said Gauthier was selected from a group of three internal candidates. Gauthier had a degree in criminal justice and as head of the police union had worked well with town officials, Hurd said.

''He brought all of those skills and all of those management styles, and in a sense, balance, to the police chief job in Bennington,'' he said.

Locals involved in the legal system had also vouched for him, Gauthier said.

''In talking with people in the law enforcement field—the state's attorney's office, lawyers who had worked with him—he really seemed to be heads and tails above everybody else in terms of his knowledge in police work,'' Hurd said.

For Gauthier, the highlight of his career in Bennington has been the ''ability to help people out that desperately need it at the time.'' As chief, being able to shape the department and focus improvements on training, equipment and the professionalism of the department has been most rewarding, he said.

Gauthier said the department has made substantial in those areas because of a quality command staff. ''I have what I consider to be a superior staff, a superior supervisory staff, and certainly this is a team effort,'' he said ''We are where we are because we have all worked together and done well.''

A strong relationship with other town officials has helped, too, Gauthier said.

''I'm kind of the envy of a lot of other chiefs around the state. My relationship with (Hurd) is excellent. We've disagreed on a couple of things, but the disagreements have always been kind of minor,'' Gauthier said. ''I've also had what I consider to be a very supportive select board, regardless of the members changing.''

Hurd agreed that any disagreements the two have had have been ''nothing of merit.''

''He's always been a part of the team. He's never been sort of egocentric, or sort of self-centered.

''He's always been willing to step up when tough budget times are necessary, and people have to look at their budgets very hard and make tough decisions,'' Hurd said.

Gauthier said he has tried to encourage the officers he commands to ''seek constant improvement,'' and hopes that will be a lasting legacy with the department.

''I hope that if I leave anything here, it's that continuous quest to improve all the time—improve yourself educationally, improve your performance as an officer, improve your training.''

He has followed his own advice, earning a master's degree while serving as chief, and may pursue a doctorate degree following his retirement.

Employment outside of law enforcement is likely, Gauthier said, who already teaches courses at Southern Vermont College. He remains coy, however, about his full plans. ''I've got a number of irons in the fire, and as I get closer to my actual retirement date, it will become clearer which one is the way I should go,'' he said.

Hurd said he intends to first look within the department to find Gauthier's replacement. The hope is to have someone on board at least 30 days before Gauthier departs, he said.

The search, once it begins, is expected to take at least two months. Hurd said he will create a review panel composed of himself, some select board members and possibly former Vermont State Police Director James Baker or former Bennington County Sheriff Gary Forrest. The panel will interview potential candidates, compare resumes to the