

Exhibit No. 2

Date 2-2-07

Bill No. 33 354



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CPT®

E-9.065 Caring for the Poor

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Cont. Med Educ (CME)

Medical ethics

Each physician has an obligation to share in providing care to the indigent. The measure of what constitutes an appropriate contribution may vary with circumstances such as community characteristics, geographic location, the nature of the physician's practice and specialty, and other conditions. All physicians should work to ensure that the needs of the poor in their communities are met. Caring for the poor should be a regular part of the physician's practice schedule.

Public health

Medical sciences

In the poorest communities, it may not be possible to meet the needs of the indigent for physicians' services by relying solely on local physicians. The local physicians should be able to turn for assistance to their colleagues in prosperous communities, particularly those in close proximity.

Legal issues

Physicians are meeting their obligation, and are encouraged to continue to do so, in a number of ways such as seeing indigent patients in their offices at no cost or at reduced cost, serving at freestanding or hospital clinics that treat the poor, and participating in government programs that provide health care to the poor. Physicians can also volunteer their services at weekend clinics for the poor and at shelters for battered women or the homeless.

In addition to meeting their obligation to care for the indigent, physicians can devote their energy, knowledge, and prestige to designing and lobbying at all levels for better programs to provide care for the poor. (I, VII)

Issued June 1994 based on the report "Caring for the Poor," adopted December 1992 (JAMA. 1993; 269: 2533-2537).

Last updated: Aug 29, 2005
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Medicare's Physician Payment Update Formula: The Facts

The Congressional Budget Office recently forecast that Medicare physician payment rates would be reduced by 10% in 2008 under current law. The 2006 Medicare Trustees report predicts cumulative reductions in Medicare physician payment rates of nearly 40% by the year 2015. These successive annual reductions are due to a statutory formula governing annual Medicare payment updates that is broken beyond repair and must be replaced.

The law provides for Medicare physician payment rates to be updated each year:

- The initial element in each year's update calculation is the Medicare Economic Index or MEI, a conservative government index of practice cost inflation.
- The update is then adjusted up or down from MEI based on the "Sustainable Growth Rate" or SGR.
- The SGR was developed because policymakers were concerned that increases in the utilization of services would lead to excessive spending growth.
- The SGR is a target rate of growth in Medicare spending for physician services.
- The key factors in setting the SGR are GDP growth, changes in law and regulation, Medicare enrollment and price changes.
- If expenditures exceed the SGR targets, then annual conversion factor updates are less than annual increases in practice cost inflation.

There are several **fatal flaws in the SGR**:

- Utilization of physician services grows more rapidly than GDP, so using GDP as the standard for utilization growth in the SGR means that the target is always set too low.
- The law and regulation factor has not been appropriately adjusted to reflect new Medicare coverage policies, such as macular degeneration treatment and implantable cardiac defibrillators.
- There is no provision in the SGR for technological change, site-of-service shifts, and practice trends.
- Spending for Part B drugs is growing much more rapidly than physician services, but this spending is counted in the SGR calculations. As a result, drug spending consumes an ever-increasing share of a target that is already too low, increasing the likelihood of SGR-driven pay cuts.

The major hurdle to securing a permanent, long-term replacement for the SGR is the enormous budget score of \$214 billion over 10 years.

Despite the cost, it is critical that a solution be identified as **the SGR is having disastrous effects**. In addition to the forecast 40% pay cuts by 2015, the SGR:

- has kept average 2007 Medicare physician payment rates about the same as they were in 2001;
- has significantly diminished the benefit of recently approved increases in relative values for primary care services and exacerbated cuts for other services;
- has prevented physicians from making needed investments in staff and data systems to support outcomes measurement and resource management;
- punishes physicians for participating in initiatives that encourage greater use of preventive care in order to reduce hospitalizations; and
- has led to a budget baseline that ties policymakers' hands and dictates payment policies based on their short-term price rather than their long-term value.

Surveys have shown that **SGR-driven pay cuts could hurt seniors' access to physician care**:

- The Medicare Payment Advisory Commission has found that increasing numbers of Medicare beneficiaries report "big problems" finding new primary care and specialist physicians. The Commission is concerned that Medicare pay cuts will worsen patient access problems.
- American Medical Association surveys of physicians have found that nearly half would have to decrease or stop accepting new Medicare patients if payments were cut.
- The Military Officers Association of America states SGR pay cuts would significantly damage military beneficiaries' access to care under TRICARE, as TRICARE payments are linked to Medicare rates.

- The congressionally-created Council on Graduate Medical Education is already predicting a shortage of 85,000 by 2020, and Medicare cuts are nearly certain to exacerbate this shortage by making medicine a less attractive career.

Physician services provide important benefits to seniors’:

- The Centers for Disease Control reported 50,000 fewer deaths in 2004, the biggest single-year reduction in mortality since the 1930s.
- An August 2006 *Health Affairs* article by Kenneth Thorpe and David Howard found that “[v]irtually all of the growth in spending from 1987 to 2002 can be traced to the twenty-percentage-point increase in the share of Medicare patients receiving medical treatment for five or more conditions during a year.”
- Medical advances added about a half year to seniors’ life spans between 1999 and 2002 alone. Deaths from heart and cerebrovascular disease have been falling by about 3% a year in recent years and the cancer death rate over the last decade has fallen by about 1% a year.

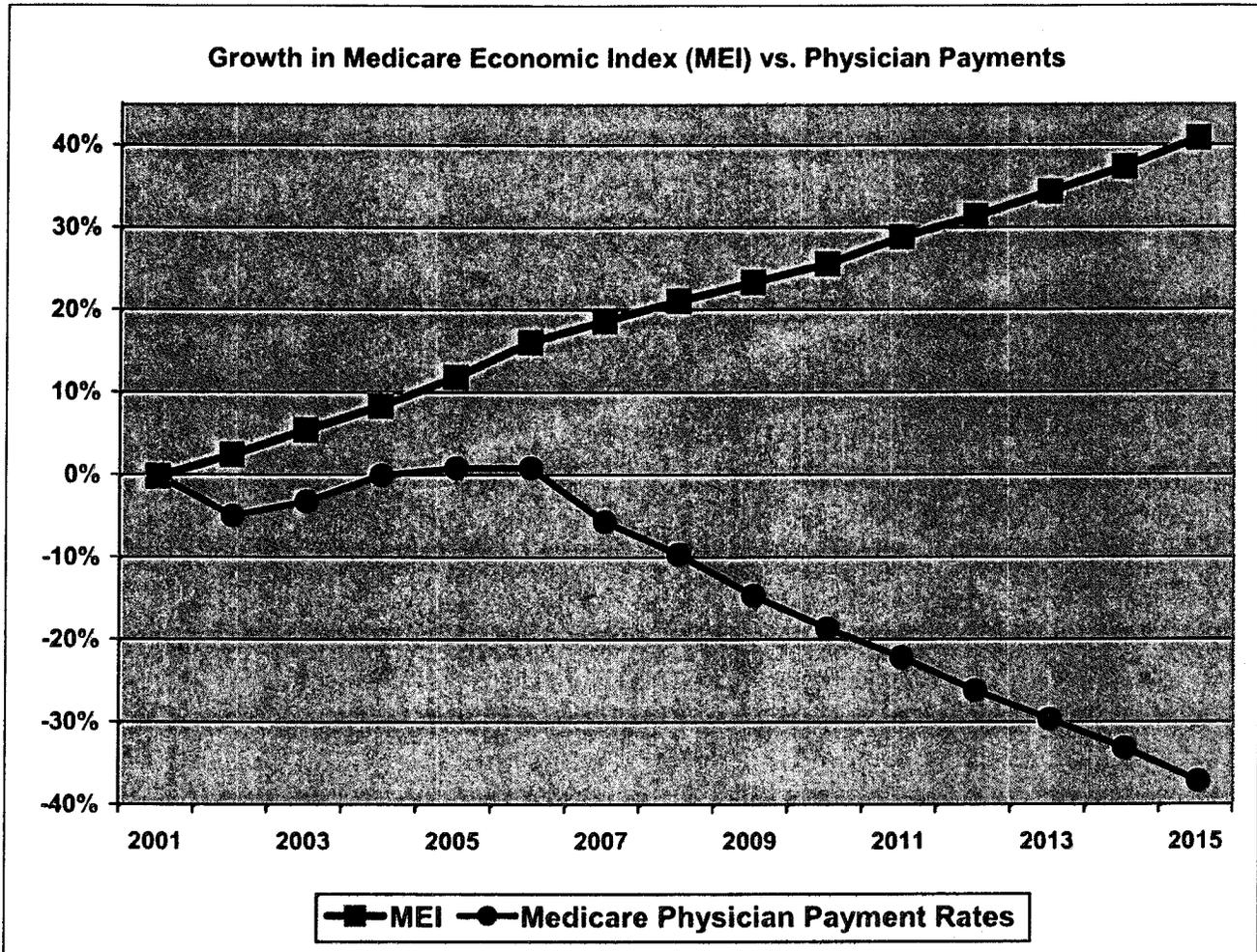
- An August 2006 *New England Journal of Medicine* article by David Cutler *et al.* concluded that, “although medical spending has increased over time, the return on spending has been high ... concern about high medical costs needs to be balanced against the benefits of the care received.”

The time has come to replace the Medicare update formula with a new approach that will provide adequate financing for physician services. The best way to accomplish this is as part of comprehensive Medicare reform. The leading edge of the baby-boomer generation will become Medicare-eligible in 2010, just as physicians are being driven out the program by consecutive steep pay cuts. The Medicare Trust Fund is projected to be exhausted by 2018, and in future years there will not be enough taxpayers working to support the costs of health care for the baby-boomers on Medicare.

Utilization of physician services is not the cause of the Medicare program’s financial predicament, and cuts in physician payment rates are not the way to improve Medicare’s financial sustainability. The Medicare program and funding for Medicare physician services have reached a critical juncture and both must be reformed.

The UN-Sustainable Growth Rate
2001 through 2015

Physicians' costs up 41%; Medicare Payments down 37%



Source: Conversion factor update and MEI data from Centers for Medicare and Medicaid Services, Office of the Actuary. Analysis of updates relative to inflation by American Medical Association, Division of Economic and Statistical Research, February 2006.

MEI – Medicare Economic Index: Measures input prices for resources needed to provide physician services. It is designed to estimate the increase in the total cost for the average physician to operate a medical practice.

MONTANA MEDICAL ASSOCIATION
February 1, 2007

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Medical/Surgical Conversion Factors for Medicare, MT Medicaid and BCBSMT - January 10, 2007.

Year	<i>Medicare</i> MedSurg CF	Montana <i>Medicaid</i> MedSurg CF	<i>Blue Cross</i> MedSurg Conversion Factor
2001	38.2581	34.15	54.5
2002	36.1992	34.15	54.5
2003	36.7856	31.9	54.5
2004	37.3374	31.18	54.5
2005	37.8975	30.11	56.01
2006	37.8975	32.59	56.57
2007	37.8975	32.81	57.70 effective 3/1/07
Overall % change:	-0.9%	-3.9%	+5.9%

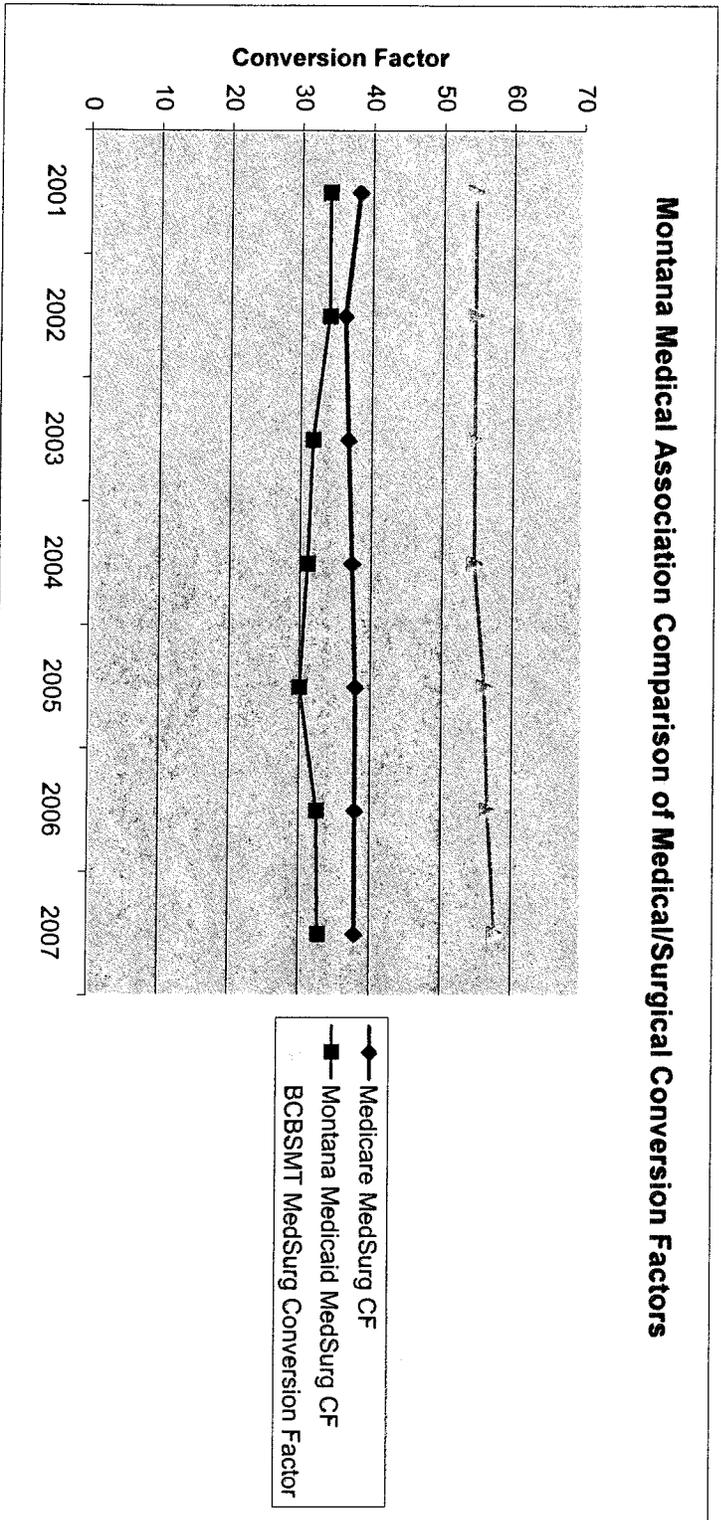
MONTANA MEDICAL ASSOCIATION

January 18, 2007

Medical/Surgical Conversion Factors for Medicare, MT Medicaid and BCBSMT

	Medicare MedSurg CF	Montana Medicaid MedSurg CF	BCBSMT MedSurg Conversion Factor
2001	38.2581	34.15	54.5
2002	36.1992	34.15	54.5
2003	36.7856	31.9	54.5
2004	37.3374	31.18	54.5
2005	37.8975	30.11	56.01
2006	37.8975	32.59	56.57
2007	37.8975	32.81	57.7

Montana Medical Association Comparison of Medical/Surgical Conversion Factors



Note:

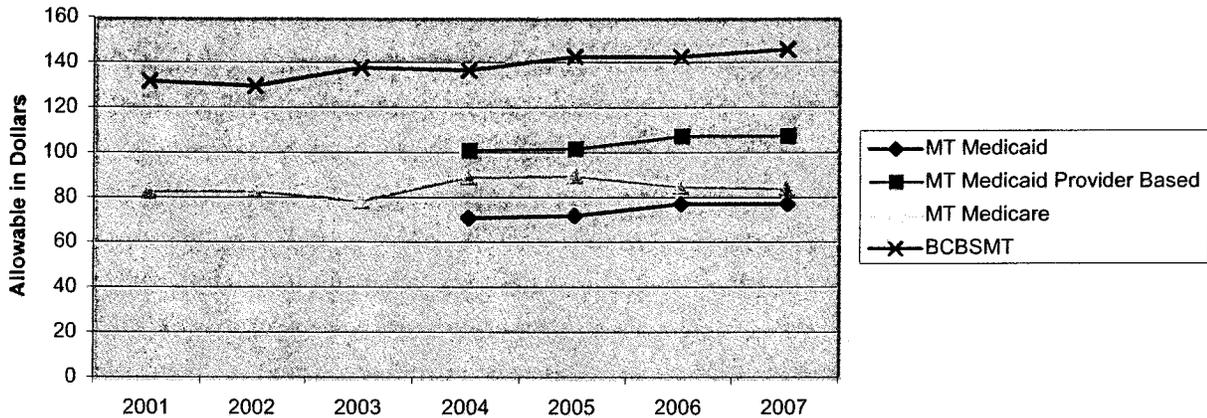
2007 BCBSMT conversion factor effective March 1, 2007

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	MT Medicaid	MT Medicaid Provider Based	MT Medicare	BCBSMT
2001			83.53	132.43
2002			83.7	130.25
2003			79.38	138.43
2004	71.56	101.75	90.04	137.34
2005	72.6	102.48	90.69	143.39
2006	77.99	108.12	85.92	143.39
2007	77.92	108.26	85.07	146.55

**Montana Medical Association Comparison of Allowed Fees for CPT Code 99203
(Level III Office Visit)**



Notes:

Fees represent the allowable on January 1st of each year, except the 2007 BCBSMT Fee which will be effective 3/1/07

MT Medicaid fees were not fully transitioned to the "natural" RBRVS until 2004, therefore the transitional fees prior to 2004 were not included in this comparison

MT Medicaid did not implement Provider Based reimbursement until October, 2003. This comparison provides fees beginning in 2004.

1/1/05 & 1/1/06 BCBSMT Fees were the same because the 2005 CF of 56.01 was effective 12/1/04 - 2/28/06

In addition to the conversion factor differential, MT Medicare and MT Medicaid RVU values are further discounted based on assigned Geographic Practice Cost Indices (GPCIs). This discount is reflected in the real world reimbursements presented on this graph.

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Primary care physicians¹ not accepting new Medicaid patients or otherwise limiting participation in the provision of Medicaid services:

1999	18%
2002	27%
2006	39% ²

January 12, 2007

¹ Primary Care defined as Family Medicine, Internal Medicine, Obstetrics/Gynecology and Pediatrics.

² 2006 MMA Survey of primary care physicians reveals that 28% are not accepting new Medicare patients.