



**Statement for the Record Submitted by the  
Association of American Medical Colleges (AAMC) to the  
House of Representatives Committee on Small Business:  
“The Doctor is Out. Rising Student Loan Debt and  
the Decline of the Small Medical Practice”  
Submitted June 11, 2019**

The Association of American Medical Colleges (AAMC) appreciates the opportunity to submit this statement for the record for the House Committee on Small Business June 12 hearing, “The Doctor is Out. Rising Student Loan Debt and the Decline of the Small Medical Practice.” The AAMC applauds the Committee for shedding light on physician workforce challenges and the need to improve access to health care in our nation’s underserved communities.

While medical education remains an excellent financial investment, the country faces a critical shortage of primary care and specialty physicians that may impact physician recruitment. The need for more physicians will be felt everywhere, but rural and historically underserved areas may experience the shortages more acutely. The AAMC highlights the following federal programs, among other factors, to help recruit physicians to health professional shortage areas: Public Service Loan Forgiveness (PSLF), the National Health Service Corps (NHSC), and the Conrad State 30 J-1 visa waiver program.

The AAMC is a not-for-profit association representing all 154 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and more than 80 academic societies. Through these institutions and organizations, the AAMC serves the leaders of America’s medical schools and teaching hospitals and their more than 173,000 full-time faculty members, 89,000 medical students, 129,000 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

**Medical Education Remains an Excellent Investment**

Medical education, while expensive, is an excellent financial investment for students. About three quarters of medical students use loans to finance their education. AAMC data shows that students graduate from medical school with a median debt of \$200,000 and only 0.5% of students accumulate education debts over \$500,000. However, numerous studies demonstrate that physicians repay their student loans, and default rates for medical school graduates are exceedingly low.

According to a 2013 AAMC study using financial planning software to model realistic household finance data, recent medical school graduates with the median amount of education debt can enter primary care, raise a family, live in an expensive urban area, and repay their debt within 10 years without incurring additional debt. However, heavily indebted primary care

graduates must plan repayment and lifestyle choices carefully and strategically.<sup>1</sup> Institutional aid, Health Resources and Services Administration (HRSA) scholarships and loans, and the Department of Education income-driven repayment caps, among other programs, can make educational debt more manageable. Programs like these also help promote a diverse and culturally competent health care workforce.

Medical education debt can be compounded by the unique repayment challenges of medical residency training and higher federal student loan interest rates for graduate and professional students. While the Department of Education income-driven repayment plans make monthly loan payments affordable for any occupation and salary, interest on student loans continues to grow during residency. For the average \$200,000 graduating debt, total repayment over a physician's career ranges from \$365,000 to \$440,000 under sample repayment scenarios.<sup>2</sup> In recent years, federal loan policy changes have made graduate and professional study less accessible and more costly, particularly for underrepresented, low-income, and first-generation students. For example, eliminating the in-school interest subsidy on graduate and professional student loans is estimated to increase repayment costs between \$10,000 and \$20,000 over the life of their loans.

The AAMC is particularly concerned about recent proposals to eliminate GradPLUS loans that allow medical students to borrow up to the full cost of attendance. Forty-seven percent of medical students currently rely on GradPLUS for medical school. Eliminating GradPLUS will have a disproportionate impact on the neediest borrowers and non-traditional students, forcing them to take out private student loans with less favorable terms to fully finance their education. A shift to the private market is an additional barrier for medical students, especially for borrowers with low credit, and creates multiple loan payments during residency training.

Moreover, GradPLUS, due to its higher interest rates and lower default rates (2% for all GradPLUS borrowers), has been a mutually beneficial use of limited federal resources. Contrary to recent criticism, a new analysis confirms, "There is no evidence to suggest the introduction and existence of the GradPLUS program has caused a significant increase in the cost of graduate and professional education. Concerns about higher education costs inflating, specifically at the graduate and professional level, because of readily available federal funds (the so-called Bennett hypothesis), are not supported by data."<sup>3</sup>

## **Factors Influencing Physician Career Choices**

A number of factors influence physician career choices: work-life balance expectations, geographic preferences, mentorship during training, income potential, regulatory complexity, administrative burden, and cost of practice — to name a few. The AAMC annually surveys medical school graduates regarding the influence of various factors on specialty choice. The results of that survey consistently indicate that education debt and/or potential income play a

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<sup>1</sup>"Can Medical Students Afford to Choose Primary Care? An Economic Analysis of Physician Education Debt Repayment", January 2013, [https://journals.lww.com/academicmedicine/Fulltext/2013/01000/Can\\_Medical\\_Students\\_Afford\\_to\\_Choose\\_Primary.15.aspx](https://journals.lww.com/academicmedicine/Fulltext/2013/01000/Can_Medical_Students_Afford_to_Choose_Primary.15.aspx)

<sup>2</sup> AAMC Debt Fact Card, October 2018 [https://store.aamc.org/downloadable/download/sample/sample\\_id/240/](https://store.aamc.org/downloadable/download/sample/sample_id/240/)

<sup>3</sup> Examining Grad PLUS: Value and Cost, April 2019 <https://www.accesslex.org/resources/examining-grad-plus>

relatively minor role in specialty choice.<sup>4</sup> Additionally, analysis of graduating debt levels across specialties shows little variance. In fact, a review of the academic literature shows little to no connection between economic factors such as debt/income potential and specialty choice.<sup>5</sup> Conversely, important factors in a student's specialty choice? includes personal interest in a specialty's content and/or level of patient care, desire for the "controllable lifestyle" offered by some specialties, and the influence of a role model in a specialty. Other central factors are the applicants' academic qualifications and the competitiveness of the residency program to which they are applying to.

The significant regulatory and administrative requirements that physicians must comply with on a daily basis also impact their decisions regarding whether to work in small private practices. Physicians spend a significant amount of their time on administrative tasks that are associated with clinician burnout, such as prior authorizations, performance measures and reporting, and electronic health record documentation, which has limited their time for direct patient care. Small practices may not have the financial ability to incorporate essential 21<sup>st</sup> century technology into their practices, nor the staffing and the infrastructure to support the changes to workflow needed for sustainable practice, including reporting requirements for quality measurement programs (e.g. the Merit-based Incentive Payment System), obtaining prior authorizations and claims submissions. It is also challenging for small practices to negotiate with commercial payers to receive adequate payment for their services. As a result of these challenges, an increasing number of physicians are choosing to work as employees in larger practices.

Exceptions to this trend include so-called "direct primary care" models, whereby physicians accept a small panel of patients, each of whom pays a fixed fee annually, and may incur additional charges for services that they are expected to pay for out of pocket. These practices typically establish a business model around a very spartan staffing structure (often just the physician with a single staff member), non-participation in 3<sup>rd</sup> party reimbursements, and closed panels to limit the workload and ensure access to those patients enrolled. As such, these models are not generalizable to the vast majority of the U.S population nor to most physicians in practice.

A 2019 American Medical Association Policy Research Perspective characterized the trend away from physician self-employment as follows:

In the research that examined shifts away from ownership and solo practice in the 1980s and early 1990s it was said, "if current trends persist, a majority of physicians will be employees in the very near future" (Kletke, Emmons, and Gillis, 1996). Given that only now has the point been reached where the number of employed physicians exceeds the number of owner physicians, caution should be taken in assuming current trends will continue indefinitely. One motivation given for the shifts toward larger practices (which typically have a higher employee to owner ratio) during the 1980s and 1990s was the desire to slow health care spending growth. Notably, in the current health care

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<sup>4</sup> AAMC Graduate Questionnaire, July 2018,

<https://www.aamc.org/download/490454/data/2018ggallschoolsummaryreport.pdf>

<sup>5</sup> "Is Medical Student Choice of a Primary Care Residency Influenced by Debt?," October 2006,

<http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1868367>.

system, the ability to participate in new models of care (e.g., accountable care organizations) and the related goals of improving efficiency in the delivery of health care, reducing spending growth, and improving quality are factors in practice consolidation and integration with hospital systems. Just as shifts in physician practice arrangements stalled after the early 1990s, should evolving models of care not deliver on their theoretical savings or improvements, that might put a break on consolidation.<sup>6</sup>

Workforce trends may also play a factor in career decisions, and will also increase competition as the country faces a shortage of physicians. The AAMC projects that the United States will see a shortage of up to 122,000 physicians by 2032, in both primary care (between 21,100 and 55,200) and specialty care (between 24,800 and 65,800). In light of these shortages, underserved communities increasingly rely on federally-supported recruitment incentives, such as PSLF, NHSC, and Conrad 30 to help meet growing health care demand.

### **Public Service Loan Forgiveness (PSLF)**

Since its enactment in 2007, the purpose of the Department of Education PSLF program has been to encourage graduates to pursue careers that benefit communities in need by providing student loan forgiveness after making loanpayments for 10 years. Through an annual survey of graduating medical students, AAMC has witnessed the success of PSLF. Now, roughly one-third of respondents indicate an interest in pursuing PSLF.

The AAMC is concerned that recent proposals that exclude physicians from PSLF or eliminate the program outright will undermine non-profit medical facilities that use PSLF as a provider recruitment incentive. It would also contradict the original intent of the program. The Higher Education Act, as amended, defines “public service” to include “public health,” and lists for example “full-time professionals engaged in health care practitioner occupations and health care support occupations.” Under this definition, we believe solo practitioners in underserved communities should qualify as public service.

In medicine, public service can include both primary care and specialty disciplines — family medicine physicians at community health centers, emergency medicine physicians at inner-city hospitals, or surgeons at VA medical centers. Though required for licensure, medical residency training is also a significant public service. Medical residents work with their supervisory physicians at teaching hospitals who:

- help care for the nation’s underserved and extend the reach of attending physicians to these vulnerable populations (including Medicare patients);
- provide indispensable patient care services, such as neonatal intensive care units (NICUs), burn units, and trauma centers, and a variety of other services provided almost exclusively at teaching hospitals; and
- deliver charity care to patients who cannot afford it.

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<sup>6</sup> AMA Policy Research Perspectives, May 2019 <https://www.ama-assn.org/system/files/2019-05/prp-fewer-owners-benchmark-survey-2018.pdf>

Furthermore, education is a critical component of teaching hospitals' not-for-profit missions that qualify these institutions as eligible PSLF employers.

PSLF is often criticized as expensive, but in reality physicians and other graduate/professional students pay a higher interest rate on federal student loans to offset the added costs of repayment and forgiveness associated with higher debt. Over the next ten years, the Congressional Budget Office estimates the Department of Education will profit \$26.5 billion from graduate and professional federal students loans compared to spending \$43.7 billion on undergraduate federal student loans.<sup>7</sup> In fact, the AAMC estimates that for every medical student that spends 10 years in public service to participate in PSLF, the cost is offset by just two medical students who do not. Furthermore, doctors in public service will earn approximately \$315,000 less over those first 10 years than their private sector counterparts.

The value of PSLF to underserved communities in need of health care services cannot be underestimated. As Congress considers reauthorization of the Higher Education Act, AAMC urges preservation of the PSLF program.

### **National Health Service Corps (NHSC)**

The NHSC is widely recognized — both in Washington and in the underserved areas it helps — as a success on many fronts. The simple, yet historically effective design of scholarship and loan repayment in exchange for primary care service in underserved communities:

- improves access to health care for rural and urban medically underserved Americans;
- increases state investments in recruiting health professionals;
- provides incentives for practitioners to enter primary care;
- reduces the financial burden that the cost of health professions education places on new practitioners; and
- helps promote access to health professions education for students from all backgrounds.

Importantly, the NHSC includes providers at solo or group private practices in rural, urban, or tribal communities with limited access to care. Given its success in improving the distribution of the primary care workforce, the AAMC supports the NHSC to help improve access to health care in underserved communities.

The AAMC echoes the Friends of the NHSC in calling for a doubling of the NHSC field strength to eliminate Health Professions Shortage Areas nationwide. For FY 2020, we recommend a total of \$475 million for the NHSC, including both annual appropriations and reauthorizing the NHSC mandatory fund beyond FY 2019. This \$60 million (15%) increase is the first stage of a five-year systematic doubling of the NHSC to meet the needs of underserved communities.

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<sup>7</sup> CBO Baseline Projections for the Student Loan Program, April 2018, <https://www.cbo.gov/system/files?file=2018-06/51310-2018-04-studentloan.pdf>

## State Conrad 30 J-1 Visa Waiver Program

Graduates of international medical schools or “international medical graduates” (IMGs) are a substantial part of GME, totaling approximately one-quarter of physicians entering the U.S. workforce. Roughly 7,000 positions in the 2019 National Residency Match were filled by graduates of international medical schools, over 55 percent of whom are not U.S. citizens.<sup>8</sup> The Conrad State 30 J-1 visa waiver program (“Conrad 30”) enables state agencies to recruit these physicians to underserved areas for at least three years.

State agencies have some discretion in shaping their Conrad 30 programs to address states’ priorities and some latitude in determining what specialties are needed, provided that they demonstrate, according to their own criteria, shortages in the specialties they recruit. Currently, non-primary care specialties constitute approximately half of Conrad 30 waivers requested by state agencies. These patterns suggest that IMGs not only help address primary care needs, but also fill deficits in specialty care as well.

In the last 15 years, over 15,000 physicians practiced in rural and underserved communities in nearly every state under the Conrad 30 program.<sup>9</sup> To put this into context, nationwide, Conrad 30 programs recruit physicians to underserved areas at levels comparable to the NHSC. In fact, Conrad 30 programs historically have out-performed the NHSC, which is limited by its annual funding. Because the NHSC recruits practitioners through scholarships and loan repayment, the Conrad 30 program accomplishes a similar goal at a lesser cost to the government.

In addition to increasing U.S. physician recruitment through NHSC and PSLF, the AAMC endorses the bipartisan Conrad State 30 and Physician Access Act (S. 948, H.R. 2141) to reauthorize and expand Conrad 30, among other improvements to the physician immigration system. To help underserved communities recruit physicians, this bill would:

- Allow the program to expand beyond 30 slots if certain nationwide thresholds are met;
- Create three new Conrad 30 slots per state to be used by academic medical centers;
- Allow “dual intent” for J-1 visa physicians seeking graduate medical education; and
- Establish new employment protections and a streamlined pathway to a green card for participants.

As the United States faces an unprecedented shortage of physicians, Conrad 30 has been a highly successful program for underserved communities to recruit both primary care and specialty physicians after they complete their medical residency training. We applaud this bipartisan reauthorization for recognizing immigrating physicians as a critical element of our nation’s health care infrastructure, and we support the expansion of Conrad 30 to help overcome hurdles that have stymied growth of the physician workforce.

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<sup>8</sup> National Resident Matching Program, April 2019, [https://mk0nrmpcikgb8jxyd19h.kinstacdn.com/wp-content/uploads/2019/04/NRMP-Results-and-Data-2019\\_04112019\\_final.pdf](https://mk0nrmpcikgb8jxyd19h.kinstacdn.com/wp-content/uploads/2019/04/NRMP-Results-and-Data-2019_04112019_final.pdf)

<sup>9</sup> U.S. Senator Susan Collins, March 2019, <https://www.klobuchar.senate.gov/public/index.cfm/2019/3/klobuchar-collins-rosen-introduce-bipartisan-legislation-to-increase-number-of-doctors-in-rural-and-other-medically-underserved-areas>

## **Federal Investments in the Physician Workforce**

In addition to the loan repayment programs discussed by the Committee at this hearing, the AAMC also strongly supports the HRSA diversity pipeline and workforce development programs and legislation to end the two-decade freeze on Medicare support for graduate medical education.

The NHSC, PSLF, and Conrad 30 programs play an important role in addressing primary care needs in underserved communities. However, the size and breadth of projected physician workforce shortages, including both primary care and specialty care, cannot be solved by recruitment alone. The major factor driving demand for physicians continues to be a growing, aging population. According to the U.S. Census Bureau, the nation's population is estimated to grow by more than 10% by 2032, with those over age 65 increasing by 48%. The resulting shortage of primary care and specialty physicians holds true despite a projected increase in the number of physician assistants and nurse practitioners and even in the presence of emerging health care delivery efforts to address overall population health.

With the demand for physicians simply outstripping our expected supply, we must advance a multifaceted strategy to ensure that Americans have access to the care they need when they need it. The AAMC strongly supports the bipartisan Resident Physician Shortage Reduction Act of 2019 (H.R. 1763, S. 348) as a critical component of any comprehensive workforce strategy to strengthen the physician workforce in both primary and specialty care by lifting the current freeze to support 3,000 new residency positions each year for the next five years.

The AAMC also supports HRSA's Title VII health professions and Title VIII nursing workforce development programs, which are structured to allow grantees to test educational innovations, respond to changing delivery systems and models of care, and address timely health threats in their communities. Titles VII and VIII programs emphasize interprofessional education and training in community-based settings, by bringing together knowledge and skills across disciplines to provide effective, efficient and coordinated care. Now more than ever support is needed for Title VII and Title VIII programs that improve the supply, distribution, and diversity of the workforce – to ensure health professionals are prepared to address the health care challenges of today and the future.

We applaud the Committee for highlighting these important health care issues and hope that Congress will increase funding for HRSA workforce development and prioritize legislation to end the freeze on Medicare support. While rural and historically underserved areas may experience the shortages more acutely, the need for more physicians will be felt everywhere unless lawmakers act now.