Folder 8

Medicare's Current Financing of Graduate Medical Education (GME) Must Continue
Talking points

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Issue: Some policy makers have proposed removing the current special payments for physician training and care for the poor from the Medicare program to enhance the solvency of the Hospital Insurance (Part A) Trust Fund. They also contend that financing these activities through Medicare Part A, which is funded by a payroll tax, places an undue burden on workers, particularly on low-wage earners, because they do not benefit directly from Medicare's support of physician and health professions training. In addition, some say that the Hospital Part A Trust Fund is an inappropriate financing source as medical care and clinical education move increasingly to non-hospital settings. Critics assert that support for these education and service activities should be financed from general revenues and subjected to the federal appropriations process so that additional oversight can be applied to them.

AAMC Position: The AAMC strongly opposes any changes in Medicare's current structure for financing graduate medical education (GME) and care for the poor. The Medicare program must maintain its current commitment to high quality health care by retaining its obligation to direct graduate medical education (DGME), indirect medical education (IME), and disproportionate share (DSH) financing because:

- The patient care and services that teaching hospitals provide, such as offering highly specialized, sophisticated patient care to the most severely ill, training health professionals, and providing an environment in which research can flourish, are the cornerstones of our health care system. These patient services are indispensable components of what the Medicare Part A Trust Fund seeks to accomplish through the funds designated for DGME, IME, and DSH: access to high quality care for the elderly and the disabled.

- The Medicare program's contributions for support of GME and DSH are not grant programs as some critics seem to argue. They are payments for the "cost of doing business" as a health care insurer, and compensate hospitals for the real, added costs they incur in providing sophisticated specialty services, care for the uninsured, training for future health professionals and an appropriate setting for research.

- Seniors, taxpayers, and all society benefit from a strong health system infrastructure and the availability of high quality health services. Taxpayers contribute to the Part A Trust Fund throughout their working lives to support the hospital care and other services that

today's senior citizens receive and to ensure that they and their spouses will have health insurance and access to a high quality health care system when they retire. While the Part A Trust Fund is financed on a pay-as-you-go basis, the public maintains its investment and trust so that Medicare and quality health care will be available when they need them.

- The Earned Income Tax Credit, which has been expanded dramatically in recent years, is available to low-income workers to offset their tax burden so that financing the Medicare program, and therefore GME and DSH, through a payroll tax is not unfair to low-income wage earners. Additionally, unlike the Social Security tax with a current limit of $68,400 subject to the maximum 6.2 percent Social Security tax, there is no limit on the maximum wage amount for Medicare tax purposes. All taxable wages are subject to the 1.45 percent Medicare tax, requiring high earners to pay more into the Medicare Part A Trust Fund than low-wage workers.

- The best way to assure a high quality health care system is to require all payers of services to invest in training and related activities. The burden of financing GME and care for the poor should be borne equitably by the Medicare program and all other payers of health care services. All payers of health care services should make these contributions and these funds should be secure and protected. Medicare's structured, "entitlement" approach is the correct model for an "all-payer" mechanism; an annual appropriation and/or grant process is not.

- As the only national insurer that provides explicit payments for GME and related activities, Medicare sets the standard, or social benchmark, for every insurer. Medicare has supported the costs related to physician and health professions training through a dependable mechanism in the Part A Trust Fund for over thirty years. Eliminating Medicare's entitlement commitment to fund these activities through payments tied to health services provided to both Medicare managed care and fee-for-service enrollees will embolden all private and public insurers to abandon their stake in helping to finance a well-trained health professions work force, continued scientific and medical advancement, and provision of care to the poor.

- Subjecting GME to an annual appropriations process would introduce inordinate uncertainty into an activity that demands careful planning. While the National Institutes of Health (NIH) and several other programs are generally well-supported in the annual appropriations process, they compete for funding with many worthy causes and are inevitably vulnerable to the changing interests of Congress. The AAMC's polling and public opinion research clearly demonstrates that physician education does not enjoy the same level of public support that biomedical research does.

- Long-term, dependable GME financing, such as Medicare's current entitlement system provides, is necessary to ensure that teaching institutions have the ability to adapt to changing market conditions. Residency training takes at least three and as many as seven-

to-ten years depending on the specialty. Accredited, high quality training programs may take several years to establish. Moving residency training increasingly from hospital to non-hospital settings takes time. Sponsors of GME training can adjust the specialty mix and size of their programs over time, but need stable funding to plan and fulfill the ethical and moral obligations they have made to physicians currently-in-training.

- In addition to hospital inpatient care, the Part A Trust Fund finances some skilled nursing facility care and home health services and hospice care--settings where physicians and health care professionals are being trained to provide the excellent and appropriate care that society needs and expects. The Balanced Budget Act (BBA) of 1997 made several changes in Medicare Part A GME payments to complement the shift in training from hospital to non-hospital settings that is already taking place.

- Teaching hospitals are still adjusting to significant, complex financial and structural changes in Medicare's GME financing mandated by the Balanced Budget Act (BBA) of 1997. Among the changes are an overall 29 percent reduction in IME payments over four years, the termination of Medicare's "open-ended" support by placing a cap on the number of residents hospitals may count for DGME and IME payments, and provisions to stimulate training in non-hospital settings. Implementation of these sweeping changes has been more complicated than anticipated. Many teaching hospitals are taking a fresh look at the number of residents they can support and their ability to place residents in non-hospital educational settings.

- Even before the 1998 payment reductions mandated by the BBA, the Medicare program just barely covered the cost of treating Medicare patients at many teaching hospitals.

  - According to the Medicare Payment Advisory Commission (MedPAC), in 1996, Medicare paid on average about 4 percent above the costs of Medicare patients, or about a 3.7 percent margin, at 110 privately-owned major teaching hospitals. This margin includes DGME, IME and DSH payments at higher levels than they are today. The margin from caring for Medicare patients was slightly below the 4.0 percent total margin for major teaching hospitals in 1995.

  - For 467 "other" teaching hospitals that provided data, MedPAC calculated that Medicare payments were not in excess of costs, but at "break even" levels.

  If the Medicare program had paid teaching hospitals at levels similar to private payers, the program would have had to pay teaching hospitals more than it paid them in 1996. The gap between Medicare and private payers may be even greater when the BBA-mandated Medicare payment reductions are taken into account.

- With all the changes mandated by the BBA and by the evolving competitive health care system, this is a particularly bad time to propose removing GME and DSH payments from

the Medicare program and making them subject to the appropriations process. Teaching institutions depend on Medicare as the bulwark of GME and DSH financing. Policy makers should remember the important precedent established and maintained by the Medicare program when setting a course for the future of GME and DSH financing in a competitive health care system.

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