association of american medical colleges

AGENDA

COUNCIL OF ACADEMIC SOCIETIES

SPRING MEETING

SHERATON WASHINGTON HOTEL

WASHINGTON, D.C.

BUSINESS MEETING

Thursday, March 27, 1986

one dupont circle, n.w./washington, d.c. 20036

COUNCIL OF ACADEMIC SOCIETIES

SPRING MEETING

March 26-27, 1986

Sheraton Washington Hotel
Washington, D.C.

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MEETING SCHEDULE FOR WEDNESDAY, MARCH 26, 1986

10:00 a.m. - 12:00 p.m. PLENARY SESSION

Dover Room **CURRENT ISSUES IN FACULTY PRACTICE:**

From the Dean's Perspective

Edward J. Stemmler, M.D., Dean
University of Pennsylvania School of Medicine

From the Hospital's Perspective

Thomas Q. Morris, M.D., President
Presbyterian Hospital of New York

From the Faculty's Perspective

Wilton Bunch, M.D., Ph.D., Dean for Medical Affairs, University of Chicago School of Medicine

Alan K. Pierce, M.D., Chairman
Faculty Practice Plan, University of Texas Southwestern Medical School, Dallas

12:00 p.m. - 1:30 p.m. LUNCHEON

1:30 p.m. - 5:00 p.m.

Dover Room

PLENARY SESSION

FEDERAL RESEARCH POLICY

An Open Discussion With Members of the AAMC ad hoc Research Policy Committee

David H. Cohen, Ph.D., Chairman
Department of Neurobiology, SUNY at Stony Brook, CAS Chairman

Robert E. Fellows, M.D., Ph.D.
Chairman, Department of Physiology and Biophysics, University of Iowa College of Medicine

Thomas Q. Morris, M.D., President
Presbyterian Hospital of New York

Benjamin D. Schwartz, M.D., Ph.D.
Professor of Medicine, Washington University School of Medicine

David B. Skinner, M.D., Chairman
Department of Surgery, University of Chicago, Pritzker School of Medicine

Peter Whybrow, M.D., Chairman
Department of Psychiatry, University of Pennsylvania School of Medicine

5:30 p.m. - 7:30 p.m.

Holmes Room

COCKTAIL RECEPTION TO HONOR AAMC PRESIDENT

JOHN A. D. COOPER, M.D., Ph.D.

MINUTES
1985 FALL MEETING
OF THE
COUNCIL OF ACADEMIC SOCIETIES

October 27-28, 1985
Washington Hilton Hotel
Washington, D.C.

OCTOBER 27 PLENARY SESSION

"Who will do Medical Research in the Future" and
"Peer Review: A Crisis of Confidence"

The 1985 Annual Meeting of the Council of Academic Societies began with a Plenary Session devoted to two major issues of interest to medical faculty: the role of physician scientists in medical research, and the recent challenges to and pressures on the peer review system.

Gordon N. Gill, M.D., professor of medicine at the University of California, San Diego, opened the first half of the meeting by stressing the importance of medical schools providing the centers for research and the communication pathways within which scientific discovery will flourish. He emphasized that research will be done by those with "talent, insight, genius and an environment that enables them to pursue scientific questions to the end." Dr. Gill stated his belief that physician scientists can bring a special quality to scientific investigation. He also warned of the problems of bureaucratizing scientific exploration by noting that structure can discourage "the serendipity of science."

John W. Littlefield, M.D., professor and chairman of physiology at the Johns Hopkins University, discussed the changing role of the M.D. in scientific research. He described the importance of giving students a realistic view of medical research careers and ways to prepare for such careers early in their decision-making. He expressed concern that the growing numbers of M.D./Ph.D.s in research is giving medical students the message that a Ph.D. is necessary to do research. Noting that medical research is becoming harder to do on a part-time basis, Dr. Littlefield stressed that physician scientists without a Ph.D. can make important contributions in areas tailored to their strengths or as part of a team effort.

Ruth Kirschstein, M.D., director of the National Institute of General Medical Sciences, began the discussion of peer review by describing the current grant award process and illustrating some of the pressures that have created a lack of confidence in the peer review system. She said that the most important problem is insufficient funds, especially compared with the number of high quality research proposals submitted. She suggested that dramatically lowered award rates have contributed to a loss of confidence in peer review on the part of scientists. In addition, academic institutions that obtain funding from Congress, circumventing the system, for "big-ticket" buildings, weaken peer review. She urged scientists to join in reaffirming the importance of peer review because it "provides the best advice about the scientific merit of competing grants" and is the foundation of biomedical research.

Edward N. Brandt, M.D., chancellor of the University of Maryland at Baltimore, discussed current congressional and public concerns about peer review and the ways in which scientific decisions are restricted by legislative or administrative action. He reviewed some alternatives to the present dual-review system for grants awards, and concluded that peer review is "the best mechanism for the determination of scientific quality."

OCTOBER 28 BUSINESS MEETING

I. CALL TO ORDER

The Annual Business Meeting of the Council of Academic Societies was called to order at 1:30 pm. Virginia V. Weldon, M.D., chairman of the CAS, presided. A total of 68 individuals, representing 58 of the 79 member societies, were present.

II. PRESIDENT'S REPORT

In his remarks to the Council, John A.D. Cooper, M.D., Ph.D., president of the AAMC, emphasized the unique role of the Association in unifying the broad and sometimes divergent interests within the academic medical community. He warned against the current pressures of narrow self-interests, which threaten to splinter the Association into "contending and uncompromising parties," each seeking "its own advantage at the expense of that of the larger whole." Characterizing the Association's strength as "the strength of common purpose," Dr. Cooper urged the Council to "emphasize those larger interests we share over the narrower ones that divide us." He concluded by saying that the future effectiveness of the AAMC will depend upon the faculty, deans, and hospital directors committing to the common purpose of advancing medical education, biomedical research, and patient care.

III. ACTION ITEMS

A. Approval of Minutes

The minutes of the October 28-29, 1984, Annual Meeting of the Council of Academic Societies were approved as submitted.

B. Election of New CAS Members

The following societies were recommended to the full council by the CAS Administrative Board for membership in the Council of Academic Societies:

American Society for Clinical Nutrition
American Geriatrics Society
Surgical Infection Society

ACTION: The above societies were unanimously approved for membership in the CAS.

NOTE: On October 28, 1985, by action of the AAMC Assembly, these societies were elected to CAS membership, increasing the total number of member societies to 82.

C. Election of Members to the 1986 CAS Administrative Board

Chairman-Elect
Frank G. Moody, M.D.
Society of Surgical Chairmen
University of Texas Medical School, Houston

Basic Science Positions
(for a one-year term)
Gordon I. Kaye, Ph.D.
Association of Anatomy Chairmen
Albany Medical College

(for a three-year term)
Joe D. Coulter, Ph.D.
Society for Neuroscience
University of Iowa

Clinical Science Positions
(for three-year terms)
Gary W. Hunninghake, M.D.
American Federation for Clinical Research
University of Iowa

Ernst R. Jaffe, M.D.
American Society of Hematology
Albert Einstein College of Medicine

ACTION: The above individuals were unanimously elected to serve on the CAS Administrative Board

IV. DISCUSSION ITEMS

A. AAMC Commentary on the GPEP Report

Douglas Kelly, Ph.D., co-chairman of the CAS-COD Working Group on GPEP, discussed the background and development of this commentary. He explained that the CAS Administrative Board had appointed a Working Group on the GPEP Report in September 1984. As a result of discussion at the 1984 Annual Meeting, this Working Group met to begin formulating a draft commentary on the report. At the same time, the Council of Deans (COD) had undertaken a similar effort. Subsequently, a combined CAS-COD Working Group met to develop a commentary, which was adopted as Association policy by the Executive Council on September 12, 1985. Dr. Kelly noted that this commentary was written to address the major concerns and criticisms that have raised with relation to the report, to clarify the GPEP panel's intent where it has been misunderstood or misinterpreted, and to provide specific guidance with regard to the panel's conclusions in selected areas. The commentary was distributed widely to both the medical schools and the academic societies.

B. Review of Medical School Applications

August G. Swanson, M.D., director of the Department of Academic Affairs at the AAMC, reviewed some of the recent trends in medical school applications. He noted that 1985 saw a significant drop (8.5 percent) in the number of medical school applicants nationwide. This resulted in a 2:1 ratio of applicants to entry positions. He expects a similar drop in applicants in 1986, and if the number of entry positions follows the same declining trend it began in 1981, the ratio will be 1.85:1. Dr. Swanson said that all evidence suggests that we can continue to expect a steady decline in the applicant pool of between 4 percent and 8 percent yearly.

Dr. Swanson also pointed out that the number of male applicants has been dropping. In 1974, males accounted for 79 percent of the applicants; by 1985, they were only 50 percent. The number of females entering medical school is increasing. Women accounted for 30 percent of the 1985 graduating class.

The Council discussed the potential causes for these trends. Dr. Swanson said that some of the decrease in applicants might be attributed to increased tuition or medical student indebtedness, but that it would be hard to explain such a precipitous drop only on that basis. He also said he believes that the time is coming when there will be a fierce competition between schools for students.

C. Investor Owned Teaching Hospital Participation in COTH

Dr. Weldon explained the background on the recommendation that the Association's Bylaws be amended to allow investor owned hospitals to become or remain as members of the Council of Teaching Hospitals. Subsequent to an extended consideration of this issue, beginning with the COTH Spring Meeting in 1984 and including the CAS Spring Meeting in 1985, the COTH Administrative Board recommended to the Executive Council in September 1985 that the AAMC Bylaws be amended. All Administrative Boards and the Executive Council have approved this recommendation. Dr. Weldon noted that the Internal Revenue Service has ruled that such a change would not violate the Association's 501(c)(3) tax status as a non-profit, educational organization. The Council discussed some of the advantages and disadvantages of this recommendation.

NOTE: On October 28, 1985, the AAMC Assembly voted to amend the AAMC Bylaws to allow investor owned hospitals as members of the COTH.

D. AAMC Committee on Financing Graduate Medical Education

Frank Moody, M.D., Louis Sherwood, M.D., and Frank Wilson, M.D., who served as CAS representatives on the Committee described the current status of its activities. The Council discussed one of the central issues before the Committee, namely the length of support for residency training to be funded by public funds (the Medicare direct graduate medical education passthrough).

It was noted that the Committee and the Association favored the Dole-Durenberger proposal for funding to initial board eligibility or 5 years. Concern was expressed that such a proposal does not adequately address the question of the length of time necessary to ensure that specialists in certain disciplines are fully trained. Another issue raised was the possible effects that the proposed limitations on Medicare support for residency training beyond initial board eligibility might have on the preparation of clinical investigators, who are currently prohibited from receiving support from research training funds for the advanced clinical subspecialty portion of their education. The Council strongly urged its ad hoc Committee members to reopen discussions in the Committee concerning the length of training which would be supported from hospital patient care revenues.

James Bently, Ph.D., assistant director of the AAMC Department of Teaching Hospitals, discussed some of the recent legislative proposals before the Congress related to the financing of graduate medical education.

E. Report of the AAMC-AAU Committee on the Management and Governance of Institutional Animal Resources

Joe Coulter, Ph.D., who served as a member of this Committee, described its final report. He noted that the scientific community's focus on the animal issue in the national arena may soon shift to more emphasis on local issues. He explained that this report concentrates on the institutional responsibilities with regard to animal facilities and research. The report, which Council members received prior to the meeting, provides a number of detailed recommendations for those individuals responsible for all aspects of an institution's education and research programs that utilize animal models. Council members were urged to implement these recommendations at their own schools.

F. AAMC Research Policy Committee

David Cohen, Ph.D., discussed the background and development of this Committee. He noted the recent initiatives in Washington to reevaluate research policy, led by the House of Representatives Task Force on Science Policy, which is chaired by Rep. Don Fuqua (D-FL). The AAMC Committee was established last June and is chaired by Edward N. Brandt. M.D., former Assistant Secretary of Health and chancellor of the University of Maryland at Baltimore. The Committee met in August and has two more meetings scheduled. A draft report of the Committee's recommendations should be available for comment at the 1986 Spring Meetings of the Councils.

G. Investigation of the VA Inspector General Regarding Conflict of Interest

John Gronvall, M.D., deputy medical director for the VA, discussed the recent investigation by the VA Inspector General into possible conflict of interest on the part of VA employees who accepted

gratuities or reimbursements for meetings from drug companies. Dr. Gronvall reported that 88 VA employees have received letters communicating actions ranging from counseling to reprimand. He also explained the specific VA regulations that govern standards of ethical conduct and outside income, and the types of activities prohibited by these regulations.

H. AAMC Faculty Practice Committee

Wilton Bunch, M.D., Ph.D., who is a CAS member on this Committee, briefly discussed the establishment of this Committee. The Committee met in September and identified two major problems. First, getting faculty to recognize the tremendous changes that are occurring in the practice environment and the necessity for change within the medical center to deal with the new environment. Second, medical centers are very divided on fiscal issues related to practice income. Dr. Bunch noted that the AAMC will undertake a series of regional workshops on the management of practice in a highly competitive environment and report on further deliberations at the Spring meeting.

V. INFORMATION ITEMS

A. Future Meetings

The 1986 Spring Meeting of the Council of Academic Societies will be held March 26-27 in Washington, D.C.

The 1986 Annual Meeting of the AAMC is scheduled for October 25-30 in New Orleans. The Annual Meeting of the Council of Academic Societies is scheduled for October 26-27.

B. Distinguished Service Member

Robert L. Hill, Ph.D., former CAS chairman has been nominated by the CAS for a Distinguished Service Membership in the AAMC.

ISSUES OF REPRESENTATION FOR THE COUNCIL OF ACADEMIC SOCIETIES

In response to the continued growth in faculty societies seeking and obtaining membership in the Council of Academic Societies and to a growing number of complaints with regard to representation of societies or disciplines on the Administrative Board, the CAS Administrative Board held an informal discussion in January on several issues related to Council representation. This discussion focused on what the criteria for Council membership should be, how member societies should be represented within the Council, and how the members of the Administrative Board should be chosen.

The general consensus among Board members was that the CAS should be broadly representative of the faculty at academic medical centers; therefore, the criteria for membership should remain relatively open. Two possible dangers were identified with an open admission policy: development of a duplicate constituency and inclusion of non-academic groups. Duplicate representation was thought to be a problem only if the Council governance would begin to rely on formal votes rather than consensus building. Rather than construct a narrow definition of an "academic" society, which might lead to the exclusion of groups that legitimately should be part of the Council, the Board decided to continue its current practice of determining each society's eligibility at the time its application for membership is reviewed on an individual basis.

With respect to the representation of the individual member societies within the Council, the members of the Board felt that the current public affairs and legislative issues facing faculty are inseparable from other academic issues. Thus the Board recommended discontinuation of the public affairs representatives (PARs). Each society would continue to have two representatives to the Council; however, the Board recommended that the CAS Rules and Regulations be amended to provide one vote for each society rather than each representative. It also was agreed that the Rules and Regulations should be amended to leave the length of the term for CAS representatives to the discretion of the individual societies. Currently, representatives are elected to 2 year terms, and individual representatives may serve up to four terms (or a total of 8 years). Societies are encouraged to have at least one of their representatives appointed to a term of sufficient length (4-8 years) to allow that individual time to develop expertise with the issues of importance to faculty and the CAS/AAMC and the governance process of the AAMC.

It was generally agreed that the most important consideration in selecting members for the Administrative Board should be the qualifications of the individuals rather than the specific disciplines or societies represented. Therefore, the Board agreed to replace the current custom of maintaining a 6:6 ratio of basic scientists to clinicians on the Board. Instead, a more flexible system calling for a minimum of 4 basic scientists and 4 clinicians will be used. This will encourage the selection of the best

possible representatives for service on the Board. At the same time, the Board disagreed with the concept that members of the Board represent only their society or discipline. The goal should be to develop an interaction between society representatives and Board members to ensure a broad-based consideration of faculty issues and concerns.

As part of this, Council representatives are reminded that the process of nominating Board members is open; that is, individual representatives are encouraged to contact the Nominating Committee with recommendations regarding possible Board members. The Nominating Committee will meet by conference call in late May. Representatives with suggestions for possible nominees should get in touch with a member of the Nominating Committee or send a written nomination to the CAS office at the AAMC prior to this call. Members of the 1986 CAS Nominating Committee are:

Frank Moody, chairman
Jo Ann Brasel
David Cohen
Rolla Hill
Mary Lou Pardue
Jerry Weiner
Nicholas Zervas

To provide clinical training for residents, nurses, and allied health personnel, teaching hospitals incur costs beyond those for patient care in non-teaching institutions. In the original Medicare committee report, the Congress permitted payments for housestaff as legitimate Part A Medicare expense. Under the prospective payment system, these direct medical education costs (including housestaff stipends and benefits, salaries and benefits for supervising faculty, and allocated overhead) are excluded from the calculation of the prospective rate (DRG) and are reimbursed on a passthrough basis at 100 percent of reasonable costs.

Beginning in late 1984 with a proposal by Senator Durenberger to establish a block grant system for paying these costs, the Congress has considered various legislative proposals to limit the cost of this direct medical education passthrough. These efforts culminated in the passage in December 1985 of a series of compromise provisions as part of the fiscal 1986 budget reconciliation package. A conferenced version of this bill passed the House before the end-of-the-year recess, but it was sent back to the conference committee by the Senate for reasons unrelated to the Medicare provisions.

A modified version of this bill passed the House on March 6, but still awaits Senate action. The provisions related to direct graduate medical education costs are unchanged from the bill passed in December. These provisions would replace the present cost reimbursement system for graduate medical education with a payment based on three factors:

(1) the hospital's allowable cost per resident in a base period adjusted for inflation;

(2) the hospital's number of full-time equivalent (FTE) residents; and

(3) the hospital's percentage of Medicare patient days.

To determine the allowable cost per resident, Medicare intermediaries would use the hospital's cost report for the first accounting year beginning on or after October 1, 1983, as the base period from which to begin. The intermediary would compute the allowable Medicare graduate medical education cost per FTE resident for this base period. For accounting years beginning on or after July 1, 1985, but before July 1, 1986, the hospital's allowable cost per resident would be its base period cost per resident increased by inflation plus 1 percent. For accounting years beginning on or after July 1, 1986, the allowable payment per FTE resident in the prior year would be adjusted for inflation using the Consumer Price Index.

While the allowable payment per FTE changes with the hospital's fiscal year, the count of FTE residents changes with the academic year. As a result, a hospital with a calendar fiscal year would receive payments for the first 6 months based on the number of residents in one academic

year, and payments for the second 6 months based on the number of residents in the subsequent academic year. The resident count becomes important because, beginning on July 1, 1986, Medicare will count FTE residents using a weighting system that limits support for residents and fellows in advanced training as follows:

	Weight Allowed per FTE Resident	
Type of Trainees	7/1/86 -- 6/30/87	7/1/87 -- and beyond
LCME Medical Graduate		
"initial residency period"	1.00	1.00
subsequent training years	.75	.50
Foreign Medical Graduate		
who has passed FMGEMS		
o "initial residency period"	1.00	1.00
o subsequent years	.75	.50
who has not passed FMGEMS		
o was on duty prior to 7/1/86	.50	.00
o was not on duty prior to 7/1/86	.00	.00

The term "initial residency period" is defined as the period of training required to qualify for board eligibility plus 1 year, but not to exceed a total of 5 years. An addition year also is provided for residents and fellows in geriatric medicine programs approved by the Secretary of Health and Human Services.

A related reconciliation measure would amend the Public Health Service Act to establish a Council on Graduate Medical Education. The 17-member Council would be charged to make recommendations with respect to:

(1) the supply and distribution of physicians in the United States;

(2) current and future shortages or excesses of physicians in medical and surgical specialties and subspecialties;

(3) issues relating to foreign medical school graduates;

(4) appropriate federal policies with respect to items (1), (2), and (3), including changes in the financing of undergraduate and graduate medical education programs and changes in the types of graduate medical education programs;

(5) appropriate efforts to be carried out by hospitals, medical schools, osteopathic schools, and accrediting bodies with respect to items (1), (2), and (3), including changes in undergraduate and graduate medical education programs; and

(6) deficiencies in, and needs for improvements in existing data bases concerning the supply and distribution of, and postgraduate training programs for physicians in the United States, and steps that should be taken to eliminate those deficiencies.

The AAMC Committee on Financing of Graduate Medical Education has completed its deliberations, and a copy of the draft final report, which will be reviewed by the Executive Council on April 10, is attached.

DRAFT

Draft Report

AAMC Committee on
Financing Graduate Medical Education

March 14, 1986

Chapter I.

The Need to Re-examine Current Policies

In the past few years, constraints on the general economy have brought significant changes to the health care sector. Health care expenditures now constitute nearly 11 percent of the gross national product. Businesses, insurers, and government agencies that pay for health care services have sought to constrain the amount they pay. Many corporations have expressed increasing concern over the amount of money they spend in providing health care coverage for their employees, and the effect those expenditures are having on their profitability. Government agencies, particularly federal officials and legislators responsible for expenditures under the Medicare and Medicaid programs, have become alarmed over the rapid increases in government expenditures for health care. In an era of grave concern over the national debt and with the realization that the number of Medicare eligible persons will increase significantly within a few years, the federal government has become eager to find ways to reduce the increases in health care costs.

Efforts to curb health care costs include regulation, such as price or rate setting, and enhancing price competition among health care providers. Many health care payers are currently experimenting with a variety of approaches that will allow them to spend their health care dollars "more wisely." These payers have attempted to find out precisely for what they are being charged and to restrict themselves to paying for only those goods and services they believe are necessary and reasonable for the care of the patients for whom they are responsible. They then negotiate the most favorable price they can for those goods and services.

Some payers have developed or entered into capitated arrangements for a defined set of benefits. Others have retained the more traditional fee for service model, but they have sought to change how those services are purchased by setting prices or engaging in competitive arrangements to encourage efficient, low cost delivery of services. The best known arrangement to set prices for services delivered is Medicare's Prospective Payment System which redefines the unit of service delivered as all hospital care rendered to a patient during a hospital admission and pays a fixed price based on the patient's diagnosis. Other fixed price arrangements have been established by law or negotiated by large insurers to pay for hospital care on a per case or patient day basis. In other instances, large scale purchasers of health services have been able to create preferred provider arrangements to achieve price discounts from hospitals.

A related and equally challenging recent development has been the growth of ambulatory care. As a result of new technologies and treatments, patients who previously would have been hospitalized for several days are now being cared for in a few hours in an ambulatory setting. Neither the pace of the patient-physician interaction nor the financing arrangements for ambulatory care are conducive to traditional graduate medical education experiences. Unless a means is found to support medical education in ambulatory care sites, residents will lose the opportunity to be trained to deliver care to a large and growing number of patients.

These new approaches have caused concern in the medical education community because the explicit or implicit reluctance of payers to pay for graduate medical education costs places its financing in jeopardy. This report has been developed by the AAMC's Committee on Financing Graduate Medical Education to examine current developments affecting the financing of graduate medical education and to

recommend principles and changes in current policies on financing this training. This report assumes the reader has some familiarity with the current structure and method of financing residency and fellowship training programs. Those who do not may wish to begin by reading Appendix A.

Current Policy Debate

The task facing this Committee was to identify a method of financing graduate medical education that would preserve quality educational opportunities in all medical disciplines while recognizing the financial constraints under which the hospitals must operate. The Committee believed, and continues to believe, that certain aspects of the current structure of graduate medical education must be preserved to provide appropriate educational opportunities for those who will become practicing physicians. These include:

(1.) The opportunity for every graduate of a United States' medical school to become capable of the independent practice of medicine through the successful completion of a residency program;

(2.) The assurance of quality in the training programs through the review and accreditation of programs;

(3.) The opportunity for each trainee to be exposed to an appropriate mix and number of patients to learn the type of diagnostic and therapeutic modalities used;

(4.) The ability to balance the competing demands of research, teaching, and patient care as appropriate for each institution;

(5.) The flexibility to meet the differing needs of the training programs in various specialties and subspecialties; and

(6.) The ability to choose the setting or settings for training based on the educational needs of the trainees.

To date, graduate medical education programs sponsored and conducted by teaching hospitals generally have been successful in meeting the first five goals, but have had difficulty in achieving the last goal. With the increasing use of the ambulatory care setting and with the constraints on payments to teaching hospitals, the ability of the academic medical community to continue to meet these goals and provide high quality education to trainees is at risk.

Currently, the chief means of support for graduate medical education is teaching hospital revenues derived from services provided to patients. The Committee was concerned that teaching hospital revenues in the price competitive health care market would be insufficient to sustain the current level of graduate medical education. Thus, the Committee believed the current structure of graduate medical education and the method by which it is financed had to be reconsidered. In considering what options were possible, it was important to be cognizant of those within and outside the medical education community who were advocating a change from the current dependence on teaching hospital revenues for the financing of graduate medical education. Those seeking change can be broadly classified into four groups:

- Those who believe graduate medical education is a legitimate public expense, but who believe hospital revenue should be used for patient care and not to subsidize other functions;

- Those who are supportive of graduate medical education, but wish to gain control over the number and types of physicians being trained and who believe they can achieve this goal through restructuring the financing;

- Those who simply wish to purchase quality health care for the lowest price possible and are not concerned with what elements go in to creating that price;

- Those who believe graduate medical education is a legitimate teaching hospital expense, but who believe the amount of support teaching hospitals are asked to provide must be constrained or curtailed.

While the views and objectives of these four groups differ, their simultaneous interest in changing or eliminating support for graduate medical education threatens the financial stability of residency and fellowship programs.

Debate Over Source of Funding

Some business leaders, policy makers and analysts believe graduate medical education is a function worthy of public investment; however, they do not believe it should be cross subsidized by patient care expenditures. One argument this group makes is that the public ought to be cognizant of how much it is spending on graduate medical education and should make explicit judgments regarding future expenditures in light of other demands for public funds. This philosophy was exemplified in the 1984 report of the 1982 Social Security Advisory Council which examined the future of the Medicare program. It recommended:

> In view of the financial crisis facing the Medicare program and the expanding supply of physicians and other health care professionals, the Advisory Council on Social Security believes that there is a serious question concerning the use of the Medicare Hospital Insurance trust fund for the training of physicians, nurses, and other health care professionals. The Council recognizes that the Medicare program has had a significant

impact upon the supply of health professionals by subsidizing the expense of training and medical education for these groups. However, the Council thinks that the involvement of the Medicare program in underwriting these costs is inappropriate since the program is designed to pay for medical services for the elderly, rather than to underwrite the costs of training and medical education.

The Council recognized that the extent of public support for medical education and training health professionals is a complex and difficult matter to determine and implement. The abrupt discontinuance of the use of the Medicare Hospital Insurance trust fund for medical education without an analysis of the impact upon training institutions and concomitant search for alternative public funding sources would be a disservice to the training and medical education institutions in the country and the training of prospective health care professionals. The Council believes that a study on the restructuring of medical education financing should be undertaken immediately in order to recommend another source for training support that is now being provided under the Medicare program. The Council does not intend to suggest that governmental funding for medical education is inappropriate. This study should be completed within three years under the direction of the Department of Health and Human Services.*

Another point raised by people who do not believe graduate medical education funding should be derived from patient care revenues is that such a financing mechanism constitutes a "sick tax". In other words, those who are ill pay for the education of physicians through their hospital bill, while those who are healthy have no bill to pay. Others counter this argument by noting that the vast majority of payments for hospital services comes from health insurance premiums paid by employers and employees or payroll deductions and general taxes supporting Medicare and Medicaid. Therefore, the support for graduate medical education is from payments made on behalf of both the sick and the well and is broad-based.

Control Over Production

Several key senators, congressmen, and others who have studied the current situation have suggested it is time for explicit manpower policies to ensure the training of the types of physicians needed by the public. This group points to:

*Medicare Benefits and Financing, Report of the 1982 Advisory Council on Social Security, pg. 70.

- The Graduate Medical Education Advisory Commission (GMENAC) Report which predicted an oversupply of physicians in nearly every specialty and subspecialty by 1990,

- Reports from the bureau of health manpower of the Department of Health and Human Services which predict surpluses in most specialties, and

- Reports from some state and local governments that suggest there is a geographic maldistribution of physicians such that people in some rural and inner city areas do not have adequate access to physicians, while in other areas there is an abundance of physicians. This group believes that through intervention in the funding, changes can be made in the specialty and/or geographic distribution of physicans.

Some federal policy makers have advocated changes in the Medicare and Medicaid payment systems to address these concerns. Bills were introduced in both houses of Congress that would curtail Medicare funding for graduate medical education by controlling the number and type of residents to be financed. Generally, these proposals have attempted to foster primary care training opportunities while restricting more specialized training.

In addition, some states, notably New York, Michigan, and Wisconsin have begun examinations of the numbers and types of residents being trained in the state. These are indications of a public desire for a heightened and more visible accountability of the medical education community.

Paying the Lowest Price

In the current marketplace for hospital services, many large scale purchasers are shopping on behalf of their beneficiaries for the best price for

each service. Such purchasers include HMOs, commercial insurance companies, self-insured employers, and some Medicaid plans. They may choose to purchase selected services or packages of care for patients, but they commonly make no distinction between the price they are willing to pay to a teaching hospital versus a non-teaching hospital. This group is not espousing any view with regard to if or how medical education should be funded. They are simply purchasing a service without specifying the components that go into creating that service. However, because graduate medical education adds costs to a hospital, teaching hospitals are at a disadvantage when their prices are set to recover costs. Health care payers are likely to try to encourage their patients to use less costly providers. In fact, several already have begun to use explicit and implicit means of directing patients to less costly hospitals. If this trend continues, teaching hospitals will lack the number and variety of patients needed to provide an appropriate educational experience for residents and fellows.

Constraining Teaching Hospital Investment in Graduate Medical Education

The final group is comprised of those who believe graduate medical education is a legitimate expenditure for teaching hospitals, but who believe those expenditures must be curtailed. In this group there are public policy makers, representatives of patient care payers, and medical center and hospital executives who traditionally have been supportive of graduate medical education. They have observed the growth in the number of residents trained and the extension of the length of training needed to fulfill the requirements of the various specialty boards. However, constraints on teaching hospital and insurance company income, either through regulation or competition, have prompted those in this group to doubt that the current open-ended commitment to graduate medical eduction can be sustained. Therefore, they are seeking to establish a

line of demarcation between those medical education expenses that may be funded from teaching hospital revenues and those expenses for which other sources of revenue must be found.

Many teaching hospital executives, medical school deans, faculty members and others involved in medical education have examined the current price-competitive environment and do believe that teaching hospital revenues will not be sufficient to support current commitments to graduate medical education. They believe teaching hospitals can not sustain their current commitments to graduate medical education and remain price competitive. If teaching hospitals do not remain price competitive for the provision of a wide array of patient care services, this group believes the multiple missions of the hospital will be compromised.

Summary

Concerns over the open-ended nature of the financing of graduate medical education, the inability of the public to influence the type of specialists being trained, and the appropriateness and continued viability of patient care payments as a source of financing for residency and fellowship training have all been raised previously, but usually at separate times. It is the convergence of these concerns as well as the impetus of the impending federal deficit and other general economic concerns that compels reassessment of the structure of graduate medical education financing.

Chapter II

Issues and Policy Recommendations

In the last decade, health care providers have experienced significant changes in the services they offer and in the ways in which they are organized and financed. As a result, hospitals may not provide residents adequate exposure to some types of patients nor be able to provide as much financial support as they have previously. Thus, it is the change in how health services are purchased and the growing constraints on how much purchasers are willing to pay for services that greatly concern the entire medical education community.

The AAMC's current policy on financing graduate medical education, stated in 1980 by the AAMC's Task Force on Graduate Medical Education, is:

> Graduate medical education should continue to be financed from multiple sources, with the principal source being the general operating revenues of the teaching hospitals. The financing of special educational initiatives in graduate medical education from a variety of sources should be encouraged. These initiatives include programs in new and developing specialties, programs to achieve local and regional objectives, and programs to prepare clinical investigators and medical educators. Special initiatives should be supported through grants from private, voluntary agencies and from federal and state governments.

This policy was consistent with then existing congressional intent for Medicare and the payment practices of other payers. However, the rapid changes in the financing of hospital care since 1980 and the refocusing of congressional intent for Medicare have caused the AAMC leadership and many of its members to question whether this policy will be realistic in the future.

In the face of growing price sensitivity within the health care market and the strength of the wide-spread perception that the current level of financial commitment to education can not be sustained by the teaching hospitals, acceptable alternatives for financing graduate medical education need to be found. The following key policy questions have become the focus of debates.

- o If teaching hospitals' revenues are, or will soon be, inadequate to provide sufficient support for residency training, what policy options are available for the medical education community?
  - What would happen if no explicit changes were made in the current system of financing graduate medical education?
  - What would happen if the current system were radically changed to fund graduate medical education out of a single national fund or a series of state funds?
  - Can modifications be made to the current methods of financing graduate medical education that will enable the teaching hospital to be competitive while maintaining the stability of the educational program?

Each of the three options - make no change, change to a single source of funding, and modify the current structure - must be considered, and the benefits and risks associated with each identified and assessed.

The financing of GME through patient care revenues has admirably served the purposes of society, teaching hospitals, and physicians-in-training for decades. If residency training could continue to rely substantially on hospital patient

care revenues for support, many of its advantages would be retained. These advantages include the freedom of medical students to choose the program in which they wish to train; the ability of teaching hospitals to offer a variety of training programs appropriate to their missions, the patient population they serve, and the faculty on their medical staff; and, the ability of training programs to be designed to meet perceived needs for physicians.

However, the risk of continued reliance on patient revenues in the price-competitive market is that the revenues probably will be insufficient to sustain current hospital investments in graduate medical education. Payers may reduce or totally withdraw their explicit or implicit support of graduate medical education. Medical education will become another priority in a series of competing priorities in which hospitals may invest. As such, hospitals may choose to limit their investments in medical education to support only those programs and trainees that are commensurate with the hospitals' goals. That is, hospitals might choose to invest in programs and trainees that augment, or at least do not diminish, their ability to generate revenues. For example, hospitals might seek to have residents and fellows near the culmination of their training while avoiding those in their initial years of training because they are "inefficient."

Another option for hospitals seeking to limit their investments in medical education would be to reduce the support for faculty and other related costs of the educational programs. In some institutions, reductions in the support for faculty would seriously damage the quality of the training. The residents and fellows might receive inadequate instruction and supervision in the treatment of patients.

A single national fund for graduate medical education would provide comprehensive funding, would avoid conflicting manpower policies that may be exhibited by the various payers in different states, and would permit financing of training in patient care sites that are not hospital-based. However, residency training would be dependent on a single source of revenue, and it would be one of many competing priorities in the annual debate over the Federal budget. Currently, the impact of federal policy changes for Medicare and Medicaid payment of graduate medical education may be somewhat buffered because other hospital payers may not act simultaneously and may choose other funding strategies. However, if a single national fund for graduate medical education were created, no such buffer would exist. This might result in fiscal instability for training programs. It is highly likely that the accompanying regulations would not only determine how the proceeds of the fund would be distributed but also lead extensive intervention in medical education, including a determination of the number of each type of specialty to be trained, the location in which the training would take place, and the amount that could be paid for stipends, faculty salaries, and the other components of training costs. In 1985, legislative and regulatory proposals were introduced* to attempt to influence these aspects of medical education, even though the federal government currently controls only Medicare and Medicaid payments. If the federal government controlled all expenditures on graduate medical education, such intervention would be more likely to be adopted.

*For example, Congressman Waxman introduced a bill H.R.____ that would have paid more for residents in the primary care specialties than in the non-primary care specialties in an attempt to influence specialty distribution. Senatory Quayle introduced a bill (S. 1210) that would have empowered a Council on Graduate Medical Education to determine the appropriate mix of primary care versus non-primary care specialists to be trained in a hospital or a group of hospitals affiliated with a medical school.

Another approach to this option could be to establish state controlled funds to provide comprehensive funding for graduate medical education. State control over the number and types of graduate physicians trained could result in conflicting health manpower planning decisions by failing to recognize the interstate migration of students and practitioners. Just as with the national fund, each state fund would have to compete annually with other expenditure priorities. Additionally, given the distribution of residents depicted in Table 9, it would result in very different financial burdens for some states.

The third option is to modify the current reliance on the teaching hospital to support such a large proportion of graduate medical education. This would allow teaching hospitals to be more competitive in the price conscious patient care market while preserving many of the current benefits of the educational structure. The disadvantage to this option is that there are no guarantees that teaching hospitals will be able to sustain even a modified commitment to medical education in light of the price competition and other drains on hospital revenue. Additionally, if a limit is established on what support may be expected from teaching hospital revenues, it will be necessary to eliminate some trainees, programs, or portions of faculty support or to find other sources of support.

The AAMC Committee on Financing Graduate Medical Education concludes that price competition and other changes in hospital payments are likely to reduce the amount of support teaching hospitals can provide for graduate medical education. It believes that if the representatives of the medical education community do not specify how teaching hospital payments for medical education reasonably can be curtailed, then individual teaching hospitals may act in their own best interests which may not be commensurate with the provision of quality educational experiences in all physician specialties and subspecialties. Therefore the

Committee believes some change from the current financing system should be made. Presently, the full effects of the current environment on the teaching hospitals' ability to support graduate medical education are not known; but they do not appear to warrant acceptance of the disadvantages of a single national fund would impose. The Committee believes the problems associated with such a fund currently outweigh the benefits it might offer. A discussion of this option is provided in Appendix B. The Committee therefore urges the AAMC to continue its long-standing policy that residency training should be supported from a variety of sources with the principal source being the revenues of teaching hospitals, but with substantial modifications to the current structure of graduate medical education financing. It recommends:

(1.) TEACHING HOSPITAL REVENUES FROM PATIENT CARE PAYERS SHOULD CONTINUE TO BE THE PRINCIPAL SOURCE OF SUPPORT FOR GRADUATE MEDICAL EDUCATION, BUT THAT MODIFICATIONS BE MADE IN WHAT THEY ARE EXPECTED TO FUND.

Obligations of Society and Educators

It is important that there be stability in the funding provided for graduate medical education programs. In order for there to be stability, society must understand why support for graduate medical education is in its best interest and must encourage health care payers and other sources to act as it agents in providing appropriate support. Medical educators should help society understand why its interests will be served by providing stable and adequate funding.

American society is, and should continue to be, willing to provide support for graduate medical education because it needs fully trained physicians to meet its health care needs. Medical school alone does not provide sufficient clinical

training for the independent practice of medicine. In the past five years, the AAMC has completed comprehensive reviews of undergraduate and graduate medical education.* Both studies recognized that medical schools provide the general professional education which is the foundation of all medical practice, and residency training provides the formal clinical education that develops the skill and experience necessary for independent practice. Since graduate medical education is necessary to the preparation of a fully trained physician, it is a public service. Thus, the public should be willing to provide support. Additionally, it should be recognized that society has been providing support for residency training virtually since its inception. Through this support, medical educators have developed an educational system that is unsurpassed in the world. American society continues to need these highly skilled, highly trained physicians to provide care of the quality it has come to expect.

Quality programs are developed and maintained across many years by attracting high quality faculty members to teach and practice in the educational setting and by providing those faculty members with the technology, space and staff needed to provide appropriate care, work with residents and medical students, and explore ways in which medical care may be enhanced. Commitments to such faculty members both for their own compensation and for the provision of the necessary technology and staff are made only when the teaching hospital can be assured of some degree of predictability about its own funding. Substantial fluctuations in the way in which payment is made for graduate medical education will preclude hospitals from making this commitment and may force faculty members to re-evaluate their commitment to teaching hospitals. Therefore, the public

*Physicians for the Twenty-First Century: The GPEP Report published by the AAMC in 1984 and Graduate Medical Education: Proposals for the Eighties, the report of the AAMC Task Force on Graduate Medical Education published in the Journal of Medical Education, Vol. No. 9, September, 1981.

benefits from stable and adequate support for graduate medical education. The Committee believes that on behalf of the public:

(2.) ALL HEALTH CARE PAYERS, INCLUDING MEDICARE, SHOULD CONTINUE TO PROVIDE THEIR APPROPRIATE SHARE OF SUPPORT FOR GRADUATE MEDICAL EDUCATION. MEDICARE MAY BE A KEYSTONE IN ASSURING THIS SUPPORT SINCE MEDICARE POLICIES ARE DETERMINED BY CONGRESS AND THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, BODIES WHICH ARE SUPPOSED TO THE GUARD THE PUBLIC INTEREST.

(3.) IN ADDITION TO PATIENT CARE PAYERS, OTHER SOURCES CURRENTLY PROVIDING FUNDS FOR HEALTH CARE TRAINING NEED TO CONTINUE TO PARTICIPATE IN FUNDING RESIDENCY TRAINING, OR, IN FACT, MAY BE CALLED UPON TO PROVIDE GREATER SUPPORT IN THE FUTURE. THESE OTHER SOURCES INCLUDE STATE AND LOCAL GOVERNMENTS, SPECIAL PURPOSE FEDERAL GOVERNMENT PROGRAMS, AND PRIVATE ORGANIZATIONS THAT PROVIDE SUPPORT TO MEET SPECIFIC NEEDS.

While the Committee believes the most appropriate approach is to rely on payers to provide the majority of funding for graduate medical education, and calls upon all payers to share in the costs of residency training, it recognizes that all payers may not subordinate their economic self interest to provide sufficient funding for graduate medical education. As a result, the revenue base for residency training may be incomplete and constantly in flux.

The Committee believes public support and continued financing can best be assured if the medical education community acknowledges that it has an obligation to society to provide residency training that meets the needs of society. First, medical educators must provide quality training so that residents are capable of independent practice upon completion of their training. Secondly, medical

educators must provide the type of specialists that will be needed by society. The open ended nature of the size and length of training programs and the institutional autonomy in controlling training programs must be reassessed in terms of current fiscal constraints and societal needs. Thirdly, the institutions receiving these funds must recognize their obligation to ensure that the training is conducted as efficiently as possible. Currently, housestaff make a contribution to the support of their education by working long hours participating in the provision of patient care services.

In recognition of the responsibilities concommitant with societal support, the Committee recommends:

(4.) THE MEDICAL EDUCATION COMMUNITY SHOULD CONTINUE TO MONITOR THE QUALITY OF ITS RESIDENCY TRAINING AND PROVIDE ASSURANCES THAT GRADUATES OF ITS RESIDENCY PROGRAMS ARE ADEQUATELY PREPARED FOR PRACTICE.

(5.) THE INSTITUTIONS RECEIVING FUNDING SHOULD RECOGNIZE THEIR OBLIGATIONS TO TRAIN THE TYPES OF PHYSICIANS NEEDED BY SOCIETY.

(6.) THESE INSTITUTIONS ALSO MUST RECOGNIZE THEIR OBLIGATION TO OPERATE THE TRAINING PROGRAMS IN A COST-EFFECTIVE MANNER.

Subsequent recommendations of the Committee will address possible limitations in teaching hospital support, the open-ended nature of the training programs, explicit mechanisms for providing quality assurances and alternate sources of funds.

Chapter III.

General Funding Principles

The Committee believes that future policies on funding graduate medical education should be based on the general principles articulated below. The recommended principles cover the criteria for training and programs that would qualify for funding, the way in which initial and advanced residency training periods should be funded, the means for monitoring the supply of physicians, the opportunities and responsibilities for other medical systems such as the Veterans Administration, and transition issues.

Quality Assurances

Because societal support for graduate medical education is based on the need to train competent clinicians, society is entitled to assurances that the programs it funds provide quality training. Society's support should be contingent upon a requirement that the trainees funded are in programs that at least meet the qualifications that ensure the physicians will be adequately prepared to practice medicine in the field they have chosen.

The medical school experience provides both the basic science and the initial clinical experience necessary as a foundation for the residency training. The Liaison Committe on Medical Education and the American Osteopathic Association accredit medical schools based on a series of criteria established to ensure that medical students are afforded appropriate educational experiences. Accreditation provides assurances that the medical school is preparing its graduates to accept responsibilities of a residency training program as conducted here in the United States. Some foreign medical schools may provide excellent

training for the practice of medicine, but there is no objective review process by which these schools can be distinguished from the others that provide training of questionable quality. Additionally, there is sufficient capacity within the United States' medical schools to train enough physicians to fulfill the health care needs of the American public. Table 10 shows the growth in the capacity of U.S. medical schools since 1954. Therefore, the Committee recommends:

(7.) FUNDING FOR GRADUATE MEDICAL EDUCATION SHOULD BE LIMITED TO GRADUATES OF MEDICAL SCHOOLS APPROVED BY THE LIAISON COMMITTEE ON MEDICAL EDUCATION OR THE AMERICAN OSTEOPATHIC ASSOCIATION.

Accreditation by the Accreditation Council for Graduate Medical Education or the AOA provides assurances that the residency training programs society is supporting are of high quality. They ensure that the residents receive appropriate and adequate supervision and education so that upon completion of the program they may practice independently. Thus, the Committee recommends:

(8.) ONLY RESIDENTS IN PROGRAMS APPROVED BY THE ACCREDITATION COUNCIL ON GRADUATE MEDICAL EDUCATION OR THE AMERICAN OSTEOPATHIC ASSOCIATION'S COMMITTEE ON MEDICAL EDUCATION SHOULD BE FUNDED.

The Committee also believes program accreditation and health manpower planning should be separate activities. The ACGME and the AOA should approve all residency training programs that meet the established criteria. The ACGME and AOA should not be asked to implement health manpower planning objectives by limiting the number of programs granted approval to train residents. The Committee recommends:

(9.) THE ACGME AND THE AOA SHOULD ACCREDIT PROGRAMS SOLELY ON THE BASIS OF WHETHER THE PROGRAMS MEET THE EDUCATIONAL CRITERIA ESTABLISHED.

Each resident graduating from an accredited school needs to complete residency training before independent practice, and sufficient residency positions should be funded so that each graduate has this opportunity. Thus, the Committee recommends:

(10.) FUNDED TRAINING OPPORTUNITIES IN RESIDENCY PROGRAMS SHOULD BE SUFFICIENT TO ENABLE ALL GRADUATES OF LCME OR AOA APPROVED SCHOOLS OF MEDICINE TO ENROLL IN AN ACGME OR AOA APPROVED RESIDENCY TRAINING PROGRAM.

In making this recommendation, the Committee was concerned that if funding for residency positions was severely constrained or if explicit manpower restrictions regarding the number of residency positions were adopted, the number of available residency positons might decrease to a point where graduates of LCME or AOA accredited medical schools might be unable to enter graduate training. The Committee believes it is inappropriate to eliminate a student's opportunity to train midway through the educational process needed for the independent practice of medicine. Once a student has entered medical school and as long as the student meets or exceeds all of the standards for attainment of skills and knowledge, the Committee believes the student should have the opportunity to complete sufficient residency training to practice independently in their specialty.

Funding of Residents Through Teaching Hospital Revenue

As noted in the preceding chapter, the ability of teaching hospitals to fund residency training programs is diminishing as price competition intensifies. Reasonable options for limiting the amount of training that is expected to be funded from this source must be identified.

Several options for limiting the funding to be derived from teaching hospital revenues were considered by the Committee including approaches that would fund all residents for a set length of time (e.g., 3 years, 3.5 years, or 4 years); options that would fix the amount of money to be spent; and options that establish the number of residents and fellows to be trained in each specialty and subspecialty. The Committee concluded that to meet society's expectations, residency education must be supported by payments to teaching hospitals by patient care payers at least until the trainees are eligible for their primary specialty board.

Residents were identified as being capable of the independent practice of medicine if they had completed enough formal training to be eligible to sit for first board certification in their chosen specialty field. The specialty board for each specialty determines the length of training necessary for competent practitioners in their field. These decisions are codified in the "Essentials of Accredited Residency Training" which are published in the 1985-1986 Directory of Residency Training Programs. Thus, the Committee believes residents should be supported primarily by general hospital revenues which are either explicitly paid to support graduate medical education or implicitly included in the price an insurer is willing to pay at least until they have completed sufficient training to be eligible to become board certified in their discipline.

The Committee recommends:

(11.) RESIDENTS IN APPROVED-TRAINING PROGRAMS SHOULD BE FUNDED LARGELY BY PAYMENTS TO TEACHING HOSPITALS BY PATIENT CARE PAYERS AT LEAST THROUGH THE NUMBER OF YEARS REQUIRED TO ACHIEVE INITIAL BOARD ELIGIBILITY IN THEIR CHOSEN DISCIPLINE.

In making this recommendation, the Committee recognizes that the various specialties have structured their training programs differently. For example, in internal medicine, residents must generally complete a three year internal medicine residency before entering subspecialty training. In surgery, residents are allowed to enter some specialized surgical programs and complete them within the same time period required for a resident in general surgery. Similar differences are present in other specialties. As a result of the differences in the structures of training programs, specialties would be affected differently if the proposal were limited to support residents solely through initial board eligibility.

The Committee was concerned that the fiscal stability of fellowship programs that provide the training for those who want to practice in the subspecialties or who wish to become academic physicians would be unduly jeopardized if no support were provided from teaching hospital revenues. In reaching this conclusion, the Committee was aware that the majority of those enrolled in fellowship programs have completed residency training in internal medicine and that a recent study by Schleiter and Tarlov* found that only two-fifths of fellowship funding for the subspecialties of internal medicine are supported by non-federal hospital revenues. However, the extent to which hospital revenues provide support for particular programs differs greatly across hospitals. The fellows in some programs are funded almost completely out of teaching hospital revenues. In other programs, the support comes largely from a combination of research and

training grants and physician fees. A third group of programs has a mixture of revenue sources. This disparity means that some programs would be greatly affected by the sudden elimination of hospital revenues as a source of funding. Therefore, the Committee recommends:

(12.) ONE ADDITIONAL YEAR OF FUNDING BEYOND INITIAL BOARD ELIGIBILITY SHOULD BE PROVIDED FROM TEACHING HOSPITAL REVENUES FOR FELLOWS IN ACCREDITED TRAINING PROGRAMS TO THE EXTENT THAT THE HOSPITAL FUNDED SUCH TRAINING IN 1984.

The Committee has recommened restricting the extension of fellowship funding to one year as a means of balancing the needs of the hospitals to reduce expenditures on graduate medical education with the need for adequate support for training programs that provide skilled practitioners in all of the subspecialties as well as the specialties. In recognition of the fact that hospital patient care payers are unlikely to be willing to spend more in the aggregate on gradute medical education than they do now, the Committee recommended the reliance on teaching hospital revenues as a source of fellowship support be limited to the hospital's current level of fellowship support. By this, the Committee does not intend to suggest a freeze in the dollars of support provided. Instead, the Committee intends that the proportion of support provided from the teaching hospital should not increase.

To be responsive to the concerns of society and the teaching hospitals over the length of training to be supported, the Committee believed it was necessary to establish a limit on the maximum number of years to be supported for an individual resident. The Committee recommends:

(13.) AN INDIVIDUAL SHOULD BE SUPPORTED FROM PATIENT CARE PAYERS' PAYMENTS TO TEACHING HOSPITALS FOR A MAXIMUM OF SIX YEARS OF GRADUATE MEDICAL EDUCATION.

This recommendation would mean that residents in thoracic surgery, which requires seven years of formal training, would not be funded by the hospital in the final year of training. Also, residents that change specialties after completing some portion of their initial training may reach the six year limit.

As another expression of the medical education community's accountability to the American public, the Committee believes that any increase in the required training periods deemed necessary by the specialty boards should be made only after full deliberation and public consideration of the educational needs and the additional costs attributable to the extension of the required training period. In 1984, the president of the AAMC wrote the executive vice president of the American Board of Medical Specialties (ABMS) stating:

> The AAMC believes that the time has come when the ABMS must extend its role beyond simply coordinating the activities of its members and assume the power to approve or reject changes that are proposed in educational requirements. We believe that this is essential to avoid conflicts among member boards and between boards and the institutions and organizations that provide the resources for graduate medical education in the United States. Accordingly, the AAMC requests that Section 12.4 of the by-laws of the ABMS be amended as shown (below).

(a) Primary and Conjoint Boards have the responsibilty of establishing their own educational requirements for certification and may change such requirements. Changes that alter the resources that must be provided by teaching hospitals for their graduate programs or changes that impinge on the resources of educational programs in other specialties shall be submitted to the ABMS for approval prior to their implementation. Specifically, changes that lengthen the duration of training or that require a portion of the training period to be spent in an accredited program of another specialty shall be submitted for approval.

The ABMS discussed and tabled the AAMC's recommended change. The Committee believes it is time for the issue to be reconsidered.

Other Sources of Revenue for Advanced Training

The advanced training of subspecialists is vital and appropriate. Advanced clinical training must be supported if the American public is to have physicians competent in cardiology, endocrinology, pediatric surgery, and a host of other medical fields. However, unlike the training required to reach initial board eligiblity, advanced clinical training is not necessary for a physician to enter the independent to practice of medicine. Those involved in graduate medical education should not expect payers to augment teaching hospitals payments to recognize the costs of subspecialty or other advanced training beyond the year of funding provided for fellowship training in those hospitals that currently are supporting this training. If they choose, hospitals could use their general revenues to support the second or third year of training of subspecialists. In addition, continued funding of some particular subset of the subspecialists may

be in the public interest and unlikely to occur without explicit public support. In such instances, government or public intercession is necessary. Examples of such programs may include training in public health and preventive medicine or the new and developing field of geriatrics.

Other advanced residency training programs may reflect personal and professional goals which individuals should pursue and support on their own. Institutions or physician groups may also perceive the presence of advanced fellows to be in their best interest. They may be willing to support the advanced training of fellows in order to have those individuals available to provide services in the institution or in their practice setting. Thus, training for practice in the subspecialty areas of medicine and surgery would be funded in a similar manner to the way other professionals are trained to achieve full recognition in their professions. The Committee recommends:

(14.) BEYOND THE FIRST YEAR OF FELLOWSHIP TRAINING, CLINICAL TRAINING FOR FELLOWS SHOULD INCREASINGLY BE SUPPORTED BY GOVERNMENT OR CORPORATE GRANTS, PHYSICIAN PRACTICE INCOME, PRIVATE PHILANTHROPY, AND OTHER SOURCES.

Monitoring Physician Supply

An area of particular concern to the Committee is that of physicians in advanced training for specialties in which there is a physician shortage. Under the current unrestricted financing structure, it generally is not the lack of funding that deters residents from electing to train in these specialties. However, to the extent that training in these specialties extends beyond the period recommended for support from teaching hospital revenues, the reduced financing would further diminish the attractiveness of these programs. There are

two problems associated with these specialty shortage areas: (1.) how to identify them, and (2.) how to provide sufficient funding for them. Identifying shortage areas can be accomplished within the broader context of examining physician distribution in general.

One means of monitoring the supply of physicians by specialty would be the establishment of a private sector effort to collect data on the supply of physicians in general and of each type of specialist in particular. While this effort would only collect and disseminate data regarding the supply of physicians, it may be influential in convincing hospitals not to offer and residents not to enter oversubscribed specialties and instead to seek to practice in the shortage areas. Thus, the Committee recommends:

(15.) A COORDINATED, NATIONWIDE, PRIVATE SECTOR EFFORT SHOULD BE MADE TO COLLECT AND DISSEMINATE INFORMATION ON THE SUPPLY OF PHYSICIANS BY SPECIALTY.

Ideally, this data collection effort would be non-governmental; that is, it would be conducted by an organization from the health care provider sector. If possible, it should obtain its funding from the private sector as well.

The data may be useful in helping to identify potential shortage specialties. Once these areas have been identified, the use of positive incentives by public or private organizations to encourage providers to offer more of a particular type of training position or to encourage more trainees to enter training programs in undersubscribed specialties would be justifiable. The incentives offered might include payment bonuses to providers for the training of residents in the shortage specialities, and to the residents who would enter the

undersubscribed specialties, or the enhancement of the opportunities available in the practice of medicine in the specialty after post-graduate training.

In influencing the trainee to select certain specialties, it must be recognized that a number of factors will affect specialty choice. One of those factors is likely to be fees paid to the fully trained physicians who practice in that specialty. Unless physician payments support the desired manpower mix it is unlikely the mix will be attained.

In addition to shortages in particular specialty fields, there may be shortages of physicians willing to pursue certain types of careers, such as those who would wish to become physician investigators and faculty members. The resources necessary to complete the research portion of the training of future academicians and investigators have come from a mixture of federal and private research training grants, endowments and gifts. The clinical portion of the advanced training has been supplied by a mixture of hospital and physician patient care revenues as well as private grants. Currently NIH research training grants are not used to support clinical training and it would require a major policy change to accomplish this. New approaches to funding the clinical training of future investigators will be needed if governmental and charitable programs must replace hospital revenues for such support in the future.

It is important to remember that the future service needs of the American population and the treatment capabilities that will be available during the next decade cannot be precisely predicted. Using the data collected through this private sector effort to determine which residency training programs to fund in the future would be inappropriate.

Support of Training in New Practice Areas

Current payment mechanisms for graduate medical education are more supportive of training in the inpatient hospital setting than of the training in ambulatory care sites or other alternate care settings. Increasingly, care that was in a hospital inpatient setting is now being moved to ambulatory surgery centers, clinics, and other alternate settings. Health maintenance organizations and other forms of managed care are growing rapidly, and public interest has been expressed in promoting non-hospital care. If physicians are to practice appropriately in these settings, it is important for them to be trained in similar settings. Changes are needed to ensure that the training site chosen by the residency program directors are chosen because they offer appropriate educational opportunities, not because they are more easily funded. Therefore, the Committee recommends:

(16.) THE FUNDING FOR GRADUATE MEDICAL EDUCATION MUST SUPPORT THE RESIDENTS AND INSTITUTIONS IN AMBULATORY AND INPATIENT TRAINING SITES THAT ARE MOST APPROPRIATE FOR THE EDUCATIONAL NEEDS OF THE TRAINEES.

The most appropriate method for funding these ambulatory care training sites has not yet been identified. Family practice training programs housed in model practice clinics currently are allowed to bill on behalf of the residents for services provided, and this arrangement has provided substantial support for these programs. Another option might be to require a linkage between the ambulatory training site and a teaching hospital and channel the funding for the ambulatory site through the hospital. Other creative options need to be developed and explored to assure adequate opportunities for ambulatory training.

Since current payment sources do not achieve the objective expressed in the Committee's recommendation, supplemental funds should be made available from government and private sources as needed to promote training opportunities

available in HMOs, ambulatory surgical centers, and other non-hospital sites. Currently, federal and state governments fund some initiatives in ambulatory and primary care training through grant programs such as that enacted under Title VII of the Public Health Service Act. These initiatives may need to be augmented in light of the increasing price sensitivity of the health care market.

The Veterans Administration and the Department of Defense

By operating health care programs which include hospitals, rehabilitation centers, and ambulatory care centers, the Veterans Administration and the Department of Defense are major providers and payers of patient care services. In this dual role, they have provided important sites for the training of residents and the funding for that training as well. The need of the Veterans Administration and the Department of Defense for adequately trained physicians to serve their patient population has not diminished, and by all predictions, will grow in the next several years. As representatives of one sector of the society that will continue to need increasing amounts of health care services, the Veterans Administration and the Department of Defense should continue their support of residency training. It must be recognized that the VA and DOD have unique service needs and must provide the training sites and funding for physicians to meet these needs in the future. Such needs will certainly include physicians experienced in physical and rehabilitation medicine, orthopedics, trauma surgery, and geriatric care. Thus, the Committee recommends:

(17.) THE VETERANS ADMINISTRATION AND THE DEPARTMENT OF DEFENSE SHOULD CONTINUE THEIR SUPPORT OF RESIDENCY TRAINING, PARTICULARLY PROVIDING SUPPORT FOR THE EDUCATION OF PHYSICIANS TO MEET THE SPECIAL SERVICE NEEDS OF VETERANS AND ARMED FORCES PERSONNEL.

Other Health Care Delivery Systems

Other providers who operate health care delivery services that are not dependent on revenues for services rendered to individual patients may also have unique patient care service needs. For example, the Shriners may have particular needs for physicians experienced in burn care or orthopedics to provide care for the unique patient population seen in their hospitals. These providers may also be called upon to provide both the site and support necessary for the training of physicians who will provide care for their unique patient population. Therefore, the Committee recommends:

(18.) OTHER PROVIDERS OF SERVICE THAT ARE NOT TYPICALLY AMONG THOSE RECEIVING DIRECT PAYMENT FOR SERVICES RENDERED TO INDIVIDUAL PATIENTS SHOULD CONTINUE THEIR SUPPORT OF GRADUATE MEDICAL EDUCATION, PARTICULARLY FOR THOSE SPECIALTIES NEEDED FOR THEIR UNIQUE PATIENT POPULATIONS.

Transition for Foreign Medical Graduates

The Committee has recommended that only graduates of LCME or AOA approved schools be funded. In making this recommendation, it recognizes that a number of hospitals have large numbers of foreign medical graduates in their training programs and depend on these FMGs to provide a significant amount of their patient care services. To allow these hospitals sufficient time to develop alternate strategies to provide this care, the Committee believes funding for FMGs should be phased-out over a three year period. Additionally, to respect the commitments made to residents currently in training, funding should be provided for any resident currently enrolled in a training program until the training requirements of that program have been met.

The withdrawal of patient care support for foreign medical graduates does not mean that all foreign medical students should be precluded from training in American hospitals. There are public policy reasons why the United States may wish to support the education of a limited number of alien foreign medical graduates. For example, the United States may wish to train physicians from developing nations, who will return to their native land. Special purpose funds should be made available for the training of these physicians, but only if their training is requested by the government or their educational institution. The requesting government or educational institutions would be responsible for guaranteeing that there are positions available to the trainees upon return to their native countries.

Appendix A

THE STRUCTURE OF GRADUATE MEDICAL EDUCATION AND ITS FINANCING

Graduate medical education describes the period of formal education in clinical practice that begins with graduation from medical school and ends with the fulfillment of the requirements for certification in specialty or subspecialty practice. This training, which varies from three to seven years, traditionally takes place in "teaching hospitals." Trainees in programs leading to eligibility for initial board certification are generally called "resident physicians" or, more concisely, "residents." Trainees who complete residency training and enroll in subsequent programs leading to a certificate of special competence are generally called "clinical fellows" or simply "fellows."

Each specialty has a formally organized board that establishes the minimum length of time to be spent in training (Table 1) and the other criteria a resident must fulfill to be eligible for certification. The 23 certifying boards are autonomous, but they consult with each other and exchange information under the auspices of the American Board of Medical Specialties (ABMS). The certifying boards work to achieve high standards for specialty practice and to improve the quality of graduate medical education.

Certificates of special competence are granted to recognize proficiency in subspecialty fields by ten of the specialty boards. There are eleven subspecialty fields in internal medicine for which certificates are granted, nine in pathology, six in pediatrics, four in obstetrics and gynecology, three in surgery, two in psychiatry and neurology, one each in allergy and immunology, anesthesiology, dermatology, and radiology. (Table 2)

In addition to the ABMS and its specialty certifying boards, a variety of professional societies influence graduate medical education. The Council of Medical Specialty Societies has as members major specialty colleges and academies. Each of these colleges and academies has a close relationship with its respective specialty board, and several name representatives to their respective boards.

In 1972, the Liaison Committee on Graduate Medical Education (LCGME) was established to accredit graduate medical education programs. It was sponsored by the Association of American Medical Colleges, the American Board of Medical Specialties, the American Hospital Association, the American Medical Association, and the Council of Medical Specialty Societies. In 1981 the LCGME was reorganized and renamed the Accreditation Council for Graduate Medical Education (ACGME). The ACGME relies on residency review committees (RRCs) to perform the actual review of each training program. A residency review committee consists of representatives from the specialty appointed by the AMA, the appropriate specialty board, and, in some cases, a national specialty society. Residency programs are accredited either by the ACGME upon recommendation of the RRC or by the RRC itself if the ACGME has delegated authority to it.

Thus, a large number of professional organizations are involved in graduate medical education to provide control over the quality of the training and to assure that those completing training programs are capable of practicing safely and efffectively.

The Financing of Graduate Medical Education

Sponsors of graduate medical education incur real and significant costs in providing these programs. There are "direct" costs consisting of stipends and

fringe benefits for residents, faculty salaries, institutional space and facilities devoted to education, and allocated overhead. There are also "indirect" costs for medical education. These include the processing of additional diagnostic tests and the reduced pace at which members of the hospital staff function because they are helping to educate the residents. The inability to separate clearly clinical care from clinical education makes agreement on the determination of educational costs virtually impossible. Any attempt to distribute the costs of joint products simultaneously produced cannot be done objectively, but only subjectively. Differences in the assumptions made by the subjective assessments probably explain the differences in the outcomes of various studies attempting to estimate the costs of graduate medical education.*

While there have been studies of graduate medical education costs,* no widely accepted measure of either the indirect cost or the benefit from the trainee's service is available. With regard to direct costs, data on the costs of faculty and space also are not available; however, the costs of stipends and benefits for the housestaff are collected for members of the Council of Teaching Hospitals in an annual survey.* Using these data, it is estimated that current annual expenditures on housestaff stipends and benefits amount to $2 billion.

There are no comprehensive data on the sources of funding for graduate medical education costs. However, the Council of Teaching Hospitals' survey on housestaff stipends asks for sources of funding for stipend and benefit expenditures, and these data provide some indication of the sources of funding for support of all residency training. Residents' stipends, according to the survey, are funded from a variety of sources, but primarily from patient care revenues of teaching hospitals (Table 3). Patient care revenues in non-federal members of the Council of Teaching Hospitals account for approximately

four-fifths of the support for residency training. Another six percent of the funding comes from state or local governments, and the remaining 14 percent from a diverse group of sponsors.

According to the data from the COTH survey, three-fifths of the support for clinical fellows in non-federal hospitals is derived from hospital patient care revenues. Other significant support for fellows comes from physician fee revenues, NIH grants, foundation grants and voluntary agencies. These survey results do not include the Veterans Administration hospitals. The survey may underestimate the role of the non-hospital sources because only fellows for whom the hospital keeps financial records are reported. Fellows engaged in research activities in non-hospital settings or whose funding is not administered by the hospital may not be included. Schleiter and Tarlov* have reported more refined and specific data for fellowship programs in internal medicine that show 39 percent of the funding comes from non-federal hospital revenues (Table 4), 20 percent from the Veterans Administration and military, 11 percent from federal grants and 8 percent from physician fees. The remaining funds come from an assortment of sources, none of which contributes more than 6 percent.

Using federal data, the Committee estimates that roughly $3 billion were provided from teaching hospital patient care revenues for the support of the direct costs of graduate medical education last year, with Medicare providing just over $1 billion. Medicare pays for its portion of the direct costs on a cost reimbursed basis; that is, hospitals compute the sum of their total direct medical education costs and determine Medicare's prorated portion of those costs based on the ratio of Medicare days to total patient days. Some Medicaid programs and some Blue Cross programs also provide explicit cost-based funding for residency training. However, most other patient care payers provide funding

for graduate medical education only because such costs are included in the hospital's charges. Notably, the states that have developed "all payer rate" setting programs have included the costs of graduate medical education in approved hospital payments.

As changes are considered in the current method of financing graduate medical education, it is important to be cognizant of characteristics of graduate medical education which may determine how particular hospitals and residents are affected by the changes. Residents and the institutions in which they train differ along a variety of important dimensions.

Variations in Resident Characteristics

Nearly 85 percent of the first year residency positions were filled by graduates of American medical schools as of September 1, 1984*. The remaining 15 percent of residents in their first year of training were graduates of foreign medical schools (FMGs). Almost 18 percent of all the residents in training were from foreign medical schools (Table 5). The percentage of FMGs in residency training peaked during the mid-seventies at approximately 30 percent.

Foreign medical graduates come from a variety of schools to enter residency positions in the United States. In recent years, a large proportion have come from the medical schools located in the Caribbean and Mexico. Concern about the quality of the medical education provided in many of the Caribbean schools was raised by the 1980 General Accounting Office (GAO) study, "Policies on U.S. Citizens Studying Medicine Abroad Need Review and Reappraisal" and by the 1985 GAO study, "Federal, State, and Private Activities Pertaining to U.S. Graduates of Foreign Medical Schools."

Another dimension along which medical students vary is educational debt. The most recent data from the AAMC Medical School Graduation Questionnaire* show that upon graduation from a U.S. medical school, eighty-seven percent of the graduates have debt, and the average size of the debt is $29,943. Nearly thirteen percent of the graduates have debt in excess of $50,000. The prospect of decreasing physician income coupled with the growing substantial debt would make it difficult for residents to finance their training with additional borrowing.

Variation by Type of Training Program

While there are many speciality training choices for residents, the greatest percentages of residents on duty in September of 1984 were in internal medicine (24.4%), general surgery (11.0%), family practice (9.9%), pediatrics (8.1%), and obstetrics and gynecology (6.2%) training programs. Thus, these five programs account for approximately 60% of all residents.

During current discussions of graduate medical education, the term "primary care residency programs" has been usually used to identify residents in internal medicine, pediatrics, and family practice. In 1984, there were 31,600 residents in these programs, and they were 42.4% of all residents. In some analyses, ob/gyn residents are considered primary care trainees. In 1984, when 6.2% of the residents were in ob/gyn, the inclusion of this specialty would mean that 48.6% of all residents were in primary care training. It is important to note that not all residents training in these specialties intend to practice primary care medicine exclusively. Schleiter and Tarlov report that 60 percent of all internal medicine residents go on to receive fellowship training* (Table 7). Data on the proportion of pediatric, ob/gyn, and family practice residents that enter fellowship programs are currently unavailable.

Residents are not evenly distributed among the states (Table 8). In 1984, eight states - California, Illinois, Massachusetts, Michigan, New York, Ohio, Pennsylvania and Texas provided the site for the training of 55.1% of the residents. These eight states are among the largest states on a variety of demographic dimensions, and it is not surprising that they should be the largest in terms of graduate medical education, as well. However, the proportion of residents in these states, as well as the other states, does not vary precisely with the general population data. Thus, New York and Massachusetts support disproportionately more residents per capita than states such as Wyoming or North Dakota (Table 9).

Variations by Institutions

In 1984 there were 1343 hospitals and 187 other organizations involved in graduate medical education. If all 74,495 residents were distributed evenly, the institutions would each have about 49 residents. However, residents are not evenly distributed. The fifty non-federal members of the Council of Teaching Hospitals with the largest residency programs train 29 percent of all residents. They have an average of 425 residents in their programs. The fifty COTH members with the next largest programs train 17 percent of the residents and have an average of 239 residents in their programs. At the other end of the spectrum, there are teaching hospitals with just one or two residents in the hospital. Thus, while responsibility for residency training is widely dispersed across more than 1500 institutions, it is also highly concentrated in a small percentage of the institutions.

Teaching hospitals also vary in the type of patients they serve, and that characteristic determines the types of training programs they can conduct successfully. For example, some general acute care teaching hospitals do not

have the patient population or referral network to provide an adequate educational experience for some subspecialists or other more focused types of training.

Other teaching hospitals have assessed the patient care resources available within their community and have elected to concentrate in certain types of care but not in others. For example, some teaching hospitals have elected not to offer pediatric care because nearby children's hospitals were meeting that community need. Some teaching hospitals may have more sophisticated and well developed internal medicine patient care capabilities while other teaching hospitals may have highly developed and focused surgical capabilities. These two groups of hospitals will treat very different mixes of patients, and therefore, will have very different capacities to train medical or surgical residents. Different proposals for changing the payment for graduate medical education can have different effects on these two groups of institutions.

Summary

Graduate medical education is a generic term used to describe a very diverse group of programs designed to train physicians to practice medicine competently and safely in 23 specialty areas and numerous subspecialty areas. A large number of professional organizations are involved in determining the standards to be met by each type of specialty training program and in assessing whether or not individual programs meet the standards. Programs currently meeting these criteria exist in a variety of institutions, but primarily in a small percentage of hospitals. The residents and fellows are supported by many sources, the largest of which is the patient care revenues of the hospital.

Appendix B 1736

A National Fund for Graduate Medical Education 1747

As new hospital payment systems are developed and introduced, purchasers of hospital services are placing increased emphasis on the prices paid for services. In this price competitive environment, teaching hospitals may be at a disadvantage because of their additional costs for special services such as medical education. To help maintain teaching hospital competitiveness, it has been suggested that a national fund be created to finance graduate medical education (GME) separately from patient service charges.

In its discussions, the AAMC Committee on Financing Graduate Medical Education considered recommending a national fund for GME. Having considered the advantages and disadvantages of such a fund, the Committee does not favor establishing a national GME fund at this time. The Committee does recognize, however, that there is an interest in this approach. Therefore, this appendix describes the primary and secondary policy issues which must be addressed in considering a national GME fund.

The appendix addresses three primary issues: What is the total funding needed for GME? How should the needed funds be raised? and How should the funds be distributed? The secondary issues discussed include balancing a variety of GME objectives, influencing health manpower, and setting the locus of administration for the fund. The Committee recognizes that these issues overlap. They have been separated for ease of presentation.

PRIMARY ISSUES

What is the total funding needed?

Identifying the costs of graduate medical education are not a simple task. First, data on total spending for graduate medical education are not readily

available. Similarly, data are not available readily on spending for the individual components that make up GME spending.

One component of GME spending can be estimated. Assuming the average resident is paid at the national average for a second year resident, total expenses for resident stipends are currently about $1.75 billion(1). When benefits are added, total expenses for resident stipends and benefits are estimated to be $1.99 billion(2). To obtain a complete estimate of national GME costs, the $1.99 billion for resident stipends and benefits would have to be increased for (1) the costs of individuals in fellowship programs, (2) the costs of supervising faculty, and (3) the costs of program overhead (e.g., clerical support, program administration, teaching facilities, and library resources).

The inability to estimate accurately total national spending on GME is not a pivotal matter for this appendix. The partial cost estimate of $1.99 billion for resident stipends and benefits demonstrates that any special fund would have to be large. Therefore, the fund would tend to have the budgetary, political and administrative characteristics of large, special purpose funds. It should be understood, however, that if a fund were to be established, each of the presently unknown costs would have to be determined and determining the size of the fund would be a point of disagreement between those financing the fund and those receiving its monies.

How Should Funds be Raised?

(1). Computation of total resident stipend expenditures: $22,900 per resident from 1985 COTH Survey of Housestaff Stipends and Benefits times 74,495 residents from Directory of Residency Training Programs equals $1,705,935,500.

(2). 1985 COTH Survey of Housestaff Stipends and Benefits reports a mean ratio of benefits to stipend expenditures of 16.7%

At the present time, the costs of graduate medical education are supported primarily by the patient service revenues with limited supplementary funds from government appropriations, governmental and private grants and philanthropy. The patient service revenues are derived from a combination of prospectively determined payments, negotiated prices, cost reimbursement, and payments for charges. In order to raise monies for a single national fund for graduate medical education, the following three approaches are generally identified:

- o the monies could be raised by general taxes (i.e., income or payroll) from a single source, such as the Federal government; or
- o the monies could be raised by a special tax on health providers in order to spread the costs of GME across all providers; or
- o the monies could be raised by taxing the large number of health insurers, business, and governmental units currently helping to underwrite GME costs.

Each of the approaches to raising the necessary funds involves substantial problems.

The first alternative is in many ways the simplist. Federal tax revenues would be increased and Federal funds would support all GME costs. With a Federal program assuming this responsibility, other payers would no longer have to support GME in their payments. Ideally, the increase in Federal taxes would be offset by a corresponding reduction in insurance premiums, health service charges, and grants so that total spending did not change. In spite of the simplicity of using a single revenue source, the approach seems politically

unlikely. If the Federal government created a national GME fund, either taxes would have to be levied to finance that portion of GME funds presently underwritten by the private sector or the deficit would be increased. As a federal fund, the money would have to be collected, administered, and distributed by a federal agency. The President has repeatedly stated his opposition to increased taxes, and the Federal Government is reducing spending to reduce budget deficits.

The second alternative seeks to reduce the economic disadvantage of teaching institutions by spreading GME costs across a larger provider base, perhaps all hospitals, physicians, and health plans. For example, all hospitals could be taxed (on admissions or revenues) and the monies raised could be allocated to teaching hospitals. In recent years, a similar approach has been explored for financing charity (or uncompensated) care. While attempts to tax hospital revenues or incomes to finance charity care have been successful in some states, the approach has generally been opposed by hospitals paying more in the tax than they receive in return. The opposing hospitals believe financing charity care is a societal responsibility not a hospital responsibility. It seems likely that a tax on providers to support GME would encounter similar opposition.

The final alternative seeks to capture and centralize the present expenditures of health insurers, self-insured employers, and government programs. The approach presents three difficulties. First, insurance regulation is generally a state administered function. Second, the current Employee Retirement Income Security Act (ERISA) law would have to be changed to direct the expenditures of self-insured corporations. Since ERISA was enacted, corporations have opposed efforts to amend it to control plan expenditures. Finally, the GME

expenditures of the various insurers, corporations and government programs differ. An attempt to impose uniform expenditures would be opposed as unfair by those who currently have below average expenditures for GME. An attempt to simply collect current expenditures would be opposed as inequitable by those with above average expenditures for GME.

Each of the approaches to underwriting a national GME fund presents problems. This does not mean a national fund is impossible. It does mean, however, that the difficulties of any approach are unlikely to be overcome unless the continuation of GME is clearly threatened by inadequate financial support. If a crisis was present and a fund was established and underwritten, issues concerning distributing the fund would become important.

How Should Funds be Distributed?

While there are numerous ways in which the monies in a GME fund could be distributed, they are primarily variations on three approaches. One approach is reimbursement. Providers with GME costs could submit a budget of planned expenses or a report of actual expenses as the basis for determining payment. The reimbursement can be open-ended, as Medicare has traditionally been, or close-ended with payment limits set in advance.

A second distribution method would be the establishment of a GME grants program. The recipient could be state governments, providers, or trainees. Grants could be competitive with an evaluation mechanism for selecting the best proposals or non-competitive with a formula used to determine the amount of the award.

A third approach for distributing GME funds would be to use the monies to increase otherwise determined service payments. For example, a surgical procedure might be paid at price $X in a non-teaching provider and a price $X+Y in a teaching provider. While this would provide added funding for teaching hospitals, it would be difficult technically to set a price difference which appropriately compensates different teaching hospital for their individual GME costs.

The design of the distribution mechanism is important. For example, a reimbursement approach requires review of costs. Decisions must be made on the types of costs which will be recognized and on the reasonableness of the costs. Reporting forms must be created and reviewed. Grant programs also require application and reporting forms. If the grant is competitive, a mechanism to review and evaluate grants must be developed. Grantee actions must be reviewed to ensure that the funds are used as intended. As these examples illustrate, the form and nature of the distribution mechanism determines how interventionist the fund will be.

Second Order Issues

Currently, providers sponsoring graduate medical education programs have considerable autonomy. Within program essentials and accreditation requirements established by the Accreditation Council for Graduate Medical Education and the Residency Review Committee, providers can choose the types of GME programs and the number of trainees they will support. While it is possible that a national GME fund would not interfere with the provider's present autonomy, it is unlikely. Spending several billion dollars a year imposes an accountability on the agency. The agency must be able to defend what has been supported with its funds. Unlike the present system where authority and decision-making are

diffuse, a single national fund centralizes decisions. National policy becomes an objective rather than a consequence of local decisions.

In a centralized national fund, the administrative mechanism is of critical importance. Is the administration to be incorporated into an existing agency or is a special purpose agency to be established? Does the agency have an advisory (or governance) body or only a paid staff? If an advisory body is included, how are members selected, which viewpoints are represented, and what is the relationship to staff? Administering a program requires decisions on broad policies and operational details. Each of the decisions has important implications for graduate medical education.

The distribution of funds makes an explicit statement about the desired specialty mix of training programs. If the agency continues to fund present programs, it is making an explicit statement that the current specialty mix is at least acceptable. Those who believe the present mix is unacceptable will try to have the agency use its funds to change the specialty mix. Similarly, funding decisions embody policies about the geographic distribution of training programs and the type of provider sponsoring the training program. In short, establishing a single, national GME fund will require those administering the fund to make explicit decisions about the number of residents trained, the specialty mix of programs, the geographic distribution of programs, and the type of provider sponsoring the training. The diffused autonomy of the present system will be replaced by more centralized decisions.

Secondly, those administering the fund will have to balance a number of competing interests. The educational needs of the trainees will have to be balanced with the service needs of the sponsoring provider. Emphasizing the learner role means an emphasis on rounds, lectures, and library time with less

time available for direct patient care. Also, the service needs of the sponsoring provider will have to be balanced with the needs of the trainee's ultimate practice setting. The training program must include learning new skills for independent practice in different settings rather than becoming a technical specialist for the training institution. To ensure that these and other balances are maintained, those administering the fund will become involved in program decisions specifying the length and content of funded programs.

The centralization of GME financing will in all likelihood be accompanied by a centralizing of GME decision-making. This centralization of educational decisions will occur at the same time that patient service and health care financing decisions are being decentralized and subjected to local marketplace forces. The impacts of this inconsistency are unknown and untested.

SUMMARY

The financing of graduate medical education has been stable for two decades. Now, there is increased uncertainty about GME financing. Because the present GME system and its financing have served the needs of patients, trainees, and training institutions, the AAMC Committee does not advocate a single national fund for GME. The primary and secondary issues surrounding a national fund for GME are substantial and make it acceptable only if GME financing in the future becomes grossly inadequate.

TABLE 1

GME YEARS REQUIRED TO CERTIFICATION

Specialty	Preliminary Training Requirements	Specialty Residency Training Requirement	Total Years to Certification (Minimum)
Allergy and Immunology	3	2	5
Anesthesiology	1	3	4
Colon and Rectal Surgery	5	1	6
Dermatology	1	3	4
Emergency Medicine	1	2	3
Family Practice	---	3	3
Internal Medicine	---	3	3
Neurological Surgery	1	5	6
Nuclear Medicine	2	2	4
OB/GYN	---	4	6
Ophthalmology	1	3	4
Orthopaedic Surgery	---	5	7
Otolaryngology	1	3	5
Pathology	---	4	4
Pediatrics	---	3	3
Physical Medicine & Rehabilitation	1	3	4
Plastic Surgery	3	2	5
Preventive Medicine, General	3	1	4
Psychiatry & Neurology	---	4	4
Radiology	---	4	4
Surgery	---	5	5
Thoracic Surgery	5	2	7
Urology	2	3	6 1/2

Source: American Board of Medical Specialties Annual Report & Handbook 84

TABLE 2

SPECIALTY BOARDS: CATEGORIES OF CERTIFICATION

Specialty Boards	General Certifications	Special Certifications
Allergy & Immunology	Allergy & Immunology	Diagnostic Laboratory Immunology
Anesthesiology	Anesthesiology	Critical Care Medicine
Colon & Rectal Surgery	Colon & Rectal Surgery	
Dermatology	Dermatology	Dermatopathology Dermatological Immunology
Emergency Medicine	Emergency Medicine	
Family Practice	Family Practice	
Internal Medicine	Internal Medicine	Cardiovascular Disease Critical Care Medicine Diagnostic Laboratory Immunology Endocrinology and Metabolism Gastroenterology Hematology Infectious Disease Medical Oncology Nephrology Pulmonary Disease Rheumatology
Neurological Surgery	Neurological Surgery	
Nuclear Medicine	Nuclear Medicine	Cooperates with American Board of Pathology and American Board of Radiology in Radioisotopic Pathology and Nuclear Radiology
Obstetrics & Gynecology	Obstetrics & Gynecology	Critical Care Medicine Gynecologic Oncology Maternal & Fetal Medicine Reproductive Endocrinology

Source: American Board of Medical Specialties Annual Report & Handbook 1984

TABLE 2, (continued)

SPECIALTY BOARDS: CATEGORIES OF CERTIFICATION

Specialty Boards	General Certifications	Special Certifications
Orthopaedic Surgery	Orthopaedic Surgery	
Ophthalmology	Ophthalmology	
Otolaryngology	Otolaryngology	
Pathology	Anatomic & Clin. Path. Anatomic Pathology Clinical Pathology	Blood Banking Chemical Pathology Dermatopathology Forensic Pathology Hematology Immunopathology Medical Microbiology Neuropathology Radioisotopic Pathology
Pediatrics	Pediatrics	Critical Care Medicine Diagnostic Laboratory Immunology Pediatric Cardiology Pediatric Endocrinology Pediatric Hemato-Oncology Pediatric Nephrology Neonatal-Perinatal Medicine
Physical Medicine & Rehabilitation	Physical Medicine & Rehabilitation	
Plastic Surgery	Plastic Surgery	
Preventive Medicine	Aerospace Medicine Occupational Medicine Public Health and General & Preventive Medicine	

Soource: American Board of Medical Specialties Annual Report and Handbook 1984

TABLE 2, (continued)

SPECIALTY BOARDS: CATEGORIES OF CERTIFICATION

Specialty Boards	General Certifications	Special Certifications
Psychiatry & Neurology	Psychiatry Neurology Neurology with Special Qualifications in Child Neurology	Child Psychiatry Critical Care Medicine
Radiology	Radiology Diagnostic Radiology Therapeutic Radiology	Nuclear Radiology
Surgery	Surgery	Critical Care Medicine Pediatric Surgery General Vascular Surgery
Thoracic Surgery	Thoracic Surgery	
Urology	Urology	

TABLE 3

PERCENTAGE DISTRIBUTION OF FUNDING SOURCES USED TO PAY HOSPITAL COSTS OF HOUSESTAFF STIPENDS AND FRINGE BENEFITS

	Source of Funding			
	Residents		Clinical Fellows	
Funding Source	1984	1978	1984	1978
Patient Revenues and General Operating Appropriations	81.10%	73.56%	60.92%	50.75%
State Appropriations Earmarked for Housestaff Expenses	4.98	5.13	2.30	2.27
Municipal Appropriations Earmarked for Housestaff Expenses	1.19	5.77	0.64	1.38
Veterans Administration Appropriations	1.98	2.30	4.04	1.33
Physician Fee Revenue	0.60	1.51	9.03	9.01
Medical School/University Funds	1.91	2.96	2.35	4.67
NIH	0.29	0.43	8.75	10.88
Other Federal Agencies	0.27	0.17	0.88	5.05
Endowment Income, Foundation Grants, Voluntary Agencies	0.46	0.45	5.92	8.78
Other	7.23	7.72	5.18	5.96

Source: COTH Survey of Housestaff, Stipends, Benefits, and Funding, 1985

TABLE 4

SCHLEITER AND TARLOV DATA ON SOURCES OF
FUNDING FOR INTERNAL MEDICINE FELLOWSHIP PROGRAMS

	1983-1984	
	Percent	Dollars
Sources:		
Hospital revenue	39.0%	$64,552
State and local governments	6.0	9,931
Veterans Administration and military	20.0	33,104
Federal training grants	11.0	18,207
Research grants	3.0	4,966
Professional fees	8.0	13,242
Medical school funds	4.0	6,621
Foundation training grants	6.0	9,931
Other	3.0	4,966
Total		165,519
Mean stipend/program		109
Mean stipend/fellow		24

TABLE 5

NUMBER OF RESIDENTS BY TYPE OF MEDICAL SCHOOL

Residents* on Duty as of September 1:	U.S. Medical School Graduates	Foreign Medical School Graduates	Total Residents	% FMGs
1984	61,158	13,337	74,495	17.9%
1974	44,381	18,131	62,512	29.0
1964	30,128	10,974	41,102	26.7
1954	24,524	5,036	29,560	17.0

*Includes interns

Source: Directory of Residency Training Program for years 1984-85, 1974-75, 1964-65, and 1954-55.

TABLE 6

UNDERGRADUATE INDEBTEDNESS: DEBT BY YEAR

Debt	1981	1984	1985	Percent Change 81-84	84-85	81-85
None	64%	64%	47%	0	-26.6	-26.6
$1 - $6,000	29%	28%	29%	- 3.4	+ 3.6	0
$6,000 +	7%	8%	24%	+14.3	+200.0	+242.9

MEAN DEBTS OF SENIOR MEDICAL STUDENTS*
1978-79 THROUGH 1984-85

Academic Year	All Seniors	Seniors with Debt	Percent of Seniors with Debt
1978-79	$11,602 (N=5823)	$15,663 (N=4313)	74
1979-80	$13,243 (N=8061)	$17,212 (N=6202)	77
1980-81	$15,167 (N=8142)	$19,697 (N=6274)	77
1981-82	$16,352 (N=10,629)	$21,051 (N=8627)	83
1982-83	$20,389 (N=10,073)	$23,647 (N=8683)	86
1983-84**	$23,347 (N=10,547)	$26,496 (N=8041)	88
1984-85	$25,938 (N=10,844)	$29,943 (N=9438)	87

*Includes both pre-medical and medical school debt, excludes spouse's debt.

**Due to an error in survey instructions, data for this year may be subject to a slight downward bias.

Source: AAMC Graduation Questionnaire

TABLE 7

SCHLEITER AND TARLOV DATA ON NUMBER OF RESIDENTS AND FELLOWS IN TRAINING BY TYPE OF MEDICAL SCHOOL

Type of Graduate	Year of Residency						Year of Fellowship			
	R1	R2	R3	R4	R5	Totals	F1	F2	F3	Totals
	n					n(%)	n			n(%)
1983-84										
USMG	5,587	4,372	4,110	487	76	14,632 (78)	2,608	2,272	742	5,622 (80)
US-FMG	771	664	529	23	9	1,996 (11)	124	128	18	270 (4)
FMG	734	626	625	57	25	2,067 (11)	533	453	147	1,133 (16)
Totals	7,092	5,662	5,264	567	110	18,695	3,265	2,853	907	7,025

TABLE 8

DISTRIBUTION OF RESIDENTS BY STATE

Region/State	Percent of Residents on Duty 1984	1974
New England	7.3%	---
Connecticut	2.0	2.0%
Maine	0.2	0.1
Massachusetts	4.0	4.3
New Hampshire	0.2	0.2
Rhode Island	0.5	0.5
Vermont	0.2	0.2
Middle Atlantic	23.7	---
New Jersey	2.7	2.4
New York	14.6	17.5
Pennsylvania	6.4	6.3
East North Central	17.7	---
Illinois	5.6	5.7
Indiana	1.2	1.1
Michigan	4.0	4.3
Ohio	5.1	5.0
Wisconsin	1.7	1.4
West North Central	6.8	---
Iowa	0.9	0.8
Kansas	0.8	0.9
Minnesota	2.0	2.9
Missouri	2.3	2.6
Nebraska	0.5	0.6
North Dakota	0.1	---
South Dakota	0.1	---
South Atlantic	14.7	---
Delaware	0.2	0.2
District of Columbia	2.2	2.5
Florida	2.3	2.4
Georgia	1.7	1.2
Maryland	2.6	2.6
North Carolina	2.2	1.9
South Carolina	1.0	0.7
Virginia	1.9	1.9
West Virginia	0.6	0.4
East South Central	4.4	---
Alabama	1.1	0.8
Kentucky	1.0	1.0
Mississippi	0.5	0.5
Tennessee	1.8	1.7

Source: Directory of Residency Training Programs 1984-85.

TABLE 8, (continued)

DISTRIBUTION OF RESIDENTS BY STATE

Region/State	Percent of Residents on Duty 1984	1974
West South Central	9.1%	---
Arkansas	0.5	0.4%
Louisiana	1.8	1.4
Oklahoma	0.9	0.6
Texas	5.8	4.5
Mountain	3.1	---
Arizona	1.0	0.8
Colorado	1.2	1.5
Montana	---	---
New Mexico	0.3	0.3
Utah	0.5	0.5
Wyoming	---	---
Pacific	12.1	---
Alaska	---	---
California	9.6	9.9
Hawaii	0.5	0.4
Idaho	---	---
Nevada	0.1	---
Oregon	0.6	0.7
Washington	1.2	1.2
Territory	1.1	---
Puerto Rico	1.1	0.8

TABLE 9

RESIDENTS PER THOUSAND POPULATION BY STATE

	State	Approximate # of Residents	Population (in "000's")	Residents per Thousand Population
1.	District of Columbia	1,639	631	2.60
2.	New York	10,876	17,659	.62
3.	Massachusetts	2,980	5,781	.52
4.	Connecticut	1,490	3,153	.48
5.	Maryland	1,937	4,265	.46
6.	Pennsylvania	4,768	11,865	.41
7.	Rhode Island	372	958	.39
8.	Hawaii	372	994	.38
9.	Minnesota	1,490	4,133	.37
10.	Illinois	4,172	11,448	.37
11.	Ohio	3,800	10,791	.36
12.	Missouri	1,713	4,951	.35
13.	Michigan	2,980	9,109	.33
14.	Louisana	1,341	4,362	.31
15.	Colorado	894	3,045	.30
16.	California	7,152	24,724	.29
17.	Vermont	149	516	.29
18.	Texas	4,321	15,280	.29
19.	Tennessee	1,341	4,651	.29
20.	New Jersey	2,011	7,438	.28
21.	North Carolina	1,639	6,019	.28
22.	Arizona	745	2,860	.27
23.	Wisconsin	1,266	4,765	.27
24.	Virginia	1,415	5,491	.26
25.	Delaware	149	602	.25

Source: Directory of Residency Training Programs 1984-85
World Book Almanac

TABLE 9, (continued)

RESIDENTS PER THOUSAND POPULATION BY STATE

	State	Approximate # of Residents	Population (in "000's")	Residents per Thousand Population
26.	Kansas	596	2,408	.25
27.	Iowa	670	2,905	.24
28.	Nebraska	372	1,586	.24
29.	South Carolina	745	3,203	.24
30.	Utah	372	1,554	.24
31.	West Virginia	447	1,948	.23
32.	Georgia	1,266	5,639	.23
33.	Oklahoma	670	3,177	.22
34.	Washington	894	4,245	.22
35.	Alabama	819	3,943	.21
36.	Kentucky	745	3,667	.21
37.	Arkansas	372	2,291	.17
38.	Florida	1,713	10,416	.17
39.	Indiana	894	5,471	.17
40.	New Mexico	223	1,359	.17
41.	Oregon	445	2,649	.17
42.	New Hampshire	149	951	.16
43.	Mississippi	372	2,551	.15
44.	Maine	149	1,133	.14
45.	North Dakota	75	670	.12
46.	South Dakota	75	690	.11
47.	Nevada	75	881	.09
48.	Idaho	0	965	.00
49.	Montana	0	801	.00
50.	Alaska	0	438	.00
51.	Wyoming	0	502	.00

TABLE 10

U. S. MEDICAL SCHOOL ADMISSIONS

Class Year	First-Year Enrollment	Graduates
1984	16,997	16,318
1974	14,978	12,716
1964	8,856	7,409
1954	7,576	6,977

Source: AAMC Data Book

TABLE 11

DISTRIBUTION BY SPECIALTY

Specialty	Percent of Residents on Duty 1984	1974	1964
Allergy and Immunology	0.3%	---	---
Anesthesiology	5.2	3.9%	3.9%
Colon and Rectal Surgery	0.1	0.1	---
Dermatology	1.1	1.4	1.3
Dermatopathology	---	---	---
Emergency Medicine	1.5	---	---
Family Practice	9.9	5.1	---
Internal Medicine	24.4	21.0	17.7
Neurological Surgery	0.9	1.2	1.5
Neurology	1.9	2.0	1.6
Nuclear Medicine	0.3	0.2	---
OB/GYN	6.2	6.5	8.1
Ophthalmology	2.1	3.0	3.4
Orthopedic Surgery	3.9	4.5	4.7
Otolaryngology	1.4	1.9	2.2
Pathology	3.3	5.4	6.5
Blood Banking	---	---	---
Forensic Pathology	---	0.1	---
Hematology	---	---	---
Neuropathology	0.1	0.1	---
Pediatrics	8.1	9.1	6.2
Pediatric Cardiology	0.2	0.2	0.1
Neonatal-Perinatal Medicine	0.3	---	---
Physical Medicine & Rehabilitation	1.0	0.8	0.6
Plastic Surgery	0.6	0.8	0.6

Source: Directory of Residency Training Programs, 1984-85, 1974-75 1964-65.

TABLE 11, (continued)

DISTRIBUTION BY SPECIALTY

Specialty	Percent of Residents on Duty 1984	1974	1964
Preventive Medicine, General	0.3%	---	0.1%
Aerospace Medicine	0.1	---	0.3
Occupational Medicine	0.1	---	0.2
Public Health	---	---	0.2
Combined General Preventive Medicine/Public Health	0.1	---	0.3
Psychiatry	6.1	8.3	11.2
Child Psychiatry	0.7	1.1%	1.1
Radiology, Diagnostic	4.3	1.4	2.8
Radiology, Diagnostic (Nuclear)	0.1	---	---
Radiology, Therapeutic	0.7	0.7	---
Surgery	11.0	14.0	19.0
Pediatric Surgery	---	---	---
Vascular Surgery	---	---	---
Thoracic Surgery	0.4	0.6	0.8
Urology	1.4	2.1	2.5
Transitional Year	2.0	---	---

APPENDIX A

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COMMITTEE ON FINANCING GRADUATE MEDICAL EDUCATION

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General Director
Massachusetts General Hospital

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Executive Vice President
New York University Medical Center

David W. Gitch
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Louis J. Kettel, M.D.
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Frank G. Moody, M.D.
Chairman, Department of Surgery
University of Texas Medical School
at Houston

Gerald T. Perkoff, M.D.
Professor of Family Medicine
School of Medicine
University of Missouri

Robert G. Petersdorf, M.D.
Vice Chancellor, Health Sciences and
Dean, School of Medicine
University of California, San Diego

Louis Sherwood, M.D.
Chairman, Department of Medicine
Albert Einstein College of Medicine
of Yeshiva University

Charles C. Sprague, M.D.
President
Health Sciences Center at Dallas
University of Texas

William Stoneman, III, M.D.
Dean and Associate Vice President
School of Medicine
St. Louis University

Richard Vance, M.D.
Senior Resident
Department of Pathology
Wake Forest University Medical Center

W. Donald Weston, M.D.
Dean, College of Human Medicine
Michigan State University

Frank C. Wilson, Jr. M.D.
Chairman, Division of Orthopaedics
School of Medicine
University of North Carolina

APPENDIX B

REFERENCES

1. American Board of Medical Specialties, Annual Report & Reference Handbook-1984.

2. Association of American Medical Colleges Committee on Financing Graduate Medical Education, Statement of Issues, March 1985.

3. Background Information and Selected Readings, Prepared for Committee on Financing Graduate Medical Education, November 1984.

4. 1985-1986 Directory of Residency Training Programs, Accredited by the Accreditation Council for Graduate Medical Education.

5. Graduate Medical Education: Proposal for the Eighties, Journal of Medical Education, Volume 56, No. 9.

APPENDIX C

AMERICAN BOARD OF ALLERGY AND IMMUNOLOGY, INC.

Approved: 1971 Incorp: 1971

SPONSORING, NOMINATING, OR CONSTITUENT ORGANIZATIONS:
American Board of Internal Medicine
American Board of Pediatrics
American Academy of Allergy and Immunology
American College of Allergists
American Association for Clinical Immunology and Allergy
American Academy of Pediatrics Section on Allergy and Immunology
American Medical Association

THE AMERICAN BOARD OF ANESTHESIOLOGY, INC.

Approved: 1941 Incorp: 1938

SPONSORING, NOMINATING, OR CONSTITUENT ORGANIZATIONS:
American Society of Anesthesiologists
American Medical Association

THE AMERICAN BOARD OF COLON AND RECTAL SURGERY, INC.

Approved: 1949 Incorp: 1935

SPONSORING, NOMINATING, OR CONSTITUENT ORGANIZATIONS:
American Society of Colon and Rectal Surgeons
Southern Medical Association Section on Colon & Rectal Surgery
American College of Surgeons
American Medical Association

THE AMERICAN BOARD OF DERMATOLOGY, INC.

Incorp: 1932

SPONSORING, NOMINATING, OR CONSTITUENT ORGANIZATIONS:
American Dermatological Association
American Academy of Dermatology
American Medical Association

AMERICAN BOARD OF EMERGENCY MEDICINE, INC.

Approved: 1979 Incorp: 1976

SPONSORING, NOMINATING, OR CONSTITUENT ORGANIZATIONS:
American Board of Family Practice
American Board of Internal Medicine
American Board of Obstetrics and Gynecology, Inc.
American Board of Otolaryngology
The American Board of Pediatrics, Inc.
American Board of Psychiatry and Neurology, Inc.
The American Board of Surgery, Inc.
American College of Emergency Physicians
American Medical Association
University Association for Emergency Medicine

CAS ALERT

COUNCIL OF ACADEMIC SOCIETIES

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
1 Dupont Circle, N.W.
Washington, D.C. 20036

March 19, 1986

TO: CAS Society Representatives

FROM: Elizabeth M. Short, M.D. E M Short
Steering Committee
Ad Hoc Group on Medical Research Funding

The Ad Hoc Group has again this year reviewed the budget situation for NIH/ADAMHA research and research training (R&RT), including the FY86 congressional appropriations of last fall and the President's FY87 budget which proposes a 10.2 percent cut from the congressional FY86 appropriation for NIH and a 4.9 percent cut for ADAMHA R&RT.

The Ad Hoc Group proposes an NIH budget of $6.079 billion for a 10.6 percent increase over the FY86 appropriation. The NIH increase would provide a current services budget for NIH; that is, all programs originally funded in FY86 would be continued at that level of effort, all research project grants would be funded at full study section recommended levels, and 6100 competing grants would be funded for a total portfolio of 19,434, the highest ever. This would enable NIH to reach an estimated 33 percent award rate in FY87. A small increase of $86 million above current services would 1) permit funding of the full NAS recommended number of trainees (11,075), 2) add needed funds to General Clinical Research and other Centers, 3) add funds for primate centers and animal laboratories, and 4) permit the Research Career awards (K series) to grow modestly. In addition, the cost of moving nursing research to NIH this year in the newly mandated Center for Nursing Research would add $16 million, for a total of $6.079 billion.

The Ad Hoc Group proposes an ADAMHA R&RT budget of $465 million, a 27 percent increase over FY86. This request provides for current services to continue all programs from FY86, including 850 competing research awards and a research awards total of 1,800, the highest ever. It also provides a 14.8 percent increase above current services as part of the growth plan recommended by the NAS/IOM report on mental health research. This "growth" merely restores the ADAMHA research budget, which was severely cut in the late 70's, to its 1974 purchasing power.

The AAMC urges all CAS societies to immediately go on record in support of this proposal for NIH and ADAMHA. As you know, our recommendation gathers strength by the sheer number of scientific societies which sign on in support of it (over 150 last year). Within the total, each society is free to lobby for whatever amounts it wishes for its own favorite programs or institutes.

Please call David Moore at (202) 828-0482 IMMEDIATELY UPON RECEIPT OF THIS MEMO to sign on your society. The final color version of this year's brochure will again be delivered to Congress with a list of all signatory societies, so call now. We will send each of you a copy of the glossy presentation as soon as it is printed. You may order more for distribution within your society. Please refer to the Ad Hoc brochure and budget proposals when contacting your Senators and Congressmen about the budget for medical research.

Ad Hoc Group for Medical Research Funding:
A Proposal for the National Institutes of Health

FY 1986 Congressional Appropriation	FY 1987 Current Services	Ad Hoc Group FY 1987
$5.498 billion	$5.993 billion	$6.079 billion

This proposal brings the increase for the NIH into line with those requested by the President for science support in other agencies, with the exception of the Department of Defense. (See Figure 1.) It provides very modest program growth of about $86 million or 1.4 percent over a current services budget (which includes $15.6 million for nursing programs recently transferred to NIH).

The Fiscal Year 1987 Ad Hoc Group proposal for NIH provides funds sufficient to support research activities at levels provided for by the Fiscal Year 1986 congressional appropriation, with modest increases for a variety of important programs. Our proposal emphasizes the need for program balance at NIH with a diversity of support mechanisms and recognizes the multi-faceted mission of the agency -- to conduct basic and applied research, train qualified promising investigators, and speed the transfer of life-prolonging and life-saving research and technology to the public. Our proposal also emphasizes the high degree of flexibility required in the management of NIH for the greatest effectiveness in the use of research funds, considering the substantial variations in the pace of research in different fields supported by the various institutes.

The Ad Hoc Group proposal for FY 1987 provides for:

- a current services dollar level for full funding at study section - recommended levels of competing and non-competing research projects grants (approximately $3.4 to $3.6 billion).
- some growth in research career awards and funds sufficient to raise the current level of research trainees to that recommended by the National Academy of Sciences (NAS).
- needed upgrading and renovation of primate centers and outmoded and inefficient research laboratories.
- some additional funding for General Clinical Research Centers (GCRCs) to facilitate the conduct of clinical research projects and trials.
- a slight increase in the number of research centers: specialized/comprehensive, biotechnology, etc.

For the remainder of NIH research activities -- contracts, biomedical research support grants (BRSGs), minority biomedical research support, intramural research and full-time equivalent (FTE) personnel -- we propose maintenance levels as established in the Fiscal Year 1986 Congressional appropriation.

A PROPOSAL FOR THE ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION*

*Research and Research Training only

FY 1986 Congressional Appropriation	FY 1987 Current Services	Ad Hoc Group FY 1987
$366 million	$405 million	$465 million

The proposal for ADAMHA reflects the magnitude of the Agency's mission by providing necessary program growth over the FY '86 level-of-effort. Our recommended funding levels are consistent with the recommendations of the Institute of Medicine of the National Academy of Sciences for a doubling of the ADAMHA research budget over the 1986 to 1991 period. This increase is necessary to achieve catch-up growth in funding of mental health and addiction research. The FY '87 current services budget of $405 million merely restores ADAMHA purchasing power for research and research training to the constant dollar level of 1974.

The Fiscal Year 1987 Ad Hoc Group proposal for ADAMHA provides funds sufficient to conduct biomedical and behavioral research activities at levels only modestly in excess of the Fiscal Year 1986 congressional appropriation, with necessary increases for a variety of important programs. Our proposal emphasizes the need for program balance and recognizes the multi-faceted missions of the agency -- to conduct basic and applied research, train qualified promising investigators, and speed the transfer of life-prolonging and life-saving clinical knowledge and technology to the public. Our proposal also emphasizes a high degree of flexibility required in the management of ADAMHA for the greatest effectiveness in the use of research funds considering the diverse research funding mechanisms. We urge ADAMHA to continue to use its multiple support mechanisms in recognition of the many ways in which excellent research can be organized.

The Ad Hoc Group proposal for FY 1987 provides for:

- o necessary expansion in the level of competing research project grants with full funding at study section-recommended levels (approximately $265 million);
- o critical growth in Research Centers (including sufficient-funding for competing renewals), Research Scientist Development Awards (which particularly focus on establishing a pool of talented young investigators), and funds sufficient to raise the level of research trainees to that recommended by the National Academy of Sciences.
- o needed renovation of outmoded research laboratories and equipment;
- o necessary funds for the Intramural programs to provide for replacement of obsolete equipment and to regain lost positions;

This proposal recognizes the extraordinary contributions of ADAMHA-supported research and would hasten the growth and refinement of new knowledge and clinical applications.

TAX REFORM BILL OF 1986

The House of Representatives passed the Tax Reform bill H.R. 3838 on December 17, 1985 and sent it to the Senate. An outline of the provisions of that bill is attached (AAMC memorandum #86-5). At its meeting of January 23, 1986, the Executive Council established the AAMC position on a number of the issues presented by that bill. These same issues will be addressed by the Senate version of the bill which we anticipate will be released by Senator Packwood's Finance Committee in draft form at the end of March. A number of the House provisions which are detrimental to all higher education institutions, and especially provisions relating to the faculty retirement plan TIAA-CREF, will need to be protested vigorously and massively if we are to prevent their passage by the Senate. We must mobilize a large scale faculty effort to affect the outcome. It is important that your Senators hear a great deal from you. This memorandum sets out the AAMC positions. Attached is a draft of material of which you may wish to modify appropriately to reflect your own views and distribute to your faculty and staff. It urges them to become involved in this effort.

AAMC POSITIONS

Tax Exempt Bonds (Sec. 701)

We believe that the House bill should be modified to relieve hospitals and universities from the institutional and state per capita dollar caps. We accept the retention of restrictions on the use of the funds to functions directly related to the non-profit missions of the institutions and reasonable restrictions on arbitrage earnings and advanced refundings.

Retirement Benefits

- Taxation of TIAA-CREF

The AAMC opposes the taxation of pension funds held by TIAA-CREF. Attached is a one page summary of TIAA's testimony before the Senate Finance Committee on February 4, 1986. This unprecedented and unparalleled taxation of pension funds is not only a reversal of long standing policy, but would work an inequity on the more than 1,000,000 current and retired employees of over 3,600 United States colleges, universities, independent schools, and related non-profit educational organizations. It is estimated that this tax would reduce the amount available to purchase annuities at the time of retirement for someone just now entering the system by approximatley 15 percent.

- **Cap on Sec. 403(b) Annuities**

The Association opposes the imposition of the new limitation on salary reduction contributions to $7,000. This and other restrictions will place non-profit organizations at a competitive disadvantage in the employment market because of the disparate and much more favorable treatment available to private sector organizations. Qualified defined benefit pension plans, for example, would be limited to annual contributions of $75,000 under the bill while 403(b) plans (defined contribution plans such as TIAA-CREF) are limited to $25,000 under the bill. Additionally, we are very concerned about the impact of this provision on academic governance. These changes would increase the incentives of physician faculty to organize their clinical practices as independent for-profit corporate entities in order to avoid these restrictions.

- **IRA Dollar Offset**

The AAMC opposes the effective elimination of individual retirement accounts as an available option to employees of non-profit organizations.

- **Non-Discrimination Test**

The AAMC urges that a less costly and more administratively feasible test of non-discrimination be developed than that of H.R. 3838. Alternatively, we suggest that criteria of pension plans be established which, if met, would relieve an institution of the necessity to compare different plans by currently approved, but unwieldy approaches.

- **Deferred Compensation Plans**

The AAMC urges that non-profit organizations not be placed at an additional competitive disadvantage with profit making organizations by the imposition of a cap of $7,500 or one-third of includible compensation. This ceiling is reduced by amounts set aside under 403(b) (TIAA-CREF). For-profit organizations have no comparable limitations.

Miscellaneous Provisions

- **Scholarship and Fellowship (Sec. 123)**

The AAMC opposes the inclusion of scholarships and fellowships as income subject to taxation. H.R. 3838 would exclude only grants to degree candidates for tuition and related fees. This provision would significantly diminish the attractiveness of Health Research Service Awards which have proven an important mechanism for encouraging research careers.

- **Prizes and Awards (Sec. 123)**

The AAMC believes that taxing awards to individuals for scientific achievement, for example, the Nobel Prize and the AAMC Research Award, is mean spirited and not worthy of our society.

For further details regarding tax exempt bonds contact Nancy Seline at (202) 828-0496, for other tax matters contact Joseph A. Keyes, Jr. at (202) 828-0555.

Enclosures: TIAA Testimony
Senate Finance Commitee Membership List

cc: Principal Business Affairs Officers

DRAFT

MEMORANDUM

TO: Members of the Faculty and Staff

FROM: Dean or Hospital CEO

SUBJ: Impact of Tax Reform Proposal: A Call to Action

As participants in the retirement program of this institution, you have received an alert from TIAA-CREF. It suggested that you write your Senators informing them of the adverse impact that the House passed bill, H.R. 3838, would have on your pension. This is to reinforce your sense of urgency about that alert.

H.R. 3838 would:

- Tax pension funds held by TIAA-CREF.
- Cap the amount which could be set aside under salary reduction agreements at $7,000.
- Limit total annual contribtions to defined contribution plans (like TIAA) to $25,000.
- Effectively eliminate Individual Retirement Accounts (IRA's) as an available option to employees of non-profit organizations.
- Impose a costly and administratively difficult non-discrimination test on institutional retirement plans.
- Cap amounts which can be set aside under deferred compensation plans at the lessor of $7,500 or one-third of compensation, and reduce this ceiling by any amounts set aside under salary reduction agreements.

The effect of these provisions is not to create an even handed elimination of tax loopholes. Each reduces pension options now available of employees of non-profit organizations. Together they make retirement benefits of our organization significantly less attractive than are available to for-profit organizations. In particular, I urge your attention to the attached statement of the TIAA chairman on the taxation of pension plan funds.

H.R. 3838 would also affect other matters of interest to this institution and its ability to carry out its mission:

- It would limit the availability of tax exempt bonds to fund hospital and university needs by the imposition of institutional and state per capita dollar caps. (*Comment here on the importance of tax exempt bonds to your institution's financing strategy.*)
- It would include scholarships and fellowships as income subject to taxation except for amounts provided to degree candidates for tuition and related fees.
- Tax awards to individuals for scientific achievement, for example, the Nobel Prize.

You may wish to comment on these provisions as well.

Unless each of us makes our views known on these provisions, they may well become the new tax law!

BEFORE THE SENATE FINANCE COMMITTEE
HEARINGS ON H.R. 3838 - FEBRUARY 4, 1986

STATEMENT OF JAMES G. MacDONALD, Chairman and Chief Executive Officer
Teachers Insurance and Annuity Association - College Retirement Equities Fund

PROPOSED TAXATION OF PENSION PLAN FUNDS HELD BY TIAA-CREF

SUMMARY

THE ROLE OF TIAA-CREF IN HIGHER EDUCATION: TIAA-CREF is the nationwide fully funded, fully vested, portable pension system for 3,600 U.S. colleges, universities, independent schools and related nonprofit educational organizations. It holds the retirement funds for approximately one million current and retired employees of these nonprofit educational organizations.

TAX-EXEMPT STATUS OF TIAA-CREF: TIAA in 1920, and CREF in 1953, were determined by the Internal Revenue Service to be exempt from Federal income taxes because they are organized and operated exclusively for educational purposes. For more than 65 years, participating institutions have relied on the tax-exempt status of the TIAA-CREF system when depositing their retirement funds.

THE TIAA-CREF PENSION SYSTEM SHOULD NOT BE TAXED AS A COMMERCIAL INSURER: TIAA-CREF's nationwide pension system operates as a unique multi-employer pension fund and is very different from a commercial insurance company. TIAA-CREF serves only nonprofit educational organizations and is itself a nonprofit organization. All of TIAA-CREF's assets support pension and related benefits for higher education, and by charter and trust law cannot be diverted for any other purpose.

HAZARDS OF PROPOSED SECTION 1012 of H.R. 3838: Section 1012 of H.R. 3838 would terminate the long-standing tax exemption of the TIAA-CREF pension system, while continuing tax exemption for virtually all other pension funds. This would treat higher education's pension system unfairly and reduce participants' pension benefits. Therefore, we urge the Committee to continue the long-standing tax exemption of the TIAA-CREF pension system.

SENATE
FINANCE COMMITTEE

Republicans (11)	Democrats (9)
Bob Packwood, OR, Chairman	Russell B. Long, LA
Robert Dole, KS	Lloyd Bentsen, TX
William V. Roth, Jr., DE	Spark M. Matsunaga, HI
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Malcolm Wallop, WY	Bill Bradley, NJ
David Durenberger, MN	George J. Mitchell, ME
William L. Armstrong, CO	David Pryor, AR
Steven D. Symms, ID	
Charles E. Grassley, IA	

Letters should be addressed to:

The Honorable _____
United States Senate
Washington, D.C. 20510

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

January 13, 1986

MEMORANDUM #86-5

TO: Council of Deans
Council of Teaching Hospitals
Council of Academic Societies

FROM: John A. D. Cooper, M.D., Ph.D.

SUBJECT: Impact of H.R. 3838, The Tax Reform Act of 1985 on AAMC Members

On December 17, the House of Representatives passed H.R. 3838, "The Tax Reform Act of 1985," and sent it to the Senate. This memorandum provides a brief outline of provisions of the bill which should be of interest to AAMC members. This outline is excerpted (in part) from a paper prepared by John Holt Myers of Williams, Myers and Quiggle.

SUMMARY OF FEATURES OF INTEREST

Tax Exempt Bonds (Section 701)

- The outstanding amount of tax exempt bonds issued on behalf of any one organization, other than a hospital, could not exceed $150 million.
- Volume Limitations - Nongovernmental bonds issued by each state are subject to an annual limitation equal to the greater of $200 million or $175 per capita (reduced to $125 per capita beginning in 1988).
- A portion of the aggregate limit equal to $25 per capita would be reserved for Internal Revenue Code Section 501(c)(3) organizations.
- Arbitrage - Additional arbitrage restrictions were approved for...projects of the IRC Section 501(c)(3) charities.

Charitable Contribution Deduction

- The unrealized appreciation in long-term capital assets donated to a charity would be subject to the 25-percent alternate minimum tax.

Scholarships and Fellowships (Section 123)

- The exclusion for scholarships and fellowships from taxable income would be eliminated, except for grants to degree candidates which are used for tuition and related fees.

Prizes and Awards (Section 123)

- The present exclusion for a prize or award granted to an individual for religious, charitable, scientific, educational, literary or civic achievement would be repealed.

Deduction for State and Local Taxes

- Would continue to be deductible.

Research and Experimentation Credit

- Amounts contributed to universities for the conduct of basic research would continue to be a business tax deduction for three years; however, the credit would be reduced from 25 to 20 percent and the definition of "qualified costs" would be tightened.

Retirement Benefits
(Discussed in greater detail in Attachment I)

- IRC Section 403(b) Annuities
  - The annual contributions via a salary reduction would be capped at $7,000 with an offset reducing the IRA dollar limit by elective distributions through 403(b) salary annuity option programs.
  - Discrimination Test (Section 1113) - The general nondiscrimination test applicable to qualified plans (which requires that comparable plans to be offered to highly paid and lower paid employees) will be imposed on tax sheltered annuity programs.
  - Withdrawal Rules - a tax surcharge would be imposed on early withdrawls.
- Deferred Compensation Plans of Tax Exempt Organizations, Other Than State (Section 1103):
  - the maximum amount that may be deferred under such a plan is the lesser of $7,500 or one third of the participant's includible compensation.
- IRC Section 401(k) - Cash or Deferred Arrangements, IRC Section 401(k)
  - tax exempt organizations would not be eligible to adopt an IRC Section 401(k) cash or deferred arrangement plan.
- Tax Exempt Organizations Engaged in Insurance Activities - TIAA-CREF assets would be taxed reducing the rate of return on their policies.

- Alternate Minimum Tax - The untaxed appreciation in property contributed to a charitable institution would be included in the items subject to the new alternate minimum tax at 25 percent.

- IRC Section 127 Educational Assistance Programs to Be Extended to 1987.

Accrual Method of Accounting

- Corporate taxpayers and partnerships having corporate partners would be required to use accrual method of accounting. Exempt from this limitation are:

  - Subchapter "S" corporations (taxed as partnerships);

  - Those with less than $5 million gross receipts annually (three year average); and,

  - Certain "qualified personal service corporations"--fundamentally those owned by present or past employees.

Miscellaneous

- Employer Provided Health Insurance (Section 132)

  - Employer contributions to health plans will continue to be free of taxation as under the present rules.

- Floor on Employee Business and other Miscellaneous Deductions

  - Employee business expenses and miscellaneous itemized deductions would become consolidated into a single category. A deduction would be allowed only to the extent that these items in the aggregate exceed 1 percent of the taxpayer's adjusted gross income.

- Deduction for Travel Expenses - The cost of attending a convention or seminar for personal investment purposes would not be deductible.

  - No travel deductions would be allowed for travel, meals and lodging incurred in performing services for a charitable organization unless there is "no significant element of pleasure, recreation or vacation in the travel away from home."

- Business Meals and Entertainment Deduction - The deduction for business meals and entertainment would be limited to 80 percent of the cost.

ATTACHMENT I

DISCUSSION OF IMPACT ON PENSION PLANS

You should be aware of the impact of the provisions of this bill on the pension plans commonly offered by our member institutions. Despite our efforts, which included contacts with key members of the Ways and Means Committee, and despite efforts of other members of the higher education community (which were substantial), the bill contained provisions relating to tax deferred plans authorized under Sec. 403(b) (such as TIAA-CREF plans), deferred compensation arrangements, and 401(k) plans which would make these arrangements substantially less attractive than they have been in the past and significantly less generous than those available to the for-profit sector of our economy. I urge you to acquaint youself with these impacts and alert your Senators to your views.

IRC Sec. 403(B) Tax Deferred Annuities

I) Limitation of the Maximum Annual Deferral

Characteristically, 403(b) plans (under which TIAA/CREFF operate) involve at least two components and often involve a third:

- The first component is the employer's contribution which is generally some defined percent of the employee's salary. This constitutes a fringe benefit and has been regarded under the Internal Revenue Code (IRC), as not taxable on a current basis. It is taxed when received by the person on retirement.

- The second is the employee's contribution which is often required as a condition of the employer's participation. The second is also generally a percentage of salary. Sec. 403(b) permits the employee to enter into agreement with employer under which the employee's salary is reduced by the amount of the employee's contribution (salary reduction agreement). As a consequence of this agreement, the amount subject to current income tax is the employee's stated salary reduced by the amount of the contribution. This is a significant tax benefit historically available to employees of educational institutions in recognition of their generally lower salaries. It is a public policy designed to support the ability of higher education institutions to compete with other employers for high quality people as faculty.

- The third component authorized under Sec. 403(b) are so-called, "Supplemental Retirement Annuities (SRAs)." SRAs allow employees to contribute additional amounts under a salary reduction agreement at their own initiative up to a limit (defined by formula, but roughly amounting to a total permissible contribution of all three components equivalent to 20% of salary).

Under the proposal adopted by the House of Representatives, the maximum annual amount which may be deferred from income taxable on a current basis under a salary reduction agreement would be $7,000. That is, the maximum total contribution under the second component (employee contribution) and the third (SRA) described above could be no more than $7,000 annually.

For employees with 15 years of service with a (particular?) qualified organization--including, but not limited to, colleges and univerities--the limitation may be increased by an amount determined by a formula, but in no event greater than $3,000.

II) Imposition of New "Non-discrimination Rules"

Under the Bill, new "non-discrimination" rules would be applied to IRC 403(b) entities. These rules were imposed in the absence of any showing that colleges and hospitals had a practice of discriminating against lower compensated employees. For colleges and universities with more than one retirement plan, for example, a defined contribution plan (such as TIAA-CREF) for faculty and a defined benefit plan for support personnel, this will generate expensive new requirements for accounting and actuarial services on a continuing basis to demonstrate compliance.

III) Withdrawal Rules Regarding TIAA-CREF Supplemental Retirement Annuity

Current law recognizes that there are occasions in which an employee might find it necessary to withdraw funds contributed to the Supplemental Retirement Annuity portion of their pension program. The bill would impose a new set of rules regarding penalty for such withdrawals:

A) Contributions made before December 31, 1985 and income earned thereon:

1) Could be withdrawn;

2) But is subject to 15% additional tax (above income tax), unless employee:

a) is 59-1/2 or over;

b) dies; or

c) is disabled.

B) Withdrawal of contributions made on or after January 1, 1986 are:

1) Not permitted, unless employee:

a) is 59-1/2;

b) becomes disabled;

c) encounters financial hardship;

d) terminates service with the institution; or

e) dies.

2) A hardship withdrawal is limited to the original salary reduction contributions and may not include income earned on those contributions.

3) Amounts withdrawn before 59-1/2 are subject to 15% additional tax, unless the staff member dies or is disabled.

C) The additional tax is not applied to any benefits received in substantially equal periodic payments as a life annuity (or joint and survivor annuity).

IRC Sec. 401(k) Plans (Qualified Cash or Deferred Arrangements)

The limitations on 403(b) plans described above (paragraph A) are also applicable to 401(k) plans.

Deferred Compensation Arrangements

Current law recognizes that under certain circumstances an employer and employee may agree that some portion of the employee's salary would not be paid on a current basis, but would instead be distributed to the employee at some later date. The amount of compensation thus deferred, so long as it remains a contractual obligation of the employer (not paid into a trust or otherwise set aside in a fashion to guarantee payment to the employee), have not been taxable on a current basis. Under the Bill, deferred compensation arrangements would become subject to a new limit. The annual deferral amount could be no greater than one-third of the employee's compensation or $7,500, whichever is less. This amount would be further reduced by any amount contributed by the employee under a salary reduction agreement, to a 403(b) plan.

Taxation of the TIAA-CREF as a Corporate Entity

The House bill would tax the assets of TIAA-CREF. This would result in the reduction of funds available to purchase annuity contracts at retirement for participants in the TIAA-CREF. For a person now entering the system this is estimated to be a reduction of approximately 15% of the funds which otherwise would have been available. As a revenue source, this is expected to generate $80 million a year to the federal treasury. This is an unprecedented and unparalleled departure from the general public policy of long standing that pension fund assets are not taxed as such, that is, they are not taxed until received by the retiree. This provision would apply to funds accumulated over 65 years in reliance on the exempt status of TIAA-CREF, including funds received as charitable grants and funds held to pay current pensions to persons already retired. However, it is possible for TIAA-CREF to restructure itself as an organization to avoid such taxes. It would be at an enormous cost and would make the program substantially less attractive. Thus, it will achieve no compensating benefit to the Federal government and we are unaware of any public policy to be served by this maneuver.

Coordination of IRA Deductions

Under the rules of the bill, an individual's IRA deduction limit for a taxable year is reduced, dollar for dollar, by the amount of an individual's elective 401(k) or 403(b) deferrals for the year. (The effect of this provision is to discourage Individual Retirement Accounts since the contribution of any amount to an IRA will result in a ceiling on both IRA and 403(b) accounts of $2,000).

For further information or questions, please contact Joseph A. Keyes, Jr. at (202) 828-0555.

ADMINISTRATION PROPOSALS FOR PART B REIMBURSEMENT OF PHYSICIANS AND PART A REIMBURSEMENT OF HOUSE STAFF TEACHING COSTS

The administration's budget for fiscal 1987 proposes a number of substantial changes in Medicare. These changes would result in a $3.94 billion reduction in Medicare spending. The administration plans to implement many of these changes through the use of regulations. At least one of these proposed regulatory changes already has been published in the Federal Register; the others are expected in the near future.

Direct Medical Education Payments

There are three major proposals for the Medicare passthrough for direct graduate medical education payments. For fiscal 1987, the reductions in payments that would result from these changes are projected at $495 million. The first change is the elimination of the educational costs associated with residency training. Detailed language is not available at present, but sources within the Department of Health and Human Services have indicated that the Health Care Financing Administration (HCFA) will propose the elimination of faculty salaries, benefits, and support costs from the passthrough. The second change is for "hospital specific" limits on house staff salaries. Hospitals would be required to compute an allowable cost per resident (including stipend, benefits, and allocated overhead). Future costs for residents would be limited to the computed base cost adjusted for inflation. The third proposal would eliminate nursing and allied health programs as allowable costs in the passthrough.

Indirect Medical Education Adjustment

The administration also proposes two changes in the resident-to-bed or indirect medical education adjustment. First, legislation is proposed that would reduce the adjustment from the current 11.59 percent per 0.1 resident-per-bed to 5.79 percent. This is despite an analysis by the Congressional Budget Office that shows the adjustment should be reduced only to 8.7 percent. This change would reduce payments to teaching hospitals by $990 million in fiscal 1987. The administration also is proposing regulations to modify the current adjustment so that it increases at a slower rate as the resident-to-bed ratio increases. This change would reduce payments to teaching hospitals by an additional $120 million.

Reasonable Charge Limits

HCFA published a proposed regulation in the Federal Register of February 16, 1986, to adopt "special reasonable charge limits" on payments for services (including supplies and equipment) reimbursed under Medicare Part B. This regulation is purported to address instances where the standard method for determining the reasonable charge results in payments that may not be reasonable. Situations where HCFA states this might occur include: 1) the marketplace is not truly competitive because of limited suppliers, 2) charges that involve new and expensive technology for which there is not an extensive charge history, 3) charges that do not reflect changing technology or increased facility with that technology, 4) charges grossly

in excess of acquisition or production costs, or 5) prevailing charges in a locality that are out-of-line with prevailing charges in other localities. HCFA stated that it rejected the establishment of specific criteria for setting these limits because it wanted to avoid "an inflexible process [that] could result in limits being based on factors specifically relevant to the issue." The result regulation is particularly worrisome because the criteria and procedures to be used in establishing these charge limits are extremely vague. The Association and other groups have protested the draft regulation, and it is possible, but unlikely, that the final regulation will be altered in response to these criticisms.

Physician Fees

The administration's budget appears to imply an end to the freeze on physician fees. At the same time, the budget proposes to recalculate the Medicare economic index, which limits prevailing fees. This index would be revised retroactively, with the result that prevailing fee limits would increase slightly or possibly decline. Payments for lens replacements, assistants at surgery, and "standby" anesthesia services also would be reduced. Altogether, these proposals would reduce physician payments by $432 million in fiscal 1987.

DRG Rates

The administration suggests a "tentative" increase of 2 percent in DRG rates in fiscal 1987. This follows a freeze in fiscal 1986. In addition, if the Gramm-Rudman-Hollings sequestration of budgetary resources takes effect in fiscal 1987, this "tentative" increase of 2 percent will be accompanied by a 2 percent reduction in payments. The next result would be payments for care provided in fiscal 1987 at 1985 prices.

Suggested action

1) Contact the Senate Finance/House Ways and Means Committees and Budget Committees to protest these proposals in the President's FY87 budget.

2) Write to HCFA to protest regulations to implement these proposals by administration fiat, as they are published for comment. AAMC pink memos will notify you of each such draft regulation when published for comment.

AMICUS BRIEF ON ANIMAL STANDING CASE

The International Primate Protection League, the Animal Law Enforcement Association, People for Ethical Treatment of Animals and six named individuals have successfully petitioned the Federal Court of Appeals for the 4th Circuit (Richmond) to rehear their case to obtain legal standing to take possession of the primates used in Edward Taub's experiments. The co-defendants in the case are the NIH, which maintains custody of the animals under a longstanding agreement, and the Institute for Behavioral Research (IBR), which owns the animals. The AAMC, the National Association for Biomedical Research (NABR) and a number of other professional societies have joined together to provide the court with an amicus or "friend of the court" brief. Through the amicus, we will give the court information about the issues being discussed and the ramifications for biomedical research of providing standing to animal groups.

The current case is a significant legal test case. If standing is granted to these animal groups, the number of similar suits in other jurisdictions could be substantial. Some societies have contributed money to:

1) develop the amicus brief to provide expert opinion not otherwise available to the court about the need for animal research and how biomedical research would be affected if animal groups may petition a court successfully to take possession of laboratory animals, because they are ombudsmen for the animals who will protect them from cruel experiments;

2) provide financial support to the Institute for Behavioral Research (IBR), the co-defendant with NIH, to allow them to maintain their able attorney, ensuring that the case is well-handled and the amicus used effectively.

In 1984, the International Primate Protection League, et al., sought to obtain an injunction to prevent the return of the seventeen primates, formerly used in Taub's experiments, to IBR. Dr. Taub is no longer a party to the legal case, having been cleared of any wrongdoing by a Maryland appeals court which ruled that the Maryland animal cruelty statute does not apply to medical research activities at a federally funded laboratory subject to federal statutes and regulations. The animal groups sought custody claiming "bonding" with the animals through regular visits and by gifts of playthings for their cages. IBR requested that the motion be dismissed for lack of standing. The Federal District Court in Baltimore agreed and the case was dismissed. The animal groups have successfully appealed their case and have submitted their initial brief. The defendants, NIH and IBR, have until March 28 to respond. The plaintiffs will have 14 days to file a rebuttal. The amicus brief will be drafted in March.

Recommended Action

Any CAS societies who would like to be signatories to the amicus brief, which will gain weight by the number of sponsors, should contact Melissa Brown (202) 828-0525 at AAMC. You need not contribute to be a signatory.

CURRENT PROPOSALS ON REIMBURSEMENT OF INDIRECT COSTS OF RESEARCH

On February 7, 1986, the Office of Management and Budget published a proposed revision to OMB Circular A-21, "Cost Principles for Educational Institutions," in the Federal Register (attached). The revision would impose a ceiling on university administrative costs for federally-sponsored grants and contracts. Only administrative costs would be so capped, not the total indirect cost rate, but the cap would be a total ceiling for all four current components of administrative costs; 1) general administration, 2) departmental administration, 3) sponsored projects administration, and 4) student administration and services.

The ceiling was set at 26 percent of MTDC (modified total direct costs) as of April 1, 1986 and 20 percent of MTDC as of April 1, 1987. Agencies were given the option to delay this implementation by one year; an option already exercised by all agencies except HHS. The OMB estimates that this cap if fully implemented on the April 86 and April 87 timetable will save $100 million in FY87 and $200 million in FY88. These sums would not be shifted to direct costs in the budgets of agencies but saved to the Treasury to meet deficit reduction targets.

The 26 percent rate for FY86 (HHS) or FY87 is the average rate for administrative costs at 146 of the top research universities in FY84. Thus, over half of these research universities would have their indirect cost reimbursements reduced below FY84 percentages.

OMB proposed this rule with only a 30 day comment period and implementation (by HHS at least) 2 weeks later. A number of Associations, including AAMC, have protested the arbitrary and accelerated timetable for such a major change in federal funds flowing to universities and medical schools and pleaded for a longer period of discussion and analysis of what cost cap should be implemented.

The Council on Government Relations (COGR), representing the business officers of the top 100 research universities, has written OMB proposing as an alternative:

1) a yet to be detailed plan to define departmental administrative costs more tightly to limit them and eliminate the faculty effort reporting needed to document them

2) freeze in place each university's current administrative rate components throughout FY87, and

3) suspend retroactive reimbursement of increases in indirect cost rates which are negotiated during the federal fiscal year. Only HHS currently does within year rate adjustments.

The latter two proposals are expected to save OMB an equivalent sum to that which would be saved by their 26 percent cap in FY86 and FY87. The first proposal is intended to resolve the longstanding friction among OMB, the universities, and the research faculties over effort reporting and administrative costs which created some of the political pressures leading to the proposed revision of Circular A-21.

The Association has written OMB in support of these alternate proposals of COGR to reduce costs and control departmental administration costs, and requested that these changes be realized through a negotiation between OMB and representatives of both the faculties and university administrators. The Association also urged that any changes of large magnitude be phased-in over a reasonable time frame to allow universities to adjust their research operations to continue full support of sponsored research projects, despite the revenue loss.

1986 COGR SURVEY

INSTITUTION	1986 TOTAL ADMINISTRATION RATE	LOSS OVER 26% (in 1987 $)	LOSS OVER 20% (in 1987 $)	1987 Projected FEDERAL NIDC BASE $
GEORGIA INSTITUTE OF TECHNOLOGY	49.60%	11,930,036	16,160,144	54,595,680
COLUMBIA UNIVERSITY	36.80%	7,236,000	13,128,998	78,148,800
PENNSYLVANIA, UNIVERSITY OF	38.10%	7,865,000	12,706,200	70,200,000
CARNEGIE - MELLON UNIVERSITY	44.88%	8,496,000	12,091,680	48,600,000
STANFORD UNIVERSITY	29.00%	2,941,050	9,529,002	105,877,800
MICHIGAN, UNIVERSITY OF	30.80%	3,744,000	9,097,920	84,240,000
YESHIVA UNIVERSITY	42.00%	4,976,000	7,389,360	33,588,000
CALIFORNIA, UNIVERSITY OF - LOS ANGELES	28.30%	1,846,900	7,198,092	86,724,000
CALIFORNIA, UNIVERSITY OF - BERKELEY	30.40%	2,578,400	6,581,952	63,288,000
	30.40%	2,552,000	6,514,560	62,640,000
VANDERBILT	38.00%	3,840,000	6,220,800	34,560,000
BOSTON UNIVERSITY	43.30%	4,131,603	6,009,692	25,792,668
ILLINOIS, UNIVERSITY OF - CHAMPAIGN GENERAL RESEARCH	30.05%	1,906,133	5,108,435	50,830,200
MIAMI, UNIVERSITY OF	35.08%	2,814,800	5,048,784	33,480,000
WISCONSIN, UNIVERSITY OF	26.08%	58,240	4,780,339	78,624,000
OHIO STATE UNIVERSITY	32.83%	2,335,764	4,738,694	36,934,484
JOHNS HOPKINS UNIVERSITY	26.20%	140,000	4,687,200	75,600,000
DUKE UNIVERSITY	30.83%	1,888,530	4,573,292	42,228,000
WASHINGTON, UNIVERSITY OF	24.23%	0	4,262,317	100,764,000
SOUTHERN CALIFORNIA, UNIVERSITY OF	26.92%	510,664	4,148,371	59,947,560
HARVARD MEDICAL AREA RATE	45.60%	2,729,104	3,849,708	15,037,920
VIRGINIA COMMONWEALTH UNIVERSITY	37.33%	2,144,187	3,542,053	20,438,852
CALIFORNIA, UNIVERSITY OF - SAN DIEGO	24.00%	0	3,499,200	87,480,000
ROCKEFELLER UNIVERSITY	31.36%	1,483,361	3,395,347	29,888,616
EMORY	30.15%	1,261,600	3,332,448	32,832,000
HOWARD UNIVERSITY	59.00%	2,418,553	3,086,953	7,915,265
	34.73%	1,652,724	3,011,707	20,446,876
ROCHESTER, UNIVERSITY OF	28.00%	690,900	2,984,688	37,308,600
ILLINOIS, UNIVERSITY OF - CHICAGO CIRCLE	36.50%	1,676,745	2,845,676	17,246,520
TUFTS UNIVERSITY	38.90%	1,758,012	2,781,747	14,718,240
MASSACHUSETTS INSTITUTE OF TECHNOLOGY	21.73%	0	2,300,617	132,983,640
CHICAGO, UNIVERSITY OF	25.70%	0	2,179,224	38,232,000
VIRGINIA, UNIVERSITY OF	30.16%	821,029	2,165,622	21,315,174
SOUTH CAROLINA, MEDICAL UNIVERSITY OF	42.00%	1,436,712	2,133,517	9,697,805
NORTH CAROLINA, UNIVERSITY OF - CHAPEL HILL	24.90%	0	2,126,243	43,392,717
CORNELL UNIVERSITY - STATUTORY COLLEGES	37.00%	1,237,500	2,065,500	12,150,000
MINNESOTA, UNIVERSITY OF	22.34%	0	2,062,195	88,128,000
MIAMI, UNIVERSITY OF - MEDICAL SCHOOL	35.85%	1,182,000	2,054,160	12,960,000
SOUTH FLORIDA, UNIVERSITY OF	36.83%	1,036,030	2,028,147	12,050,783
SUNY - STONY BROOK	30.90%	776,441	2,014,589	18,482,466
	37.14%	1,169,700	1,943,676	11,340,000
CONNECTICUT, UNIVERSITY OF	29.30%	634,878	1,932,339	20,777,840
MICHIGAN STATE UNIVERSITY	23.38%	0	1,927,411	57,024,000
CALIFORNIA, UNIVERSITY OF - IRVINE	27.80%	403,200	1,886,976	24,192,000
CORNELL UNIVERSITY - ENDOWED	24.00%	0	1,866,240	46,656,000
MASSACHUSETTS, UNIVERSITY OF - WORCESTER MEDICAL	41.50%	1,227,290	1,838,560	8,551,440

1986 COGR SURVEY

INSTITUTION	1986 TOTAL ADMINISTRATION RATE	LOSS OVER 26% (in 1986 $)	LOSS OVER 20% (in 1987 $)	1987 Projected FEDERAL MTDC BASE $
RENSSLELAER POLYTECHNICAL INSTITUTE	36.50%	1,066,744	1,810,417	10,972,222
CALIFORNIA, UNIVERSITY OF - SAN FRANCISCO	22.40%	0	1,765,152	73,548,000
ARIZONA, UNIVERSITY OF	24.50%	0	1,728,452	38,410,038
DENVER, UNIVERSITY OF - DRI	65.00%	1,365,000	1,701,000	3,780,000
COLORADO STATE UNIVERSITY	26.40%	98,124	1,695,578	26,493,405
MASSACHUSETTS, UNIVERSITY OF - AMHERST CAMPUS	26.70%	162,540	1,680,199	25,077,600
WASHINGTON STATE UNIVERSITY	26.70%	160,090	1,654,873	24,699,600
FLORIDA, UNIVERSITY OF	25.61%	0	1,614,995	28,787,789
HARVARD SCHOOL OF PUBLIC HEALTH	34.80%	876,480	1,592,006	10,756,800
SUNY - BUFFALO	32.20%	687,815	1,578,655	12,939,797
WASHINGTON UNIVERSITY	24.10%	0	1,558,656	38,016,000
RUTGERS THE STATE UNIVERSITY OF NEW JERSEY	30.95%	597,435	1,541,513	14,077,747
	25.80%	0	1,534,329	26,453,952
VERMONT, UNIVERSITY OF - BURLINGTON	34.19%	804,012	1,504,475	10,602,360
PURDUE UNIVERSITY	25.60%	0	1,487,808	26,568,[illegible]
PENNSYLVANIA STATE UNIVERSITY - MEDICAL CENTER	32.00%	660,000	1,425,600	11,880,[illegible]
SOUTHERN ILLINOIS UNIVERSITY	28.60%	397,800	1,421,064	16,524,[illegible]
DELAWARE, UNIVERSITY OF	35.90%	756,570	1,417,290	8,913,775
PRINCETON UNIVERSITY	28.10%	331,800	1,382,184	17,064,000
PITTSBURGH, UNIVERSITY OF	23.40%	0	1,362,312	40,068,000
INDIANA UNIVERSITY	26.40%	77,875	1,345,683	21,026,304
BROWN UNIVERSITY	29.00%	405,000	1,312,200	14,580,000
NORTHWESTERN UNIVERSITY	23.88%	0	1,303,214	33,588,000
CALIFORNIA, UNIVERSITY OF - SANTA BARBARA	27.90%	277,400	1,245,672	15,768,000
TEMPLE UNIVERSITY	30.30%	479,665	1,240,882	12,047,400
OKLAHOMA, UNIVERSITY OF	33.50%	630,000	1,224,720	9,072,000
SYRACUSE UNIVERSITY	39.80%	771,395	1,195,327	6,037,806
TENNESSEE, UNIVERSITY OF - KNOXVILLE	34.42%	639,920	1,183,594	8,208,000
HARVARD UNIVERSITY - AFFILIATED HOSPITALS	46.60%	844,600	1,177,848	4,428,000
GEORGE WASHINGTON UNIVERSITY	34.50%	623,815	1,149,287	7,926,120
CUNY CITY COLLEGE	38.00%	696,000	1,127,520	6,264,000
GEORGE WASHINGTON UNIVERSITY - MEDICAL CENTER	39.70%	721,442	1,120,394	5,687,280
NEW YORK UNIVERSITY - ON-CAMPUS	27.37%	177,072	1,111,081	15,075,720
DAYTON, UNIVERSITY OF	26.26%	40,696	1,058,214	16,904,370
CORNELL UNIVERSITY - MEDICAL COLLEGE - NYC	25.20%	0	1,043,116	20,059,920
MAINE, UNIVERSITY OF	30.20%	393,750	1,032,750	10,125,000
VIRGINIA POLYTECHNICAL INSTITUTE AND STATE UNIVERSITY	24.00%	0	1,008,246	25,206,141
SOUTH CAROLINA, UNIVERSITY OF	29.83%	363,697	1,008,133	10,255,680
WEST VIRGINIA UNIVERSITY	24.76%	0	936,228	19,668,652
CALIFORNIA, UNIVERSITY OF - DAVIS	22.90%	0	933,336	32,184,[illegible]
	31.50%	394,335	890,480	7,74[illegible]
THOMAS JEFFERSON UNIVERSITY	31.60%	395,584	884,978	7,629,[illegible]
ILLINOIS INSTITUTE OF TECHNOLOGY	44.40%	614,192	879,630	3,605,040
MIAMI, UNIVERSITY OF - MARINE SCHOOL	40.29%	571,600	876,528	4,320,000
NEW HAMPSHIRE, UNIVERSITY OF	37.40%	524,400	864,432	4,968,000
HARVARD UNIVERSITY - UNIVERSITY AREA	23.10%	0	860,469	27,757,080
PENNSYLVANIA STATE UNIVERSITY	[illegible]	[illegible]	[illegible]	[illegible]

1986 COGR SURVEY

INSTITUTION	1986 TOTAL ADMINISTRATION RATE	LOSS OVER 26% (in 1987 $)	LOSS OVER 20% (in 1987 $)	1987 Projected FEDERAL MTDC BASE $
CINCINNATI, UNIVERSITY OF	24.50%	0	767,880	17,064,000
ALABAMA, UNIVERSITY OF - BIRMINGHAM	22.91%	0	766,843	26,352,000
COLORADO, UNIVERSITY OF - BOULDER CAMPUS	23.20%	0	734,746	22,960,800
	26.50%	51,957	729,473	11,222,663
NEW YORK MEDICAL COLLEGE	37.60%	402,887	712,994	4,051,102
CALIFORNIA STATE UNIVERSITY - SAN DIEGO	37.69%	373,425	711,850	4,024,024
BRANDEIS UNIVERSITY	26.60%	59,592	707,950	10,726,515
CASE WESTERN - HOSPITAL	27.61%	133,441	681,194	8,951,300
GEORGIA, UNIVERSITY OF	24.34%	0	649,855	14,973,608
LEHIGH UNIVERSITY	31.00%	211,233	632,237	5,747,613
	33.50%	318,750	619,650	4,590,000
NOTRE DAME, UNIVERSITY OF	31.70%	273,600	606,528	5,184,000
	21.60%	0	590,164	36,885,240
NEW MEXICO, UNIVERSITY OF - MEDICAL CENTER	29.40%	193,116	576,622	6,134,280
NEW MEXICO STATE - CAMPUS	35.18%	312,913	558,826	3,681,329
CALIFORNIA, UNIVERSITY OF - SANTA CRUZ	27.80%	117,000	547,560	7,020,000
SUNY - ALBANY	29.60%	162,174	544,781	5,674,806
DENVER, UNIVERSITY OF	33.60%	279,300	539,784	3,969,000
SUNY - DOWNSTATE MEDICAL CENTER AT BROOKLYN	30.90%	202,112	524,408	4,811,080
DARTMOUTH COLLEGE	26.70%	48,476	501,099	7,479,084
	25.00%	0	485,488	9,709,754
BOSTON COLLEGE	37.00%	283,910	473,872	2,787,480
CUNY GRADUATE SCHOOL & UNIVERSITY CENTER	50.00%	336,000	453,600	1,512,000
KENTUCKY, UNIVERSITY OF - MEDICAL CENTER CAMPUS	26.71%	43,637	445,388	6,637,680
LOUISIANA STATE UNIVERSITY - A & M - NO MED SCHOOL	24.75%	0	438,243	9,226,172
KENTUCKY, UNIVERSITY OF - LEXINGTON CAMPUS	25.65%	0	416,400	7,369,920
UTAH, UNIVERSITY OF	21.35%	0	407,773	30,205,440
ALABAMA, UNIVERSITY OF	31.22%	161,820	375,646	3,348,000
NEW MEXICO, UNIVERSITY OF	27.90%	82,640	371,096	4,697,423
ALABAMA, UNIVERSITY OF - HUNTSVILLE	33.60%	190,000	367,200	2,700,000
	24.30%	0	365,341	8,496,291
WAKE FOREST UNIVERSITY	24.40%	0	359,208	8,163,824
TENNESSEE, UNIVERSITY OF - MEMPHIS MEDICAL CAMPUS	24.65%	0	351,540	7,560,000
	30.30%	124,700	348,404	3,382,560
CUNY HUNTER COLLEGE	28.00%	78,000	336,960	4,212,000
	40.65%	210,960	321,149	1,555,200
NEW MEXICO STATE - PRIMATE CENTER	58.83%	246,502	314,876	810,910
BAYLOR COLLEGE OF MEDICINE - ON CAMPUS	21.60%	0	311,040	19,440,000
AUBURN	25.64%	0	310,651	5,508,000
CALIFORNIA STATE UNIVERSITY - SAN JOSE	34.00%	160,000	302,400	2,160,000
ARKANSAS, UNIVERSITY OF	24.70%	0	301,406	6,412,894
MARYLAND, UNIVERSITY OF - COLLEGE PARK	21.11%	0	297,920	26,839,650
	21.00%	0	288,828	28,882,841
KANSAS, UNIVERSITY OF	22.50%	0	275,805	11,032,194
TEXAS, UNIVERSITY OF - HEALTH SCIENCE CENTER - SAN ANTONIO	22.06%	0	258,077	12,528,000

INSTITUTION	1986 TOTAL ADMINISTRATION RATE	LOSS OVER 26% (in 1982 $)	LOSS OVER 20% (in 1987 $)	1987 Projected FEDERAL MTDC BASE $
	38.00%	149,563	242,292	1,346,066
FLORIDA STATE UNIVERSITY	22.86%	0	233,513	8,164,800
CUNY BROOKLYN COLLEGE	29.00%	72,000	233,280	2,592,000
BAYLOR COLLEGE OF MEDICINE - OFF CAMPUS	22.33%	0	223,960	9,612,000
SUNY - BINGHAMPTON	30.40%	80,171	221,027	2,125,258
SUNY - UPSTATE MEDICAL CENTER AT SYRACUSE	26.10%	2,646	188,298	3,086,851
TEXAS, UNIVERSITY OF - HEALTH SCIENCE CENTER - DALLAS	20.81%	0	183,708	22,680,000
	25.40%	0	182,282	3,375,593
CALIFORNIA STATE UNIVERSITY - LONG BEACH	30.06%	62,118	166,231	1,652,400
CUNY QUEENS COLLEGE	26.00%	0	155,520	2,592,000
SUNY - COLLEGE OF ENVIRONMENTAL SCIENCES & FORESTRY SYRACUSE	30.60%	46,417	124,758	1,176,962
HARVARD UNIVERSITY - OFF CAMPUS	26.20%	3,600	120,528	1,944,000
NEBRASKA, UNIVERSITY OF - LINCOLN	22.00%	0	115,841	5,792,040
MISSOURI, UNIVERSITY OF - ROLLA	24.00%	0	112,825	2,820,628
	26.20%	3,122	104,509	1,685,636
	31.10%	44,057	103,559	932,967
MISSISSIPPI STATE UNIVERSITY - AGRICULTURAL RESEARCH	24.22%	0	100,267	2,376,0
MISSOURI, UNIVERSITY OF - COLUMBIA	21.60%	0	62,647	3,915,447
CASE WESTERN - OFF CAMPUS	25.33%	0	61,478	1,153,436
	22.43%	0	52,908	2,177,280
NEBRASKA, UNIVERSITY OF - AG STATION	22.00%	0	46,181	2,309,040
CALIFORNIA STATE UNIVERSITY - NORTHRIDGE	29.94%	16,548	45,088	453,600
TEXAS, UNIVERSITY OF - EL PASO	23.82%	0	37,130	972,000
LOUISIANA STATE UNIVERSITY - A & M	20.47%	0	35,517	7,556,795
MISSOURI, UNIVERSITY OF - ST. LOUIS	27.60%	4,686	24,038	316,293
MISSOURI, UNIVERSITY OF - MEDICAL CENTER	20.50%	0	17,278	3,455,606
ARKANSAS, UNIVERSITY OF - MEDICAL SCHOOL	12.23%	0	0	3,179,928
	19.73%	0	0	37,109,880
CALIFORNIA, UNIVERSITY OF - RIVERSIDE	19.30%	0	0	9,072,000
COLORADO, UNIVERSITY OF - HEALTH CENTER - DENVER	18.59%	0	0	17,299,709
EAST TENNESSEE STATE UNIVERSITY	17.90%	0	0	707,333
GEORGIA STATE UNIVERSITY	15.69%	0	0	1,566,000
HOUSTON, UNIVERSITY OF	18.51%	0	0	12,096,000
IOWA STATE - AG STATION	10.60%	0	0	22,320,922
IOWA STATE UNIVERSITY - RESEARCH	13.14%	0	0	19,556,982
	20.00%	0	0	3,456,000
LOUISIANA STATE UNIVERSITY - A & M - AGRI CENTER	19.71%	0	0	2,010,110
LOUISIANA STATE UNIVERSITY - A & M - WETLANDS	17.80%	0	0	1,581,698
LOUISIANA STATE UNIVERSITY - MO	19.20%	0	0	2,893,345
LOUISVILLE, UNIVERSITY OF	18.31%	0	0	4,762,800
MISSISSIPPI STATE UNIVERSITY - ACADEMIC DIV. RESEARCH	16.78%	0	0	4,644,000
MISSOURI, UNIVERSITY OF - AGRICULTURAL STATION	15.70%	0	0	3,923,0
NEW MEXICO STATE - AG RESEARCH	14.71%	0	0	617,0
NORTH CAROLINA STATE UNIVERSITY - RALEIGH	18.99%	0	0	15,626,198

1986 COGR SURVEY

INSTITUTION	1986 TOTAL ADMINISTRATION RATE	LOSS OVER 26% (in 1987 $)	LOSS OVER 20% (in 1987 $)	1987 Projected FEDERAL MTDC BASE *
NORTHERN ILLINOIS UNIVERSITY	11.13%	0	0	1,620,000
OKLAHOMA STATE UNIVERSITY	19.15%	0	0	5,940,000
	15.67%	0	0	64,260,000
TEXAS, UNIVERSITY OF - AUSTIN	19.19%	0	0	30,348,000
TEXAS, UNIVERSITY OF - DALLAS	18.53%	0	0	3,132,000
TEXAS, UNIVERSITY OF - HEALTH SCIENCE CENTER - HOUSTON	14.70%	0	0	10,584,000
TEXAS, UNIVERSITY OF - MEDICAL BRANCH GALVESTON	10.20%	0	0	8,640,000
TEXAS, UNIVERSITY OF - SYSTEM CANCER CENTER	18.83%	0	0	14,256,000
WILLIAM AND MARY, COLLEGE OF	8.83%	0	0	7,920,000
TOTAL		$120,681,007	$300,828,831	$3,780,333,775

* Volumes projected to estimate FY 1987 levels.

association of american medical colleges

JOHN A.D. COOPER, M.D., PH.D.
PRESIDENT

(202) 828-0460

March 14, 1986

Ms. Carole J. Dineen
Associate Director for Management
Executive Office of the President
Office of Management and Budget
Washington, D.C. 20503

Dear Ms. Dineen:

The Association of American Medical Colleges, whose member institutions include our nation's 127 medical schools, over 400 teaching hospitals and over 80 academic societies of the faculties, urges OMB to withdraw the February 12, 1986 Federal Register Notice of Revision of Circular A-21. We wrote you on February 28 urging that you lengthen the period of comment on this notice to permit for full and thoughtful comment by all those with an interest in the subject. We have since examined further the proposed change in accounting of the administrative components of the indirect cost rates of universities and believe that you should withdraw this notice and enter into negotiation with the research faculty community and university administrators to develop a fair and equitable means of accounting the administrative cost components. The present proposal seems primarily budget driven and will remove over $420 million from federal research grants to universities in the first 18 months of its implementation (FY86-87). A loss of this magnitude, especially since it will not be evenly borne by all universities, will be detrimental to federally supported extramural research.

We urge instead that you impose an immediate freeze in place of each university's present administrative rate through FY87 and permanently eliminate the DHHS system of retroactive reimbursement of indirect costs adjustments during the grant year. These two actions would realize budgetary savings distributed more equitably and prevent further growth in administrative indirect cost rates while negotiations go forward.

All interested parties should then participate with OMB in negotiations to reorganize the accounting of the indirect costs pools to achieve the following goals: adoption of a fair and reliable method of determining departmental administrative costs which also permits relief from the need for faculty effort reporting, a separate cost pool for those administrative expenses mandated by federal regulation (such as animal care and human subjects committees), methods for accounting the costs of university-purchased equipment and instrumentation, and more realistic use/depreciation allowances for scientific facilities and equipment used in federal research.

One Dupont Circle, N.W. Washington, D.C. 20036

This nation's research enterprise is presently second to none and a key source of the ideas and products which undergird the economic vigor of our nation. Concern about mounting federal deficits is appropriate and measures should be taken to reduce the deficit, but arbitrarily removing over $420 million from federally funded research is short-sighted, inequitably borne and could seriously damage the economic health of our major research universities and therefore our nation as well.

Thank you for your consideration of these proposals.

Sincerely yours,

John A. D. Cooper, M.D.

MALPRACTICE INSURANCE LEGISLATION

The high cost of malpractice insurance has become a major issue for hospitals and practicing physicians. Some physicians have stopped or restricted their practice to limit malpractice liability. Hospitals and physician groups have employed various strategies to reduce the cost of insurance, including the creation of their own insurance companies or insurance pools. Still, the expense for this insurance is rising rapidly. One reason cited for the increase in premium expense is the size of the awards granted. Another is the frequency with which suits are filed because it is a lucrative business for attorneys.

Hatch Bill (S. 1804)

To curb the cost of malpractice insurance, Senator Hatch (R-UT) and Congressman Lent (R-NY) have introduced a bill (S. 1804 in the Senate, H.R. 3865 in the House) that would establish a federal incentive grant program for states that reformed their laws governing malpractice insurance to:

- allow installment payments of awards in excess of $100,000;
- require that the award to an individual be offset by any other payments made to compensate for the injury, including disability insurance and private health insurance payments;
- prohibit awards for non-economic damages, such as pain and inconvenience, from exceeding $250,000;
- establish a fee schedule for attorneys that would allow attorneys to collect -

  no more than 40 percent of the award if the settlement or award is $50,000 or less;

  $20,000 plus a third of the amount awarded over $50,000 if the settlement or award is more than $50,000 but less than $100,000;

  $36,667 plus 25 percent of the amount awarded in excess of $100,000 if the award or settlement is more than $100,000 but less than $200,000; and

  $61,667 plus 10 percent of the amount awarded in excess of $200,000 if the award or settlement is more than $200,000.

- allocate an amount equal to the licensing or certification fees of each type of health care professional to the state agency responsible for the conduct of disciplinary action for such health professionals;
- require each health care provider to have a risk management program;

- require each professional liability insuror in the state to make available to licensing boards data on settlement, judgments, and arbitration awards and to establish risk management programs that must be attended once every three years by any professional seeking malpractice insurance; and

- authorize state agencies to enter into agreements with professional societies to review malpractice actions or complaints against a health care professional.

Qualifying states would be eligible for a development grant of $250,000 to plan and implement these necessary legislative reforms. Once the reforms are in place, the state would be eligible for incentive grants of $2,000,000 that could be used to study professional liability programs or to augment state health programs.

The AMA has been the force behind the introduction of this bill and has asked if the AAMC wishes to join in its efforts to muster support for the legislation. The cost of malpractice insurance is a major concern for academic medical centers, especially if it forces physicians to limit the cases seen or treatments performed. Such limits could mean that residents being trained in some specialties or subspecialties may not be exposed to the full scope of patients normally treated by practitioners in that field. Additionally, teaching hospital emergency rooms could become the treatment sources for patients who are difficult to treat and, therefore, more likely candidates for malpractice claims. Thus, it is important for the AAMC to consider options for addressing the malpractice issue.

Critics of the proposed federal legislation suggest that:

- The bill may appear self-serving for the medical community because it places a limit on the "non-economic" damages that is considerably below the amount of some awards.

- One of the functions of the current tort law system is that it places a financial penalty on those who fail to meet the standard of care required of them. To the extent that the penalty is being ameliorated, some would argue that there is a need for a different type of assurance that quality care will be rendered. For example, some might suggest that a physician whose practice is found negligent should be required to attend some educational session analogous to a driver education program.

- Insurance is a matter within the jurisdiction of the state governments, not the federal government; therefore, more appropriate reforms could be achieved by working directly with state legislatures to enact reforms.

At the January 21, 1986 meeting of the Executive Council there was discussion of the features of the malpractice problem that were unique to the academic setting, including the mobility of faculty and the use of part-time faculty.

There was also a discussion of the need for the profession to improve disciplinary procedures. Finally, there was a realization that large awards associated with liability judgments have jeopardized forms of liability insurance beyond medical malpractice.

Although there was general support for the bill, there was some concern about the provisions relating to the attorney fee schedule and some questions about the bill's constitutionality. It was decided that the Association would support the bill in its overall thrust, particularly stressing the areas of concern to academic medical centers, and would work with the AMA to achieve tort reform.

Durenberger Bill (S. 1960)

Recently, Senator Durenberger (R-MN) and Congressman Moore (R-LA) introduced a medical malpractice bill (S. 1960, H.R. 3084) to encourage voluntary settlement of personal injury claims under Medicare, Medicaid, CHAMPUS and other federal programs. The legislation provides a model system to be adopted by the states. If states do not implement it, it would be implemented at a federal level. Key provisions include:

- tender of compensation - if a potentially liable physician provides the injured patient with a written tender to pay compensation benefits for the injury as specified in this bill, the injured individual would be foreclosed from later bringing suit. If a tender is not offered within 180 days, the injured individual may request arbitration and the arbitrator will decide the degree of liability of the doctor.

- amount of compensation - would equal only economic loss as defined in the bill, plus attorneys fees. Non-economic loss, such as pain and suffering, would not be compensated.

- payment schedule - compensation would be paid within 30 days of each legitimate bill to a maximum period of 5 years, but could be paid in equivalent medical services when appropriate. A lump sum payment settlement could be negotiated at any time, but if the economic loss exceeded $5,000, the settlement would require court approval.

- M.D.s could not participate in this alternative liability program without professional malpractice insurance or suitable other indemnity.

The AAMC Executive Council has not yet considered our Association position on the Durenberger bill.

By Mr. HATCH (for himself, Mr. GARDNOR, and Mr. INOUYE):

S. 1804. A bill to provide for Federal incentive grants to encourage State health care professional liability reform; to the Committee on Labor and Human Resources.

FEDERAL INCENTIVES FOR STATE HEALTH CARE PROFESSIONAL LIABILITY REFORM ACT

Mr. HATCH. Mr. President, I send to the desk the "Federal Incentives for State Health Care Professional Liability Reform Act of 1985." This bill addresses a growing problem in maintaining a wide range of affordable health care services for the American people. I am talking about the problem of soaring medical malpractice costs and the resulting increased expense, and sometime unavailability, of medical professional liability insurance.

Last year, the Labor and Human Resources Committee held hearings which revealed the extent of this problem and the threat it poses to our health care system. In many areas, premiums for professional liability insurance for physicians continue to rise 20, 30, 40 percent a year and more.

The crisis is particularly acute for those rendering obstetrical care. In Florida, 20 percent of obstetricians have reportedly stopped delivering babies and now limit their practice to surgery. In North Carolina, family physicians' malpractice coverage for obstetrics just increased 400 percent, and the majority are reported to be stopping delivering babies.

Nor is the problem confined to physicians. Nurse-midwives, though traditionally at considerable lower risk of suit than physicians, are sometimes categorized with them by insurance companies for premium purposes. In many States, nurse-midwives have recently been unable to obtain insurance, or can obtain it only at exorbitant rates which put it beyond the reach of their incomes. The consequences of such trends among health professionals are obvious—access to health care may be seriously jeopardized unless a prescription is written to treat this malpractice fever.

State governments shoulder the responsibility of defining the judicial or administrative system governing recovery for malpractice injuries, and they are not blind to the medical professional liability insurance crisis. All but one have at least begun reform of their negligence or tort law systems, and many of them are considering further steps. Among these are submission of claims to arbitration panels, limitations on attorney's contingency fees, modification of the collateral source rule, limits on recoverable damages, the establishment of a patient compensation fund, the requirement of periodic payment of large awards, the establishment of pretrial screening panels, and shortening the statute of limitations.

Many of these represent worthwhile improvements. By and large, they respond to perceived failings in the current tort law system, such as the ability of skillful attorneys to obtain exaggerated judgments for pain and suffering, the inducement to unwarranted litigiousness afforded by an escalating contingency fee schedule for attorneys, and the slowness of the legal system in delivering compensation to the injured. Studies have shown that different reforms have different abilities to achieve the overall goals of reducing the total costs of medical malpractice litigation, and thus of liability insurance, and more efficiently delivering compensation.

The legislation I am introducing today sets up monetary incentives to encourage States to adopt further administrative improvements and four tort law reforms, three of which have been found to be among the most effective in holding down litigation costs. This represents a refined version of a proposal drafted by the American Medical Association, and will serve to move the debate on malpractice insurance forward into the consideration of specific legislative solutions.

Briefly, this proposal would fund development grants by which States would design and implement a strategy leading to adoption of these reforms. Additionally, it would grant $2 million the first year and $1 million per year for the next 2 years to any State which adopts all the recommended measures. This money could be used for a broad variety of public health programs, or to conduct studies of the professional liability problem specific to that State.

The reforms named in the bill are: First, periodic payment of damage awards over $100,000; second, elimination of the collateral source rule, thus providing for the reduction of awards by amounts received from other sources for the same injury; third, limitation of non-economic damages (pain and suffering) to $250,000; fourth, limitation of attorney's contingency fees; fifth, allocation of an amount equivalent to that collected from physician licensing fees to the State agency responsible for disciplinary actions; sixth, requirement that hospitals develop risk management programs and require physician participation as a condition to receipt of insurance; seventh, requirement that insurance companies make certain data available to State agencies; and eighth, provision for increased peer review by State medical societies of questionable practice patterns.

I note that some of these proposals strengthen the ability and resources of State boards entrusted with the duty

of weeding out incompetent health practitioners. I am encouraged that this is part of the AMA's program. The AMA forthrightly admits that malpractice does exist. And I am firmly convinced that much can be done to alleviate the current explosion of liability costs if physicians and other health professionals will police their own ranks conscientiously. Healing the sick is a high calling. It is generally very well paid. And the public has a right to expect that State medical boards will force out of the profession alcoholics, drug abusers, the incompetent, and the unprincipled. To the extent the profession has not done so, it has itself to blame for the current situation.

However, claims are also skyrocketing among health professionals who are skilled and conscientious. Part of this may result from the increase in the variety and complexity of medical technology and services; from higher, sometimes unrealistic, public expectations of what medicine can do; from a new readiness of the ordinary citizen to sue; and from a greater number of patients and attorneys willing to file suits that may be marginal or unfounded, hopeful of huge awards or settlements. It is to address some of these factors that the bill I am introducing was drafted. If adopted by States, the bill's reforms would bring down the cost of medical litigation and would result in a higher level of competence among health professionals.

However, I am well aware of the many problems raised by the bill itself. First, I long have doubted in other contexts the wisdom of using Federal dollars to persuade State governments to alter their laws to reflect some grand Federal design. Those doubts persist here. Further, I note again that many of these reforms have already been considered and some adopted by a number of States. The benefit from these reforms is yet to be realized, but when they have gone into effect, the current "crisis" may be less evident.

This leads to another issue: The most recent information available to me indicates that one or another of the listed provisions has been invalidated under State constitutions in five States. Since it would certainly not be our intention to try to preempt State consitutions, there would be at least five States which, from the start, may have no possibility of participating under this proposal. There are pending constitutional challenges in many other States where reforms have been adopted, as well, and the number of invalidations and ineligible States will likely rise. Finally, the individuals tort law reforms raise not only constitutional issues but issues of equity and policy, which we will want to examine as the debate proceeds.

Regardless, the insurance problem is a serious one. The relentless increase in liability costs and insurance premiums not only threatens access to care in many fields, it leads directly to the practice of defensive medicine, in which health professionals opt for greater frequency of health care testing and services. According to a recent study, costs resulting from professional liability, including premiums and defensive medicine expenses, total an estimate $11 billion to $13 billion of the $75 billion spent on physician's services in 1984. Expected savings if this bill were fully implemented would, by one estimate, exceed $500 million annually, while the total cost of the bill for 3 years would be $324.9 million.

Through the introduction of this bill, I intend to highlight these problems and begin in earnest the search for the appropriate Federal and State roles in malpractice reform. The American Medical Association has provided us with a thoughtful, useful discussion piece. I challenge the best minds in law, medicine, and public policy to concur or to respond with concrete alternatives.

Mr. President, I ask that the bill be printed in the RECORD.

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

S. 1804

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Federal Incentives for State Health Care Professional Liability Reform Act of 1985".

FINDINGS AND PURPOSE

SEC. 2. (a) The Congress finds that—

(1) there are serious problems with current systems for compensating individuals injured by the malpractice of health care professionals and health care providers;

(2) the increasing costs and unavailability of professional liability insurance are causing competent health care professionals to cease or limit practice in high risk specialties or to totally cease the practice of their profession;

(3) current health care malpractice compensation systems cause substantial numbers of health care professionals and health care providers to engage in defensive health care practices, such as the conduct of tests and procedures primarily to provide protection against legal actions, and such practices result in unnecessary health care costs;

(4) the number of professional liability claims against health care professionals and health care providers is increasing at disproportionate rates, beyond any relationship to the quality of the health care provided;

(5) the increase in the number of liability claims and the size of awards and settlements, and the excessive time and expense devoted to the resolution of such claims, pose threats to State systems for compensating individuals injured through negligence and to continued access by all individuals to health care;

(6) the Federal Government has an interest in State health care malpractice compensation systems because the Federal Government pays health care costs through Medicare, Medicaid, and other Federal health care programs;

(7) experience in States which have enacted reforms in their tort and judicial systems indicates that certain reforms can reduce unnecessary expenditures related to health care liability claims while providing more rapid and more efficient compensation for individuals injured by malpractice; and

(8) Federal incentives to encourage States to adopt reforms to improve State health care malpractice compensation and professional disciplinary systems will result in—

(A) the maintenance of access to quality health care;

(B) a more rational health care malpractice compensation system; and

(C) substantial savings by the Federal Government and State governments.

(b) It is the purpose of this Act to establish a system of Federal incentive grants to States to encourage the adoption of reforms in State health care malpractice compensation systems.

DEFINITIONS

SEC. 3. For purposes of this Act—

(1) the term "injury" shall have the meaning given to such term by each State in its State liability reforms, except that in defining such term, each State shall include in such term injuries arising from the negligent delivery of health care services by a health care professional or health care provider;

(2) the term "health care professional" means any individual who provides health care services in a State and who is required by State law to be licensed or certified by the State to provide such services in the State;

(3) the term "health care provider" means any organization or institution which is engaged in the delivery of health care services in a State and which is required by State law to be licensed or certified by the State to engage in the delivery of such services in the State;

(4) the term "malpractice" shall have the meaning given to such term by each State in its State liability reforms, except that in defining such term, each State shall include in such term malpractice or professional negligence by a health care professional or health care provider in the delivery of health care services;

(5) the term "professional liability" shall have the meaning given to such term by each State in its State liability reforms, except that in defining such term, each State shall include in such term liability arising from the negligent delivery of health care services by a health care professional or health care provider;

(6) the term "Secretary" means the Secretary of Health and Human Services;

(7) the term "State" means each of the several States, the District of Columbia, Puerto Rico, Guam, and the Virgin Islands; and

(8) the term "State liability reforms" means the reforms described in section 6.

DEVELOPMENT GRANTS

SEC. 4. (a) A State may submit an application to the Secretary for a grant to develop programs to undertake State liability reforms. Any such application shall—

(1) be submitted to the Secretary within 180 days after the date of enactment of this Act;

(2) contain assurances that the State intends to obtain enactment or adoption of the State liability reforms described in section 6 in order to qualify for incentive grants under section 5; and

(3) contain such other information, and be in such form, as the Secretary may prescribe.

(b)(1) If a State submits an acceptable application under subsection (a), the Secretary shall make a grant to such State.

(2) The amount of a grant under paragraph (1) to a State (other than Puerto Rico, Guam, and the Virgin Islands) shall be

$250,000, except that if the amount appropriated under section 8(a)(1) is less than $12,000,000, the amount of a grant under paragraph (1) to such a State shall be an amount equal to the quotient obtained by dividing the total amount appropriated under section 8(a)(1) by the number of States (other than Puerto Rico, Guam, and the Virgin Islands) submitting acceptable applications under this section, except that no grant to such a State under this section shall exceed $250,000.

(3) The amount of a grant under paragraph (1) to Puerto Rico, Guam, or the Virgin Islands shall be $125,000, except that if the amount appropriated under section 8(a)(2) is less than $375,000, the amount of a grant under paragraph (1) to Puerto Rico, Guam, or the Virgin Islands shall be an amount equal to the quotient obtained by dividing the total amount appropriated under section 8(a)(2) by 3.

(c) The Secretary may provide technical assistance to States in planning and carrying out activities with grants under this section.

INCENTIVE GRANTS

SEC. 5. (a) A State may submit an application to the Secretary for a grant under subsection (b)(3). Any such application shall—

(1) be submitted to the Secretary within three years after the date of enactment of this Act;

(2) contain a certification by the chief executive officer of the State that, on the date the application is submitted, the State has enacted, adopted, or otherwise has in effect, the State liability reforms described in section 6;

(3) be accompanied by documentation to support the certification required by paragraph (2), including copies of relevant State statutes, rules, procedures, regulations, judicial decisions, and opinions of the State attorney general; and

(4) contain such other information, and be in such form, as the Secretary may prescribe.

(b)(1)(A) Within 60 days after receiving an application under subsection (a), the Secretary shall review the application and determine whether the application demonstrates that the State has enacted, adopted, or otherwise has in effect, the State liability reforms described in section 6. If the Secretary determines that the application makes such a demonstration, the Secretary shall approve the application.

(B) If an application submitted under subsection (a) cites a State statute or other evidence of compliance with the standards for a State liability reform described in section 6, the Secretary shall consider such State to be in conformance with the requirements of such section with respect to such reform if the statute or other evidence of compliance cited in such application is equal to or more stringent than the reform described in such section.

(2) If, after reviewing an application under paragraph (1), the Secretary determines that the application does not make the demonstration required under such paragraph, the Secretary shall, within 15 days after making such determination, provide the State which submitted such application with a written notice which specifies such determination and which contains recommendations for revisions which would bring the State into compliance with this Act.

(3)(A) Within 30 days after approving an application of a State under paragraph (1), the Secretary shall pay to the State a grant in the amount required under subparagraph (B) or (C), as the case may be.

(B) The amount of a grant under subparagraph (A) to a State (other than Puerto Rico, Guam, or the Virgin Islands) shall be $2,000,000, except that if the amount appropriated under section 8(b)(1) is less than $102,000,000, the amount of a grant under subparagraph (A) to such a State shall be an amount equal to the quotient obtained by dividing the total amount appropriated under section 8(b)(1) by 51.

(C) The amount of a grant under subparagraph (A) to Puerto Rico, Guam, or the Virgin Islands shall be $1,000,000, except that if the amount appropriated under section 8(b)(2) is less than $3,000,000, the amount of a grant under subparagraph (A) to Puerto Rico, Guam, or the Virgin Islands shall be an amount equal to the quotient obtained by dividing the total amount appropriated under section 8(b)(2) by 3.

(c)(1)(A) One year after the date on which the Secretary makes payment of a grant to a State (other than Puerto Rico, Guam, or the Virgin Islands) under subsection (b)(3), the Secretary shall pay to such State a grant in an amount equal to $1,000,000, except as provided in paragraph (3)(A) and subsection (d).

(B) One year after the date on which the Secretary makes payment of a grant to Puerto Rico, Guam, or the Virgin Islands under subsection (b)(3), the Secretary shall pay to Puerto Rico, Guam, or the Virgin Islands, as the case may be, a grant in an amount equal to $500,000, except as provided in paragraph (3)(B) and subsection (d).

(2)(A) Two years after the date on which the Secretary makes payment of a grant to a State (other than Puerto Rico, Guam, or the Virgin Islands) under subsection (b)(3), the Secretary shall pay to such State a grant in an amount equal to $1,000,000, except as provided in paragraph (3)(A) and subsection (d).

(B) Two years after the date on which the Secretary makes payment of a grant to Puerto Rico, Guam, or the Virgin Islands under subsection (b)(3), the Secretary shall pay to Puerto Rico, Guam, or the Virgin Islands, as the case may be, a grant in an amount equal to $500,000, except as provided in paragraph (3)(B) and subsection (d).

(3)(A) If the amount appropriated under section 8(c)(1) for grants under paragraph (1)(A) is less than $51,000,000, or if the amount appropriated under section 8(d)(1) for grants under paragraph (2)(A) is less than $51,000,000, the amount of a grant to a State (other than Puerto Rico, Guam, or the Virgin Islands) under paragraph (1)(A) or paragraph (2)(A), as the case may be, shall be an amount equal to the quotient obtained by dividing the amount appropriated under section 8(c)(1) or section 8(d)(1), respectively, by 51.

(B) If the amount appropriated under section 8(c)(2) for grants under paragraph (1)(B) is less than $1,500,000, or if the amount appropriated under section 8(d)(2) for grants under paragraph (2)(B) is less than $1,500,000, the amount of a grant to Puerto Rico, Guam, or the Virgin Islands under paragraph (1)(B) or paragraph (2)(B), as the case may be, shall be an amount equal to the quotient obtained by dividing the amount appropriated under section 8(c)(2) or section 8(d)(2), respectively, by 3.

(d)(1) If, at any time after a State receives a grant under this section, the Secretary determines that the State does not have in effect all of the State liability reforms described in section 6, the Secretary shall provide the State with written notice of such determination. Such notice shall specify—

(A) the reasons for the determination of the Secretary;

(B) that after the date of such determination, the State will not be eligible to receive a grant under paragraph (1) or (2) of subsection (c) unless the State takes such corrective action as may be necessary to ensure that the State liability reforms are in effect in the State, except as provided in paragraph (2) of this subsection; and

(C) that the State may request a hearing before an administrative law judge to appeal the determination of the Secretary.

(2) After making a determination under paragraph (1) of this subsection, the Secretary shall not pay any grant to a State under paragraph (1) or (2) of subsection (c) unless the determination of the Secretary under paragraph (1) of this subsection has been reversed by an administrative or judicial decision.

(e)(1) Any grant received by a State under this section shall be used by the State to—

(A) supplement, and not supplant, funds expended by the State on programs for the provision of health care services, including programs supported with any type of Federal assistance, except as provided in paragraph (2);

(B) support programs of peer review and risk management for health care professionals and health care providers in the State; or

(C) conduct studies of professional liability problems in the State, including studies to determine the impact of the State's malpractice compensation system on health care availability and health care costs in the State.

(2) A grant received by a State under this section may not be used by such State to satisfy any provision of Federal law which requires that, in order to qualify for Federal assistance under such law, the State pay a portion of the costs of the project, program, or activity to be conducted with such Federal assistance.

STATE LIABILITY REFORMS

SEC. 6. (a) The State liability reforms which shall be developed with a grant under section 4, which shall be enacted, adopted, or be in effect in a State in order for the State to receive a grant under section 5(b)(3), and which shall be in effect in a State in order for the State to receive grants under section 5(c), are the reforms specified in subsections (b) through (f) of this section.

(b) A State shall require that, in any legal action for damages for malpractice in which a court of the State awards an individual future damages in excess of $100,000—

(1) the payment of such future damages shall be made on an annual or other periodic basis, in such amounts and at such intervals as may be determined by the court;

(2) the court shall determine a schedule for such payments to ensure that damages are paid over the estimated lifetime of such individual or until the total amount of such award is paid to such individual, whichever occurs first, except that—

(A) in any case in which such individual dies prior to the date on which the final payment is to be made under such schedule to such individual, the party obligated to make payments to such individual shall not be required to make any additional payments to the heirs or assigns of such individual unless, after application by the spouse or child of such individual, the court orders such party to make payments to such spouse or child for the support of such spouse or child; and

(B) in any case in which such individual lives beyond the date on which final payment is to be made to such individual under such schedule, such individual may apply to the court for additional payments for economic damages resulting from such malpractice, which shall be calculated at the

annual rate at which such damages were calculated under such schedule; and

(3) the court shall require that such periodic payments be made through the establishment of a trust fund or the purchase of an annuity for the life of such individual or during the continuance of the compensable injury or disability incurred by such individual.

(c)(1) A State shall require that, in any legal action for damages for malpractice in which a court of the State awards damages to an individual, the total amount of such damages shall be reduced by any other payment which has been made or which will be made to such individual to compensate such individual for the injury sustained as a result of such malpractice, including payments under—

(A) Federal or State disability or sickness programs;

(B) Federal, State, or private health insurance programs;

(C) employer wage continuation programs; and

(D) any other source of payment intended to compensate such individual for such injury.

(2) The amount by which an award of damages to an individual for an injury shall be reduced under paragraph (1) shall be an amount equal to the difference between—

(A) the total amount of any payments (other than such award) which have been made or which will be made to such individual to compensate such individual for such injury, minus

(B) the amount paid by such individual (or by the spouse or parent of such individual) to secure the payments described in subparagraph (A).

(d) A State shall require that, in a legal action for damages for malpractice, the amount of any award of damages for noneconomic losses resulting from such malpractice shall not exceed $250,000. For purposes of this subsection, the term "noneconomic losses" means losses for pain, suffering, inconvenience, physical impairment, disfigurement, and other nonpecuniary losses.

(e)(1) Except as provided in paragraph (2), a State shall require that in any legal action for damages for malpractice in which an individual receives a settlement or an award of damages, the amount of payments to such individual's attorney shall be in accordance with the following:

If the total settlement or award is:	The attorney's fee shall not exceed:
Not more than $50,000	40% of such amount
More than $50,000 but less than $100,000.	$20,000 plus 33⅓% of the excess over $50,000
More than $100,000 but less than $200,000.	$36,667 plus 25% of the excess over $100,000
$200,000 or more	$61,667 plus 10% of the excess over $200,000.

(2) A State shall require that in any legal action to which paragraph (1) applies, the court may, after receiving a petition from the attorney representing the individual who receives a settlement or an award of damages, permit such attorney to be paid an amount of fees in excess of the amount specified by paragraph (1) if such court determines the petition has adduced evidence justifying such additional fees.

(f)(1) Each State shall provide for the allocation of the total amount of fees paid to the State in each year for the licensing or certification of each type of health care professional, or an amount of State funds equal to such total amount, to the State agency or agencies responsible for the conduct of disciplinary actions with respect to such type of health care professional.

(2) The State shall require each health care provider to have in effect a risk management program which complies with the laws of the State and which is acceptable to the agency responsible for licensing or certifying such health care provider.

(3) The State shall require each company which provides health care professional liability insurance in the State to—

(A) make available, upon the request of any State board or agency responsible for licensing, certifying, or disciplining health care professionals, information concerning any settlement, judgment, or arbitration award for damages for malpractice against any health care professional over which such board or agency has jurisdiction; and

(B) establish, from the data available to such company, programs of risk management for health care professionals, and require each such professional, as a condition of maintaining insurance, to participate in such programs at least once in each three-year period.

(4)(A) The State shall authorize each State agency responsible for the conduct of disciplinary actions for a type of health care professional to enter into agreements with State or county professional societies of such type of health care professional to permit the review by such societies of any malpractice action, complaint, or other information concerning the practice patterns of any such health care professional. Any such agreement shall comply with subparagraph (B).

(B) Any agreement entered into under subparagraph (A) for the review of any malpractice action, complaint, or other information concerning the practice patterns of a health care professional shall—

(i) provide that the health care professional society conduct such review as expeditiously as possible;

(ii) provide that after the completion of such review, such society shall report its findings to the State agency with which it entered into such agreement and shall take such other action as such society considers appropriate; and

(iii) provide that the conduct of such review and the reporting of such findings be conducted in a manner which assures the preservation of confidentiality of medical information and of the review process.

(C) The State shall provide that any activity conducted pursuant to an agreement under this paragraph shall not be grounds for any civil or criminal action under the antitrust laws of the State or for any other civil action under the laws of the State.

(D) Notwithstanding any other provision of Federal law, any activity conducted pursuant to an agreement under this paragraph shall not be grounds for any civil or criminal action under Federal antitrust laws, as defined in the first section of the Clayton Act and in section 4 of the Federal Trade Commission Act.

REPORTS

SEC. 7. (a) Within two years after the date of enactment of this Act, and every two years thereafter, each State which receives a grant under section 5 during any such two-year period shall prepare and transmit to the Secretary a report which describes—

(1) the State liability reforms enacted, adopted, or in effect in the State;

(2) the activities conducted by the State with any grants received under section 4 or 5 during the preceding two-year period; and

(3) any current problems in the State with respect to health care professional liability or health care professional liability insurance.

(b) Within 30 months after the date of enactment of this Act, and every two years thereafter, the Secretary shall prepare and transmit to the Congress a report which summarizes the information submitted to the Secretary in the most recent reports of the States under subsection (a).

AUTHORIZATION OF APPROPRIATIONS

SEC. 8. (a)(1) For grants under section 4(b)(2), there are authorized to be appropriated $12,500,000 for fiscal year 1987.

(2) For grants under section 4(b)(3), there are authorized to be appropriated $375,000 for fiscal year 1987.

(b)(1) For grants under section 5(b)(3)(B), there are authorized to be appropriated $102,000,000 for fiscal year 1987.

(2) For grants under section 5(b)(3)(C), there are authorized to be appropriated $3,600,000 for fiscal year 1987.

(3) Amounts appropriated under this subsection shall remain available from October 1, 1986, to September 30, 1989.

(c)(1) For grants under section 5(c)(1)(A), there are authorized to be appropriated $51,000,000 for fiscal year 1988.

(2) For grants under section 5(c)(1)(B), there are authorized to be appropriated $1,500,000 for fiscal year 1988.

(3) Amounts appropriated under this subsection shall remain available from October 1, 1987, to September 30, 1990.

(d)(1) For grants under section 5(c)(2)(A), there are authorized to be appropriated $51,000,000 for fiscal year 1989.

(2) For grants under section 5(c)(2)(B), there are authorized to be appropriated $1,500,000 for fiscal year 1989.

(3) Amounts appropriated under this subsection shall remain available from October 1, 1988, to September 30, 1991.

By Mr. TRIBLE:

S. 1805. A bill to amend title 5, United States Code, to increase the opportunity to provide a survivor annuity under subchapter III of chapter 83 of such title; and to improve retirement counseling for Federal Government employees; to the Committee on Governmental Affairs.

ELECTION OF SURVIVOR ANNUITY

Mr. TRIBLE. Mr. President, today I am introducing legislation of critical importance to Federal retirees and their spouses. This legislation would ensure that retired Federal employees are provided with a sufficient opportunity to elect a survivor annuity under civil service retirement. My colleague from Virginia, Representative FRANK WOLF, is introducing similar legislation in the House.

Under current law, Federal employees must make a decision regarding the selection of survivor benefits prior to retirement. Once that decision is made it is irrevocable. If a retiree does not elect to provide a survivor annuity, then there is no opportunity to change that decision.

Far too often, this decision is based upon incorrect or incomplete information and advice provided by the Federal employee's personnel retirement counselor. As a result, and in spite of the retiree's wishes, some survivors of Federal retirees are left unprotected and without any source of income upon the death of their spouse.

Mr. President, my legislation will eliminate this unfortunate situation. It would provide Federal retirees with a second opportunity to elect survivor benefits if they have not already done

By Mr. DURENBERGER (for himself and Mr. DANFORTH):

S. 1960. A bill entitled the "Medical Offer and Recovery Act"; to the Committee on Finance.

MEDICAL OFFER AND RECOVERY ACT

● Mr. DURENBERGER. Mr. President, today I am introducing the Mdicial Offer and Recovery Act along with my distinguished colleague, the Senator from Missouri [Mr. DANFORTH]. I am introducing this bill as a courtesy to my distinguished House colleagues, Representatives MOORE and GEPHARDT. It is a companion bill to H.R. 3084 which would propose to reform this country's medical malpractive system. This measure includes refinements to the proposal which they introduced last year and I am including a summary of the bill after my statement which outlines the provisions and changes from last year's version.

My House colleagues spent considerable time and effort developing this proposal and it is a serious contribution to a much needed national debate. It is the one major measure that provides an alternative to State tort reform, and therefore deserves examination and scrutiny in the Senate along with another important measure, S. 1804, introduced by my distinguished Senate colleague, ORRIN HATCH. His proposal is authored by the American Medical Association.

Mr. President, there is no question that the funding of malpractice insurance is reaching a crisis point. I was reading an article in the Mankato Free Press from my own State of Minnesota, about a young woman named Ann McCall, who was looking forward to having the doctor who had delivered her 21 years before also deliver her new baby. Just 2 weeks before the anticipated delivery date, her doctor informed her that he was turning over his obstetric practice to another doctor because he could no longer afford the escalating cost of his malpractice insurance premiums. Zachary McCall was born to Ann and Pat McCall with the assistance of a physician they had known for only 2 weeks.

This story is repeated every day all over this country. And it's happening because there are major problems with the medical malpractice system in the United States.

Malpractice insurance premium costs are skyrocketing, reaching as high as $100,000 a year for some speciality physicians in certain areas of the country. The number of malpractice claims has tripled over the past decade and million dollar settlements happen on a regular basis. The average settlement has grown from $5,000 to over $300,000 in just 6 years.

Growing numbers of claims have resulted in physicians practicing defensive medicine. The AMA estimates that this may cost Americans at least $15 billion a year in extra costs. Still the number of claims against doctors continues to grow, and the public pays for it through high hospital bills, doctor bills, and health insurance premiums.

Higher malpractice insurance costs force doctors and hospitals to raise their charges and pass these costs on to third party payers and consumers. It is also pricing some physicians out of business. The Minnesota Medical Association estimates that 40 family practice doctors have stopped delivering babies and more are expected to drop the obstetric part of their practice. This could create serious problems for residents in rural Minnesota and similar areas around the country who rely on their community doctor for all their medical care.

The litigation of malpractice cases is unwieldy and expensive. It is also time-consuming and inequitable. A few plaintiffs are awarded large recoveries, but only after a long, drawn out litigation process. But the real tragedy is that the expense of litigation discourages many with valid claims from even prosecuting those claims. And international reinsurance companies are threatening to quit reinsuring American malpractice insurance companies. These reinsurers are concerned that damage awards in the United States have gotten too far out of line from premium revenues.

These problems are not new. In the mid-1970's, in response to increased numbers of claims and sizes of settlements, many liability insurance carriers were left out of the market and others had to raise their premiums by as much as 750 percent. The States responded to this by enacting medical malpractice before legislation. But these reforms have obviously not had much of an effect.

States are now taking even more steps to reform their tort laws. I was in Florida in November and learned about their newly passed law which includes a sliding fee scale for attorneys' contingency fees. States are trying other methods of reform, and the jury is still out on the likely success of these measures. We will watch these changes closely. But it is time to determine whether a Federal role in this area is appropriate.

The crisis may be upon us again. This demands action. We must bring down the cost of malpractice insurance to physicians, insurers, and the public, and at the same time, create a more equitable, efficient system to adjudicate malpractice. At a time when the health care marketplace is becoming more and more cost conscious, we can ill afford this lopsided, ineffective malpractice system that perpetuates an insensitivity to price and unresponsiveness to fairness.

I trust the new year will bring serious debate and resolution of the professional liability crisis. I intend to be at the center of that debate. Mr. President, I ask unanimous consent that the bill and summary of the Medical Offer and Recovery Act be printed in the RECORD.

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

S. 1960

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Medical Offer and Recovery Act".

SEC. 2. ALTERNATIVE LIABILITY SYSTEM FOR MAL. PRACTICE

(a) MEDICARE AMENDMENT.—Part A of title XVIII of the Social Security Act is amended—

(1) by inserting after the heading to part A the following new subpart heading:

"Subpart I—Hospital Insurance Program", and

(2) by adding at the end the following new subpart:

"Subpart II—Alternative Liability System for Malpractice

"TENDER OF COMPENSATION BENEFITS IN SETTLEMENT OF MALPRACTICE CLAIMS

"SEC. 1821. (a)(1)(A) In the case of a health care provider (as defined in paragraph (4)(D)) which—

"(i) is participating in an assigned claims plan under section 1826 and

"(ii) is potentially liable for a personal injury (as defined in paragraph (4)(A)) to an injured individual,

if the provider provides the individual not later than the date specified in subparagraph (C) with a written tender to pay compensation benefits with respect to such injury in accordance with this subpart, the individual and any other entity shall (except as provided in paragraph (3)) be foreclosed from bringing any civil action described in paragraph (2) against such provider or other entity joined under subsection (b) based on such personal injury.

"(B) If the provider fails to provide an individual with such a written tender on a timely basis with respect to a personal injury, the individual may, during the 90-day period beginning on the date specified in subparagraph (C), serve on the provider a written request for arbitration on the question of the legal liability for the personal injury and the provisions of this section shall apply as though a tender under subparagraph (A) had been made. If the arbitrator determines that the provider was wholly or partly legally liable for the personal injury—

"(i) the amount of the liability of the provider shall be determined as though the provider had made a timely tender under subparagraph (A), and

"(ii) the provider shall be liable for reasonable attorneys fees incurred by the individual who requested the arbitration.

"(C) The date referred to in subparagraphs (A) and (B) is—

"(i) in the case of a personal injury resulting from a stay as an inpatient in an institution, 180 days after the date of the patient's discharge from the institution,

"(ii) in the case of failure to provide informed consent, erroneous diagnosis, or injury to a new born caused by action or inaction before or at the time of birth, 180 days after the date of the filing of a claim against the provider, or

"(iii) in the case of any other personal injury, 180 days after the date of the action or inaction giving rise to the personal injury,

except that such date may be extended for up to an additional 60 days for purposes of subparagraph (A) if the provider and the patient agree in writing to such extension.

"(D) Nothing in this subpart shall be construed as changing any applicable statute of limitations of any State or of the United States.

"(2)(A) Except as provided in subparagraph (B), civil actions referred to in paragraph (1) include any civil action (whether brought in a Federal or State court) which could have been brought against a compensation obligor (as defined in subsection (d)(1)) for recovery of damages relating to personal injury, whether based on (i) negligence or gross negligence, (ii) strict or absolute liability in tort, (iii) breach of express or implied warranty or contract, (iv) failure to discharge a duty to warn or instruct or to obtain consent, or (v) any other theory that is (or may be) a basis for an award of damages for personal injury.

"(B) Civil actions referred to in subparagraph (1) do not include—

"(i) any action to recover for compensation benefits tendered under this subpart, or

"(ii) any action in the nature of a wrongful death action, but only in the case of such an action for losses accruing to survivors after the death of an injured individual and resulting from the death of the individual.

"(3) In no event shall a civil action be foreclosed under paragraph (1) against any entity which intentionally caused or intended to cause injury, except that this paragraph shall not apply with respect to a personal injury unless the injured individual provides the provider making a tender with a notice of election not later than 90 days after the date the tender of compensation benefits was made.

"(4) As used in this subpart:

"(A) The terms 'injury' and 'personal injury' mean sickness or disease or bodily harm arising in the course of the provision of health care services provided pursuant to (or for which payment may be made under) this title, a State plan approved under title XIX, plans under sections 1079 and 1086 of title 10, United States Code (relating to the CHAMPUS program), section 613 of title 38, United States Code (relating to the CHAMPVA program), a health benefits plan pursuant to a contract with the Office of Personnel Management under chapter 89 of title 5, United States Code (relating to the Federal employees health benefits program), title 10 or title 38 of the United States Code (relating to the Department of Defense and the Veterans' Administration), or any other program established under Federal law.

"(B) The term 'injured individual' means an individual suffering injury in the course of health care provided by an individual or entity.

"(C) An entity intentionally causes or attempts to cause a personal injury when the entity acts or fails to act for the purpose of causing injury or with knowledge that injury is substantially certain to follow; but an entity does not intentionally cause or attempt to cause injury merely because the individual's act or failure to act is intentional or is done with the individual's realization only that it creates a grave risk of causing injury without the purpose of causing injury or if the act or omission is for the purpose of averting bodily harm to the individual or another entity.

"(D) The term 'health care provider' means—

"(i) any institution described in subsection (e)(1), (f)(1), (j)(1) of section 1861 which is a Federal institution or meets the requirement of section 1861(e)(7),

"(ii) an agency or organization described in section 1861(e)(1) which meets the requirement of section 1861(o)(4),

"(iii) any health care professional described in section 1861(r), and

"(iv) a rural health clinic (as defined in section 1861(aa)(2)), a comprehensive outpatient rehabilitation facility (as defined in section 1861(cc)(2)), and a hospice program (as defined in section 1861(dd)(2)).

"(E) The term 'entity' includes an individual or person.

"(b)(1)(A) A health care provider which has tendered (or deemed to have tendered) compensation benefits under subsection (a) may, by written notice to the entity, join in the foreclosure provided under subsection (a) any entity which is potentially liable, in whole or in part, for the personal injury and who may benefit from foreclosure of action against the entity under subsection (a). Joinder under this subparagraph may only be by written notice to the entity to be joined and such notice shall not be effective if provided later than the date the provider makes the tender under subsection (a).

"(B) Any entity which would benefit from foreclosure of action against the entity under subsection (a) with respect to a personal injury shall be joined in any tender made (or deemed to have been made) under subsection (a) with respect to that injury if the entity requests such joinder by written notice to the provider making the tender under subsection (a) not later than the date the tender under subsection (a) is made.

"(2) By joinder under this subsection, an entity is deemed to have agreed to pay a share of (A) such compensation benefits and (B) the reasonable costs incurred by the provider in preparing and making such tender and paying compensation benefits. Any disagreement between such entities involved as to any entity's share of the benefits and costs or the amount of such costs shall be submitted to binding arbitration for determination and each entity's share shall be based on the comparative fault of the entities (other than the injured individual) involved.

"(c)(1) Any entity which has tendered (or deemed to have tendered) compensation benefits with respect to an individual under subsection (a) or been joined in the tender under subsection (b) shall be subrogated to any rights of the individual against another entity (other than against another entity joined under subsection (b)) arising from or contributing to the personal injury and shall have a cause of action separate from that of the individual to the extent that (A) elements of damage compensated for by compensation benefits are recoverable and (B) the entity has paid or becomes obligated to pay accrued or futare compensation benefits.

"(2) In the case that a foreclosure from liability is effected under subsection (a), no right of subrogation, contribution, or indemnity shall exist against a compensation obligor other than the right of contribution among compensation obligors under subsection (b)(2), nor shall any provision of any contract be enforced that has the effect of limiting or excluding payment under that contract because of the existence or payment of compensation benefits under this subpart.

"(3) The District Courts of the United States shall not have jurisdiction under section 1331 or 1337 of title 28, United States Code, over any civil action arising under this subpart.

"(d) As used in this subpart:

"(1) The term 'compensation obligor'—

"(A) means, with respect to a personal injury, the health care provider that has obligated itself to pay compensation benefits under subsection (a) with respect to that injury, and

"(B) includes—

"(i) any entity that has been joined under subsection (b) with respect to that injury, and

"(ii) any other entity (including an insurance company) which is contractually responsible for payment of the obligations of a compensation obligor under this subpart.

"(2) The term 'initiating compensation obligor' means, with respect to a personal injury, the compensation obligor which (A) first tenders compensation benefits to the injured individual, or (B) agrees to serve as an initiating compensation obligor and has been designated as such by a majority of the compensation obligors for that injury for purposes of this subpart.

"AMOUNT OF, AND ADJUSTMENTS TO, COMPENSATION BENEFITS

"Sec. 1822. (a)(1) The amount of compensation benefits payable with respect to a personal injury is equal to the net economic loss (as defined in subsection (b)(1)) resulting from such injury, plus attorney's fees (as provided under subsection (c)).

"(b) For purposes of this subpart:

"(1) The term 'net economic loss' means—

"(A) economic detriment, consisting only of—

"(i) allowable expense (as defined in paragraph (2)(A)),

"(ii) work loss (as defined in paragraph (2)(B)), and

"(iii) replacement services loss (as defined in paragraph (2)(C)),

whether, caused by pain and suffering or physical impairment, but not including noneconomic loss (as defined in paragraph (3)), less collateral benefits (as defined in paragraph (4)).

"(2)(A) The term 'allowable expense' means reasonable expenses incurred for products, services, and accommodations reasonably needed for medical care, training, and other remedial treatment and care of an injured individual, but includes expenses for rehabilitation treatment and occupational training only in accordance with subsection (d).

"(B) The term 'work loss' means 100 percent of the loss of income from work the injured individual would have performed if the individual had not been injured, reduced by any income from substitute work actually performed by the individual or by income the individual would have earned in available appropriate substitute work the individual was capable of performing but unreasonably failed to undertake.

"(C) The term 'replacement services loss' means reasonable expenses incurred in obtaining ordinary and necessary services in lieu of those the injured individual would have performed, not for income but for the benefit of the individual or the individual's family, if the individual had not been injured.

"(3) The term 'noneconomic detriment' means pain, suffering, inconvenience, physical impairment, mental anguish, emotional pain and suffering, punitive or exemplary damages, and all other general (as opposed to special) damages, including loss of earning capacity and loss of any of the following which would have been provided by an injured individual to another: consortium, society, companionship, comfort, protection, marital care, attention, advice, counsel, training, guidance, and education. Such term does not include pecuniary loss caused by pain and suffering or by physical impairment.

"(4) The term 'collateral benefits' means all benefits and advantages received or entitled to be received (regardless of any right any other entity has or is entitled to assert for recoupment through subrogation, trust agreement, lien, or otherwise) by an injured individual or other entity as reimbursement of loss because of personal injury, payable or required to be paid, under—

"(A) the laws of any State or the Federal government (other than through a claim for breach of an obligation or duty), or

"(B) any health or accident insurance, wage or salary continuation plan, or disability income insurance;

except that no benefits payable with respect to an injury under a State plan approved under title XIX shall be considered to be collateral benefits for purposes of this subparagraph.

"(c)(1) Compensation benefits shall include reasonable expenses incurred by the injured individual in collecting such benefits, including a reasonable attorney's fee. Such expenses may be offset from the amount of compensation benefits otherwise provided, if any significant part of a claim for compensation benefits is fraudulent or so excessive as to have no reasonable foundation.

"(2) A compensation obligor defending a claim for compensation benefits shall be allowed a reasonable attorney's fee, in addition to other reasonable expenses incurred, in defending such a claim or part thereof that is fraudulent or so excessive as to have no reasonable foundation. The fee or expenses may be treated as an offset to any compensation benefits due. The compensation obligor may recover from the claimant any part of the fee or expenses not offset or otherwise paid.

"(d)(1) Allowable expenses under subsection (b)(2)(A) include expenses for a procedure or treatment for rehabilitation and rehabilitative occupational training if the procedure, treatment, or training is reasonable and appropriate for the particular case, the expenses are reasonable in relation to the probable rehabilitative effects and the compensation benefits otherwise payable, and it is likely to contribute substantially to rehabilitation, even though it will not enhance the injured individual's earning capacity.

"(2) Allowable expenses shall not include expenses described in paragraph (1) with respect to a procedure or treatment for rehabilitation or a course of rehabilitative occupational training which exceed $2,000 in any 30-day period unless the injured individual has provided the initiating compensation obligor with notice of such procedure, treatment, or course of training before expenses totaling $2,000 with respect to such procedure, treatment, or course of training during such period have been incurred.

"PAYMENT OF COMPENSATION BENEFITS

"SEC. 1823. (a)(1)(A) Compensation benefits shall be paid not later than 30 days after the date there is submitted to the initiating compensation obligor reasonable proof of the fact and amount of net economic loss incurred, except that payment may be made, for expenses incurred over periods not exceeding 31 days, within 15 days after the end of the period. If reasonable proof is supplied as to only a portion of net economic loss, and the portion totals $100 or more, the compensation benefits with respect to that portion shall be paid without regard to the remainder of the net economic loss. An injured individual to whom a tender of compensation benefits has been made under section 1821 shall be entitled to interest, at the annual rate of interest applied to judgments in the State in which the injury occurred, on such benefits not paid on a timely basis.

"(B) If there elapses a period of five years after a claim for payment of net economic loss incurred is last made with respect to a personal injury, the injured individual is no longer entitled to receive compensation benefits with respect to that injury.

"(2) A compensation obligor who rejects in whole or in part a claim for compensation benefits shall give to the claimant prompt written notice of the rejection and the reasons therefor.

"(3) Compensation benefits with respect to allowable expenses may be paid either to the injured individual or to the entity supplying the products, services, or accomodations to the individual.

"(b) In lieu of payment therefor as a part of allowable expenses and with the consent of the injured individual, a health care provider may provide medical or rehabilitative services needed by the injured individual.

"(c)(1) Except as otherwise provided in this subsection, subsection (d)(2), or section 1822(c)(2), compensation benefits shall be paid without deduction or setoff.

"(2) An assignment or an agreement to assign any right to compensation benefits under this subpart for net economic loss accruing in the future is unenforceable except as to benefits for—

"(A) work loss to secure payment of alimony, maintenance, or child support; or

"(B) allowable expenses to the extent the benefits are for the cost of products, services, or accomodations provided or to be provided by the assignee.

"(3)(A) Compensation benefits for allowable expense are exempt from garnishment, attachment, execution, and any other process or claim, except upon a claim of a creditor who has provided products, services, or accommodations to the extent benefits are for allowable expense for those products, services, or accommodation.

"(B) Compensation benefits other than those for allowable expense are exempt from garnishment, attachment, execution, and any other process or claim to the extent that wages or earnings are exempt under any applicable law exempting wages or earnings from process or claims.

"(4)(i) Except as provided in clause (iii), a claim for compensation benefits shall be paid without deduction or offset for collateral benefits, if the collateral benefits have not been paid to the injured individual before the incurring of expenses included in net economic loss.

"(ii) The compensation obligor is entitled to reimbursement from the entity obligated to make the payments or from the entity which actually receives the payments.

"(iii) A compensation obligor may offset amounts it is entitled to recover under clause (ii) against any compensation benefits otherwise due.

"(d)(1) An entity making payment of compensation benefits under this subpart may bring an action against an entity to recover compensation benefits paid because of an intentional misrepresentation of a material fact by that entity upon which the entity relied, except that such an action may not be brought against the injured individual unless the injured individual made or had knowledge of the making of the misrepresentation.

"(2) If such entity secures judgment in an action under paragraph (1), the entity may offset amounts it is entitled to recover under such judgment against any compensation benefits otherwise due.

"REQUIRING DISCLOSURE OF FACTS ABOUT, AND MENTAL AND PHYSICAL EXAMINATION OF, INJURED INDIVIDUALS

"SEC. 1824. (a)(1) Upon request of an injured individual or compensation obligor, information relevant to payment of compensation benefits shall be disclosed as follows:

"(A) The injured individual shall furnish evidence of the individual's earnings, if self-employed.

"(B) An employer of the individual shall furnish a statement of the work record and earnings of an injured individual who is or was an employee of the employer, for the period specified by the injured individual or obligor making the request, which may include a reasonable period before, and the entire period after, the injury.

"(C) The injured individual shall deliver to the compensation obligor upon request a copy of every written report, not otherwise available to the compensation obligor, previously or thereafter made, available to the individual, concerning any medical treatment or examination of the injured individual and the names and addresses of hospitals, physicians, and other entities, examining, diagnosing, treating, or providing accommodations to the individual in regard to the injury or to a relevant past injury, and the injured individual shall authorize the compensation obligor to inspect and copy all relevant records made by such entities.

"(D) A hospital, physician, or other entity examining, diagnosing, testing, or providing accommodations to an injured individual in connection with a condition alleged to be connected with an injury upon which a claim for compensation benefits is based, upon authorization of the injured individual, shall furnish a written report of the history, condition, diagnosis, medical tests, treatment, and dates and cost of treatment

of the injured individual in connection with that condition or any previous or other condition which may be relevant to assessing such condition, and permit inspection and copying of all records and reports as to the history, condition, treatment, and dates and cost of treatment.

Any entity (other than the injured individual or a compensation obligor) providing information under this paragraph may charge the entity requesting the information for the reasonable cost of providing it.

"(2) In case of dispute as to the right of an injured individual or compensation obligor to discover information required to be disclosed under this subsection, the individual or obligor may petition a court having jurisdiction over the matter for an order for discovery, including the right to take written or oral depositions. Upon notice to all entities having an interest, the order may be made for good cause shown. It shall specify the time, place, manner, conditions, and scope of the discovery. To protect against oppression, the court may enter an order refusing discovery or specifying conditions of discovery and directing payment of costs and expenses of the proceeding, including reasonable attorney's fees.

"(b)(1) If the mental or physical condition of an injured individual is material and relevant to compensation benefits, a compensation obligor may petition a court having jurisdiction over the matter for an order directing the individual to submit to a mental or physical examination by a physician. Upon notice to the individual to be examined and all entities having an interest, the court may make the order for good cause shown. The order shall specify the time, place, manner, conditions, scope of the examination, and the physician by whom it is to be made.

"(2) If requested by the individual examined, a compensation obligor causing a mental or physical examination to be made shall deliver to the individual examined a copy of the written report of the examining physician, and reports of earlier examinations of the same condition. By requesting and obtaining a report of the examination ordered or by taking the deposition of the physician, the individual examined waives any privilege the individual may have, in relation to the claim for compensation benefits, regarding the testimony of every other person who has examined or may thereafter examine the individual respecting the same condition. This subsection does not preclude discovery of a report of an examining physician, taking a deposition of the physician, or other discovery procedures in accordance with any rule of court or other provision of law. This paragraph applies to examinations made by agreement of the individual examined and a compensation obligor, unless the agreement provides otherwise.

"(3) If any individual refuses to comply with an order entered under this subsection, the court may make any just order as to the refusal, but may not find a individual in contempt for failure to submit to a mental or physical examination.

"(c) If a health care provider tenders compensation benefits with respect to an injured individual under this subpart and there is a dispute between the initiating compensation obligor and the injured individual respecting the determination of the amount of the compensation benefits owing, except as otherwise provided under this subpart, the initiating compensation obligor or the individual may apply to a court with appropriate jurisdiction for a declaration as to the amount of the compensation benefits owed.

"LUMP SUM AND INSTALLMENT SETTLEMENTS AND DECLARATIONS OF BENEFITS

"SEC. 1825. (a) An obligation to pay compensation benefits may be discharged initially or at any time thereafter by a settlement or lump sum payment, except that no such discharge shall be made with respect to an injury with a current value of net economic loss exceeding $5,000 unless a court having jurisdiction over the matter determines that the settlement is fair to the injured individual. A settlement agreement may also provide that the compensation obligor shall pay the reasonable cost of appropriate medical treatment or procedures, with reference to a specified condition, to be performed in the future.

"(b)(1) In an action for payment of unpaid compensation benefits, a judgment may be entered for compensation benefits, other than allowable expense, that would accrue after the date of the award. The court may enter a judgment declaring that the compensation obligor is liable for the reasonable cost of appropriate medical treatment or procedures, with reference to a specified condition, to be performed in the future if it is ascertainable or foreseeable that treatment will be required as a result of the injury for which the claim is made.

"(2) A judgment for compensation benefits, other than with respect to allowable expenses, that will accrue thereafter may be entered only for a period as to which the court can reasonably determine future net economic loss.

"(3) If the injured individual notifies the initiating compensation obligor of a proposed specified procedure or treatment for rehabilitation or specified course of rehabilitation occupational training the expenses of which are an allowable expense and the compensation obligor does not promptly agree to such characterization, the injured individual may move the court in an action to adjudicate the individual's claim, or, if no action is pending, bring an action in a court having jurisdiction over the matter for a determination respecting whether or not such expenses are allowable expenses for which compensation benefits are payable. The initiating compensation obligor may move the court in an action to adjudicate the injured individual's claim, or, if no action is pending, bring an action in a court having jurisdiction over the matter for such a determination as to whether or not expenses for such a procedure, treatment, or course or training which an injured individual has undertaken or proposes to undertake are allowable expenses for which compensation benefits are payable. This subsection does not preclude an action by the initiating compensation obligor or the injured individual for declaratory relief under any other applicable law, nor an action by the injured individual to recover compensation benefits.

"(4) If an injured individual unreasonably fails, either directly or through one legally empowered to act on the individual's behalf, to obtain medical care, rehabilitation, rehabilitative occupational training, or other medical treatment which is reasonable and appropriate, the initiating compensation obligor may move the court in an action to adjudicate the injured individual's claim, or, if no action is pending, may bring an action in a court having jurisdiction over the matter for a determination that future benefits will be reduced or terminated so that they equal the benefits that in reasonable probability would have been due if the injured individual had submitted to the procedure, treatment, or training, and for other reasonable order. In determining whether an injured individual has reasonable ground for refusal to undertake the procedure, treatment, or training, the court shall consider all relevant factors, including the risks to the injured individual, the extent of the probable benefit, the place where the procedure, treatment, or training is offered, the extent to which the procedure, treatment, or training is recognized as standard and customary, and whether the restriction of this paragraph because of the individual's refusal would abridge the individual's right to the free exercise of religion.

"(c)(1) A settlement agreement or judgment under this section may be modified as to amounts to be paid in the future upon a finding that a material and substantial change of circumstances has occurred after the date the agreement or judgment was made, or that there is newly discovered evidence concerning the injured individual's physical condition, loss, or rehabilitation, which would not have been known previously or discovered in the exercise of reasonable diligence prior to such agreement or judgment.

"(2) The court may make appropriate orders concerning the safeguarding and disposing of the proceeds of settlement agreements and funds collected under judgments under this section.

"(3) A settlement agreement or judgment for compensation benefits may be set aside if it is found to have been procured by fraud.

"ASSIGNED CLAIMS PLAN

"SEC. 1826. (a) In order to participate in the alternative liability program under this subpart, a health care provider must participate, directly or through an insurance company which has agreed to be the compensation obligor with respect to that provider, in an assigned claims plan which meets the requirements of this section in order to insure the payment of compensation benefits by compensation obligors.

"(b)(1) Entities (including insurance companies) in a State may organize and maintain, subject to approval and regulation by the regulator of insurance therein, an assigned claims plan and adopt rules for its operation (including designation of assignees) consistent with this section.

"(2) If such a plan is not established or maintained in a State, whether organized by such entities or otherwise under State law, the Secretary shall organize and maintain an assigned claims plan for the State meeting the requirements of this section for purposes of this subpart. The Secretary may not establish an assigned claims plan under this paragraph with respect to health care providers located in a State unless the Secretary determines that no plan under paragraph (1) has been established in the State and the Secretary has provided the State with notice providing the State at least six months in which to establish such a plan.

"(3) Each assigned claims plan shall provide for assessment of costs on a fair and equitable basis consistent with this subpart and providing for assignment of claims in accordance with subsection (c). An assigned claims plan may not permit an entity covered under the plan to withdraw from the plan retrospectively.

"(c)(1) An injured individual entitled to compensation benefits from a compensation obligor pursuant to this subpart may obtain them through the assigned claims plan established pursuant to this section if the initiating compensation obligor obligated therefor is financially unable to fulfill its obligation.

"(2) Where an assigned claims plan finds that a compensation obligor which is associated with such plan reasonably is financially unable to pay the compensation benefits

it owes, the assigned claims plan shall promptly assign the claims to a member or members of the plan and notify the individual or individuals entitled to receive such benefits of the identity and address of the assignee or assignees. Claims shall be assigned so as to minimize inconvenience to injured individuals. Any such assignee shall have all rights and obligations as if it had lawfully obligated itself to pay such compensation benefits and the plan and assignee may seek payment (including interest) from the compensation obligor or its successor of 120 percent of the costs and expenses incurred in fulfilling the obligor's obligations.

"(d) If an obligation qualifies for assignment under this section, the assigned claims plan or any compensation obligor to whom the claim is assigned is subrogated to all rights of the injured individual against any compensation obligor, its successor in interest or substitute, legally obligated to provide compensation benefits to the injured individual, for compensation benefits provided by the assignee.

"ACTIVITIES TO ENHANCE QUALITY OF CARE

"SEC. 1827. (a)(1) As a condition of participation for an institutional health care provider (as defined in subsection (c)(3)) under this title, if the provider—

"(A) takes an action adversely affecting the clinical privileges of a health care professional (other than a suspension of clinical privileges for a period of 30 days or less), or

"(B) terminates or does not renew a contract with a health care professional,

for reasons relating to the professional incapability (as defined in subsection (c)(7)) of the professional, the provider shall submit a written report detailing the action to the appropriate health care licensing board in the jurisdiction where the provider is located.

"(2)(A) Except as provided in subparagraph (C), no one shall disclose—

"(i) the identity of an entity that provides information to an institutional health care provider (or to a peer review committee) concerning the professional incapability of a health care professional who is or was a member of (or who has applied for membership in) the medical staff of the provider, and

"(ii) the minutes, analyses, findings, deliberations, and reports of a peer review committee.

"(B) Except as provided in subparagraph (C), information described in subparagraph (A) shall not be subject to discovery, and is not admissible into evidence, in any civil, administrative, or criminal proceeding.

"(C) The restrictions of subparagraphs (A)(ii) and (B) shall not apply to the disclosure, upon the request of a health care professional against whom an adverse action is taken by the institutional health care provider, of information relating to that professional, but only if the disclosure is made in a proceeding to determine the lawfulness of the adverse action.

"(b)(1) In the case of a health care professional who is or was a member of (or who has applied for membership in) the medical staff of an institutional health care provider, no one shall be liable to anyone in damages—

"(A) for an institutional health care provider transmitting to a health care licensing board or to another institutional health care provider information respecting the professional, or

"(B) for any entity transmitting to an institutional health care provider (or a peer review committee) information bearing on the professional incapability of the professional,

unless—

"(i) the information transmitted was false, and

"(ii) the entity transmitting the information (I) knew (or had reason to believe) that the information was false, and (II) acted with actual malice in transmitting the information.

"(2) No one shall be liable in damages for any decision (or recommendation of a peer review committee) adversely affecting the clinical privileges of a health care professional or terminating or failing to renew a contract with a health care professional, if the decision (or recommendation) was made in good faith for the purpose of enhancing the quality of care furnished by the provider.

"(c) As used in this section:

"(1) The term 'adversely affecting the clinical privileges' means reducing, restricting, suspending, revoking, denying, or failing to renew clinical privileges.

"(2) The term 'health care licensing board' means, with respect to a health care professional, the governmental board, commission, or other authority (if any) responsible for the licensing of a health care professional of that type.

"(3) The term 'institutional health care provider' means a health care provider described in section 1821(a)(4)(D)(i).

"(4) The term 'medical staff' means the professional staff of an institutional health care provider.

"(5) The term 'peer review activity' means any activity engaged in by an institutional health care provider—

"(A) in determining which health care professionals may have clinical privileges at the provider,

"(B) in determining the scope and conditions of these privileges, or

"(C) in changing or modifying these privileges.

"(6) The term 'peer review committee' means—

"(A) the governing body (or any committee thereof) of an institutional health care provider when conducting a peer review activity, and

"(B) any committee of the medical staff of an institutional health care provider assisting the governing body in a peer review activity under the authority of (and with functions delineated by) the governing body.

"(7) The term 'professional incapability' means professional incompetence, mental or physical impairment, or unprofessional or unethical conduct.

"REQUIRING MALPRACTICE INSURANCE FOR PHYSICIANS TO OBTAIN BENEFITS OF SUBPART

"SEC. 1828. A health care professional described in section 1861(r) may not participate in the alternative liability program under this subpart unless the professional has insurance against professional malpractice (or has a suitable bond or other indemnity against liability for professional malpractice) at least in such amount as the Secretary determines to be appropriate, based on the amounts that are consistent with the insurance or bond maintained by professionals in the community and specialty involved.

"EFFECTIVE DATE AND APPLICATION OF ALTERNATIVE STATE MEDICAL LIABILITY LAW

"SEC. 1829. Notwithstanding any other provision of this subpart, the preceding provisions of this subpart shall not apply to any personal injury occurring—

"(1) before January 1, 1988, or

"(2) in a State which has in effect a law that the Secretary determines is designed to bring about prompt payment for loss in the case of damages relating to sickness, disease, or bodily harm arising from the provision of health care services.".

(b) PREVENTING DUPLICATE PAYMENTS.—The first sentence of section 1862(b)(1) of the Social Security Act (42 U.S.C. 1395y(b)(1)) is amended by inserting before the period at the end the following: "or as compensation benefits under subpart II of part A or under an alternative State liability law meeting the requirements of section 1829(2)".

EXPLANATION OF THE MEDICAL OFFER AND RECOVERY ACT OF 1985 BY CONGRESSMEN W. HERSON MOORE AND RICHARD A. GEPHARDT

RATIONALE

The country again is facing a medical malpractice crisis. Litigation is increasing rapidly. The relationship between physicians and patients has become an adversarial one. Physicians engage in the practice of defensive medicine. They raise their fees to patients to offset increased insurance premiums. In some cases they abandon their practices, making it more difficult for patients to obtain care.

Patients are not being well-served by the current malpractice litigation system. Today's system does not provide a fair, rapid or rational method for compensating victims of medical malpractice. The process requires patients, physicians and hospitals to assume stances diametrically opposed to their best interest. The high cost of malpractice insurance is causing some physicians to abandon their practice, making it more difficult for patients to obtain care.

Today's system for determining and paying compensation for malpractice is unfair and inefficient. A few plaintiffs win large recoveries but only after the long and arduous litigation process, while others equally deserving receive nothing. Most insurance money currently is spent on transactional costs (fees for expert witnesses and lawyers and other costs of litigation) and on payment to a few victims of damages for noneconomic loss (pain and suffering, loss of consortium, etc.)

PROVISIONS OF THE BILL

Model for State Legislation.—The Medical Offer and Recovery Act is designed to serve as model legislation for state legislatures to consider in passing their own mechanism for providing prompt payment of a patient's economic loss. The federal provisions of the Medical Offer and Recovery Act will not apply to states that implement such reforms by January 1, 1988.

Mechanics of Proposal.—1. A health care provider would, within 180 days of an occurrence, have the option of making a commitment to pay the patient's economic loss. Payments from collateral sources such as private health insurance and workers compensation would offset the amount owed by the provider.

2. If the provider makes the commitment to pay the patient's economic loss, a patient's right to sue for malpractice under the conventional tort system would be foreclosed except for cases where the provider intentionally caused the injury or a wrongful death occurred.

3. The *offer must by definition encompass all of the patient's economic loss.* Economic loss includes the cost of continued medical and hospital care, rehabilitation, nursing care, wage loss, the cost of a housekeeper and adapting the patient's house and car, as well as reasonable attorneys' fees in advising the patient. The *payments would occur periodically* as the patient's economic loss accured.

4. The provider making a commitment to pay a patient's economic loss may join to

the settlement other third parties (potential defendants) who may be responsible for the injury. Similarly, other third parties may request to be joined. Any disagreement between the joined parties will be settled by binding arbitration.

Patient Protections.—1. The patient's rights to sue for the enforcement of the commitment are protected should the provider default or breach the commitment.

2. If a provider and patient wish to settle for a lump sum payment instead of periodic payments, they may do so by agreement. However, the agreement would be ineffective (if the patient's net economic loss was in excess of $5,000) without court approval and the provider would be responsible for all of the patients net economic loss.

3.[1] Patients are *assured of payment.* The bill requires physicians to carry sufficient malpractice insurance or post bond in order to participate in the program. This protects patients against judgement proof providers.

4.[1] A patient may demand compensation for economic loss without going to court. In the event that a provider does not choose to voluntarily make a commitment for economic loss, a patient who believed he or she had been a victim of malpractice could request that an expeditious arbitration proceeding be conducted. If the arbitrator determined the provider was at fault, the patient would be awarded compensation for economic loss as if the provider had voluntarily made the commitment. A request for arbitration would foreclose the patient's right to sue for noneconomic damages.

5.[1] A patient is further protected by provisions to reduce malpractice by preventing incompetent physicians and other health care professionals from practicing. Health care institutions must notify state licensing authorities if they terminate the privileges or take other adverse actions with respect to the privileges of a health care professional. It also provides confidentiality and immunity for those who provide information to a hospital or its medical staff that a member of the staff is incompetent or impaired. Finally, it provides immunity from suit for those who review health care professionals' conduct and those who take disciplinary action against them.

● Mr. DANFORTH. Mr. President, I am pleased to join my colleague on the Senate Finance Committee, Senator DURENBERGER, as a cosponsor of the Medical Offer and Recovery Act. This legislation addresses one of the Nation's critical health care problems—the spiraling cost of medical malpractice insurance.

In my own State of Missouri, malpractice insurance rates for family practice physicians rose by 135 percent this year, and hospital insurance costs increased by more than 150 percent. The problem is particularly severe in obstetrics and gynecology, where skyrocketing malpractice insurance rates are discouraging many rural physicians from performing such services and greatly diminishing and availability of care to high-risk maternal patients, who in many cases are poor.

At the Wetzel Clinic in Clinton, MO, which provides care to a wide rural area in the western part of the State, 7 of the 10 doctors who used to deliver babies have been squeezed out of this essential part of their practice by insurance rate increases.

Faced with a tenfold increase in its medical malpractice insurance premiums, Truman Medical Center, a public hospital in Kansas City, was forced to seek a $1.5 million loan from the city to form a self-insurance pool and avoid closing down or operating without insurance. A recent series of medical malpractice jury awards in excess of $10 million has made commercial reinsurance coverage virtually unavailable in western Missouri.

As these examples clearly demonstrate, the medical malpractice insurance crisis is not a problem faced only by doctors and hospitals—it is a problem which affects every one of us. The costs of medical malpractice—which include not only the rising price of insurance, but also the cost of additional tests and procedures ordered by doctors primarily to guard themselves against lawsuits—are paid by employers and individuals in the form of higher health insurance premiums and higher taxes.

This malpractice insurance crisis is but one facet of a much larger problem affecting all purchasers of liability insurance. Accountants, truck drivers, commercial fishermen, municipal governments, and many other groups also are confronting huge increases in the cost of insurance coverage. Indeed, the problem of cost and availability of liability, insurance is so widespread and severe that it is becoming one of the most pressing economic issues the country faces today.

At the heart of the problem is a complicated and expensive civil justice system which consumes more money determining fault than compensating victims. If we are to get at the true cause of our insurance woes—in medical malpractice and other areas—something must be done to provide for more just and predicatable awards to injured parties, while reducing the massive transactions costs associated with litigating disputes.

Although I am not yet certain that the legislation introduced today provides the best proposal for civil justice reform in the medical malpractice area, it is an important beginning. The Medical Offer and Recovery Act would provide for an alternative compensation scheme similar in design to legislation I have sponsored with regard to products liability. The goal is to get people out of the court system and to encourage swift and certain compensation for out-of-pocket losses. The products bill is moving ahead in the Commerce Committee, and I look forward to working on this legislation in the Finance Committee.

While I support the concept of setting up alternatives to formal court litigation of personal injury disputes, I am also aware that tort law reform is an issue within the purview of the States. Many States, including Missouri, have been very active recently in attempting to reform their laws governing personal injury litigation. This legislation is not attempting to discourage these efforts, but rather to complement and support them.

Mr. President, the Medical Offer and Recovery Act is directed at a complex problem, and there are a number of competing interests involved. While the task ahead is a challenging one, I am encouraged by the prospect of real reform that would benefit both the providers and consumers of medical care.●

By Mr. THURMOND (for himself, Mr. DECONCINI, Mr. ANDREWS, Mr. BURDICK, Mr. D'AMATO, Mr. DIXON, Mr. SIMON, and Mr. WARNER) (by request):

S. 1961. A bill to amend title 28 and title 11 of the United States Code to authorize a new U.S. trustee system by providing for the appointment of U.S. trustees to supervise the administration of bankruptcy cases in judicial districts throughout the United States, and for other purposes; to the Committee on the Judiciary.

UNITED STATES TRUSTEES ACT

Mr. THURMOND. Mr. President, on behalf of the administration, I rise to introduce the United States Trustee Act of 1985. This bill would expand and make permanent the U.S. Trustee Pilot Program for Bankruptcy Administration, which was established by title I of the Bankruptcy Act of 1978 (Public Law 95-598). The initial period for the project was 4½ years, but it was extended twice: First until September 30, 1984 (Public Law 98-166), and again until September 30, 1986 (Public Law 98-353).

The U.S. trustees would be charged with overseeing the administration of bankruptcy cases filed under chapters 7, 11, and 13 of the Bankruptcy Code. Under the aegis of the Justice Department, the U.S. trustee system would effect a separation of the administrative and case monitoring functions from the adjudicative functions carried out by the bankruptcy judges and the judiciary. In the nonpilot areas, the bankruptcy judges have continued to adjudicate legal issues and to supervise the administration of bankruptcy cases.

This legislation would expand the pilot program from 10 field offices covering 18 judicial districts to 30 regional offices covering the entire United States. Each region would be headed by a U.S. trustee appointed by the Attorney General for a 4-year term.

Pursuant to the 1976 act, an independent study to compare the pilot and nonpilot programs was undertaken by Abt Associates, Inc. of Cambridge, MA. The findings of that study indicate that the pilot program has resulted in "enhanced honesty and efficiency in bankruptcy administration" in the pilot districts. Certainly this approach deserves careful consideration.

[1] Denotes a new provision added to H.R. 5400 from the 98th Congress.

FISCAL YEAR 1987

PRESIDENTIAL BUDGET REQUESTS

FOR

BIOMEDICAL/BIOBEHAVIORAL PROGRAMS

PUBLIC HEALTH SERVICE
(dollars in millions)

	FY86			FY87	
	Appropriation	GRH Sequester Request	Total After Sequestration	Presidential Request	% Decrease or Increase 1/
Food & Drug Admin.	$ 421.7	$- 18.3	$ 403.6	$ 423.6	+ .4
Health Resources and Services Admin.	2,341.1	- 60.1	2,281.0	1,905.0	-18.6
Centers for Disease Control	461.9	- 20.3	441.6	379.8	-17.8
National Institutes of Health	5,494.0	-236.2	5,269.0	4,936.2	-10.2
Alcohol Drug Abuse and Mental Health Admin.	968.9	-41.7	927.2	906.1	-6.5
Office of the Assistant Secretary for Health	195.8	-7.2	188.6	413.0	+110.4
(Priority Disease Control & Research Projects (AIDS))	(234)	(-10)	(224)	(203.5)	(-13.2)

1/ Percentages derived from Presidential request as compared to the FY86 appropriation component.

NATIONAL INSTITUTES OF HEALTH

(dollars in millions)

	FY86			FY87	
	Appropriation	GRH Sequester Request	Total After Sequestration 2/	Presidential Request 3/	% Decrease or Increase 4/
NIC	$1,252.7	-$ 53.9	$1,202.6	$1,158.1	- 7.5
NHLBI	859.2	- 36.9	822.9	785.7	- 8.5
NIDR	103.3	- 4.4	98.9	96.5	- 6.6
NIADDK/NIDDK	569.3	- 24.5	548.1	419.0	- 7.6
NIAMSD 5/				106.7	
NINCDS	433.4	- 18.6	414.7	399.3	- 7.9
NIAID	383.4	- 16.4	367.5	330.5	-13.8
NIGMS	514.8	- 22.1	493.8	471.5	- 8.3
NICHHD	321.8	- 13.8	308.4	309.1	- 3.9
NEI	195.1	- 8.4	186.8	179.2	- 8.1
NIEHS	197.5	- 8.5	189.0	188.0	- 4.8
NIA	156.5	- 6.7	151.1	145.8	- 6.8
RR	305.7	- 13.1	292.5	234.2	-23.4
C	11.6	- .5	11.1	11.3	- 2.6
NLM	57.8	- 2.5	55.3	56.4	- 2.4
OD	117.0	- 5.0	112.0	36.7	-68.6
Buildings	14.9	- .6	14.3	8.0	-46.3
Total NIH 6/	$5,494.0	-$236.2	$5,269.0	$4,936.2	-10.2
AIDS/OASH 3/				143.9	

1/ Appropriation available for sequestration (none of the NIH accounts were exempted) and published by the Office of Management and Budget and the Congressional Budget Office in the Federal Register, January 15, 1986 (Vol. 51, No. 10, pages 1999-2001). Reflects administrative reduction of $3 million and transfer of $4.5 million from NCI to DHHS for the Mary Babb Randolph Cancer Center.

2/ Includes carryover in research project grants of $11.2 million.

3/ AIDS funding to be centralized in the Office of the Assistant Secretary of Health (OASH). Total AIDS request, $213 million in FY87.

4/ Percentages derived from actual Presidential request without AIDS funding in each institute as compared to FY86 appropriation with AIDS funding.

5/ National Institute of Arthritis and Musculoskeletal and Skin Disease, formerly part of NIADDK.

6/ Totals may not add due to rounding.

NIH BUDGET (by Mechanism)
(dollars in millions)

	FY86			FY87	
	Appropriation	GRH Sequester Request	Total After Sequestration	Presidential Request	% Decrease or Increase 1/
RESEARCH GRANTS					
Noncompeting and admin. supplementals	$2,086.7	$-74.8	$2,011.9	$2,018.7	- 3.3
Competing	954.7	-56.0	898.7	784.5	- 17.8
Research Centers	487.8	-21.0	466.8	447.2	- 8.3
Other Grants	311.2	-13.4	297.9	237.5	- 23.7
TRAINING	218.8	- 9.4	209.4	198.2	- 9.4
CONTRACTS	373.1	-16.0	357.1	328.5	- 11.9
INTRAMURAL RESEARCH	584.3	-25.1	559.2	548.4	- 6.1
RESEARCH MANAGEMENT AND SUPPORT	215.1	- 9.2	205.8	210.9	- 1.9
DISEASE CONTROL	63.9	- 2.7	61.1	61.1	- 4.4
CONSTRUCTION	8.6	- .4	8.2	0	-100.0
NATIONAL LIBRARY OF MEDICINE	57.8	- 2.5	55.3	56.4	- 2.4
OFFICE OF THE DIRECTOR	117.0	- 5.0	112.0	36.7	- 68.6
BUILDING AND FACILITIES	14.9	- .6	14.3	8.0	- 46.3
TOTAL NIH	$5,494.0	-$236.2	$5,257.7	$4,936.2	- 10.2

1/ Percentages derived from Presidential request as compared to the FY86 appropriation component.

ADAMHA

(dollars in millions)

	FY86			FY87	
	Appropriation	GRH Sequester Request	Total After Sequestration	Presidential Request	% Decrease or Increase 1/
NIMH	$ 309.1	- $13.2	$295.9	$248.7	-19.5
(research)	(214.0)	- (9.2)	(204.8)	(199.9)	- 6.6
(research training)	(18.0)	- (.8)	(17.2)	(15.8)	-12.2
(clinical training)	(20.0)	- (.9)	(19.1)	--	-100.0
NIDA	91.8	- 3.9	87.9	90.5	- 1.4
(research)	(74.0)	- (3.2)	(70.8)	(73.2)	- 1.1
(research training)	(1.5)	- (.1)	(1.4)	(1.3)	-13.3
NIAA	70.1	- 3.0	67.1	68.8	- 1.8
(research)	(57.0)	- (2.5)	(54.5)	(56.6)	- .7
(research training)	(1.5)	- (.1)	(1.4)	(1.3)	-13.3
ADAMHA TOTAL	$ 968.9	- $41.7	$927.2	$906.1	- 6.5

1/ Percentages derived from Presidential request as compared to the FY86 appropriation component.

VETERANS ADMINISTRATION

(dollars in millions)

	FY86			FY87	
	Appropriation	GRH Sequester Request	Total After Sequestration	Presidential Request	% Decrease or Increase[1/]
dical Care	$9,255.7	-$117.6	$ 9130.1	$ 9,083.9	- 1.8
dical & Prosthetic Research	189.3	- 8.2	181.1	188.9	- .2
Medical Research[2/]	(168.5)	- (7.2)	(159.3)	(164.4)	- 2.4
Rehabilitation Research	(16.0)	- (.7)	(15.3)	(16.5)	+ 3.1
Health Svcs Research	(6.7)	- (.2)	(6.5)	(8.0)	+19.4
nstruction					
Major Projects	507.4	- 21.8	485.6	301.2	-40.6
Minor Projects	136.9	- 5.9	131.0	107.0	-21.8

[1/] Percentages derived from Presidential request as compared to the FY86 appropriation component.

[2/] Includes agent orange funds appropriated to VA but expended by CDC
- FY86 appropriation - 2.3 million
- FY86 appropriation - GRH 2.2 million
- FY87 request - 3.5 million

FUTURE MEETINGS

CAS Administrative Board Meetings

April 9-10, 1986	Washington Hilton Hotel
June 18-19, 1986	Washington Hilton Hotel
September 10-11, 1986	Washington Hilton Hotel

CAS Spring Meeting

March 19-20, 1987	Washington, D.C.

AAMC Annual Meetings

October 25-30, 1986	New Orleans, Louisiana	(CAS meets Oct. 26-27)
November 7-12, 1987	Washington, D.C.	(CAS meets Nov. 8-9)

MEETING REGISTRATION

Please complete the registration form on the back and return, with the registration fee of $75, **by March 14** to:

Ms. Carolyn Demorest
Division of Biomedical Research
AAMC
One Dupont Circle, N.W., #200
Washington, D.C. 20036

Questions may be directed to Ms. Demorest at (202) 828-0480.

HOTEL RESERVATIONS

The Sheraton Washington is holding a block of rooms for this meeting. In order to guarantee a room at the Sheraton, you must return the enclosed reservation card **by February 25** to:

Sheraton Washington
2660 Woodley Road at
Connecticut Ave., N.W.
Washington, D.C. 20008

Reservations received after February 25 will be on a space available basis.

Cocktail Reception
To Honor John A.D. Cooper
5:30 pm–7:30 pm
Holmes Room

Thursday, March 27

Continental Breakfast
8:30 am–9:00 am
Holmes Room

CAS Business Meeting
9:00 am–Noon
Dover Room

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FUTURE CAS MEETINGS

October 26–27, 1986
New Orleans, LA

March 12–13, 1987
Washington, D.C.

November 8–9, 1987
Washington, D.C.

1986 SPRING MEETING OF THE COUNCIL OF ACADEMIC SOCIETIES

March 26–27, 1986

Sheraton Washington
Washington, D.C.

Program and Registration Information

PROGRAM

Wednesday, March 26

Panel Presentation 10 am–11 am
Council Discussion 11 am–Noon
Dover Room

Current Issues in Faculty Practice:

From the Dean's Perspective
Edward J. Stemmler, M.D.
Dean, University of Pennsylvania
School of Medicine

From the Hospital's Perspective
Thomas Q. Morris, M.D.
President
Presbyterian Hospital of New York

From the Faculty's Perspective
Wilton Bunch, M.D., Ph.D.
Dean for Medical Affairs
University of Chicago
School of Medicine

Alan K. Pierce, M.D.
Chairman, Faculty Practice Plan
University of Texas, Southwestern
Medical School, Dallas

Luncheon

Noon–1:30 pm
Wilmington Room

Federal Research Policy

An Open Discussion
with Members of the
AAMC Research Policy Committee

1:30 pm–5:00 pm
Dover Room

David H. Cohen, Ph.D., Moderator
Chairman, Department of Neurobiology
SUNY at Stony Brook
CAS Chairman

Robert E. Fellows, M.D., Ph.D.
Chairman, Department of Physiology
and Biophysics
University of Iowa
College of Medicine

Thomas Q. Morris, M.D.
President
Presbyterian Hospital of New York

Benjamin D. Schwartz, M.D., Ph.D.
Professor of Medicine
Washington University
School of Medicine

David B. Skinner, M.D.
Chairman, Department of Surgery
University of Chicago,
Pritzker School of Medicine

Peter Whybrow, M.D.
Chairman, Department of Psychiatry
University of Pennsylvania
School of Medicine

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Please Print

1986 CAS SPRING MEETING REGISTRATION FORM

Please Enclose Registration Fee and Return **by March 14**

Name: _____ Society: _____

Address: _____

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A registration fee of $75 is being charged. This fee includes the luncheon and reception on Wednesday and the breakfast on Thursday. Please enclose a check made payable to "AAMC" with this registration form.