Association of American Medical Colleges
Statement for the Record
before the
House Judiciary Committee
Subcommittee on Administrative State, Regulatory Reform, and Antitrust hearing

"The MATCH Monopoly: Evaluating the Medical Match Residency Antitrust Exemption"
May 14, 2025

The Association of American Medical Colleges (AAMC) appreciates the opportunity to submit this statement for the record regarding the hearing entitled "The MATCH Monopoly: Evaluating the Medical Match Residency Antitrust Exemption" before the House Judiciary Subcommittee on Administrative State, Regulatory Reform, and Antitrust on May 14, 2025.

The AAMC (Association of American Medical Colleges) is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, biomedical research, and community collaborations. Its members are all 160 U.S. medical schools accredited by the LCME; 12 accredited Canadian medical schools; nearly 500 academic health systems and teaching hospitals, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools, academic health systems and teaching hospitals, and the millions of individuals across academic medicine, including more than 210,000 full-time faculty members, 99,000 medical students, 162,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

Residency is the second step of the medical education training program, starting when students in their final year of medical school transition from their undergraduate medical education (UME or more commonly, medical school) to graduate medical education (GME or more commonly, residency). In order to be a physician in the US, an individual must complete medical school and a medical residency. Participation in a matching process is the most common method to obtain a residency placement. Graduates of U.S. MD-granting medical schools have a very high level of success in securing residency placement. According to a 2015 study, between academic years 2004-2005 to 2014-2015, the mean percentage of graduates of U.S. MD-granting medical schools unplaced in GME during the academic year of their graduation from medical school was only 3%.[1] Therefore, the mean percentage of U.S. MD-granting medical school graduates placed in GME within the year of their graduation was 97% for those graduating between 2004-2005 to 2014-2015.[2] And within six years of their medical school graduation, more than 99% of all MD-granting medical school graduates entered GME.[3] According to a 2025 study, between academic

[1] Sondheimer HM, Xierali IM, Young GH, Nivet MA. Placement of US Medical School Graduates Into Graduate Medical Education, 2005 Through 2015. JAMA. 2015;314(22):2409–2410. | doi:10.1001/jama.2015.15702.
[2] *Id.*
[3] *Id.*

years 2015-2016 to 2021-2022, the mean percentage of graduates of U.S. MD-granting medical schools placed in GME at graduation was 97.1%.[4]

The MATCH was created to abate the chaos created by the pressure of individual residency programs engaging in the recruitment and selection process of medical students to be medical residents.[5] This pressure resulted in residency offers being made and accepted as early as students' third year of medical school.[6] Residency programs wanted more information about students' performance, and students felt pressure to accept the first offer without knowing if other offers would be forthcoming.[7] All states require at least one year of residency training to apply for an unrestricted medical license.[8] Therefore, without a residency position, the investment in medical school would be for naught, as they would be unable to be licensed to practice medicine in the United States. This places additional pressure on medical students to secure a residency position and hold as many offers as made for the best chance at securing the medical residency of their choice.

If a medical student subsequently rejected an offer, it was often too late for the residency program to contact their next preferred candidate.[9] The MATCH has been administered by the National Residency Matching Program (NRMP) since 1952 and allows for the preferences of both medical students and residency programs to be considered.[10]

While not all residency programs and medical students use The MATCH or another matching service for residency placement, the overwhelming majority of them do. The AAMC does not administer The MATCH or another matching service. The AAMC operates the Electronic Residency Application Service (ERAS), which streamlines the residency application process for applicants, their medical schools, letter of recommendation authors, and residency program directors. AAMC also provides operational support for the NRMP's Supplemental Offer and Acceptance Program (SOAP) that facilitates unmatched residency applicants to obtain unfilled residency positions during Match Week (the third week of March).

There are multiple options in the current medical residency matching process. Medical specialty societies recommend to programs which application and matching service to use with the goal of all programs within a specialty being available in the same place. Presently, there are at least four

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[4] Andriole, Dorothy A. MD; Grbic, Douglas PhD; Jurich, Daniel P. PhD; Mechaber, Alex J. MD; Roskovensky, Lindsay; Young, Geoffrey H. PhD. U.S. Medical School Graduates' Placement in Graduate Medical Education: A National Study. Academic Medicine 100(2):p 158-169, February 2025. | doi: 10.1097/ACM.0000000000005893.
[5] Roth AE. The Origins, History, and Design of the Resident Match. *JAMA.* 2003;289(7):909–912. | doi:10.1001/jama.289.7.909
[6] *Id.*
[7] *Id.*
[8] State Specific Requirements for Initial Medical Licensure, Federation of State Medical Boards, https://www.fsmb.org/step-3/state-licensure/#:~:text=Minimum%20Postgraduate%20Training%20Required%20*%201%20year,*%202%20years%20ACGME%20training%20for%20IMG's (last visited May 13, 2205).
[9] Roth, *supra* note 5.
[10] *Id.*

application services and at least three matching services (not including the Military Match). Each residency program chooses which application service and which matching service to use. Residency programs (or their institutions) set resident compensation, working conditions, and hiring restrictions, if any, for their residents. Residency programs,[11] the AAMC,[12] and the American Medical Association (AMA)[13] allow prospective residency applicants to explore data on residency program characteristics, compensation data, and residency working conditions as reported by programs via the National GME Census.[14] The interview process and site visits provide opportunities for medical students to learn more about a residency program.

The AAMC wants to ensure the members of the Committee understand how important it is to have the matching process in place for medical students and residency programs, and to consider the disruption that would surely occur if the matching process were upended without a suitable substitute. The MATCH or any other matching service does not contribute to the physician shortage, but rather, ensures that medical residents are dispersed throughout the country, meeting the health needs and providing medical training in every single American state.

1. The matching process provides an efficient, unified process in the residency application and selection process.

A centralized matching process also ensures that applicants are applying at the same time. Prior to the current process, medical students could receive and be pressured to accept offers well before the completion of medical school. Not only is this problematic for other applicants, but it also puts immense pressure on the applicant to make a decision before they may be able to appropriately evaluate other options.

Absent a matching program, the medical residency selection process would create uncertainty and chaos for applicants and programs, dismantling the residency system. Residents at a teaching hospital begin their post-graduate year 1 (and subsequent years in residency) as a cohort and move as a learning unit. It is in this cohort that training occurs along with peers and other health practitioners under the supervision of an attending physician. Vacancies that would be created by treating medical residency as any other job market would inevitably leave residency positions unfilled, resulting in fewer residents learning synchronously and wasting attending physician resources by having too few residents to supervise.

A centralized matching process is also key for residency programs. Residency programs receive applications at the same time from any applicant who chooses to apply. Having an established

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[11] Resident compensation and working conditions reported in the Residency Explorer tool are generally available on the residency programs' websites.
[12] Residency Explorer, AAMC, https://www.residencyexplorer.org/ (last visited May 13, 2025). The AAMC owns and operates the Residency Explorer tool.
[13] FREIDA, AMA, https://freida.ama-assn.org/ (last visited May 13, 2025). The AMA owns and operates the Fellowship and Residency Electronic Interactive Database (FREIDA).
[14] GME Track, AAMC, https://www.aamc.org/data-reports/students-residents/report/gme-track (last visited May 13, 2025).The National GME Census is jointly conducted by AAMC and AMA, through AAMC's GME Track tool.

schedule allows residency program directors, who are practicing physicians, to efficiently schedule their time to review applications and schedule and conduct interviews, knowing they are seeing all applicants at the same time.

Finally, upending the current matching process without a suitable alternative could disadvantage applicants from rural and underserved areas who may not have the fiscal means or other connections to otherwise secure competitive residencies. This could lead to a race to the bottom with medical students negotiating artificially low salaries in order to secure a residency position, as all state medical boards require at least one year of residency to apply for an unrestricted medical license, leaving those without the ability to work for lower pay out of the consideration process for the position.

2. The matching process is merit-based and ensures most residency positions do not go unfilled.

The matching process ensures that the maximum number of positions are filled each year. For example, in 2024, 41,503 positions were offered, and after The MATCH and SOAP were completed, a mere 176 residency positions remained unfilled.[15] Less than 0.43% of residencies participating in The MATCH went unmatched in 2024. Other matching services have similar residency position fill rates.[16] Without the matching process, it would be virtually impossible to achieve this type of success rate.

Matriculating and completing medical school does not guarantee that a medical student will be matched to a residency program, nor should it. The matching process allows for programs to assess each medical student as an individual on their merit and their desire to be trained at a specific institution. And the matching process allows applicants to evaluate programs and select those that they feel best suit their goals. The matching process takes into account applicant and program preferences via rank order lists that feed the algorithm. The MATCH uses an algorithm that places focus on applicant-optimal matches.

From the residency program perspective, the matching process ensures that the residency selection process is a finite process with the residency program position being filled with by a qualified applicant The matching process avoids the risk of applicants accepting multiple offers, holding out for a better offer, and rejecting offers at the last minute, leaving residency positions unfilled and otherwise qualified applicants unmatched or unable to complete their training in the cohort.

[15] Results and Data: 2024 Main Residency Match, NRMP, https://www.nrmp.org/match-data/2024/06/results-and-data-2024-main-residency-match/ (last visited May 13, 2025).
[16] Match Statistics, San Francisco Match, https://sfmatch.org/specialty/ophthalmology-residency/Statistics (last visited May 13, 2025). The San Francisco match had only two unfilled positions in 2024.

3. There are proven legislative solutions to address the physician shortage that Congress should pursue.

The United States faces a shortage of up to 86,000 physicians by 2036.[17] The AAMC is the leading authority in calculating the shortage, including understanding the factors related to the dearth of physicians. The matching process is not and has never been cited as giving rise to the physician shortage. Instead, the matching process helps to ensure that all available residency positions are filled with qualified medical school graduates who may complete their training promptly and transition to being licensed, board-certified physicians, meeting the health needs and providing medical training in every single American state.

Although outside the jurisdiction of this particular committee, there are numerous bipartisan legislative actions that Congress could take to address the physician shortage:

Increase the number of Medicare-supported GME slots.
Medicare supports the training of residents through Graduate Medical Education (GME) payments, which help offset a portion of the training expenses such as resident stipends and benefits, faculty salaries and benefits, and allocated institutional overhead costs. This support, which is directly tied to the number of Medicare beneficiaries a teaching institution cares for, was capped by Congress as part of the Balanced Budget Act of 1997.[18] To that end, Medicare support for GME had been effectively frozen for nearly a quarter century.

While Medicare is the primary source of public support for physician training, teaching hospitals provide the majority of GME funding. AAMC-member teaching health systems and hospitals train approximately 77,000 residents across the country. Of these residents, Medicare supports approximately 57,000 trainees, meaning these teaching health systems and hospitals are fully funding the training of nearly 20,000 residents.[19] Additionally, teaching health systems and hospitals spend approximately $23.1 billion on physician training annually, but they are reimbursed only Medicare's "share" of the costs, which is approximately $5 billion (about 22%). This amounts to over $18 billion in direct costs not paid for by Medicare.[20] Despite the immense financial pressures teaching hospitals face, AAMC-member teaching health systems and hospitals continue to train above and beyond their caps out of their commitments to their missions and the patients and communities they serve.

To help remedy the situation, the AAMC and its Congressional partners have long championed an increase in the number of Medicare-supported GME positions, and we are grateful that Congress invested in additional positions in both the Consolidated Appropriations Act (CAA),

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[17] AAMC. *The Complexities of Physician Supply and Demand: Projections from 2021 to 2036* (Mar. 2024) (available at https://www.aamc.org/media/75236/download?attachment).
[18] P.L. 105-33.
[19] DGME counts include allopathic and osteopathic residents. Includes redistributed slots under Section 422, Section 5503, and Section 5506. DGME counts are unweighted FTEs.
[20] AAMC Analysis of FY2021 Medicare Cost Report data, July 2023 Hospital Cost Reporting Information System (HCRIS) release. If FY2021 data is not available, FY2020 data is used.

2021 and 2023.[21] These two increases in Medicare-supported GME marked the first investments of their kind since 1997. As the U.S. population has grown and geographically shifted, Medicare GME has been unable to mirror these changes. While the nation's teaching health systems and hospitals have been inappropriately criticized over the years for the perceived concentration of positions in certain regions, we must emphasize that these institutions have been leaders in helping ensure and support access to care in their communities by their commitment to investing in physician training despite nearly a quarter-century of restrictions on the program.

The AAMC strongly supports the bipartisan Resident Physician Shortage Reduction Act, which is expected to be reintroduced soon.[22] This legislation would provide 14,000 Medicare-supported GME slots over seven years to hospitals in all types of communities across the country, and would produce an additional 3,500 new physicians each year once fully implemented. We urge Congress to pass the Resident Physician Shortage Reduction Act, thereby taking an impactful step toward alleviating the physician shortage.

Invest in the Rural Residency Planning and Development program.
The Health Resources and Services Administration's (HRSA's) Rural Residency Planning and Development (RRPD) grants provide up to $750,000 for new rural residency training programs. One of the biggest obstacles to developing new training programs is the startup costs, because hospitals do not receive any Medicare support for GME programs until residents arrive to train at the facility. This means that hospitals are left to fund the substantial startup costs without any assurance that the program will receive future Medicare support. RRPD grants provide startup capital for new programs to hire faculty, achieve accreditation, and upgrade the hospital infrastructure to accommodate resident trainees. Since 2019, RRPD grants have led to the development of 46 new rural residency programs, training 460 resident physicians. The impact of this program on rural communities across the country cannot be understated, and the AAMC encourages Congress to codify this program in statute and ensure its continued funding.

Provide adequate funding for and reauthorization of HRSA Title VII and Title VIII Workforce Programs.
The HRSA Title VII Health Professions and Title VIII Nursing Workforce Development play an irreplaceable role in educating providers who will serve the nation's ever-growing health needs, including those in rural and other underserved communities, while preparing for the health care demands of tomorrow. The HRSA Title VII and VIII programs successfully recruit, train, and support physicians and physician associates/assistants, nurses, geriatricians, mental and behavioral health providers, public health practitioners, social workers, and other frontline health care workers. In particular, the HRSA Title VII health professions help improve access to care in rural and other underserved areas; bolster training opportunities in primary care, mental and behavioral health, oral health, and pediatric and geriatric care; and promote team-based care through their focus on interprofessional education.

[21] P.L. 116-206, P.L. 117-238.
[22] Previously H.R. 2389/ S. 1302 (118th Congress).

Given the critical need to address health workforce shortages and develop the future workforce, the AAMC urges the reauthorization of the Title VII and VIII programs – which are set to expire at the end of fiscal year 2025 – as well as a robust and sustained investment in the programs to ensure the health workforce is equipped to respond to future health threats and challenges facing all Americans.

Support funding and extend authorization for the National Health Service Corps and Teaching Health Centers GME.

The National Health Service Corps (NHSC) has played a significant role in recruiting primary care physicians to federally-designated health professional shortage areas (HPSA) through scholarships and loan repayment options. Despite the NHSC's success, its funding still falls far short of fulfilling the wide-ranging health care needs of all HPSAs due to growing demand for health professionals across the country. Further, the Teaching Health Centers GME (THCGME) program helps increase the number of residents training in community health centers and mitigate the physician workforce shortage in those settings. The AAMC urges Congress to reauthorize and extend investment in the NHSC and THCGME programs before their funding expires on September 30, 2025.

Additionally, the Children's Hospitals GME (CHGME) program helps increase the number of residents training in children's hospitals and improve pediatric physician workforce shortages. The AAMC also encourages robust funding for the CHGME program to provide the necessary support for the training programs at children's hospitals across the country.

Support Conrad 30 Expansion and Reauthorization

The Conrad 30 J-1 Visa Waiver program has been highly successful in improving access to care for underserved communities by recruiting both primary care and specialty physicians after they complete their medical residency training under the J-1 visa exchange visitor program. This program allows states to waive the 2-year home residency requirement for foreign medical graduates upon completion of their medical residencies on a J-1 visa and requires up to 3 years of service obligation in an underserved area. As such, more doctors can practice in underserved communities, including both rural and urban community health centers.

Over the last 30 years, the Conrad 30 program has facilitated the placement of approximately 20,000 physicians in communities that otherwise might not have had access to health care. In the face of health workforce shortages, the AAMC supports the expansion of the Conrad 30 program to help overcome hurdles that have stymied the growth of the physician workforce. The AAMC endorses the Conrad State 30 and Physician Access Reauthorization Act (S. 709, H.R. 1585), which would reauthorize the Conrad 30 program for three years, establish a process to gradually increase the number of available waivers per state if certain thresholds are met, and clarify and improve the waiver process. Further, the AAMC also supports the Doctors in Our Borders Act (H.R. 1201), which would implement new waiver limits, which have not been increased in the past two decades, by increasing the number of state-issued waivers from 30 to 100. These bills would help bolster our nation's health care infrastructure, expand access to quality health care

services, and increase the number of physicians serving in rural and medically underserved areas.

The AAMC remains committed to working with the Subcommittee to understand the unique characteristics of medical residency that necessitate a matching process. If you have any further questions, please contact AAMC Chief Public Policy Officer Danielle Turnipseed (dturnipseed@aamc.org).