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Shuren: Financing the Nation's Graduate Medical Education

FINANCING THE NATION'S GRADUATE MEDICAL EDUCATION: A HYBRID APPROACH

Jeffrey E. Shuren*

I. INTRODUCTION

The education of medical students, interns, and residents plays an important and essential role in the provision of quality healthcare. In the current cost-conscious healthcare market, medical education has become a financial albatross that threatens the survival of United States teaching institutions.¹ As a result, the Clinton administration's American Health Security Act sought to establish a fund from which to pay for medical education and thereby ease the financial hardship of academic medical centers and medical schools. In the aftermath of the failed effort to pass the proposed reform measure, the burden of paying for medical education remains with the academic centers.

This paper proposes that graduate medical education should be funded through a tax levied on all healthcare payers in conjunction with market-based incentives. Using a model similar to the Federal Unemployment Tax Act (FUTA), the generated revenues from the proposed tax would be returned for distribution by those states that adopt a system for the assessment of taxes on individual healthcare payers. Part I outlines the history of medical education in the United States and describes the impact of managed care on medical education. Part II reviews attempts by some academic medical centers, medical schools, and states to provide medical education in the current market.

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¹ According to an Association of American Medical Colleges-sponsored study conducted by Lewin-VHI, the average cost of medical care in 1991 in teaching hospitals, excluding the direct costs of graduate medical education, was \$6000 per admission whereas the average cost per admission in nonteaching hospitals was \$4,400. The study determined that teaching hospitals would need an additional \$14 to \$16 billion dollars to support medical education to make them competitive with nonteaching hospitals. John K. Iglehart, *Rapid Changes for Academic Medical Centers: First of Two Parts*, 331 NEW ENG. J. MED. 1391, 1392 (1994). Academic medical centers also place a financial drain on government resources. In 1996, Medicare provided \$6 billion dollars to teaching hospitals through add-ons to reimburse the care of sicker patients and reimbursement of the direct costs of employing residents (about \$70,000 per resident). Fitzhugh Mullan, *Graduate Medical Education and Water in the Soup*, 334 NEW ENG. J. MED. 916 (1996); Julie Rovner, *United States Medical Education Faces Federal Funding Changes*, 346 LANCET 892 (1995).

Part III argues that the burden of funding graduate medical education should be spread across all healthcare payers. Part IV adopts a taxation plan similar to FUTA and addresses the costs and benefits of the proposed system. This paper concludes that the taxation plan would best secure the continued provision of quality medical education.

II. MEDICAL EDUCATION AND THE RISE OF MANAGED CARE

Medical education is divided into two parts: undergraduate medical education and graduate medical education.² Undergraduate medical education is provided by medical schools at approximately 125 academic medical centers (or major teaching hospitals) in the United States.³ These centers also train medical residents and fellows, treat patients with more serious illnesses, develop and assess new technologies, and study new drugs.⁴ Graduate medical education is provided by teaching hospitals which include the academic medical centers. Today approximately 1300 hospitals (18 percent of the hospitals in the United States) take part in at least one medical residency program.⁵

Teaching hospitals finance graduate medical education through revenues generated from patient care⁶ and governmental subsidies. The federal government, through Medicare reimbursement and payments by the Department of Defense and Veteran Affairs, is the largest single source of funding.⁷ Medicare provides payments through two

² John K. Iglehart, *The American Health Care System: Teaching Hospitals*, 329 NEW ENG. J. MED. 1052 (1993). Undergraduate medical education refers to the four years of medical school. *Id.* Graduate medical education refers to the clinical training period following medical school. *Id.*

³ Roger C. Nauert, *Academic Medical Centers and the Fight for Survival in the New Era of Managed Care: Information Systems for Managed Care Contracting*, 21 J. HEALTH CARE FIN. 47 (1995).

⁴ *Id.* Academic medical centers provide about 44% of all charity care. John K. Iglehart, *Rapid Changes for Academic Medical Centers (Second of Two Parts)*, 332 NEW ENG. J. MED. 407 (1995).

⁵ *Id.*

⁶ *Id.* Income from patient care comprises about 40% of medical school budgets. Iglehart, *supra* note 4, at 407. In 1971, such income comprised only 7% of medical school budgets. Iglehart, *supra* note 1, at 1394. Patient care revenues include "practice plans" whereby physicians who practice at the teaching hospital return part of their fees to the hospital. Julie Rovner, *Where is the Money for Education and Research?*, 14 BUS. & HEALTH 21 (1996).

⁷ Iglehart, *supra* note 1, at 1392. Federal-state Medicaid programs also provide indirect medical-education payments through disproportionate share payments to compensate teaching hospitals for treating sicker and poorer patients than their community hospital counterparts. Rovner, *supra* note 6, at 22.

mechanisms. It directs medical-education payments to hospitals to pay a portion of resident and faculty salaries, administrative costs, and general overhead. It also gives indirect adjustments to case-by-case patient reimbursements to compensate hospitals for the greater costs involved in resident management of patients and for the specialized services that Medicare patients with more serious illnesses tend to require.⁸ As a result, the cost of patient care at teaching hospitals is higher than at community hospitals.⁹ Medical education, therefore, is supported by cross-subsidization through funding by the government and third-party payers.

For three decades following World War II, academic medical centers experienced limitless expansion secondary to a rapid increase in federal support and unrestricted third-party payer reimbursements.¹⁰ In 1945, students' tuition paid for medical education and clinical departments that typically did not employ any full-time faculty.¹¹ The National Institutes of Health (NIH) spent only \$180,000 that year on medical research. By 1947, NIH spending had increased to \$4 million, to \$81 million by 1955, and to \$400 million by 1960.¹² The American Medical Association (AMA), however, continued to oppose direct federal funding of medical education. Instead, teaching hospitals diverted research funds to faculty salaries resulting in a tripling of full-time faculty from 4,212 in 1950 to 11,319 in 1960.¹³ In 1965, Congress enacted the Medicare

⁸ Iglehart, *supra* note 2, at 1053. The federal government has dispensed Medicare payments without regard to the total number of residents or the ratio of residents in general as compared to specialist training programs. Iglehart, *supra* note 1, at 1393.

Although the Medicare statute, Title XVIII of the Social Security Act, 42 U.S.C. § 1395, does not expressly address payments for medical education, its legislative history demonstrates that Congress recognized that the cost of medical education constitutes a portion of patient care expenses that should be covered, in part, by Medicare. See *Ohio State University v. Sullivan*, 777 F. Supp. 582, 583 (S.D. Ohio 1991). Subsequently, the Department of Health, Education, and Welfare (now the Department of Health and Human Services) promulgated regulations authorizing the reimbursement of particular medical education costs. 42 C.F.R. § 413.85 (1997). In 1980, the Health Care Financing Administration adopted an indirect "teaching adjustment factor" to allow for an increase in a teaching hospital's cost limits. See *Hennepin County v. Sullivan*, 883 F.2d 85, 88-89 (D.C. Cir. 1989).

⁹ Donna Vavala, *The New Academic Health Center Hybrids: Part Business, Part Academic* 22 PHYSICIAN EXECUTIVE 5 (1996).

¹⁰ M. Gregg Bloche, *Corporate Takeover of Teaching Hospitals*, 65 S. CAL. L. REV. 1035, 1046 (1992).

¹¹ *Id.*

¹² *Id.* at 1046, 1048. This rapid increase in NIH spending resulted, in part, from the medical community's acceptance of federal support of research. *Id.* The needs of warfare overcame the medical community's prior reluctance to accept federal funds. *Id.* at 1047.

¹³ *Id.* at 1048.

and Medicaid statutes to provide insurance for the elderly and the poor. Under the Medicare statute, hospitals could increase their charges to cover for the depreciation of their capital assets.¹⁴ At the same time, third-party payers, sympathetic to the needs of the teaching hospitals, allowed larger inpatient hospital charges without scrutinizing the hospitals' claimed expenses. As the academic medical centers grew, they became more dependent on cross-subsidization through government and third-party payer reimbursements.¹⁵ Moreover, hospital-based provision of care operated in a decentralized system. Clinical departments functioned independently setting their own priorities and business practices.¹⁶

By 1970, the cost of medical care had jumped to 7.3% of the Gross National Product.¹⁷ This explosion in healthcare expenditures provoked a political outcry. The Nixon administration enacted several pieces of legislation to combat the uncontrolled escalation of healthcare expenditures. As part of this effort, Congress passed the Health Maintenance Organization Act of 1973.¹⁸ Under the Act, the federal government subsidized the formation of private, not-for-profit health maintenance organizations that would compete with fee-for-service healthcare. The Act also required all employers with more than twenty-five employees to offer a Health Maintenance Organization Plan (HMO) plan, if one was available. Moreover, the Act mandated certain minimum benefits and enrollment requirements. In 1981, the Reagan administration terminated this federal assistance program proclaiming that the Act had achieved its intended goal.¹⁹

Managed care is a type of healthcare system wherein the financing and the delivery of healthcare are integrated into one entity. One precept

¹⁴ Bloche, *supra* note 10, at 1049.

¹⁵ *Id.* at 1051. The hospital industry continued to increase price and supply in response to the greater demand generated by the unchecked reimbursements of the federal government and third-party payers. *Id.*

¹⁶ Iglehart, *supra* note 4, at 408.

¹⁷ Bloche, *supra* note 10, at 1053.

¹⁸ Health maintenance organizations are entities that orchestrate or provide specified health services to plan members for set, prepaid sums. See generally PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 395-97 (1982). Congress also enacted the National Health Planning and Resource Development Act of 1974, which established a countrywide network of federal and state agencies to constrain and control hospital capital expenditures. However, this Act was repealed in 1987. *Id.* See also Bloche, *supra* note 10, at 1054.

¹⁹ John K. Iglehart, *The Struggle to Reform Medicare*, 334 *NEW ENG. J. MED.* 1071, 1072 (1996). At the time, the Department of Health, Education, and Welfare had awarded 657 federal grants and created approximately 100 not-for-profit HMOs. *Id.*

of managed care holds that medical costs may be controlled by emphasizing early diagnosis and outpatient care.²⁰ This tenet posits that generalists provide less costly healthcare than specialists.²¹

Few people enrolled in HMO's at first. By 1985, however, national enrollment neared 10%. An estimated 60% of the United States population will be covered under a managed care plan by 1998.²² Private employers, in an effort to better control and contain the costs of their employees' health benefits, have promoted the growth of managed care.²³

In 1983, United States Healthcare became the first HMO to convert to a for-profit organization.²⁴ Subsequently, other HMOs followed suit. In recent years these organizations have reported record profits, while teaching hospitals experienced record losses.²⁵ Because managed care encourages competition on the basis of cost and efficient use of services, teaching hospitals, by devoting resources to medical education and the treatment of patients with more severe illnesses, found themselves at a disadvantage. Moreover, the decentralized structure of clinical departments at teaching hospitals favors a fee-for-service system but is less competitive in the managed care market.²⁶

²⁰ Nauert, *supra* note 3, at 48.

²¹ Vavala, *supra* note 9, at 6. The University Health System Consortium (UHC) developed a market-evolution model that identified a four-stage process whereby managed care becomes the principle means of healthcare delivery and financing within a community. *Id.* In Stage One, independent hospitals and doctors provide traditional fee-for-service. *Id.* In Stage Two, HMO's emerge and hospitals align to form provider networks. *Id.* In Stage Three, managed care growth accelerates and reaches critical mass; managed care systems recruit primary care practices while specialist services are underutilized. *Id.* In Stage Four, purchasers form contractual arrangements with integrated hospital-physician systems to provide comprehensive services to plan beneficiaries. Vavala, *supra* note 9, at 6.

²² Laurel K. Leslie, *Can Pediatric Training Manage in Managed Care?*, 96 PEDIATRICS 1143 (1995).

²³ Iglehart, *supra* note 19, at 1071.

²⁴ *Id.* at 1072.

²⁵ Columbia/HCA Healthcare Corporation generated almost \$1 billion in profits in 1995 with \$20 billion in assets. Robert Kuttner, *Columbia/HCA and the Resurgence of the For-Profit Hospital Business (First of Two Parts)*, 335 NEW ENG. J. MED. 362 (1996).

²⁶ Iglehart, *supra* note 2, at 1054. UHC predicts a 30% decline in hospital revenues and a 24% decline in patient stays for academic medical centers from 1994 to 1998. Mark Hagland & Peter MacPherson, *Anything But Academic*, 70 HOSP. & HEALTH NETWORKS 20 (1996). Community hospital admissions, however, plummeted as well. Total annual admissions to community hospitals fell from 36.4 million to 31.1 million over the ten year period between 1981 and 1991. John K. Iglehart, *American Health Care System: Community Hospitals*, 329 NEW ENG. J. MED. 372, 373 (1993). At the same time, outpatient care increased. *Id.* A 1994

The managed care market poses a three-fold risk to teaching hospitals and the medical education they provide. Managed care systems threaten the survival of teaching hospitals through acquisition,²⁷ competition,²⁸ and diversion of federal reimbursements from teaching hospitals to managed care organizations (MCOs).²⁹ For-profit managed

Association of Academic Health Centers study reported that 67% of academic medical centers experienced decreased state funding and 72% reported Medicare losses of \$805 million dollars in the aggregate (85% response rate). Vavala, *supra* note 9, at 6.

²⁷ Some for-profit MCOs have sought to purchase or lease teaching hospitals in an effort to enhance their reputation and to provide specialized services and expertise. Acquisition of teaching hospitals serves these goals under both vertical and horizontal growth strategies. Bloche, *supra* note 10, at 1076.

In 1984, the first acquisition of a teaching hospital by an MCO occurred. American Medical International Inc. purchased Saint Joseph Hospital in Omaha, Nebraska, the principle teaching hospital of Creighton University School of Medicine. *Id.* at 1040. Subsequently, MCOs bought or leased few academic medical centers secondary to public and private sector endeavors to contain healthcare costs and diminishing profits. *Id.* at 1041-42. Humana's purchase of Michael Reese Hospital in Chicago in 1991 sparked new interest in acquiring teaching hospitals. *Id.* at 1044.

Although leasing or selling a teaching hospital to an MCO may threaten the hospital's emphasis on medical education, developing new technologies, and providing care to the indigent, the acquisition may offer several advantages: protection from the adverse effects of a competitive market, additional funds for hospital operations, and possibly, new support for teaching and research. *Id.* at 1063.

²⁸ Teaching hospitals have relied on patient care revenues to fund education and research. Managed care's emphasis on price competition, however, triggered a decline in hospital admissions and length of stay. Rovner, *supra* note 6, at 21; Nauert, *supra* note 3, at 47. Managed care plans disfavor paying the higher fees of teaching hospitals when cheaper alternatives exist in the community. Iglehart, *supra* note 4, at 407. Referrals to teaching hospitals also dropped secondary to community hospitals' amenability to treat sicker patients to capture managed care plan dollars. Iglehart, *supra* note 1, at 1394.

Teaching hospitals, however, share the blame for the escalation in healthcare costs. Overutilization of expensive technologies, cross-subsidization, and limited emphasis on prevention contributed to the demise of the traditional fee-for-service medical system. *See, e.g.,* Rovner, *supra* note 6, at 21. Moreover, residents and medical students increase the costs of healthcare provided by teaching hospitals. Larrie W. Greenberg, *Managed Care, Re-engineering and Downsizing: Will Medical Education Survive Change?*, 96 PEDIATRICS 1146 (1995).

²⁹ Teaching hospitals have encountered an assault on government funds from three fronts: diminishing federal funds, shifting of Medicare and Medicaid payments from teaching hospitals to MCO's, and diminishing state funds.

The federal government first tried to limit its outlay for healthcare in 1983. In an effort to reduce medical expenditures, Medicare changed its reimbursement system to one based on diagnostic categories (called Diagnosis Related Group (DRG)) rather than services provided. Bloche, *supra* note 10, at 1057. Congress subsequently decreased Medicare subsidies for teaching hospitals in the late 1980's. *Id.* at 1043. The legislature attempted to cut Medicare expenditures several times in following years. Its most recent attempt occurred during the past sessions of the 104th Congress.

care plans, however, typically lack concern for medical education.³⁰ Some managed care plans favor public funding of medical education but have yet to indicate what role, if any, they would play to support that education.³¹

The current Republican Congress' support of increased Medicare participation in managed care plans puts teaching hospitals at risk of losing valued federal support. Medicare's per patient reimbursement includes funds intended for graduate medical education. However, once the payment is made, there is no requirement that the monies be spent on education. John K. Iglehart, *Academic Medical Centers Enter the Market: The Case of Philadelphia*, 333 NEW ENG. J. MED. 1019, 1021 (1995). Therefore, MCO's who enroll Medicare beneficiaries retain the additional monetary inclusion for education. In 1996, four million Medicare recipients (approximately 10% of all Medicare recipients) were enrolled in managed care plans. Iglehart, *supra* note 19, at 1072. In 1994, 7.8 million Medicaid recipients were enrolled in managed care plans, a 200-fold increase over the previous year. John K. Iglehart, *Medicaid and Managed Care*, 332 NEW ENG. J. MED. 1727, 1728 (1995). Since 1993, several states, such as Florida and New York, have followed Arizona's lead in requesting a § 1115 waiver (under the Social Security Act) to contract with managed care plans for Medicaid patients. Although results across states are mixed, the Arizona Health Care Cost Containment System acute care program reduced medical costs by 11% and total costs (medical and administrative) by 7%. *Id.*

State-supported medical education declined in recent years as well. For example, in 1994-1995, California's state legislature decreased support for the state's five university teaching hospitals by \$15 million and mandated that they transfer their reserve funds to support non-medical university activities. Iglehart, *supra* note 4, at 409. Furthermore, some states have diverted federal monies away from medical education. In 1995, Tennessee, in an effort to increase funds for TennCare, the state's managed care plan for Medicaid recipients, stopped funding for graduate medical education. Teaching institutions in Tennessee lost \$54 million in state and federal funds. Rovner, *supra* note 6, at 22.

³⁰ See, e.g., Howard Wolinsky, *Ethics in Managed Care*, 345 LANCET 1499 (1995).

³¹ Iglehart, *supra* note 4, at 411.

III. TEACHING HOSPITALS' RESPONSE TO MANAGED CARE

Teaching hospitals have sought to remain competitive through institutional restructuring and legislative reform. The pressure on these institutions increased when efforts to enact comprehensive health care reform collapsed. Common methods employed by teaching hospitals include integrating hospital and group practices to create entities such as physician-hospital organizations and clinical service organizations, downsizing, and consolidating services to prevent duplication.³²

Integration occurs through contractual agreements such as alliances, mergers, acquisitions, and joint ventures.³³ In St. Louis, Washington University Medical Center aligned with seven hospitals.³⁴ Duke University Medical Center in North Carolina entered into a joint venture with Sanus Corporation Health Systems, a for-profit subsidiary of the New York Life Insurance Company, to provide managed-care products in North Carolina, South Carolina, and Virginia.³⁵ The institution purchased sixty-seven primary care practices to create its own provider network.³⁶ Moreover, Duke lowered expenses, in part, through a 30% reduction in employees and consolidation of purchases and laboratory services.³⁷ The institution derives additional funds as a testing center for Hewlett Packard.³⁸ Duke also considered raising capital through public stock offerings but has yet to pursue this option.³⁹

University Healthcare System, the joint venture between Tulane University Medical Center in Louisiana and Columbia/HCA (Columbia), represents another example of changes in teaching hospital practices. Tulane lacked the funds to develop its own provider network. It sold an 80% interest in the institution to Columbia. In return, Columbia promised \$20 million to subsidize Tulane's academic programs and \$75

³² 43% of academic medical centers who responded to a 1994 Association of Academic Health Centers survey reported owning or managing a health maintenance organization, a preferred provider organization, or an independent practice association. Vavala, *supra* note 9, at 5.

³³ Hospitals align or merge with other hospitals to reduce management costs and duplication of services, acquire primary care practices to increase their referral base, and engage in joint ventures with for-profit organizations to increase capital.

³⁴ Iglehart, *supra* note 4, at 409.

³⁵ *Id.* at 410.

³⁶ Rovner, *supra* note 6, at 24.

³⁷ Vavala, *supra* note 9, at 9.

³⁸ *Id.* at 8. Duke uses some of the profits made by performing research for Hewlett-Packard to finance various academic endeavors. *Id.*

³⁹ Iglehart, *supra* note 4, at 411.

million over five years to support Tulane's building and renovation projects.⁴⁰ As a result of the joint venture, Tulane formed an affiliation agreement with seventeen of Louisiana's thirty hospitals to train medical students and residents.⁴¹

Several academic medical centers have formed joint ventures with pharmaceutical and medical device companies. The Cleveland Clinic in Ohio joined with Berlex Biosciences in California to develop drugs to combat atherosclerosis and multiple sclerosis. Under their agreement, the Cleveland Clinic may patent any invention that results from its research whereas Berlex retains the right to obtain a license to market the invention.⁴²

Greater efficiency in the provision of medical education may furnish greater returns on the dollar for teaching hospitals in addition to reducing operating costs.⁴³ Currently employed solutions include downsizing of graduate medical education programs, partnering among medical schools, and greater reliance on community practices to educate residents in primary care. For example, Children's National Medical Center places its second-year pediatric residents in community physicians' offices.⁴⁴ Washington University School of Medicine's Community Outpatient Practice Experience (COPE) replaces the traditional hospital-based continuity clinic for pediatric residents with experiences in the community. Residents provide patient care in the offices of community pediatricians for one half-day each week during the entire three years of their residency. As a result, residents in the COPE program saw 6.2 patients for every 1.7 patients that were seen by residents in the hospital clinic.⁴⁵

⁴⁰ Vavala, *supra* note 9, at 10.

⁴¹ *Id.* at 11.

⁴² Rovner, *supra* note 6, at 24.

⁴³ Kevin Sexton, vice president of Lewin-VHI, advises academic medical centers that, "[I]f you can cut your academic expenses by a dollar, you can reduce your need for clinical services by \$20. It takes a big clinical services side to generate the education dollars." *Id.* at 25. An added problem is the number of medical students and residents trained. The number of medical students educated in the United States increased 66% over the past 25 years. As a result, by 2020, the expected physician-to-population ratio will be more than twice the ratio in the Kaiser Permanente system. *Id.* at 26.

⁴⁴ Greenberg, *supra* note 28, at 1147.

⁴⁵ See Kimberlee C. Recchia et al., *Implementation of the Community Outpatient Practice Experience in a Large Pediatric Residency Program*, 96 PEDIATRICS 90 (1995). The University of Pennsylvania, through the University of Pennsylvania Health System, intends to use affiliated community hospitals and ambulatory care facilities as resident teaching sites. Iglehart, *supra* note 29, at 1022. The advantages include greater exposure of residents to

The merger of two medical schools represents the latest technique to decrease the costs of undergraduate medical education. In 1993, the Medical College of Pennsylvania and Hahnemann University combined their medical schools to bring the two schools under one administration and reduce duplicative teaching positions. As a result, the joint enterprise netted an annual savings of \$35 million.⁴⁶

Strict state regulations pertaining to hiring and purchasing, limitations on capital acquisition through the bond market, and micromanagement by political bodies adds an additional burden to many public teaching hospitals. As a result, several academic medical centers have convinced their state legislatures to diminish the number of restrictions by establishing private non-profit corporations or new public authorities.⁴⁷ The West Virginia state legislature removed the financing and management of the West Virginia University Hospital from the governance of the state to a separate not-for-profit corporation. The corporation retains the right to make contractual agreements with other entities, assumes liability for its decisions, and is responsible for the provision of healthcare and medical education.⁴⁸

Teaching hospitals' efforts to reduce operating costs have succeeded in some instances. According to an American Association of Medical Center report, between 1988 and 1993 major teaching hospitals increased their average revenues by 33% while their costs increased by only 20%.⁴⁹ Moreover, in Minneapolis-St. Paul, Minnesota, starting in 1995, large employers contracted directly with physician groups and hospitals rather than negotiating with HMOs.⁵⁰ Although this development is encouraging for teaching hospitals, MCOs still retain the advantage in today's market.⁵¹

primary care medicine.

⁴⁶ Sherif S. Abdelhak, *How Academic Medicine Can Manage for the Future. The State of Health Care in America*, 14 BUS. & HEALTH 26, 27 (January 1996). Both medical schools ran a deficit of \$21 million prior to being brought under the aegis of the Allegheny Health, Education and Research Foundation. Hagland & MacPherson, *supra* note 26, at 22. The costs to Allegheny to teach one medical student for one year is \$50,000. Only one-half of this expense is covered by tuition and government funding. *Id.* at 26.

⁴⁷ Iglehart, *supra* note 4, at 409. Institutions that have successfully lobbied their state legislatures include the University of Arizona, the University of Colorado, the University of Maryland, *Id.*, and the University of Wisconsin. Hagland & MacPherson, *supra* note 26, at 22-23.

⁴⁸ W. VA. CODE §§ 18-11C-1-10 (1996).

⁴⁹ Iglehart, *supra* note 1, at 1395.

⁵⁰ Iglehart, *supra* note 19, at 1074.

⁵¹ Federal antitrust laws pose another threat to teaching hospitals' attempts at survival.

Beginning in 1997, New York established a statewide graduate medical education pool to which third-party payers contribute approximately half of the graduate medical education costs for private-pay patients.⁵² Third-party payers are required to include a surcharge on inpatient hospital net patient service revenues in a specified percentage amount for patients not eligible for Medicare or Medicaid. Teaching general hospitals may receive funds from the pool if they comply with several state requirements, including increasing the percentage of residents training in primary care specialties, improving the quality of training programs, and reducing the number of graduate medical education programs or the number of residents in such programs, or both. Although the New York surcharge will generate additional funds for teaching hospitals to finance their residency programs, New York teaching institutions now possess fewer incentives to find more economically efficient methods of graduate medical education while receiving an incentive to increase the costs of inpatient care because the amount of funding distributed to each hospital is dependent upon inpatient hospital revenues. Moreover, the funds generated for the pool and the monies provided to the teaching hospitals are based on inpatient care whereas the current trend is to encourage both patient care and resident training in the outpatient setting. Finally, a statewide tax, in contrast to a national program, risks imposing unnecessarily complex funding mechanisms as the result of state insurance law requirements and potential federal preemption under the Employee Retirement Income Security Act.⁵³

IV. FEDERAL EFFORTS TO SUBSIDIZE MEDICAL EDUCATION

The costs of patient care in teaching hospitals are typically higher than patient-care costs in community hospitals and staff-model HMOs, in part as the result of cross-subsidization to underwrite the added expense

Although vertical transactions by either hospitals or MCOs to acquire physician practices in the community are subject to an antitrust merger analysis, the development of physician-hospital organizations (PHO) have been subject to greater scrutiny by the Department of Justice. See David Marx, Jr., *Justice Department Consent Decrees with Danbury, Connecticut and St. Joseph, Missouri PHOs Set Forth Antitrust Rules for the Formation and Operation of Multiprovider Networks*, 8(6) HEALTH LAW 14 (1996); Jack A. Rovner, *Physician-Hospital Organizations: Antitrust and PHO Contracting Activities*, 8(5) HEALTH LAW 10 (1995); David A. Ettinger, *Physician Practice Acquisitions: Can They Survive Antitrust?*, 8(5) HEALTH LAW 14 (1995).

⁵² New York Health Care Reform Act of 1996, N.Y. PUB. HEALTH LAW § 2807 (1996).

⁵³ 29 U.S.C. §§1001-1461 (1994). In general, the Act preempts any state law that "relates to" or has a "connection with" an employee benefit plan subject to the Act. See *California Div. of Labor Standards Enforcement v. Dillingham Constr.*, 519 U.S. 316 (1997).

of medical training and medical research.⁵⁴ Although most teaching hospitals have lowered their costs to compensate for their declining ability to cross-subsidize, the added expense of medical education remains a significant obstacle for these institutions to become competitive in the current healthcare market. Moreover, medical education is a long-term benefit, a commodity disfavored by the current market that rewards short-term benefits.⁵⁵

Recognizing that teaching hospitals cannot maintain medical education in the absence of a stable source of funding, President Clinton, in the now defunct American Health Security Act, proposed that residency positions be selected and financed through a centralized regulatory process under the auspices of the federal government.⁵⁶ The proposal sought to establish three funding pools that would sever financial support of medical education from patient care.⁵⁷ The first fund would subsidize part of the direct costs of graduate medical education (e.g., resident salaries). The second fund would finance part of graduate-level nursing training. The third fund would compensate teaching hospitals for a portion of the indirect costs of graduate medical education (e.g., the time faculty spends teaching residents). The projected combined funds for the three pools was \$6.5 billion in 1996 and \$10 billion in 1999. Money for the pools would be derived from three

⁵⁴ Teaching hospitals also tend to treat more Medicaid patients as well as indigent patients than their community counterparts. Iglehart, *supra* note 2, at 1053.

⁵⁵ Comment by Jordan Cohen, President of the Association of American Medical Colleges, in Rovner, *supra* note 6, at 22.

⁵⁶ See John K. Iglehart, *Health Care Reform and Graduate Medical Education*, 330 NEW ENG. J. MED. 1167 (1994). President Clinton also shares the concern held by various members of Congress and medical academia that the growing disparity between the number of specialists and generalists in addition to the rising number of physicians contributes to the rising cost of healthcare. Unlike several congressional plans that called for a restriction on the number of residency positions to 110% of the annual number of United States medical school graduates (the actual number of positions in 1994 was 135%), the Clinton proposal sought to achieve a balance between the number of generalists and specialists by allowing the proposed National Council of Graduate Medical Education to determine the number of available residency positions. The Secretary of Health and Human Services retained the final decision-making authority. *Id.*

According to Carmella Bocchino, vice president of medical affairs for the Group Health Association of America, the major HMOs also realize that teaching hospitals require a stable flow of money from an identifiable source in order to continue to provide medical education. Rovner, *supra* note 6, at 22-23.

⁵⁷ The Association of American Medical College's support of a national funding pool for graduate medical education that is unrelated to funds generated by patient care stands in marked contrast to its earlier position disfavoring such a system. Iglehart, *supra* note 56, at 1170.

sources: a 1.5% assessment on total premiums paid to health insurance purchasing alliances, a portion of a 1% tax on the total payrolls of the remaining employers who formed corporate alliances, and Medicare funds previously spent to subsidize graduate medical education and the additional costs incurred by teaching hospitals to provide care to the indigent and to the more sick patients. Only those training programs that complied with federal mandates to cut residency positions would receive funding.⁵⁸ Following the demise of the Clinton reform proposal, the likelihood of achieving the three funding pools appears slim.⁵⁹

A recent Republican plan would establish a Teaching Hospital and Graduate Medical Education Trust Fund which would be supported by general revenues and transfers from Medicare. President Clinton, however, disfavors the formation of a trust fund. Moreover, President Clinton would remove the Medicare adjusted reimbursements that subsidize medical training when payments are made to MCOs and use these monies to support medical education. In the past, MCOs have retained these additional funds even if they did not provide medical training. Republicans oppose this measure.⁶⁰ Although other proposals addressing the cost of medical education have been offered, none have yet to capture the attention of Congress.⁶¹

⁵⁸ *Id.*

⁵⁹ Leaders of the Association of American Medical Colleges supported the creation of a fourth pool to provide funding for undergraduate medical education. *Id.* at 1169.

⁶⁰ Iglehart, *supra* note 19, at 1073. The Association of American Medical Colleges and the American Hospital Association back the Republican proposal. Hagland & MacPherson, *supra* note 26, at 22.

⁶¹ For example, the Council on Graduate Medical Education (COGME) recommends maintaining Medicare expenditures for graduates of United States medical schools by decreasing the Medicare subsidy for residencies filled by graduates of foreign medical schools. Mullan, *supra* note 1, at 916. David A. Kindig, Chair of COGME, has also suggested that Medicare reimbursements should be upweighted for resident time spent in public delivery locations and ambulatory care settings. Moreover, if a national funding pool fails to materialize, individual state "public-private academic endowments" formed by the State Medicaid Program, managed care plans, and academic centers could be established. David A. Kindig, *Residency Training in Community Health Centers: An Unfulfilled Opportunity*, 110 PUB. HEALTH REP. 300 (1995). Recent congressional efforts have focused on limiting the growth of graduate medical education. For a discussion of the Consensus Statement on The Physician Workforce and The Balance Budget Act of 1997, see Marvin R. Dunn, Rebecca S. Miller, & Thomas H. Richter, *Graduate Medical Education, 1997-1998*, 280 JAMA 809 (1998).

V. PROPOSAL: MEDICAL EDUCATION TAX ACT

Because deficiencies are inherent in a market-based approach and a centralized federal funding approach to support medical education, a more tenable proposal is the establishment of state pools derived through a tax on all healthcare payers similar to unemployment insurance under the Federal Unemployment Tax Act.

A. Market-Based Approach

Undergraduate medical education is currently financed, in part, through a combination of private and local government sources. Market-based strategies should prove sufficient to fund undergraduate medical school education.⁶² Teaching hospitals, however, cannot finance adequate graduate medical education solely through the market.

In the setting of equally efficient health delivery systems of an MCO and a teaching hospital, the teaching hospital retains the added expense of graduate medical education and medical research thereby placing it at a continued disadvantage in the absence of external funding. Although the cost of residency training can be reduced,⁶³ under present Medicare

⁶² On average, medical schools obtain only 11% of their total revenues from state and local sources. B. Barzansky et al., *Educational Programs in United States Medical Schools, 1994-1995*, 274 J. AM. MED. ASS'N 716, 722 (1995). Although tuition covers less than half of undergraduate medical education costs, a large portion of the expense derives from faculty salaries and related costs. (At Allegheny, the average cost to train a medical student is \$50,000 each year, half of which is covered by tuition and government funding). Abdelhak, *supra* note 46, at 26. Redesigning medical education to utilize faculty resources more efficiently will significantly contribute to lowering the cost of medical school training. Basing medical schools within HMOs offers an alternative method to control the expense of training. In 1992, Harvard Medical School and the Harvard Community Health Plan established the first such medical school. Gordon T. Moore et al., *The Teaching HMO: A New Academic Partner*, 69 ACAD. MED. 595 (1994). For a description of medical school revenues and source of revenues, see Robert F. Jones et al., *Review of U.S. Medical School Finances, 1996-1997*, 280 JAMA 813 (1998).

⁶³ In a recent study of the expense of training family practice residents in a Community Health Center in Fresno, California, the cost of training, including resident wages, faculty supervision and administrative charges, amounted to \$7,700 per resident. The study, however, focused on only a single month and involved only five residents. See John Zweifler, *Family Practice Residencies in Community Health Centers—An Approach to Cost and Access Concerns*, 110 PUB. HEALTH REP. 312 (1995). Moreover, although community-based training offers a cheaper means of education while potentially furnishing medical care to underserved areas of the community, not all residencies lend themselves to the outpatient community setting. In addition, residents in primary care fields trained only in the community setting cannot examine and treat the full cadre of patients they may encounter later in practice.

regulations and private insurance guidelines, direct billing for resident-provided patient care remains impermissible. Moreover, the continued drain on federal monies for graduate medical education threatens the future viability of Medicare.⁶⁴

The current market disfavors medical education. As a long-term benefit, medical education fails to command the interest of the present short-term, benefit-oriented market. Contractual arrangements between medical colleges and HMOs to sponsor graduate education exist, but remain few in number.⁶⁵ In the absence of additional incentives, market demand for medical education will likely not materialize. Therefore, successful ventures into the market by teaching hospitals will ultimately come at the expense of resident training.

B. Federal Funding Approach

President Clinton's American Health Security Act recognized that current federal sources can no longer adequately subsidize medical education. The White House's proposal to establish separate funding pools derived predominantly through a tax on all healthcare payers, however, would create a centralized bureaucracy that encourages teaching hospitals to stop investing in cheaper, more efficient systems of resident training. By supplying funds for medical education without tying their receipt to efficient practices, the Clinton plan failed to provide teaching hospitals with incentives to furnish cost-efficient medical education. The proposed federal funding pools replaced the source but not the practice of cross-subsidization. In the end, the plan offered a return to the status quo by removing market constraints and funding medical education without holding teaching hospitals accountable for their actions.

Teaching hospitals should be responsive to market demands. The United States fee-for-service system resulted in mounting expenses that now comprise fourteen percent of the Gross National Product. The call for financial efficiency heralded the rise of managed care. Today, both

⁶⁴ In 1992, Medicare spent \$5 billion for 90,000 hospital-based residents. *Id.* at 316. If Medicare continues to provide monies at its present capacity, its funding will soon dry up. Iglehart, *supra* note 19, at 1071.

⁶⁵ Janet M. Corrigan & Laurie M. Thompson, *Contractual Arrangements Between Residency Programs and HMOs*, 35 J. FAMILY PRACTICE 543 (1992). Only one in seven HMOs is either approved by the Accreditation Council for Graduate Medical Education to sponsor a residency program or has formed a contractual agreement with teaching hospitals to serve as an ambulatory rotation site. *Id.* at 544. The majority of provider contracts are with family practice programs. *Id.* at 545.

private and public healthcare enterprises seek to provide quality healthcare at the lowest cost in an effort to prevent the collapse of American medicine and the United States economy. The market offers strong incentives to cut operating costs. However, as previously discussed, the market will not adequately provide for medical education.

MCOs share the desire for quality medical education and view education as a public good.⁶⁶ Quality medical education trains physicians to provide quality healthcare. Consumer satisfaction depends on quality medical education. Although the principal objective of for-profit organizations is to foster the growth of the company by increasing the value of its stock,⁶⁷ the MCOs' product, quality healthcare, ultimately relies on quality medical education. MCOs, however, will not share the burden of paying for medical education as long as they are permitted to remain as free-riders.

An environment that encourages teaching hospitals to achieve cost efficiency without sacrificing quality medical education while enlisting the support of MCOs and other private sector organizations to provide funding and the opportunity for outpatient teaching environments would best serve our healthcare system. As medical care continues to move to the outpatient setting, residency training will need to follow the patients.⁶⁸ Managed care settings could furnish residents with the necessary training environments while allowing residents the opportunity to acquire skills necessary to supply quality, cost-efficient care. As a result, newly trained physicians would learn important management skills as well as gain a healthy respect for the managed care environment.⁶⁹ Physicians would more readily accept the practice guidelines promulgated by MCOs if they trained in a managed care environment that utilized such guidelines. In the short-term, the MCOs'

⁶⁶ Iglehart, *supra* note 4, at 411.

⁶⁷ Iglehart, *supra* note 29, at 1020.

⁶⁸ Leslie, *supra* note 22, at 1143. Home healthcare offers important practice opportunities and highlights the need for resident education in the home environment. See Allen I. Goldberg, *Pediatric Home Health: The Need for Physician Education*, 95 PEDIATRICS 928 (1995). For-profit organizations that supply home healthcare may offer the means to acquire the necessary education.

⁶⁹ In a 1991 survey of new physicians, only 60% thought that they received adequate training to offer preventive care, 41% to supply cost-effective care, and 32% to organize the provision of patient care with resources available in the community. Two-thirds of physicians responding to the survey would have preferred additional training in managed care environments and private physician offices. See Marc L. Rivo & David A. Kindig, *A Report Card on the Physician Work Force in the United States*, 334 NEW ENG. J. MED. 892, 894 (1996).

public image may improve. In the long-term, the administrative costs of physician credentialing and monitoring could decline if MCOs trained residents and then recruited their physician providers from that residency pool. Rather than standing at odds with one another, MCOs and teaching hospitals could become partners in training tomorrow's healthcare providers. A legislative act, proposed in the following section would encourage private sector participation in medical education while maintaining market incentives for teaching hospitals.

C. Medical Education Tax Act

This Section proposes that Congress enact legislation to institute a tax on all healthcare payers through a federal-state system similar to that established by the Federal Unemployment Tax Act (FUTA).⁷⁰ As a starting point, this Section reviews the approach undertaken by FUTA.

Congress first enacted a national unemployment insurance law in 1935 to provide relief to workers who lost their jobs through no fault of their own.⁷¹ Under the current system, employers pay a 6.2% tax on total wages up to \$7,000 for each employee. The United States Treasury collects the funds, retains a portion to cover administrative costs, then redistributes the funds back to those states that have enacted similar unemployment legislation. State legislation, however, determines the actual tax paid by each employer within that state. Through an experience rating system, employers with a history of fewer employee discharges, lay-offs, and good cause voluntary resignations pay a smaller tax percentage whereas employers who have experienced a larger number of employee discharges, lay-offs, and resignations shoulder more of the tax burden. Employers receive credit against the federal tax for their contributions under state law. Control over employer payments and the distribution of unemployment benefits to qualifying employees remains in the hands of the states. The federal component provides a measure of uniformity and an indirect guarantee of the provision of benefits. States who fail to meet federal standards can be penalized by a withholding of federal funds to offset state administrative costs and state employers may be denied credit against the federal tax.

⁷⁰ Federal Unemployment Tax Act, ch. 736, 68A Stat. 439 (1954) (current version at 26 U.S.C. § 3301-11 (1994)).

⁷¹ In August 1935, Congress passed Title III, "Grants to the States for Unemployment Compensation Administration," and Title IX, "Tax on Employers of Eight or More" under the Social Security Act. Most of Title IX was later added to the Internal Revenue Code as the Federal Unemployment Tax Act. See BARBARA KRUPCZAK BENNETT, *HISTORY OF UNEMPLOYMENT INSURANCE LEGISLATION IN THE UNITED STATES AND NEW YORK STATE, 1935-1983* 2 (1984).

Congress should adopt a system similar to FUTA to partially finance graduate medical education. Under the proposed Medical Education Tax Act, all healthcare payers would be taxed on the premiums paid by individual payees. States can elect to pass legislation that determines the tax liability of individual payers through an experience rating system whereby payers who provide graduate medical education are taxed at a lower rate than payers who do not provide education.⁷² Such laws must be approved by the Secretary of Health and Human Services to determine compliance with federal requirements. The state within which the payee resides determines which state's law governs, not the location of the payer. If payer A services states X and Y, payer A is taxed on premiums collected from payees in state X according to state X's laws, whereas payer A is taxed on premiums collected from payees in state Y according to state Y's laws. Federal requirements, however, will assure relative uniformity of practices across states. To protect the financial stability of the system, each state must deposit the collected taxes in a trust fund established by the United States Treasury, the money to be invested in United States government bonds. The federal government would retain a small percentage to cover administrative costs and then redistribute the funds to the states in proportion to the amount collected. The states then retain a small percentage for their administrative costs and distribute the monies to accredited residency programs to cover two-thirds of resident wages and benefits. The individual institutions that provide graduate medical education remain responsible for supplying the other one-third of resident wages and benefits.⁷³

The Medical Education Tax Act serves the goal of financing medical education. Although payers directly bare the brunt of the tax, they will likely pass the cost along, at least in part, to the consumer. Since both payers and consumers benefit from quality medical education, it is only fair that they should shoulder the cost. The product consumers seek to purchase is quality healthcare at the lowest price. Quality healthcare requires that healthcare professionals receive quality education at the lowest permissible cost. The Act accomplishes this task. States with more consumers will pay more taxes but will also receive more funds to support more resident training. Hence, the Act provides an indirect

⁷² The individual payer tax burden is proportional to the number of residency positions provided. If payers allow residents from other institutions to train on their premises, the payers can negotiate with those institutions to recapture some of the tax benefit. Moreover, Congress could establish ceilings whereby if a payer furnishes a set number of residency positions, the payer would be exempt from paying any tax.

⁷³ The two-third/one-third cutoff was determined arbitrarily. Congress should establish an appropriate cutoff level prior to enactment of the Act.

incentive to establish or maintain residency programs in more populous areas thereby ensuring that residents will be exposed to an adequate number of patients. By tying experience ratings to the provision of graduate medical education, the system gives MCOs and other payers an incentive to offer resident training.⁷⁴ By encouraging a greater number and variety of institutions to participate in graduate medical education, residents will be offered a wider range of training settings resulting in broader training experiences. Moreover, hospitals and other health facilities would possess a greater incentive to supply more cost-efficient resident training. Payers would compete on both the quality and cost of residency training. The lower the cost, the more profits the payer keeps. The higher the quality, the more residents the program will attract thereby lowering the payer's overall tax burden and, thus, allowing the payer to offer a lower premium to consumers. Although the number of permitted residency positions may be limited by federal or state mandates, the better programs will attract the better residents from which payers are more likely to recruit physicians into their employment pools. Teaching hospitals will still have the impetus to restrict the cost of graduate medical education because the funds generated by the Act only cover two-thirds of residency wages and benefits. The teaching hospitals must furnish the other one-third and all other costs. Finally, payers receive an additional incentive to keep the costs of their premiums low because the tax liability is partly dependent on the amount of the premium. A lower premium means a lower tax burden.

The Medical Education Tax Act diminishes the financial strain on Medicare. By shifting the burden of financing graduate medical education from federal and state governments to payers and consumers, the need to subsidize medical education costs through Medicare reimbursements disappears. Following passage of the Act, Congress should remove the direct medical education payments from Medicare reimbursements thereby reducing the overall burden on the Medicare system. The debate over whether MCOs should retain the education component of Medicare reimbursements would also end.⁷⁵

⁷⁴ As a result, the Act recaptures opportunity costs of MCOs, a necessary component for the success of any plan seeking to restrain medical education costs. See H.L. Kirz & C. Larsen, *Costs and Benefits of Medical Student Training to a Health Maintenance Organization*, 256 J. AM. MED. ASS'N 734, 739 (1986).

⁷⁵ Indirect adjustments to case-by-case patient reimbursements should still be permitted to the extent of adequately compensating for services provided to Medicare beneficiaries with more serious illnesses.

The system established by the Act need not continue indefinitely. As payers and teaching hospitals design more cost-efficient graduate medical education and payers like MCOs incorporate resident training into their culture, the need to support graduate medical education through a federal tax system will decrease. Should the Act prove successful, the system could be phased out over a set period of time.

Graduate medical education remains a necessary component of our healthcare system. With the future of teaching hospitals in doubt as the result of their limited competitiveness in the current market, the absence of strong incentives for nonteaching institutions to furnish medical education and diminishing federal sources of support, alternative methods to finance graduate medical education are necessary. The Medical Education Tax Act offers one possible solution.