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Presented to:

House Judiciary Committee
Subcommittee on Immigration, Border Security and Claims

May 18, 2006

Chairman Hostettler, Ranking Member Jackson-Lee, and distinguished members of the Committee. My name is John Crosby. I am the executive director of the American Osteopathic Association (AOA). The AOA, which represents the nation's 56,000 osteopathic physicians and 12,000 osteopathic medical students, is honored to be here today to discuss a very important issue—access to physicians in rural and other underserved communities. We believe that by increasing training and workforce opportunities through recruitment and placement of U.S. trained osteopathic physicians you can improve access to physician services in rural communities and better address the global health needs by encouraging U.S. trained foreign medical graduates to return home to provide care to underserved populations.

We recognize that many communities face limited access to physicians and physician services. This is especially true in rural communities. We applaud the efforts made by state governments, the federal government, Members of Congress, and rural communities to increase physician access for their citizens.

For more than 130 years the AOA and the osteopathic profession have been dedicated to educating and training the future physician workforce. Consistent with our mission, we remain committed to producing primary care physicians who will practice in rural and other underserved communities. This mission has been a tenet of the profession since it's founding in the late 1800's. Today, more than sixty-five percent of all osteopathic physicians practice in a primary care specialty (family medicine, internal medicine, pediatrics, and obstetrics/gynecology). Each year, more than 65 million patient office visits are made to osteopathic physicians.

Over the past fifteen years we have enjoyed tremendous growth. Since 1990 the number of osteopathic physicians has increased sixty-seven percent. Currently, osteopathic physicians represent six percent of the total U.S. physician workforce and over eight percent of all military physicians. However, twenty-two percent of osteopathic physicians practice in a designated medically underserved area (MUA) (Map 1). Throughout our history the osteopathic profession has placed an emphasis on primary care and rural service. Our colleges of osteopathic medicine have embraced this mission. Through the years, new colleges of osteopathic medicine have been established in some of the nation's most medically underserved regions (Map 2).

The issues facing our nation's rural health care system are complex. We do not suggest that there are easy answers, but we do believe that there are policies that would increase our ability to meet these needs. The following pages outline several recommendations. These recommendations promote the ability of the AOA and our allopathic colleagues to meet the needs of rural communities without placing a greater dependence upon international medical graduates. Additionally, we believe that the implementation of these recommendations will allow the U.S. medical education system to meet its responsibilities of training international physicians who will return home and provide quality of care to their citizens. As a result of these two missions, we fulfill our joint goal

of improving health care for all Americans and sharing our expertise with other countries as a means of improving global health.

International Medical Graduates

The U.S. health care system is widely recognized as the most advanced in the world. The rapid development of new diagnoses and treatments outpaces those in other countries. We are the world's leader in medicine and medical technology. In this role, we should share our expertise with the world. For this reason, the AOA supports the continued acceptance of international medical graduates (IMGs) into the U.S. graduate medical education system. By training international physicians, we can improve the health care delivery systems around the world by improving the quality of the physicians. However, this transfer of knowledge and skills cannot take place if international physicians do not return to their home countries.

The United States should not be an importer of physicians. Physicians should come to the U.S. to train and then return home. The "brain drain" in many countries is well documented. Many countries lose their best and brightest young physicians to the United States and other English-speaking countries. The AOA believes that policies should facilitate the opposite result. International physicians should come here to train and should not be encouraged to stay upon completion of their training. In fact, we should require that they return to their home countries and practice medicine for an extended period of time before they are eligible to petition for a visa, J-1 or otherwise.

In 2006, almost 9,000 IMGs participated in the National Residency Matching Program (NRMP). Of these applicants, approximately 6,500 were not U.S. citizens and 2,500 were U.S. citizens who attended a foreign medical school. Almost fifty percent of all IMGs match to first year residency positions. In 2006, the total number of IMGs who matched to first year positions increased to 4,382.

Of the 6,500 IMG participants who were not U.S. citizens, 3,151 (48.9%) obtained first year positions. 2006 was the fifth consecutive year that the number of non-U.S. citizen IMGs matching to first year positions increased. Of the 2,500 U.S. citizen IMG participants, 1,231 (50.6%) were matched to first year positions. 2006 was the third consecutive year that the number of U.S. citizen IMGs matching to first year positions increased. The total number of IMGs filling first year residency positions will be much higher than the approximate 4,400 who secured positions through the NRMP. Many IMGs are able to secure residency training positions outside the match. All of these IMGs are allopathic physicians (MDs) and none are osteopathic physicians (DOs).

Physician Workforce

Many experts now believe that the United States will face a shortfall in its physician supply over the next twenty years. While academic and policy experts debate the needs and expectations of the future physician workforce, the AOA recognizes that we must begin to educate and train a larger cadre of physicians, now. The time it takes to educate and train a physician is, at minimum, seven years. This means that a student accepted in the matriculating class of 2006 will not enter the physician workforce until at least 2013.

Due to the time required to educate and train future physicians, we believe a concentrated effort must be focused on increasing capacity over the next five years. If handled appropriately, the country could increase the physician workforce dramatically by 2020.

Reliance upon the J-1 Visa program is neither the most effective nor the most desirable way to increase physician supply in rural communities, although we recognize that the program can provide short-term relief. The J-1 program is not capable of meeting the physician workforce needs of our nation and should not be promoted for this purpose. Yes, a few states and communities have physician services as a result of the J-1 program. However, thousands of rural communities remain without physician services. The AOA supports increasing our capacity by adopting policies that encourage larger numbers of U.S. educated and trained physicians to practice in rural and underserved areas. An increase in U.S. educated and trained physicians, if properly selected and trained, will lead to a more predictable and reliable physician workforce and is more likely to produce larger numbers of physicians who will practice in rural communities.

Currently, there are 23 colleges of osteopathic medicine. Twenty of those are operating on 23 campuses. Three of those are in formation having recently received pre-accreditation. In 2006, these colleges will graduate approximately 2,925 new osteopathic physicians. In 2008, the number of graduates will increase to 3,463. By 2013 the number of osteopathic physicians graduating from colleges of osteopathic medicine is projected to reach 4,706.

The AOA, like the Association of American Medical Colleges, requires maintaining of quality educational standards while class sizes are increasing. Additionally, we anticipate the establishment of at least three additional colleges of osteopathic medicine over the next four years. These new colleges, once established and accredited will begin educating approximately 500 to 600 new students each. Once fully enrolled, our current colleges, along with the new colleges of osteopathic medicine, should produce an additional 1,000 physicians per year. Assuming a predictable growth pattern, the osteopathic profession should produce approximately 5,000 new physicians per year beginning in 2015.

Recruitment and Placement

Medical schools and colleges of osteopathic medicine traditionally place significant emphasis on an applicant's academic achievement—grade point average, undergraduate degree program, and scores on the Medical College Admission Test (MCAT). While I would never suggest that the academic standards required for admittance be lowered, I do recommend that the nation's medical education institutions begin evaluating "other" factors. An evaluation of the student's life, including an evaluation of where the student was raised, attended high school, and location of family members, provides an indication of where a future physician may practice. For example, an applicant from Princeton, New Jersey is less likely to practice in a rural community than an applicant from Princeton, Indiana. If the two applicants are equally qualified, we should encourage our schools to matriculate the student from Princeton, Indiana, an individual more likely to return to rural southwest Indiana once education and training is completed.

Our medical education system must increase its efforts to promote both primary care specialties and experience in rural practice locations. Over the years, the role of the rural family physician became less glamorous than that of the urban subspecialist. Far too many medical school students want to be an "ologist" instead of a general surgeon, family physician, general internist, or pediatrician. Our nation's health care system needs specialists and subspecialists, but we need far more primary care physicians. Our medical education system must place greater emphasis on educating and training primary care physicians and general surgeons. These physicians are more likely to practice in a rural or small community hospital and are far more likely to practice in rural America.

Increase Training Capacity

Currently, there are approximately 96,000 funded residency positions in the United States. Of these positions, international medical graduates fill approximately ten percent. The number of international medical graduates training in the United States has grown steadily over the past decade. The number of funded residency positions has been static since the late 1990's when Congress, as part of the Balanced Budget Act of 1997, placed a limit or "cap" on the number of residency slots any existing teaching program may have. With the exception of a provision allowing for the establishment of a rural training tract, these caps have been unaltered since their establishment.

The residency cap was established at a time when the general consensus was that the country had an adequate supply of physicians. We now recognize this is not correct. The residency caps established by the BBA limit the ability of teaching hospitals to increase training programs, thus preventing responsible growth capable of meeting our future physician workforce needs. The AOA encourages Congress to either remove or increase the cap on the number of funded graduate medical education training "slots" as established by the Balanced Budget Act of 1997.

Improve Rural Training Programs

There is an old saying in medical education circles that physicians will practice within 100 miles of where they train. While the validity of this saying either in a world that is flat or alternatively in an era of globalization is unproven, its message rings true. Physicians are more likely to practice in settings where they have the most experience. While a majority of physician training takes place in the hospital setting, it should not be limited to this setting. We need to do more to expose medical students and resident physicians to different practice settings during their training years.

A valuable component of graduate medical education is the experience of training at non-hospital ambulatory sites. These sites include physician offices, nursing homes, and community health centers. Ambulatory training sites provide an important educational experience because of the broad range of patients and conditions treated and by ensuring that residents are exposed to practice settings similar to those in which they ultimately may practice. This type of training is particularly important for primary care residency programs since a majority of these physicians will practice in non-hospital ambulatory

clinics upon completion of their training. This training also is essential to improving access to care in rural communities.

Congress has long recognized that a greater focus should be placed on training physicians in rural and other underserved communities. In the 1990s, Congress began to fear that the current graduate medical education payment formula discouraged the training of resident physicians in ambulatory settings. This opinion was based upon the fact that the payment formula only accounted for the resident training time in a hospital setting. Through the Balanced Budget Act of 1997, Congress altered the payment formula, removing the disincentives that existed for training in non-hospital settings. We accomplished this goal by allowing hospitals to count the training time of residents in non-hospital settings for the purpose of including such time in their Medicare cost reports for both indirect medical education (IME) and direct graduate medical education (DGME) payments.

This change in the payment formula was designed to increase the amount of training a resident physician received in non-hospital settings, enhance access to care for patients in rural and other underserved communities, provide an additional education experience for residents who are considering practicing in rural communities, and provide a recruitment mechanism for rural and underserved communities in need of physicians.

The program appeared to be working as intended. However, in 2002 the Centers for Medicare and Medicaid Services (CMS) began administratively altering the rules and regulations in respect to this issue. As a result, CMS intermediaries began denying the time residents spent in non-hospital settings. In many cases, hospitals were forced to repay thousands of dollars as a result of this administrative change in regulations. Many Members of Congress urged CMS to work with interested parties to resolve this issue by developing new regulations that clarify the appropriate use of non-hospital settings. Unfortunately, these conversations have not produced policies that meet the original intent of Congress as established in 1997. As a result, hospitals are being forced to train all residents in the hospital setting, eliminating the valuable educational experiences offered in non-hospital training sites. Additionally, some teaching hospitals may be forced to eliminate residency programs entirely as a result of current CMS policies.

Allowing hospitals to receive payments for the time resident physicians train in a non-hospital setting is sound educational policy and a worthwhile public policy goal that Congress clearly mandated in 1997. Additionally, it is good for rural communities. For this reason, the AOA encourages Congress to enact the provisions included in the "Community and Rural Medical Residency Preservation Act of 2005" (H.R. 4403).

H.R. 4403 would establish, in statute, clear and concise guidance on the use of ambulatory sites in teaching programs. If enacted, it will preserve the quality education of resident physicians originally envisioned by Congress in 1997. The Medicare program should promote quality graduate medical education, rather than impose unnecessary barriers.

The AOA also encourages Congress to establish a new grant program, operated by the Health Resource Service Administration (HRSA) that would provide "start-up" funding for rural hospitals that seek to establish new primary care residency programs. For many rural hospitals the costs associated with starting a new residency program are prohibitive. Due to CMS requirements, hospitals starting new residency programs are not eligible for funding for at least 12 months. This lag between the actual start-up date and the date of eligibility for funding is cited as one of the main reasons more hospitals, especially smaller hospitals, do not start teaching programs. The AOA believes that numerous primary care residency programs at rural hospitals could be established if financial assistance was available to offset the associated costs.

Expand Programs That Provide Incentives for Rural Practice

There are numerous existing programs that provide scholarships and loan repayment for physicians who choose to practice in rural communities. These programs include the National Health Service Corps, Public Health Service, Indian Health Service, and many programs operated by state governments. The AOA supports these programs and encourages Congress to continue funding them at levels that facilitate greater numbers of physicians practicing in rural and other underserved communities.

Additionally, we believe that some consideration should be given to allow physicians to participate in the programs on a part-time basis. There are numerous communities that need physician services, but they may not need them full time. We believe that modifications should be made to federal loan repayment and scholarship programs that allow participants to repay on a part-time basis in exchange for a longer term of service. For example, if a physician participates in the National Health Service Corps and agrees to a three-year commitment in a rural community—why not allow the physician the option of committing to 4 or 5 year's service on a part-time basis. We believe this would encourage more physicians to participate in these valuable programs without jeopardizing the underlying mission.

The AOA also proposes a change in the tax code that would provide physicians practicing in designated rural communities with a tax credit equal to the amount of interest paid on their student loans for any given year that they practice in such a community, or until their loans are paid in full. Under current law, individuals may deduct up to $2,500 in interest paid on student loans from their federal income taxes. However, the income thresholds associated with this provision often prevent physicians from qualifying. Our proposal would provide a direct link between practice location and the tax credit. A physician practicing in a rural Indiana who pays $8,000 in interest on her student loans in year one would get an $8,000 tax credit for that year. The program would continue until the physicians had retired her student loan debt or when she departed the rural community. We believe that this proposal provides a direct incentive to young physicians and would assist in the recruitment and retention of physicians in rural communities.

Improve Economics of Medicine

The current practice environment physicians face is challenging. Over the past decade escalating professional liability insurance premiums, decreasing reimbursements, and expanded regulations have made the practice of medicine more frustrating for all physicians. These issues are compounded in rural communities where physicians are often in solo practice or small group practices, unable to benefit from economies of scale that larger group practices in urban areas enjoy.

According to a 2004 Health Affairs study, more than half of all practicing physicians are in practices of three or fewer physicians. Three-quarters are in practices of eight or fewer. They face the same economic barriers as every other small business in America. Costs associated with staff salaries; health and other benefits, basic medical supplies, and technology, all essential components of any business, continue to rise at a rate that far outpaces reimbursements. When facing deep reductions in reimbursements at the same time that their operational costs are increasing, it is safe to project that most businesses will not be able to continue operation. While most businesses increase, or have the ability to increase, their prices to make up the differential between costs and reimbursements, physicians participating in Medicare cannot.

Physician Payment—Unless Congress acts, Medicare physician payment rates will be cut by 4.6 percent on January 1, 2007. If this cut is imposed, Medicare rates will fall 20 percent below the governments measure of inflation in medical practice costs from 2001-2007. If the projected cuts are implemented, the average physician payment rate will be less in 2007 than it was in 2001. Additionally, two provisions included in the Medicare Modernization Act (MMA), which provide increased reimbursements for physicians in rural communities, will expire over the next two years.

In 2002, physician payments were cut by 5.4 percent. Congress acted to avert payment cuts in 2003, 2004, 2005, and 2006 replacing projected cuts of approximately 5 percent per year with increases of 1.6 percent in 2003, 1.5 percent in 2004 and 2005, and 0 percent in 2006. Even with these increases, physician payments fell further behind medical practice costs. Practice costs from 2002 through 2005 were about two times the amount of payment increases. Since many health care programs, such as TRICARE, Medicaid, and private insurers link their payments to Medicare rates, cuts in other systems will compound the impact of the projected Medicare cuts. Medicare cuts actually trigger cuts in other programs.

Additional cuts in Medicare physician payments decrease Medicare beneficiaries' ability to access to physician services. A MedPAC survey conducted earlier this year found that 25 percent of Medicare beneficiaries reported having difficulties obtaining an appointment with a primary care physician. These problems will only increase if additional cuts are implemented. Additionally, reduced payments may prevent the implementation and adoption of new health information technologies.

Furthermore, reduced payments hamper the ability of physicians to purchase and implement new technologies in their practices. According to a 2005 study published in *Health Affairs*, the average costs of implementing electronic health records was $44,000 per full-time equivalent provider, with ongoing costs of $8,500 per provider per year for maintenance of the system. This is not an insignificant investment. When facing deep reductions in reimbursements, it is safe to project that physicians will be prohibited financially from adopting and implementing new technologies.

Physician payments should reflect increases in practice costs. In its 2006 March Report to Congress, the Medicare Payment Advisory Commission (MedPAC) stated that payments for physicians in 2007 should be increased 2.8 percent. Since 2001, MedPAC has recommended that the flawed SGR formula be replaced by a formula based upon increases in physician practice costs minus a productivity adjustment, which would produce annual updates equal to the Medicare Medical Economic Index (MEI).

Since its inception in 1965, a central tenet of the Medicare program is the physician-patient relationship. Medicare beneficiaries rely upon physicians for access to all other aspects of the Medicare program. This relationship has become compromised by dramatic reductions in reimbursements, increased regulatory burdens, and escalating practice costs. Given that the number of Medicare beneficiaries is expected to double to 72 million by 2030, now is the time to establish a stable, predictable, and accurate physician payment formula that reflects the cost of providing care.

Congress must act to reform the Medicare physician payment formula. Continued use of the flawed SGR formula will have a negative impact upon patient access to care. Additionally, the AOA urges Congress to approve the "Medicare Rural Health Providers Payment Extension Act" (H.R. 5118). This legislation includes provisions that extend two important rural physician payment provisions originally enacted through the MMA. H.R. 5118 extends, through 2011, a provision that provides equity in how the Medicare program views and evaluates the work of physicians regardless of geographic location. By establishing a 1.0 floor for the work geographic practice cost indices (GPCI) under the Medicare physician fee schedule, the MMA reversed years of inequities in payments between rural physicians and those in larger urban communities. The AOA was equally pleased that the MMA included a 5 percent add-on payment for physicians practicing in recognized Medicare physician scarcity areas. We believe that these are essential and positive Medicare payment policies that should be extended, if not made permanent. Both provisions will enhance beneficiary access and improve the quality of care available.

Medical Liability Reform—As you know, the nation's medical liability system is broken. In recent years physicians across the nation have faced escalating professional liability insurance premiums. According to the National Association

of Insurance Commissioners (NAIC), between 1975 and 2002 medical liability premiums for physicians increased, on average, 750 percent. These premium increases are related directly to an explosion in medical liability lawsuits filed against physicians and hospitals and the rapid increase in awards. The Government Accountability Office (GAO) confirms this. In a 2003 report, the GAO stated that losses on medical liability claims are the primary driver of increases in medical liability insurance premiums.

As a result of a broken medical liability system patients face reduced access to health care, the overall costs of health care increases, and the future supply of physicians is threatened. Many physicians no longer provide services that are deemed high-risk, such as delivering babies, covering emergency departments, or performing certain surgical procedures. This crisis also impacts primary care physicians, especially those in rural areas who are often the only physician practicing in a community. As a result, patients have seen a decrease in the availability of physician services. Additionally, the medical liability crisis has a significant impact upon the career choices of future physicians. In a recent poll conducted by the AOA, eighty-two percent of osteopathic medical students stated that the cost and availability of medical liability insurance would influence their future specialty choices, while 86 percent stated that it would influence their decision on where to establish a practice once their training was complete. This trend in career choices is disturbing and will have a long-term impact upon the health care delivery system in the years ahead.

We applaud the leadership of this Committee and the House of Representatives in approving the "Help, Efficient, Accessible, Low-Cost, Timely, Health Care Act" (HEALTH Act) (H.R. 5). The AOA believes that provisions included in H.R. 5 will prove beneficial in stabilizing the nation's broken medical liability system, thus improving access to physician services.

Summary

Again, the AOA appreciates the opportunity share our views on this important issue. We remain committed to working with Congress to enact legislation that will ensure access to quality physician services for all Americans, regardless of where they reside. In closing we would like to highlight five recommendations made in our testimony that we believe will lead to improved global health, increase the availability of U.S. trained physicians, improve the quality of training for future physicians, and improve the recruitment and retention of physicians in rural communities.

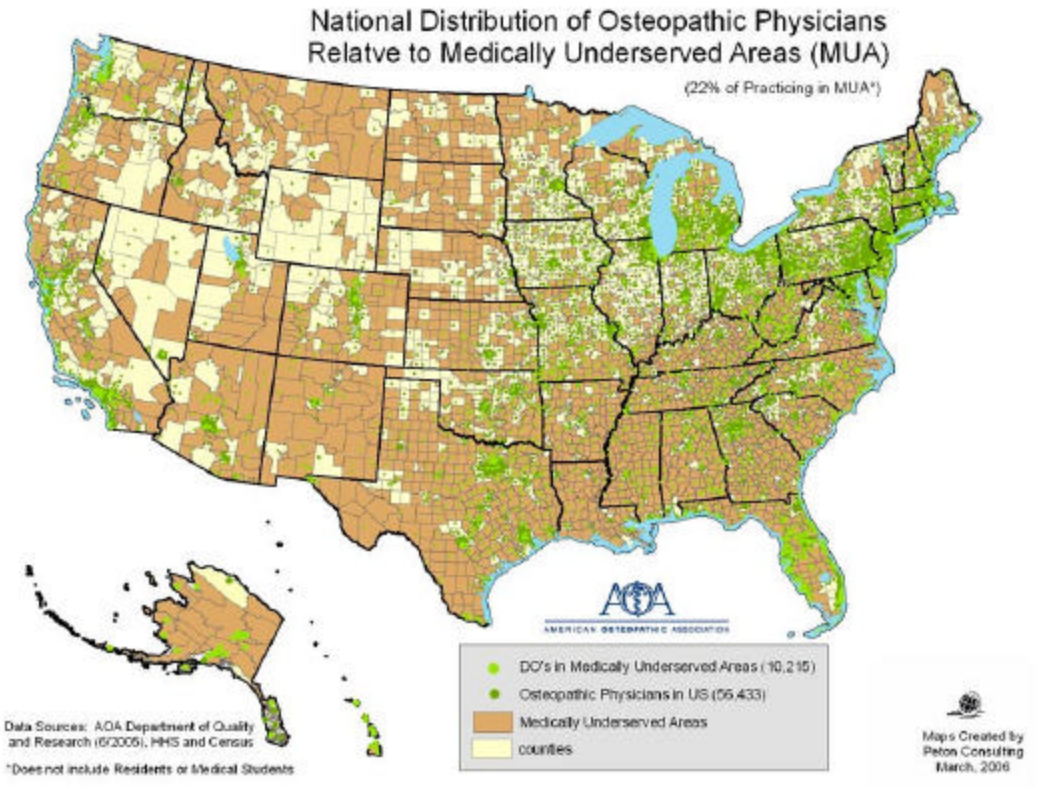
1. International Medical Graduates should be encouraged to return to their home countries to establish practices and, ultimately, improve the quality of care in those health care systems. The United States should not be an importer of physicians, thus contributing to the "brain drain" of other countries. By maintaining existing policy that requires IMGs to return home for two years before petitioning for a visa, we are fulfilling a noble mission of improving the health care needs of many countries.

2. Congress should consider eliminating the cap on available and funded residency positions in the U.S. This cap hinders the ability of osteopathic and allopathic medical schools to educate and train larger numbers of physicians. To meet the health care needs of our growing population we must have the capacity and financing to train a larger number of physicians.

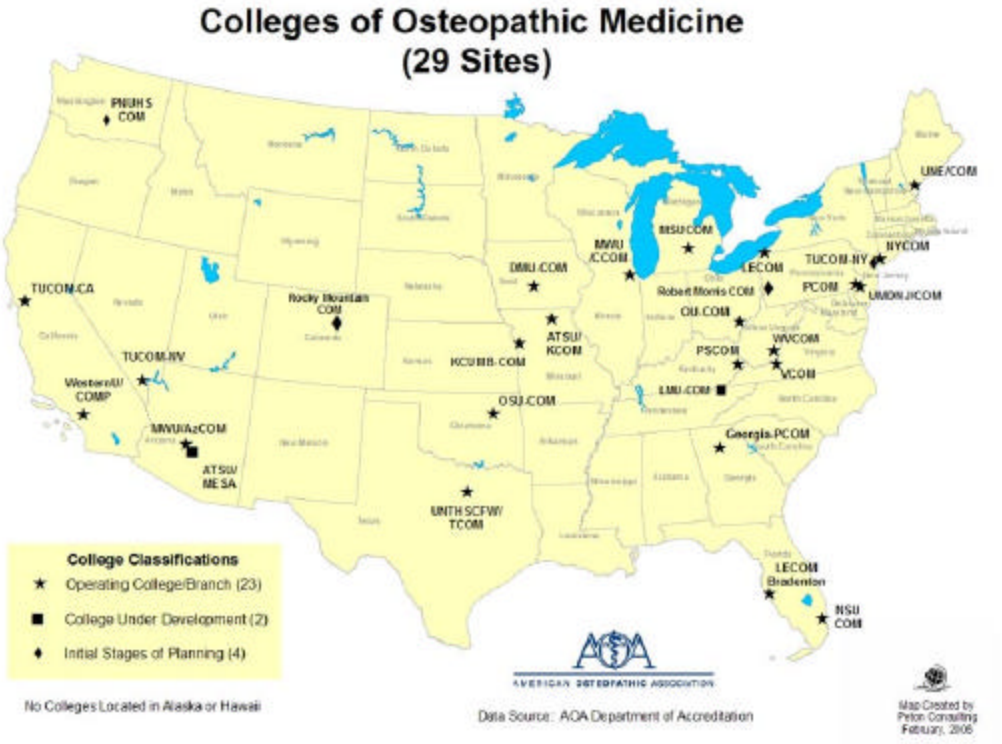
3. Congress should enact the "Community and Rural Medical Residency Preservation Act of 2005" (H.R. 4403). This legislation would establish, in statute, clear and concise guidance on the use of ambulatory sites in graduate medical education programs. If enacted, it will preserve the quality education of resident physicians originally envisioned by Congress in 1997.

4. Congress should amend the tax code to allow physicians practicing in rural communities an annual tax credit equal to the amount of interest paid on their student loans. We believe that this proposal provides a direct incentive to young physicians and would assist in the recruitment and retention of physicians in rural communities. Additionally, Congress should revise current scholarship and loan repayment programs to allow physicians to fulfill their commitment on a part-time basis.

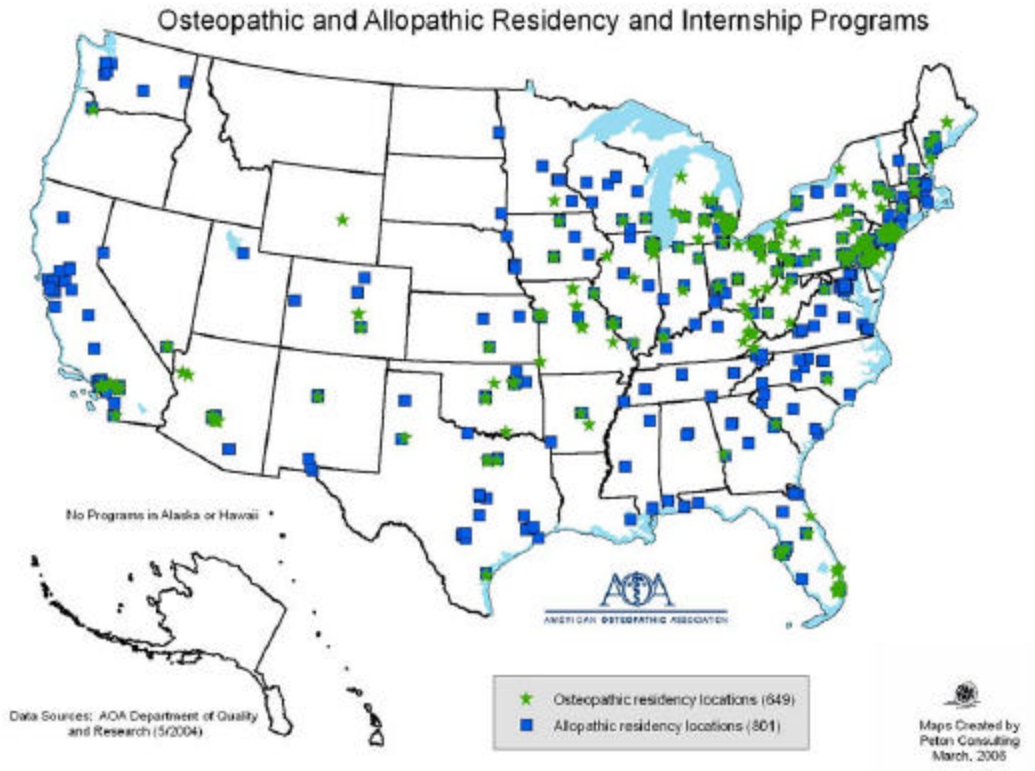
5. Congress should reform the Medicare physician payment formula by eliminating the sustainable growth rate and replacing it with a more equitable and predictable payment structure. Additionally, Congress should enact the "Medicare Rural Health Providers Payment Extension Act" (H.R. 5118), extending much need payment incentives for physicians practicing in rural communities.



[Map 1] National Distribution of Osteopathic Physicians Relative to Medically Underserved Areas



[Map 2] Colleges of Osteopathic Medicine



[Map 3] Osteopathic and Allopathic Residency and Internship Programs