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ACADEMIC HEALTH CENTERS UNDER HEALTH CARE REFORM

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

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ACADEMIC HEALTH CENTERS UNDER HEALTH CARE REFORM

THURSDAY, APRIL 14, 1994

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:00 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Daniel Patrick Moynihan (chairman of the committee) presiding.

Also present: Senators Baucus, Mitchell, Rockefeller, Packwood, Dole, Danforth, Chafee, Durenberger, and Grassley.

[The press release announcing the hearing follows:]

[Press Release No. H 24, April 8, 1994]

FINANCE COMMITTEE SETS HEARING ON ACADEMIC HEALTH CENTERS

WASHINGTON, DC.—Senator Daniel Patrick Moynihan (D–NY), Chairman of the Senate Committee on Finance, announced today that the Committee will continue its examination of health care issues with a hearing on academic health centers.

The hearing will begin at *10:00 A.M. on Thursday, April 14, 1994* in room SD–215 of the Dirksen Senate Office Building.

"The Committee will examine the expected effect of various health reform proposals on academic health centers," Senator Moynihan said in announcing the hearing. "It is important that health reform legislation assure the continued viability of our nation's academic health centers."

OPENING STATEMENT OF HON. DANIEL PATRICK MOYNIHAN, A U.S. SENATOR FROM NEW YORK, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. A very good morning to our most distinguished witnesses and our most welcome guests. This morning our hearings continue and we get to a subject that we have been waiting for with a good deal of interest and not a little anxiety—or anxiousness perhaps is the better word—which is to say the question of our academic health centers under health care reform.

From the first, one of the more evident and salient facts of our hearings has been the manifest fact that American medicine is in a heroic age of discovery. Isaac said that what physics was to the beginning of the century, medicine is at this point. Where the physics was done almost entirely in Europe the medical discoveries are taking place here. They are taking place in our academic health centers and in our pharmaceutical industry, as well. Whatever we do, we are under a solemn obligation to do no harm to, indeed to facilitate, these centers.

The President has made it very clear that if it appeared that in the draft legislation the administration sent there were difficulties,

he was prepared to address them in a separate and distinctive manner with provisions directed precisely to this question.

I think all of us—I think Senator Packwood, I think Senator Durenberger—have been dealing here with more than an insurance subject. Health insurance is important, but health is more important. It comes out of discovery, and we are in a great age of discovery. That is about enough said from me because we are looking forward to hearing from our panelists.

Senator Packwood?

Senator PACKWOOD. Mr. Chairman, no opening statement today.

The CHAIRMAN. Which speaks to our interest in what we are going to hear.

Senator Durenberger?

OPENING STATEMENT OF HON. DAVE DURENBERGER, A U.S. SENATOR FROM MINNESOTA

Senator DURENBERGER. Mr. Chairman, I agree with your opening remarks. As one of the members on this side of the aisle, I want to express to you on behalf of a lot of people who find it difficult to be part of this health care reform process how valuable these hearings have been because if you wanted to take on a difficult reform it would be health care because you cannot even define it.

One of the values to those of us who have sat here for many, many years of this particular hearing process that you have designed is that you are helping to educate all of us and a lot of people out in America as to not only the complexity of this issue, but helping us set some priorities.

I do not expect, Mr. Chairman, that we are going to solve all the problems of health care in one bill. I do think this is the forum, however, and I regret not being around in the future. But this is the forum in which they will be resolved.

I think today's hearing with the people that are here is part of a process that is going to be going on for a number of years. I do not think there is anyone's expectation that we are going to solve the problems that are going to be presented—academic medicine or medical education in general—in some bill we pass this year.

If we can anticipate them, however, in what we do, that is an important step in the right direction.

The CHAIRMAN. In the great injunction of the Hippocratic oath, if we can do no harm.

Senator DURENBERGER. Amen.

The CHAIRMAN. Senator Grassley?

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA

Senator GRASSLEY. I would only say that outside of the major cities of America we have some academic research and health centers as well and one of those is at the University of Iowa. I have had an opportunity to work with that facility, both as a State legislator and now in the Congress. I am proud of their accomplishments and I can see some of the proposed aspects, I suppose, of all of the comprehensive reforms, both Republican and Democrat, having some negative impact upon teaching hospitals and research centers.

I hope we can modify any of those proposals that will be before this body in a way so that we do not impact negatively upon those teaching centers and research centers.

Thank you.

The CHAIRMAN. Thank you.

We heard on Tuesday of the difficulties that the University of Minnesota Medical School is encountering in the context of a very advanced, progressive health care system. So we have to watch these things.

Well, let us get to the subject at hand. Our first witness is Stuart Altman, who has been a friend of this committee for many years and chairman of our Prospective Payment Assessment Commission. Good morning, Dr. Altman.

STATEMENT OF STUART H. ALTMAN, PH.D., CHAIRMAN, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, WALTHAM, MA

Dr. ALTMAN. Good morning, Senator, and thank you for inviting me. It is always a pleasure to come before your committee. This issue of funding of academic health centers is an area that PROPAC has focused on for many years. If you would like, I would like to submit my testimony in full and just focus on a few opening remarks to make a few points.

First of all, how we fund medical education in this country is a very complicated area. I think it is fair to say that nobody really understands it. The funds come in many different ways. Medicare has tried to pay explicitly for medical education through two funds—one, a direct medical education fund; and a second through a mechanism which we call the indirect medical education add-on to the DRG payments.

But it is also fair to say that hidden into patient care costs, even under Medicare, are significant dollars which teaching hospitals use to pay for medical education. And then, of course, private patients pay higher rates to most of our major medical centers to account for these higher costs.

In sort of economic jargon, if you will forgive me, we have a joint product here, where you have patient care going on, research going on, and teaching going on. And anybody who tells you that they can separate out the true cost of each is not telling you the truth, because there really is no way to do it. That does not mean we all do not try and we try like everybody else.

But there is no perfect way to do it. And that is why you are going to get wildly different estimates before this committee about really what is the true additional cost of education.

Now with that said, it is also fair to say that if you look at the complexity of the patient mix in this country, our teaching hospitals, even though they make up only 4 percent of hospitals, and account for 14 percent of all discharges, account for something like 25 percent of the patient care dollars that are attributed to low-income patients. Actually, they account for a smaller percentage of medicare days than the average—11 percent—even though they make up 14 percent of the total discharges.

The Medicare DRG payment system has been appropriately, in our judgment, generous to teaching hospitals. We have set up sev-

eral funds which pay teaching hospitals more than they would get if they just used the DRG payment.

If you look at Medicare margins, teaching hospitals are the single, almost biggest winner in a way, where the average hospital might lose 2.5 percent on Medicare, teaching hospitals gain or have the margin of plus 7.8 percent.

But if you look at their total margins, teaching hospitals do less well than the others, which in a sense says that Medicare is making up for the fact that they are treating more sicker patients and more patients that do not pay their bills.

So one of the important things we have to bear in mind is that as we move to a new payment structure, whether it is under reform or under a changing market structure, we have to appreciate the fact that teaching hospitals have been able to get their funds through higher patient care costs, which is going to get more and more difficult to do.

So, therefore, we at PROPAC support the idea of taking those funds out of the patient care dollars and setting up some separate mechanism for paying them.

Now the President's plan, the Health Security Act, establishes two different funds. Senator Chafee in his bill establishes a mechanism for experimenting, which I thought was quite ingenuous and also something that ought to be looked at.

We have not come down on one side or the other. But the one thing that is clear to me, and I think to my fellow commissioners, is that if we allow the patient care dollars to totally pay for teaching hospitals and we have a much more price sensitive world, which we seem to be moving into, the implications of it for our current education program are very unclear. I am sure you are going to hear from my colleagues on this table how potentially problematic that will be.

I am not prepared to say that the world would collapse. I think the teaching hospitals would have to adjust. But I am prepared to say that we run a big risk, as I think you said, Senator, in sort of tampering with these important institutions.

Now how much should we put into these funds? The administration has come up with an amount of money which combines indirect and the direct plus a tax on private patients. Our view is that that amount is inadequate based on our assessment.

We are still in the process of trying to find out how inadequate. But that should give you one order of magnitude. We have been having a little difference of opinion with the administration over a long period of time—with all administrations, to show our nonpartisanship here.

Their estimates suggest that, say, the teaching adjustment should be roughly in the order of a 3 percent factor add-on. We have been estimating something in the order of between 4.8 and 5.2. Of course, the current mechanism is close to 7.7. So we would suggest a cutback, but not as much as all administrations seem to want to do.

Now, if you translate that into the future, the implications of it add substantial dollars beyond the 9.6 billion that are in the President's plan. So I do believe we need to look seriously at the amount of money that those funds should have. Or if we go to some other

mechanism, we also need to look at the funding that would flow that way.

The third issue is, where does the money go. Currently, the money flows almost entirely to our large teaching hospitals and the training flows, particularly the graduate medical education, flows from these teaching hospitals. But we know that a lot of training should and needs to go on outside the hospital walls—in ambulatory care settings, in our neighborhood health centers and the like.

And, therefore, PROPAC supports changing the place where the money goes to some programmatic entity. Exactly what that program would look like, I think that is up for debate. Some consortia perhaps. Some third party. Some mechanism that ties together in a community—the teaching hospitals and the ambulatory care. I think that there is room for experimentation in this sense—one of the areas that I like about Senator Chafee's idea of some consortium.

But the flow only to the teaching hospital could lead over time to a distortion in the training programs. And so in conclusion, Senator, I think we——

The CHAIRMAN. Would you remind repeating that pleasant remark about Senator Chafee's proposal. He just came in.

Senator CHAFEE. I heard it and raced down. [Laughter.]

Dr. ALTMAN. I was slowing up hoping you would make it quickly. I was saying, Senator, that as we think about where the money should go, whether it is from some kind of a fund or two funds like the administration, or some mechanism other than that, some payment structure that uses Medicare money and private money differently, we need to think seriously about a different mechanism than just flowing it into what we traditionally have done, which is the teaching hospital, to take account of the fact that we are dealing with training going on in many different places.

While the administration has come up with one mechanism, there are many others. I like the idea of some third party, which is a consortium maybe.

Now, finally, the issue is, what are we paying for. We have allowed the marketplace of the teaching institutions, if you will, to decide what the mix of our future physicians should look like, as well as the choices made by our future physicians.

It is fair to say that this country has by far the largest percentage of specialists in the world. I mean, we are not even close to anybody else. While I am not personally opposed to specialists—they provide a lot of very high-quality care—most people that have looked at our health care system think we would be better served by a better mix between specialists and primary care.

We are a little concerned at PROPAC that we come up with some fixed mechanism and have it written into legislation.

The CHAIRMAN. That concerns you?

Dr. ALTMAN. Yes.

The CHAIRMAN. The phrase was you are a little concerned. You are concerned about that?

Dr. ALTMAN. That is right, not because I do not think we need a better balance between 75/25, which is where we may be right now, maybe closer to 50/50, but I would like to see some flexibility in that number. I get personally concerned when it is written into

law and then it sort of sticks around for a very long time and has a way of developing sort of an artificial aspect to it.

But nevertheless, we at PROPAC do support some way of targeting those teaching funds in a way to bring a better balance between our specialty training programs and our primary care training programs.

Thank you.

The CHAIRMAN. We thank you, Dr. Altman, again.

[The prepared statement of Dr. Altman appears in the appendix.]

The CHAIRMAN. In your testimony you do not give us those margins on hospitals that are very important.

Dr. ALTMAN. I would be glad to provide them to you.

The CHAIRMAN. Would you do that?

Dr. ALTMAN. That is right. I realized that when I went back to the testimony. So I pulled them out and I have them right here.

The CHAIRMAN. Good. Thank you.

Dr. Spencer Foreman, who is President of Montefiore Medical Center in the Bronx of New York, and certainly a good friend of this Senator and of the committee, is going to speak on behalf of the Association of American Medical Colleges. Dr. Foreman, good morning.

STATEMENT OF SPENCER FOREMAN, M.D., PRESIDENT, MONTEFIORE MEDICAL CENTER, BRONX, NY, ON BEHALF OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Dr. FOREMAN. Good morning, Senator. It is a pleasure to be here with members of the committee. I am the immediate past-Chairman of the Association of American Medical Colleges. As Senator Moynihan said, I am the President of Montefiore Medical Center in New York, which is the University Hospital for the Albert Einstein College of Medicine.

I am very pleased to appear before you today to comment on three issues of particular interest to academic medicine as they relate to the national health reform debate.

The first is work force planning and financing. The second is how the special missions and costs of teaching hospitals should be recognized in a competitive environment. And finally, medical school financing in an era of health care reform.

Because no reform proposal addresses the issue of medical school financing, I would like to discuss it briefly first. The Association of American Medical Colleges is concerned about the ability of medical schools to maintain the support of physician education at a time when they are being called upon to change medical education's focus from specialist training in hospital settings to a more expensive system of generalist training in ambulatory settings.

Medical schools, like teaching hospitals, finance educational and research activities through a complex system of cross-subsidization. Undergraduate medical education in the clinical setting is not recognized explicitly by any payment system. But like other academic costs, a portion has been financed by clinical income earned by faculty, a source which will diminish in managed competition environment.

The AAMC calls for the creation of a separate fund to assist medical schools in meeting their academic responsibilities and in

maintaining an infrastructure for education and research. Our preliminary estimate is that the fund should be about $1 to $1.5 billion.

Part two of my statement addresses the higher patient care costs of teaching hospitals in an environment of increasing price competition. The Association proposes the creation of all payer fund that is similar in purpose to the Medicare indirect medical education adjustment, which Dr. Altman just referred to.

The AAMC vigorously opposes any attempt to repeal or reduce the Medicare indirect medical education adjustment until and unless the new fund is in place. We are seriously concerned that that academic health center pool proposed in the Health Security Act is underfunded at $3.8 billion in the year 2000.

In an independent study conducted by Lewin-VHI and Company, they have established that the appropriate level of that fund should be somewhere between $9 and $14 billion. Again, I contrast the $9 to $14 billion with the President's proposal for a $3.8 billion fund.

The last part of my testimony focuses on work force training. The Association agrees with the need to train more physicians in generalist disciplines.

In 1992 we called for a national goal of a majority of graduating medical students committed to entering generalist careers. Whether by market forces or by regulation, as the nation's work forces reshaped, the AAMC firmly believes that an all payer fund, separate from patient care revenues, must be established to fund the full costs of graduate medical education.

Preliminary calculations by our Association and others indicate that that fund should be somewhere between $7 to $8 billion a year in the year 2000 and is about $1.5 billion more than has been proposed in the Health Security Act.

Finally, to encourage the development of ambulatory training sites, the Association believes that payment for the direct costs of graduate medical education should be made to the entity that incurs that cost, even if those entities are not hospitals or related to hospitals.

The Association is deeply concerned by a proposed national average payment methodology for direct graduate medical education costs because of its unwarranted redistributional effect across institutions.

The Health Security Act proposes to reimburse hospitals at a national average rate rather than on the basis of the real costs, which varies with each of the institutions. We oppose the national average payment methodology.

The AAMC also recognizes and supports the creation of an independent national physician work force body which as we see it would have a few functions which are of great importance.

First, it would determine on an annual basis whether adequate progress was being made toward achieving national work force goals. And if not, could conclude that a regulatory approach to physician training be implemented and that body would be charged with implementing a national allocation system.

Given the complexity of graduate medical education, any allocation system must be sensitive to many factors. Therefore, if that body were to opt for a regulatory approach, we believe that any

changes in work force that they recommend should not be implemented without the explicit review and approval by the committees of the Congress with jurisdiction over work force issues.

The CHAIRMAN. Dr. Foreman, we keep trying to compile a lexigraphic compilation of words around here. By "work force," do you mean the distribution of specialties or nonspecialties within the medical profession?

Dr. FOREMAN. Yes. The President's proposal calls for the establishment of a national council and a regulatory approach to both the numbers of physicians trained in graduate medical education and the distribution by specialty. We do not favor the implementation of a regulatory approach from the go get.

The CHAIRMAN. And the concern that Dr. Altman expressed is expressed by you?

Dr. FOREMAN. Right. We believe that the market forces have worked perfectly since 1945 to create the specialty generalist distribution we now have. That is to say, in 1945 80 percent of America's physicians were general practitioners and 20 percent were specialists. By 1994 70 percent of America's physicians are specialists and only 30 percent are generalists.

This was as a consequence, we believe, of generous support of graduate medical education and of market forces which encouraged people to seek specialty training. Those forces were an explosion of technology and information and abundant rewards for specialization, which encouraged physicians to seek specialty slots.

The CHAIRMAN. Sir, did you say that you believed that the market worked perfectly?

Dr. FOREMAN. Yes. We believe that——

The CHAIRMAN. Sir, even Alan Greenspan does not believe that. [Laughter.]

Dr. FOREMAN. What I mean is——

The CHAIRMAN. It worked well. [Laughter.]

Dr. FOREMAN. It worked well enough to produce the distortion we are now looking at. That is to say, it is no accident that we have gone from a nation of physicians that were largely generalists to a national of physicians that are largely specialists because everything in our economy was set to encourage that.

We believe that the market forces in the competitive environment are now changing dramatically and that, in fact, there is very substantial pressure to move physicians in the opposite direction.

We believe that before the government acts to control graduate medical education by regulation that it ought to give the market a chance to move in the direction we now believe it is moving in. But if the market fails to correct the specialty distribution or fails to move in that direction, we would then be in favor of having a regulatory approach and would support it.

That concludes my remarks, Senator. Thank you.

The CHAIRMAN. Thank you, Doctor.

[The prepared statement of Dr. Foreman appears in the appendix.]

The CHAIRMAN. Could I just ask—we will all have questions—by "market" surely you also intended the state of medical knowledge. When there is a great expansion in one area, people will be attracted to it because it is more important medicine.

Dr. FOREMAN. Well, I think that the professional forces which have shaped specialty distribution in the last 50 years have been the monumental explosion of knowledge in the fact that no physician can possibly master any more than a piece of it.

But there are economic forces as well and now those economic forces are beginning to encourage physicians to seek more generalist specialties.

The CHAIRMAN. Yes, both things.

And now to speak to both matters, but with particular reference to federally designated cancer centers, it is a great pleasure for this committee, an honor for this Senator, to welcome Dr. Paul Marks who is President and Chief Executive Officer of the Memorial Sloan-Kettering Cancer Center, which is very closely associated, I believe, with Rockefeller University and has been much involved with your family, sir.

If I am not mistaken, there was a nice bit of reference in your statement, Dr. Foreman, to the Association calling for the creation of a separate fund to assist allopathic and osteopathic medical schools, which is a 19th Century distinction that never got resolved, nor need it have been. It seemed to have worked out very amicably.

I believe, Dr. Marks, you once taught at the College of Physicians and Surgeons, did you not?

Dr. MARKS. True.

The CHAIRMAN. To speak of the subject, we remind some of our fellow committee members, the College of Physicians and Surgeons was chartered by George II at a time when there was a distinction between the physician, who carried a gold-knobbed cane and lace on his cuffs and never touched anybody and the poor surgeon, who cut them apart. They were quite different social classes. That, too, has been resolved over the years.

With very great pleasure, we welcome you, Dr. Marks. Everybody's statement will be placed in the record in full, as you know.

STATEMENT OF PAUL A. MARKS, M.D., PRESIDENT AND CHIEF EXECUTIVE OFFICER, MEMORIAL SLOAN-KETTERING CANCER CENTER, NEW YORK, NY

Dr. MARKS. Thank you, Mr. Chairman and members of the committee. I just might add that the College of Physicians and Surgeons is also very proud of the fact that it was the first college in the colonies to award a so-called M.D. degree.

The CHAIRMAN. The first M.D. degree. Well, here you are in front of us.

Dr. MARKS. I am a physician and a cancer research scientist. I am here on behalf of Memorial Sloan-Kettering and the other freestanding National Cancer Institute designated cancer centers across the country.

I appreciate this opportunity to express our support for health care reform. I want to take this opportunity to highlight three specific issues which we believe are critical to provide optimal cancer care in this country. These are, first, assuring guaranteed access to federally designated cancer centers for patients who need and want such care.

Second, providing coverage of patients on qualified clinical trials. And third, assuring that the federally designated free-standing cancer centers are not subjected to inappropriate payment methodologies.

Let me begin by saying that we strongly support the need for health care reform to provide universal access for all necessary and appropriate health care, including prevention, therapy and rehabilitation. We support the need to assure that health insurance is portable and that no one is prevented from obtaining health insurance because of pre-existing conditions.

We also support the need for malpractice legislative reform. The role of cancer centers as national resources should not and need not be compromised by health care reform if their special missions are taken into account. The National Cancer Program was enacted by Congress in 1971 to improve the prevention, diagnosis and treatment of cancers.

A very important element of this National program has been the designation by the NCI of centers which are the cornerstones for deepening the understanding of the causes and cures for cancers, applying this knowledge to new approaches to prevention and more effective treatment and disseminating this knowledge. Many of the major advances in cancer care have been developed in these cancer centers.

Turning now to the issue of access. Even in the absence of health care reform legislation as I am sure you are all aware, dramatic changes are occurring in the health care arena. With the rapid growth in managed care, patient access to NCI-designated cancer centers has, in fact, been restricted.

This reflects in part the fact that managed health care plans generally seek the least expensive providers with, in our judgment, inadequate regard to optimal care. We know that effective and early management of cancer from diagnosis to therapy can actually reduce the cost of this disease in both human and financial terms.

Many health care reform proposals, including that of the President, are intended to foster the development of managed care. Extreme caution must be taken to assure that cancer patients are not denied the state-of-the art care available primarily and often only at the NCI-designated cancer centers across this country.

Such care must continue to be available to the general population. It should not be limited to affluent patients who can afford high co-insurance or special insurance coverage. Health care reform legislation must assure that cancer patients enrolled in a managed care plan be guaranteed the right if they choose to be treated in an NCI-designated cancer center without the obligation of excessive financial burden.

Managed care plans should be required to inform all plan enrollees that they have this right to seek care in an NCI-designated cancer center if they need and desire such care.

Health plans should be required to permit referral of patients to an NCI-designated cancer center that can provide appropriate and necessary services regardless of location. The definition of academic health centers in the legislation should include the free-standing federally designated cancer centers.

The CHAIRMAN. Can I ask just for a clarification there? You submit this testimony on behalf of Sloan-Kettering and then one, two, three, four, five, six, seven, eight, nine, ten. Are there ten such centers?

Dr. MARKS. There are nine free-standing NCI designated cancer centers.

The CHAIRMAN. Nine.

Dr. MARKS. Those are the nine free-standing, yes, sir.

Our second issue is that the basic benefits package must cover treatment of cancer patients and qualified clinical trials that substitute for other and possibly less effective therapy. These NCI-designated cancer centers play major roles in providing clinical trials of new ways to prevent and treat cancers. These clinical trials are intended to establish the superiority of new treatment definitively.

Patients in trials can benefit since they receive therapy that may be better than other available treatment. Through such trials the cancer centers develop the standards of treatment that can and should be used by physicians and community hospitals throughout the nation.

Insurers, by inappropriately invoking provisions designed to prevent payment for questionable treatments, have adopted policies precluding reimbursement for state-of-the-art medical care that is frequently more effective and ultimately less costly.

Cancer becomes a great human and financial burden when it cannot be controlled, cured or, even better, prevented. The benefits package established in health care reform legislation must include coverage of the medical care associated with clinical trials provided to cancer patients if the trials have been approved by an appropriate agency.

Turning to my final point, the issue of reimbursement. A rate setting methodology must be designed to accommodate the atypical services and patients of the NCI-designated free-standing cancer centers. Most NCI-designated cancer centers, of which there are some 40 odd, are part of a larger diversified academic health centers. Only nine, as I have said, are free-standing facilities.

As such they are particularly vulnerable to any health care financing measures that do not take into account their unique characteristics of caring for predominantly—and by that I mean over 85 or 90 percent of their patients—may be cancer patients.

Such a patient population has substantially higher levels of acuity and complexity of illness than would be the patient mix of a general academic health center. For that reason, by law, Medicare exempts the nine centers from the prospective payment system for in-patient hospital services and instead pays them under a cost reimbursement method.

As recently as June 1993, the Prospective Payment Assessment Commission reconfirmed that the reasons for the statutory exemption continue to exist. If health care reform legislation allows or requires rate-setting, it should include special requirements governing the nine freestanding NCI-designated cancer centers comparable to the Medicare exemption.

In conclusion, I respectfully request this committee to consider these three issues in health care reform legislation. Patients in managed care plans with cancer must be guaranteed access to serv-

ices and treatment available at NCI-designated cancer centers throughout the country without overly burdensome financial penalties.

Reimbursement for qualified clinical trials should be included in the basic benefits package. And rate setting applicable to the nine NCI-designated free-standing cancer centers should be an appropriate non-DRG methodology for in-patient and out-patient services.

There are subtle ways in which well-intentioned health care reform plans can undermine the achievements of American medicine and the continued advances in medicine which may be our best guarantee of cost containment in health care without compromising quality. Thank you very much.

The CHAIRMAN. Thank you, Dr. Marks, for very clear—in this Senator's view—and compelling testimony.

Dr. MARKS. Thank you, sir.

[The prepared statement of Dr. Marks appears in the appendix.]

The CHAIRMAN. Now to hear from the head of a great academic health center, which is world reknown and properly so, Dr. Raymond Schultze, who is the Director. If Dr. Onion wonders why he is being passed over it is because Senator Mitchell is on his way. [Laughter.]

Dr. ONION. I am relieved to hear I am not a major academic health center. [Laughter.]

The CHAIRMAN. Fair enough.

Dr. Schultze, you are representing all on your own the UCLA Medical Center, and why not? Thank you, sir.

STATEMENT OF RAYMOND G. SCHULTZE, M.D., DIRECTOR, UNIVERSITY OF CALIFORNIA, LOS ANGELES MEDICAL CENTER, LOS ANGELES, CA

Dr. SCHULTZE. Thank you very much. I was asked, I believe, to comment—discuss with the committee—some of the aspects of the California revolution in health care delivery which I have had an opportunity to observe as the Director of the Medical Center for 14 years. In fact, I kid some of my colleagues that I took the job believing it was going to be really quite easy, anticipated perhaps a five-year tenure.

At that time we were receiving charges from most people without any argument and the Medicare program was reimbursing us on the basis of our costs. It was sort of like the defense industry of old. Things changed in 1983, I am afraid, and we have watched a rather dramatic turnaround in that since then.

I would like to comment on some of those aspects of our changes.

The CHAIRMAN. Things changed in 1983——

Dr. SCHULTZE. 1983, yes, sir.

The CHAIRMAN [continuing]. Because of what we did here. Is that not right?

Dr. SCHULTZE. In part, yes, sir. There are actually two things that happened. One was the adoption of the prospective payment system by the Medicare program in 1983 which put hospitals at risk by fixing reimbursement based on what were average estimates of resource utilization.

The second item was that the State of California elected to purchase in-patient services for their Medicaid population on the basis of selective contracting, with the awards going to those hospitals that generally had the lowest costs. Although to be fair to them, I have to say that they have recognized that we do carry a burden in Medicaid patients that have extraordinary needs. They have recognized that in the per diems that they provide us.

However, like many Medicaid programs, they do not reimburse us with costs. I will return to that in a minute.

The evolution of the health care system in California is really driven by the need to conserve resources to save money for the purchases of health care. That is, industry and business as well as private individuals.

Because of that, it has been driven by the payment styles that have been adopted. They consist primarily of providing for care under contract. That is, a health plan will contract with physician groups and with hospitals to provide care to a population of patients. Alternatively, there will be arrangements whereby individuals will have their care provided on a capitation basis.

Indemnity insurance of the traditional type has been virtually eliminated from our marketplace. Currently about 8 percent of the patients in the UCLA Medical Center are covered by indemnity plan and when we look at it, it is because they come from a distance. Hardly anybody in the local community is being——

The CHAIRMAN. That is a very large point, that indemnity insurance has just about disappeared from Southern California.

Dr. SCHULTZE. That is correct.

The result of this method of payment has been to produce a highly competitive marketplace, price driven. Providers of care are incentivized to conserve resources in the process of care of patients. As a result, much care has moved from the higher cost areas, such as the in-patient areas of hospitals into an ambulatory setting and primary care physicians are taking on an increasing responsibility for the care of populations as opposed to specialists.

The Los Angeles Medical Center is attempting to educate their students and residents in this environment. Unlike most of the rest of the University, we work in the real world, not in a classroom. Our classroom is the same classroom or the same place where patients are receiving care.

Therefore, we have to find a way to succeed in that real environment in a way that is quite different than our colleagues in other graduate schools. That means we must compete on price and on service and we must find a way to have our services accepted within the marketplace and actually sought after in the marketplace.

We have addressed these issues in a variety of ways. In recent months we have had an extraordinarily strenuous effort to reduce our costs. We have an objective of taking roughly 25 percent or $100 million out of our malleable operating budget. We have about $30 million of that accomplished.

Our physicians are cooperating with us in, I think, a remarkable way. We have a project underway now to have 80 percent or more of the care we provide within the medical center carried out under care algorithms. Those care algorithms are designed to reduce vari-

ations in the way care is given and to, by consensus, deliver the best possible care at the lowest resource utilization.

The CHAIRMAN. Once again, our lexigraphic exercise. A care algorithm?

Dr. SCHULTZE. Yes, sir. It is a care algorithm or care pathway. There are a number of names for it. What happens is that a group of physicians involved in the care of a patient, let us say a coronary artery by-pass procedure, will get together and will map out what the normal pathway for that patient should be from the diagnosis of the disorder until the patient is treated and recovered and a standard pathway is set up.

Physicians are obviously allowed to deviate from that pathway when the conditions allow, but it allows us to track those deviations and it allows us to correct the pathway if there seems to be a better way of doing something, by adding or deleting an element of it. But it tends to bring costs down because there is less variability, much more predictability within it. We believe that that will bring about additional savings, substantial savings.

The savings that we have had in the operations side have been due in large part to a very significant restructuring of the way in which we delivered care. That new method of care has been designed by the people involved. It is sort of a bottoms-up or middle level up type of process and so we have a lot of buy-in and a lot of enthusiasm for it.

Now simultaneous with this, we also have been able to devise some products that are, I think, very attractive to the community of physician groups that work in our area. For instance, we have one contract where we provide all of the tertiary care needed by a population of patients that are cared for under a capitation arrangement by a medical group.

We provide that tertiary care also under capitation. So that we take a financial risk and the physician group knows that they can get anything they need from us that this population of patients might want at a cost that is fixed for them.

In many respects, that takes out some of the incentives to deny care that might exist in a fee-for-service type of system.

Finally, I would like to mention that we are also reorganizing our education program. Our marketplace calls for primary care physicians. As you may understand, physicians no longer graduate and go out into the community and hang up a shingle and start up a practice.

Now they must go into a setting where they have access to patient care contracts. These are usually held by groups of physicians. The groups of physicians hire the people they need to fulfill those contracts. And in our setting, they need primary care physicians and not specialists.

So we have initiated a series of curricular changes. In the medical school they have developed a program that is called "Doctoring." It is designed to equip the medical student with the tools necessary to effectively carry out primary care tasks.

In our Department of Medicine we have agreed that we will stop training specialists in 1995. That is, no subspecialty residents will be accepted unless they are going into academic medicine and under those conditions they also must participate in what is essen-

tially a 3-a-year or Ph.D. equivalent type training to prepare them for that role.

We are adding primary care physicians to our faculty and developing sites for primary care training, along with these other changes. Again, this is motivated not simply by society's need but by the industry's need for primary care.

There are significant challenges to our efforts. One is that we are a university. We have a tradition. We have people that have been there for a long time and these are very dramatic and difficult changes and it is hard to bring them around sometimes to see the new light, as you might know.

Second, education costs money. As our system evolves, the margins that used to be available on private insurance patients or even in the beginning of the contracting era on contracts that were negotiated skillfully by my staff and, therefore, were generous to us, those are disappearing.

We have not had an increase in a contract now in 2 years and it is not uncommon for us to have to settle for prices substantially below what we had. To give you an example, there is a large organization that purchases a lot of special care from us in California and they had been paying about $12 million a year for that book of business.

Our current agreement calls for them to pay $8 million and we have to find a way to get our costs down so that we can accommodate to that new price. The same amount of work.

The other factor that is involved is that the evolving system has largely reduced our ability to care for the indigent. We no longer have a way to shift the cost of care of the indigent to other payers because they are paying closer and closer to what it actually costs us to serve that population.

I suspect that the revolution in the health care delivery system will provide many benefits to this country. We believe it will eventually bring us all under one system and everybody will be able to get appropriate care.

However, in that process we have a very rocky road as demonstrated in the testimony you heard earlier and I think what we are experiencing. We must be careful that we do not destroy what is a precious resource in the process of this evolution.

Thank you very much.

The CHAIRMAN. We thank you, Dr. Schultze. We congratulate you on 14 years of presiding over the transformation.

[The prepared statement of Dr. Schultze appears in the appendix.]

The CHAIRMAN. And now to conclude our panel, we save the biggest for last. This is only appropriate. Dr. Daniel Onion, who is Director of the Maine-Dartmouth Family Practice Residency and he is also a Professor of Clinical Community and Family Medicine at Dartmouth Medical School.

Dr. Onion, Senator Baucus asked to say that he is very interested in the rural residency program with which you are involved. As he is chairman of the Committee on Environment and Public Works, he has had to leave to preside there, but expressed his thanks for your testimony and looks forward to what you will now say.

Senator Mitchell might like to say a word.

OPENING STATEMENT OF HON. GEORGE J. MITCHELL, A U.S. SENATOR FROM MAINE

Senator MITCHELL. Mr. Chairman, I thank you very much. First, I commend you for holding this important hearing on the role of academic health centers on health care reform. I think that it is obvious medical schools and teaching hospitals are a very important part of our system and must be adequately protected. I commend you for your leadership in that area.

Equally important are the many primary care residency training programs, many of which are located in community hospitals across the nation. That is particularly true in rural States.

I am pleased that Dr. Onion, who is the Director of the Maine-Dartmouth Family Practice Residency Program is here today. He has worked for many years to train family doctors in rural practice settings. I know Dr. Onion. I have had the pleasure to meet with, talk with, and listen to him on previous occasions. I am certain that the committee will learn much from your testimony.

We are going to hear proposals today intended to provide assistance to academic health centers so that they can continue their service, teaching and research missions. We will also hear testimony from Dr. Onion about the challenge of running a primary care residency training program.

His effort to recruit students and train them in ambulatory settings is particularly difficult because of the existing residency training reimbursement structure. I know that all the committee members are concerned about this problem and many here represent rural States in addition to myself. I look forward to receiving his testimony and working with the members of the committee on dealing with these important problems.

The CHAIRMAN. Thank you, Senator Mitchell.

Dr. Onion, the floor is yours.

STATEMENT OF DANIEL K. ONION, M.D., DIRECTOR, MAINE-DARTMOUTH FAMILY PRACTICE RESIDENCY, AND PROFESSOR OF CLINICAL COMMUNITY AND FAMILY MEDICINE, DARTMOUTH MEDICAL SCHOOL, AUGUSTA, ME

Dr. ONION. Thank you, Senator Moynihan and Senator Mitchell, and others. Thank you very much for inviting me to this beautiful spring day in Washington.

The CHAIRMAN. Yes, you have not seen one of those.

Dr. ONION. I still have two or three feet of snow on my lawn. It is nice to know that it still may come where I live.

My name is Dan Onion. I, as you have heard, direct a Family Practice Residency Program in Maine. I trained and went to college and medical school in Boston and then went to Seattle where I did my residency training in internal medicine under Dr. Robert Petersdorf who is the immediate past-President of the American Association of Medical Colleges and from him learned an appreciation for the necessity and importance of primary care.

I came back to Maine, practiced 10 years, starting up a group practice; learned the family practice portion of my skills by the seat of my pants and eventually became a faculty member at the resi-

dency where I currently am. So I have been in the business for 25 years and it is a tough business.

I feel just a little bit out of place here amongst the academic health centers obviously. At a Finance Committee hearing on academic health centers, I am neither an academic health center nor an expert in finance, but I am a real doctor and I train real doctors. I am here to talk a little bit about that.

In some ways, if those of you who remember the song in the late 1940's about being a lonely petunia in an onion patch, I feel like a lonely onion in a petunia patch. [Laughter.]

I want to make four quick points, if I could. The first is that we need more real doctors. The second is that we need to have graduate medical education payments I believe go directly to the residency programs rather than filter down through the hospitals. I think third——

The CHAIRMAN. Dr. Onion, do not hurry. It will not be spring when you get back. [Laughter.]

Dr. ONION. Then I will go much more slowly. Thank you.

The CHAIRMAN. Take your time. Now, what was the second point?

Dr. ONION. I will come back to it. I think graduate medical education money should be paid directly to residency programs.

Third, I think generalist physician training costs more than specialist training and I think it is important that that be recognized in whatever system is put together.

Lastly, I think we need more nurse practitioners and physician assistants and that, too, must be addressed.

I want to go back to each of these. But first let me say I am using the word specialist, but I want to point out that language sometimes contains and perpetuates discriminatory attitudes and value systems. I never really thought about this very much until somebody called me a gatekeeper. And it seems to have gained prominence in the language.

I want to point out that the word specialist itself carries high value and almost anything opposed to it does not contain the same amount of value and it reflects the power structure that has existed for the last several generations here. So now if somebody calls me a gatekeeper, I call this a partialist or a limited care practitioner or secondary care practitioner works pretty well too. [Laughter.]

But Senator Mitchell tells me I should be careful about that because I certainly need specialists to practice good medicine and I need academic health centers. We just need more real doctors as well and we need them yesterday because the managed care system impact is there whether you pass national legislation or not and it is gobbling up what few primary care physicians we have.

I do not think the marketplace is sufficient to address these work force needs, despite what may have happened at UCLA. I think there are huge urban and rural discrepancies that will be brought out by this as well. In fact, I wonder if what Ross Perot was hearing when he was talking about the great sucking sound was not the sound of rural physicians going to the cities where they can work for twice as much money and half the hours.

There is going to be substantial displacement. The markets for medical care and the markets for medical education have been disconnected for years and need to be reconnected or redirected in some way.

Jack Colwill last month told you about the declining numbers of generalist physicians and the declining student interest. There are a couple of little blips that have us all very hopeful, but they are blips. I point out, as you already know, that HMOs in the country, certainly staff at the inverse of this, two or three generalists for every one or two specialists, as do most other industrialized countries.

Having specialists far in excess of real physicians really increases the costs of medical care. It increases the inefficiencies and I think it gives poorer care in a lot of cases. I certainly need an oncology specialist to help me take care of a patient with cancer. I want to be connected though. I want to help with the family who is also going through a lot. I want to be able to help that patient get more of their chemotherapy at home when they can.

If I could just give you a slice of my life that really tells you about the specialty mix in this country, a few years ago my children—I had two children in high school. They did well in the State cross-country ski meets and they went to Lake Placid to be in the eastern cross-country ski meets. I went there to watch them and within the first half hour of the event, one of the other kids from the same high school came to me because his father is a pharmacist and he knew me, he said, doctor, there is a man down. It looks like they need help.

I went. It was in the woods. There was a young man who was unconscious and there were a number of people around. I came on the scene and there were four or five people around and I said, what is going on. They said, we are physicians. We are trying to figure out what is going on.

I watched for a minute and they were not doing CPR and he was unconscious and he had some agonal breathing. I said that looks like agonal breathing. I said, well, he is really breathing. Can you get a pulse? No, he does not have a pulse. So I said, we have to do something guys. So we started CPR.

Then we started going around and this fellow said, I am an orthopedic surgeon. I do not do this. There was an urologist there. There were two orthopedic surgeons. There was a urologist. There was a general internist; the general internist though worked in Hartford at a teaching hospital and he said, gee, the residents always do this, I am really not comfortable. [Laughter.]

And there is an ICU nurse there, God love her, and she knew what she had to do and she and I started CPR, mouth-to-mouth and so forth in trying to make the story short. But eventually the other physicians petered out. The one orthopod stayed and helped to do CPR and the general internist stayed and helped me bag the patient. We had another woman went off and got an emergency cart and eventually came back and we intubated the fellow. We spent an hour there resuscitating him.

Finally turned him over to the ambulance crews when they came. And we had him back so he was blinking his eyes and swallowing. He was not conscious, but with CPR in a young, healthy man, it

was pretty impressive. It was a tragic story. He did not make it eventually.

But that mix of providers there who could help I think is reflective of the specialty mix in this country. In fact, the urologist on his way out, excusing himself, said in sort of gallows humor, self-depreciating way, call me if you need help catheterizing him.

There is some heavy cutting that has to be done in the specialty mix area and it is going to take courage and fortitude to do it, but we really need to do it.

My last three points, quickly, direct medical education money should go to residencies and the residencies should certainly be informed about the amount of indirect medical education monies. These are black boxes to us. Almost no residency is informed about this now. Money is influence and power.

The primary care residency training programs are politically weak in their institutions because specialists have dominated in money, time and prestige for years. And this is an unintended consequence of this generous Federal help that we have had that has encouraged the development of specialists in excess of generalists. You have heard about that from Dr. Jensen from North Dakota, where he had to use Freedom of Information Act to get the GME money figures from his hospitals.

We do medical student teaching and nurse practitioner, PA student teaching free basically. Sort of, it is another example of our inability to get appropriate subsidy. It is a cross-subsidy as Dr. Foreman was mentioning and we are at the short end of the cross.

So please do not rely on trickle down of monies to the primary care residency programs if you pay medical schools or academic health centers or even hospitals.

The third point is that it takes about $100,000 a year to train a primary care physician. It costs more because it requires more extensive supervision in out-patient facilities that are used inefficiently and that are quite expensive. I have a table that is on page 6 of my handout. I have made an extra copy of it here if you would like to see it. This is the detail of that. I can talk more about that if you would like.

And then finally I would like to say that we need more nurse practitioners and PAs who are trained in generalist fields. We do not need more orthopedic physician assistants. This whole business about nurse independent practice to me is a tempest in the teapot. We need to work in a team work way. That is what happens in primary care.

One thing is that we can train more nurse practitioners and PAs faster through this crisis that is already upon us than we can medical students, which are 5 to 10 years in the pipeline. So I think in Augusta the managed care system has just overwhelmed their primary care system. We have a system that to me is running on empty and is in danger of crashing and we need help.

I think that we certainly are in an age of discovery, a historic age of discovery, as you say, Senator Moynihan. I do not think these are mutually exclusive options. I think that we need more discovery in the area of primary health care as well and I think we need to distinguish between the training of specialists and the

doing of research. I think we certainly need lots of research and no one would want to turn that off. But we need a change in the ratio.

We are in it for the duration. Anything you folks can do to help us, we will really appreciate. Thank you.

The CHAIRMAN. Well, we thank you, Dr. Onion.

[The prepared statement of Dr. Onion appears in the appendix.]

The CHAIRMAN. We thank the whole panel and now we will begin our questioning. Senator Mitchell, would you like to speak?

Senator MITCHELL. No thank you, Mr. Chairman. I have heard from Dr. Onion often. He has acquired the Maine habit of direct speech and I appreciate his comments. I will yield to others. [Laughter.]

The CHAIRMAN. I do note that under the guise of simplicity he argues that his plain, simple half herbal teachings cost half again as much as is at Sloan-Kettering. We have your table there, Dr. Onion—$101,000 per resident as against $55,000 in those big city places.

Senator ROCKEFELLER. Yes, but there is a real reason for that.

Dr. ONION. Yes, there is.

Senator ROCKEFELLER. There sure is, yes.

The CHAIRMAN. And we will hear all of the above.

Senator Dole, you have been here all morning.

OPENING STATEMENT OF HON. ROBERT DOLE, A U.S. SENATOR FROM KANSAS

Senator DOLE. Right. If my colleagues do not mind I need to speak to the Horatio Alger in a few minutes. But I want to say first of all I had the pleasure of meeting with Dr. Schultze and a group of hospital administrators and physicians and other providers in Los Angeles in just the last 2 weeks.

I must say, when I have read some of the facts about L.A. County, 9 million people in L.A. County, more people in L.A. County than, what, 42 States; 3 million without any coverage at all and one million of those 3 million are illegals.

The CHAIRMAN. Yes.

Senator DOLE. You talk about a burden on the system. There is health care, welfare, education. It was sort of a eye-opening experience. We had a very good discussion. I hope that my other colleagues will have a chance to do the same thing. But it indicated that, you know, with 3 million not covered that is more than I have in my State, more than most of the members have. I think there are 16 small States represented on this committee.

So in that one county you have a lot of problems and I appreciate your efforts. We appreciate very much the opportunity to spend a couple of hours out there just kicking around with a lot of people who understand the problem better than we do.

I wanted to ask, my staff has prepared a number of good questions, ones I do not know anything about. [Laughter.]

The CHAIRMAN. Would you like Ms. Burke to come forward? [Laughter.]

She is busily spinning through——

Senator DOLE. I will sit back there, yes. [Laughter.]

did not mean it quite that way. I mean I understand a little bit. [Laughter.]

But I wanted to ask just a question or two. We have not mentioned foreign medical graduates. That is a key factor in the chart that I looked at earlier. The international medical students fill approximately 21 percent of the residency nationwide. They fill 42 percent in New York. They fill 42 percent in North Dakota. I think the next largest is—I do not know what State it is.

But I was going to ask, who is going to make the choice if we are going to start limiting what people do, whether they are going to be U.S. graduates or foreign graduates? How are we going to determine which, whether foreign graduates or U.S. graduates?

The CHAIRMAN. Why do we not ask Dr. Foreman who addressed the question.

Dr. FOREMAN. We presently graduate about 17,000 American graduates from U.S. medical schools every year. But we offer residency training opportunities for a substantially larger number of people. Those residency training physicians which are filled by other than U.S. graduates are filled by two groups of folks, a relatively small group, about 1,200 who are U.S. citizens who have trained abroad, and a much larger group, about 5,000, who are foreign nationals who have trained abroad who come here largely to stay. That is, they come into the training system with the intention of remaining in the United States to practice rather than to return to their native countries.

Those two groups of foreign trained physicians account for a substantial portion of the growth in trainees over the last 8 years, since American medical graduates have been relatively flat. They have tended to migrate to certain kinds of residency training programs which I think one would have to define as residency training programs which for one reason or another have not been attractive enough to fill with American graduates, at least all the way.

Those training programs are often in difficult places. And the observation that you made that there is a very substantial number of foreign medical graduates——

The CHAIRMAN. Now, careful, Doctor. [Laughter.]

Dr. FOREMAN. Well, I think it is true in New York, New Jersey and North Dakota. And when you examine where——

The CHAIRMAN. The badlands.

Dr. FOREMAN. Right. When you examine where those residents tend to be, they tend to be in institutions often that serve underserved communities and inner cities and in rural areas.

And, in fact, the health care systems in those communities are heavily dependent on that group of residents as not merely trainees, but as medical care providers.

If you look at urban general hospitals, particularly those under municipal auspices or some rural hospitals, you find that foreign medical graduates in residency training are producing a very substantial amount of the care that the community gets.

So your question, Senator Dole, is a very cogent one. What happens to those communities as we squeeze out the opportunities for foreign medical graduates to train? There are those who argue that the places of those physicians can be taken by other physicians who could be recruited in over time to those areas to replace those people who were not there.

It is our view that that process, if it works, will take time and will be very expensive and that no one should think that if we were to suddenly shut off foreign medical graduates all at once that we would not have very serious dislocations, particularly in providing care for the poor and for the rural isolated.

The CHAIRMAN. Could I just make the point for the committee that Dr. Foreman has a table attached to his testimony on this. While North Dakota is technically number two, the number of foreign medical graduates is 50.

Senator DOLE. Yes, 50. So it is a very small number.

The CHAIRMAN. In New Jersey the majority of physicians in training now are foreign medical graduates.

Not to interfere, Senator Dole, but could I just ask of the panel, certainly there is a kind of bargain for the nation that has other people do its medical training and then gets the doctor in the end, but also, is there not a certain selectivity? I mean, very good people come here, is that not the case? I mean, Dr. Marks, you——

Dr. MARKS. Yes, I would just like to make two points because I agree that Senator Dole's question is very cogent. One, it is a self-selecting process and, of course, very competitive. We receive many more applicants than we have positions and generally we can select very high quality.

But I think that we do face a challenge. I am not saying it is right, but it is a fact that house officers generally receive compensation well below what, say, nurse clinicians receive, who might have to be substituted for such house officers if that pool were to become unavailable.

Again, it is a question of public policy and strategy. But it is something that we have to recognize, that these foreign medical graduates are serving a real function, certainly at a certain given time in their career in our health care provision system in this country.

Senator DOLE. Dr. Foreman also mentioned that we probably need to take a look at anti-trust laws. I would just say if you have any specific suggestions there that would be helpful.

I wanted to ask one question of Dr. Onion. If we cannot depend on the marketplace, I think Dr. Schultze indicates maybe the marketplace will take care of this. In your testimony you indicate we cannot depend on the marketplace and it is hard for some of us to understand how some bureaucracy can do it in Washington if the marketplace cannot take care of it.

In New York there are about 14,000 residents; Kansas has about 600. So are you suggesting someone tell Chairman Moynihan that he can only train 50 radiologists because Kansas should train 10 more? I mean, I think we get into all this back and forth, who is going to make the decision or can we create some incentive. I think we are working on some incentive approach which would direct it over time. It is not going to happen very quickly but rather than just have a cap and say that you cannot do anymore.

And if we guess wrong, what happens? It takes seven or 8 years to train someone. So if we guess wrong, what happens 10, 20, 30 years from now. If we are short on specialists and have a lot of primary care physicians, it is sort of like defense again as somebody

mentioned. You have to have some lead time. You cannot just catch up and say, well, we will do that tomorrow.

So I guess the only question I would raise is, there is always a little skepticism when we—somebody indicated the government might be able to do it. Certainly we have a role to play. It is our money. There is a lot of money in the programs you mentioned. But there is an effort I think by some on the committee to work out some incentives that would get you the same place.

Dr. ONION. I understand that completely, Senator Dole. But I do think that in order to reach a target which I think most, a lot of people agree is reasonable at 50 percent generalists, we do need to both cap medical slots for residencies at 110 percent of American medical school graduates and set a target date for achieving a goal like that.

I understand that people would like to find a marketplace way to do that. I just do not think it will work, partly because right now the market is disconnected. As I said, the market for medical training is disconnected from the medical marketplace.

Now maybe in UCLA it is beginning to work. It is a very slow and painful process. I mean, I got an MPH and had a few basic health economics courses and I remember they were telling me that the medicine is not an ideal market. I mean, there are problems with consumer knowledge and there are problems with insurance and all kinds of reasons that you folks know more about than I do.

But the market is not terribly effective, not fairly fine tuned. I think whatever system you develop it has to be looked at on a regular basis and corrections made. My concern is that we are heading the wrong way. I mean, we have gone from 50 percent to 30 percent to 25 percent. And if you would ask graduating medical students whether they want to go into generalist care of specialty care, less than 20 percent of them are saying they want to do that.

It is sort of like a plane crashing. You know, I want the pilot to pull up. I am not going to tell him I am too worried about whether we might go too high later. I mean, we can figure that out. We need to figure it out and we need to plan for it.

But I do not think we have too much time. It is the pressures of time that concern me in our rural areas anyway.

Senator DOLE. Thank you. I have taken more time than I should have. If I could, Mr. Chairman, if the witnesses would not mind, if we could submit maybe a couple of questions.

The CHAIRMAN. I am sure they would appreciate it. And Dr. Altman has views on this matter, too.

Dr. ALTMAN. Well, I do. When we talk about the marketplace, I am sympathetic to the idea of not having very tight quotas. But I think you have a very artificial marketplace out there and I think that is what Dr. Onion was talking about. I think you would agree with this.

I think Dr. Foreman was sort of kidding in a serious way about that. We send out all these signals which we have been doing on the Federal level to the marketplace, that we want specialists, while the market was changing to its primary care. We have a set of signals going, incentives to produce more specialists when underneath we needed more primary care people.

And now what we are seeing is that the market for the actual delivery of care is saying, where are all your primary care physicians? While the government and others are still sending out the signal that says, you should be training specialists.

So we do need to change that marketplace. The worse thing we could do is to have some artificial mechanism bureaucracy, whatever you call it, saying we need more primary care and never developing the right set of incentives.

Senator DOLE. They are doing it at UCLA. You are just going to stop in, say, 1995.

Dr. SCHULTZE. The Department of Medicine will stop training what we call ologists—like endocrinologists, nephrologists—for practice. Only for academic medicine and the course is very rigorous for that. They must spend several years in the laboratory preparing themselves adequately for that type of career.

The CHAIRMAN. Dr. Foreman. This is very important. I wish everybody would join in at this point on this subject.

Dr. FOREMAN. I think it is important to recognize that there is some considerable amount of flexibility in medical practice that this discussion has not brought out. There are really two bundles of specialists. There are those specialists who are so highly specialized that it would be very difficult for them to become generalists without retraining.

But the very substantial excess of specialists in this country, when one does a calculous against the need for a specialist, occurs in the subspecialty areas of internal medicine and pediatrics. And all of those subspecialists, before they were subspecialists, were fully trained generalists in internal medicine and pediatrics.

Those physicians are capable of and are now back migrating into their general specialties as the demands for those services grows. So that what we have found among not only our voluntary faculty at the medical center, but even among our full-time faculty, a willingness for specialists to become primary care physicians for an increasing number of patients as capitated payment systems begin to enter the market.

I believe there is a good bit of swing in this and it is not quite as rigid or as worrisome as one—we can make a mistake as it were and not pay a terrible penalty when you think that there is some degree of flexibility within the specialties.

The CHAIRMAN. Senator Mitchell?

Senator MITCHELL. I want to let Dr. Onion comment.

Dr. ONION. I have some skepticism. It is true to some degree. But I have some substantial skepticism about that because the whole culture, the whole socialization process for these subspecialists has an impact. There are real limits.

I mean, I saw a woman just last week who is seeing a dermatologist here and an endocrinologist here and a rheumatologist here and there are four and five people involved in her care. I think we need to be careful. I agree with you, but there is a limit; and where that limit is, I think, needs to be carefully analyzed.

Senator PACKWOOD. Doctor, could I interrupt just a moment because, George, you may want to know this, two of our helicopters were just shot down in Iraq with 20 people killed.

Senator MITCHELL. Thank you very much.

The CHAIRMAN. In Iraq.

Senator PACKWOOD. In Iraq.

Senator MITCHELL. We had a bipartisan leadership meeting in the White House this morning on a separate subject and it was announced there. Thank you. Although they did not have number.

Mr. Chairman, could I ask Dr. Onion one more question?

The CHAIRMAN. If you let him finish the last question.

Dr. ONION. It is upsetting, the news you bring, Senator Packwood. It is distracting.

But I just was trying to say, we need to be careful not to trivialize primary care in the process of defining the roles. An anesthesiologist was contending the other day to me that she was a primary care physician because occasionally she gave penicillin prescriptions to a patient who she was discharging from the recovery room with a sore throat.

Senator MITCHELL. Mr. Chairman, it would seem to me that the principal recommendation made by Dr. Onion was that GME funding was made directly to residency training program rather than indirectly to teaching hospitals or some other medium.

I wonder, Doctor, if you would expand on your statement on that point. I expect there is not unanimity on the members of the panel on this subject and perhaps we could have an opportunity for people to discuss that because I think that is a very important point and one in which I have a particular interest.

Yes, I think it should be done like research grants that go to medical schools or universities. They come through the medical school but they go to the researcher. I think that the residency program needs to get the money directly.

Perhaps the IME does not make sense to go directly to the program but at least the residency needs to know that that is there. Right now 99 percent of the primary care residencies in this country, I will guarantee you, have no idea of what IME their parent institution, is getting; and maybe 5 percent of them know what DME their parent institution is getting.

And without that knowledge, given the position of generalist training so long in this country they go hat in hand and are grateful for what they get and are scraping by. And they need to know the monies that are so generously being put into the training programs, they need to know what they are. And that will not happen the way things are currently structured right now.

Senator MITCHELL. Dr. Foreman?

Dr. FOREMAN. This is one of the most complicated areas we can discuss, but it is worth it, with your permission, spending a moment to distinguish between what the direct medical education payments are and what the indirect medical education payments are.

The direct medical education payments under Medicare are cost-based payments to institutions that bear the costs of training and cover the salaries and benefits of the trainees, the salaries and benefits of the faculty, and some reasonable overhead costs incurred by the institution, both direct overhead costs—that is the secretarial support and the other kinds of things that are directly ascribable to the education programs and—indirect overhead costs which are a step down.

These costs are determined or have been determined to be appropriate institutional costs by government audit, the most recent being over the last several years and they vary from institution to institution.

For the program to receive the direct medical education payment would mean that the program would have the obligation to reimburse the institution for its indirect and direct overhead costs and would be an inappropriate distribution we think of the dollars simply because the program is only one piece of the costs. That is, the direct costs of the program is only one piece of the direct costs which the institution is being paid for in that payment mechanism.

Now you could pay presumably those dollars to anyone. But the appropriate side of payment from our perspective is the dollars should go to the entity that incurs the costs and in this case it is usually the hospitals, although we have advocated that payment be made available to non-hospital sites as well and that those payments reflect the costs in those sites.

The indirect medical education payment is not really a payment designed around educational costs at all. That is, it is a surrogate payment for costs incurred by teaching hospitals as a consequence of the kinds of patients that they attract and the complexities of care that those patients engender.

It is unfortunate from everyone's standpoint that those costs were originally labeled education costs because it does create the dilemma——

The CHAIRMAN. IME.

Dr. FOREMAN. Right. Because they are called indirect medical education costs, Dr. Onion legitimately is concerned that they may represent payment for education which his program is not benefiting from.

In fact, they represent payment not for the educational fees, but for the costs that were empirically observed to be different in teaching facilities versus non-teaching facilities based on complexity of care and the other problems that the patients at such hospitals attract, engender there.

The CHAIRMAN. Does that relate to the location of these hospitals? They typically in Los Angeles with a million undocumented aliens.

Dr. FOREMAN. Originally, in 1983 when that payment was first constructed, parts of the payment were included to pay for uncompensated care. Over time, as a result of changes in the Medicare law, most of the uncompensated care payments were pushed into what were called the disproportionate share adjustment and bled out of the indirect medical education adjustment.

So the indirect medical education adjustment now we think more fairly represents costs which are not associated with the indigent care, but clearly are associated with the conduct of care in institutions with a heavy educational mission.

The CHAIRMAN. Dr. Altman, if I could ask you.

Dr. ALTMAN. Yes, I would. I think Dr. Foreman correctly identified the differences. But in my testimony I made this comment that any ability to sort of really separate out the costs for education, the costs for research and the costs of patient care is arbitrary. There is no good mechanism for doing that.

And while it is fair to say that the IME, the indirect medical education component, is a sort of a combination of these, part of it is the educational mission after all of these institutions. It is also fair to say that when the calculation was made on what is now the Medicare indirect medical education, it was done rather quickly, to say the least, by the Congress. There had been years of research and essentially within a twinkling of the eye, that number was doubled.

And every analytical effort directed suggested that that number is too high. Although as I pointed in my testimony, not as low as the previous administration and the current administration would have you believe. We in PROPAC also believe one needs to make a distinction between the direct medical education payments and the indirect.

I want to make one other comment. I think just focusing on Medicare payments alone is a mistake. We are moving into, as I think Dr. Marks pointed out, we are moving very rapidly into a very different payment system for private patients and some mechanism needs to be established to separate out from patient care dollars those costs or those payments that we want to make for education and only relying on the Medicare program to pick up that is a mistake.

It looks like Medicare is too expensive and, in fact, it is because we are asking the Medicare program to pick up potentially more than their proportional share. We would need a longer discussion on what mechanism to use. The administration has used one. As I said, Senator Chafee has designed another one. But we ought not to lose sight of the fact that we are not only talking about Medicare.

Senator MITCHELL. Is it fair to say, Doctor, that the point you are making is that the Medicare program is being called upon to make payments for certain educational services that the benefits of which extend far beyond the Medicare system itself?

Dr. ALTMAN. In an indirect way the answer is yes. If you look at just percentages, the Medicare program now is disproportionately paying our teaching hospitals. Medicare now picks up not only the educational costs, but the costs of significant segments of our population that are not insured, and while the disproportionate share payment system is designed in part to do that, it does not completely do it.

So Medicare now has, I think, appropriately put its finger in the dike, to balance out, if you will, a payment structure that keeps all of our hospitals on average a float.

The CHAIRMAN. Watch that metaphor.

Dr. ALTMAN. Sorry, sir. I know every time I do that I get in trouble with you. But I do believe that if you stopped or cut back those payments without adding either a universal coverage system or some other mechanism for picking up the payments for these uncompensated care and these higher education costs certain of our institutions would be in serious trouble.

Senator MITCHELL. And one of the advantages of having the universal system is that costs could be properly allocated.

Dr. ALTMAN. Much better.

Senator MITCHELL. So that Medicare would not be, because it is a federally-funded public insurance program——

Dr. ALTMAN. Absolutely.

Senator MITCHELL [continuing]. Called upon to meet social needs that extend beyond the scope of the Medicare program itself.

Dr. ALTMAN. Exactly.

Senator MITCHELL. Mr. Chairman, thank you.

The CHAIRMAN. I think Dr. Onion had one comment he wanted to make.

Dr. ONION. Thank you. I just wanted to make one quick point before we leave indirect medical education. It is a crucial funding flow in the rural hospitals that I am familiar with that train family practitioners. It amounts of $45,000 a year per resident in my small, little hospitals and that is usual. That is only 5 percent of the Medicare billings where I understand the national average is 7 percent.

So if family practice residencies were faced with running a program on just DME without those IME monies flowing as well, we have huge problems.

Senator MITCHELL. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Leader.

Senator Packwood?

Senator PACKWOOD. Dr. Schultze, I am fascinated with your experience at UCLA. You basically, as you said, have nothing left in the indemnity system in southern California.

Dr. SCHULTZE. That is correct, sir.

Senator PACKWOOD. Now, explain to me how this works. First, explain to me your health center and the relation of the UCLA Medical School and how the whole complex works and then I will have further questions.

Dr. SCHULTZE. Yes. Well, we have an integrated complex physically. The Medical Center sits in the middle of the Medical School. We recently constructed a very large ambulatory care setting to carry out the types of primary care that are necessary to train primary care physicians as well as the specialty care that can be transferred to the ambulatory care setting.

We are currently operating about 400 to 475 beds, depending on the day of the week, to serve a population that comes from our county, about 90 percent from our county, over 9 million, plus another 10 percent from outside of the county.

We have programs in almost all specialties, but we have very significant primary care programs, as I indicated, and we are enlarging them.

Senator PACKWOOD. And as I understand, you had to go to this and at the same time keep up a flow of very unique specialty cases for your teaching facility.

Dr. SCHULTZE. Yes, sir.

Senator PACKWOOD. And more or less perhaps draw them from your primary care facilities as you identified the problems.

Dr. SCHULTZE. We believe that some of our tertiary care patients will come from a primary care network which we expect to serve somewhere between 200,000 and 400,000 people eventually.

Senator PACKWOOD. Which is big enough to give you a fair pool of drawing specialty cases.

Dr. SCHULTZE. A fair pool, but that will not supply all of the patients or take care of all of the patients that should come to a center like ours. We ought to have a cancer center that is not freestanding, but a substantial one. We have other very specialized programs. They serve a population probably that approaches 4 to 5 million.

Senator PACKWOOD. Now I want to understand how this works now. You have all of these capitated payments basically, you have all of these insurance providers going around and bargaining with you and other hospitals, and for a while PPOs, but they seem to be growing into HMOs.

What does AETNA do or MetLife or Blue Cross do? Do they come to you and say, Doctor, in this county we have insured 550,000 patients. We think we can steer 500,000 of them your way. What will you do for us?

Dr. SCHULTZE. That would be nice if they would do that. Actually, they contract with several tertiary care providers. In our community we have another hospital that is affiliated with us, but actually runs quite separately, Cedar Sinai. It is a very substantial teaching center, as Senator Dole visited it the other day. But it is a competitor. If you take an example like——

Senator PACKWOOD. A competitor to you.

Dr. SCHULTZE. A competitor to us, as well as an affiliate and a colleague. If we take the liver transplant program for instance, we have a very large one, probably the second largest in the country and they have a large one. We compete on price. The figure I gave earlier in my short discussion of a reduction from $12 to $8 million in compensation, a good part of that compensation comes from providing liver transplants to a very large program.

Senator PACKWOOD. Well, this is what I am getting at. Let us take liver transplants. Let us take it in terms of things that are divisible by 10. Let us say it costs $100,000 to do a liver transplant.

Dr. SCHULTZE. Right.

Senator PACKWOOD. Or that is what it has been costing. And now a major insurer comes and they have half a million people and out of that on average there is going to be a 100 liver transplants. Do they come to you and say, on average we think there is going to be 100, but we will pay you $90,000 if you want to do them and you have to decide whether you want to do them for $90,000 or not?

Dr. SCHULTZE. That is correct, sir. Make it $80,000.

Senator PACKWOOD. All right. [Laughter.]

Now I want to know what happens. Let us say we pass a bill that has the following provisions. It has a mandate, maybe individual like Germany or like auto insurance; maybe employer, where we say the employer must provide X benefits. Forget for the moment how we divide the premiums between employee and employer.

But it is a minimum benefit plan and it says here the benefits—A, B, C, D, E, F, G, H—and all plans must have those benefits. You can have higher benefits. You can have supplementary plans. But they all must have those benefits.

Then we also say—I do not think this is going to happen—but we also say we are going to phase in the Medicare population to

this plan and the Medicaid population and government employees into this plan. We are going to have a national plan and here would be the benefits.

Now insurance companies, now you can go out and bid. We have lots of people in the pool. You cannot cherry pick. You cannot eliminate because of pre-existing illness. You go out and pick. At this stage the competition between the companies becomes pretty severe for bidding on the pool or bidding on a fair portion of it.

Dr. SCHULTZE. Yes, sir.

Senator PACKWOOD. And they are not going to make a bid until they are sure what they are going to have to pay to take care of the 5 or 10 or 15 million people they may get covered. And they are not going to do that until they come to you and say, Doctor, you have to go to $75,000 on liver transplants.

As I read your testimony, and especially I look at page 7 where you say, "The effort to reduce costs is a broad-based institutional undertaking stimulated by our competitive, highly price sensitive health care environment. The effort has been characterized by high levels of creativity and innovation. It is unlikely that a regulatory process could stimulate a process of this quality and magnitude."

If everybody is in the pool, or as close to everybody as we can get—when we say universal here we think more like Hawaii, which is 93 or 94 percent—if everybody is in the pool and if the insurance companies to get business have to know what they are going to pay, based upon your experience is this going to have the tendency to drive prices down? And that kind of a competitive atmosphere will be infinitely better than our attempt to regulate prices.

Dr. SCHULTZE. That is my belief. I think our experience is, yes, there is no bottom yet on prices in the Southern California area, primarily because we have a surfeit of hospital beds and physicians. And to date, no one is refusing business because they recognize that market share lost now is market share lost forever, potentially. So everybody is trying to stay within it.

That in turn leads to rigorous cost containment. Now I think it is appropriate to add a caution here. In this kind of a system where there are incentives lines up to reserve or to keep the resource utilization down, it is possible to deny.

So in conjunction with this system, we really need a quality control system. Probably the best one that I am aware of, and I think it is still fairly primitive in its application, is the one that was developed by the business alliances in the Minneapolis, St. Paul area where as part of the request for proposal that they sent out a couple of years ago they required that the responding organizations indicate how they were going to measure outcomes, how they were going to develop care pathways, how they were going to assure that the physicians followed those care pathways.

The CHAIRMAN. The algorithm.

Dr. SCHULTZE. Algorithm, yes, sir.

Now I think that we need that kind of protection built in. I think as a professional that is highly desirable to ensure that we are providing quality care and it is a needed safeguard in this kind of a system.

Senator PACKWOOD. If I read your statement, you say initially they are now competing on price and they sort of assume the qualities uniform in prices.

Dr. SCHULTZE. That is correct.

Senator PACKWOOD. You use the word a priority. But then you said, "The future revolution of the health care delivery system in Southern California will see that physician groups, but ultimately competition between these systems will be less on price, which will be uniformly low and more on quality."

Dr. SCHULTZE. Right. I believe that is correct. That is one reason why we are investing heavily on ways, developing ways to measure outcomes and to measure process of care.

Senator PACKWOOD. Now I want to ask the rest of the panel now the same presumption I asked Dr. Schultze. Uniform coverage is say 90 to 95 percent coverage. With a minimum benefit plan, which all plans must guarantee, will we get the kind of competition for cost,and eventually for quality, that we would like without regulation? I will just start with Dr. Onion and go left.

Dr. ONION. I am not sure we will in rural areas. I think the problem in rural areas is that we only have one hospital and we are lucky if it is within 25 miles. At least in the world I live in, there is so much work and so few health care providers that I cannot even imagine that world.

I do not see, given the concentration of the population how it can ever be anything like Los Angeles obviously.

Senator PACKWOOD. You are experienced enough, Doctor. Would we get that kind of competition in urban areas?

Dr. ONION. I am not an expert on urban areas. It sounds like we can. I do not know how hard you want to——

Senator PACKWOOD. Dr. Marks?

Dr. MARKS. I think that a price driven environment is one in which we will have unintended consequences in terms of rationing and quality. You cannot get something for nothing out of the system. And while we can reduce costs substantially, and I think all of us have tremendous pressures to reduce costs, even in high-cost centers, such as the cancer centers, we know right now from our experience because we are being approached by insurance companies, health plans, managed care, and they say how much does a bone marrow transplant cost. And we will say it is $100,000. Well, we will give you all our bone marrow transplants for $60,000.

There are two things. Number one, we cannot survive as a quality provider of care doing bone marrow transplantations alone. Even if we got $100,000, we would not want to do it. And at $60,000 we cannot really provide a quality care program in bone marrow transplantation.

So I would say that at least in our environment there has to be some kind of legislation which takes into account that a price driven system today will compromise the quality of health care and will be associated with rationing. I do not think there is any question in my mind about that because they cannot compete in any other way if you are going to drive down just price.

Senator PACKWOOD. Are you suggesting—and then I will go to Dr. Foreman and Dr. Altman—that one of the cancer centers out

of desperation or otherwise will say, well, okay, we will do it for $60,000 if you are going to refer us all your bone marrow patients?

Dr. MARKS. I do not think it is going to be possible to do.

Senator PACKWOOD. Or does the insurance company having shopped around come back to you and say, well, we will give you $90,000.

Dr. MARKS. No, I think what is going to happen is that people will not get bone marrow transplantation who might need it. I think that is a more likely outcome.

Senator PACKWOOD. Even if the minimum benefit plan requires that coverage? I do not know whether it would or not.

Dr. MARKS. Yes.

Senator PACKWOOD. That is why I asked the question about a minimum benefit plan. I do not know what is going to be in it.

Dr. MARKS. When the rubber hits the road, Senator, the judgment as to whether an individual should receive a bone marrow transplantation or anything else as sophisticated as that kind of treatment is still a clinical judgment and it is a very subtle process that can be involved if price is your pressure.

Senator PACKWOOD. In this sense I may be asking the wrong person this question, because I am not thinking so much of the unique disease as I am the broken legs, the normal things that you treat in a hospital or treat in a doctor's office that are common, I guess for lack of a better word, which are the bulk of medical costs.

The bulk of medical costs are not bone marrow transplants. They are just normal, routine things.

Dr. MARKS. Thank God.

Senator PACKWOOD. Yes, thank God. And when I was addressing my question to Dr. Schultze I was thinking more because he is talking about turning this entire set upside down and having a primary, a secondary, and a tertiary care basis of treatment and a method of sorting them out if I understand it and bone marrow would be tertiary, I guess. You will get them somehow. You will be prepared to do it.

But I am really wondering if there is competition. Let us look at the primary level of medicine and whether or not that would exist in rural areas. In urban areas would it exist with insurance companies competing against each other—and I understand the price argument—but would it lead to a deterioration in quality?

Dr. MARKS. I would have to say one of the problems I have with the whole issue of quality, is that we do not know how to measure it yet, and we certainly do not have the data. I think it is going to take 5 to 10 years to really get the data even with a commitment to obtain it.

When we have those kind of data, then I think we can really look at price and quality and to the best of our ability not compromise quality for price. But I do not think we can do it today. That is the reality.

I would say there are measures though that have to be taken to reduce costs. As Dr. Onion referred, he would like to have an oncologist around to make sure that these patients can get community-based, home-based care when they need things like complex chemotherapy.

I think we support this very, very vigorously. This is a whole area that has not been exploited. It is not just for cancer care. But I think that one of the things that the changing health care environment is forcing on us is to look at the way we are delivering care—we, the large academic health centers or cancer centers are delivering care—what our responsibilities are to reach out into communities, how we can more effectively relate to the physicians in community-based provider situations.

I think that is a very felicitous thing that is happening. I think also, and we have data to prove this, it is reducing the cost of care—as much as a third.

Senator PACKWOOD. Dr. Foreman?

Dr. FOREMAN. I do not have an answer for the question.

Senator PACKWOOD. All right.

Dr. FOREMAN. It is a very difficult question. New York is very different from Los Angeles. First, there is no surplus of hospital beds or doctors. Occupancies in hospitals tend to be close to 90 percent and competition has not made its way into the New York scene until very lately.

We have had instead our costs rung out by a draconian state regulatory system which has squeezed us over the past 20 years and rung out the costs that competition now is ringing out elsewhere.

We are convinced—we, my institution; and we, the Association for American Medical Colleges—that in a competitive market, unless the special missions of academic medical centers are protected that the teaching programs will disappear because they will be seen unfortunately long-term as costly baggage that would make the institution noncompetitive and that is the basis for our testimony today to protect it.

If we make the assumption that we will get the protection for that special mission, then we are prepared to see the system move to a competitive environment and watch the market develop as it has in Los Angeles.

There is no question in my mind that this will ring out additional costs through the system and it will ring it out in precisely the way that you have described—that is that insurers bidding for business from the insured will go to their suppliers of services and bargain the rates down.

What is not clear to me, however, at this point is whether anyone in that food chain knows what real quality is or cares about it. So I have no sense as we get closer and closer and closer to whatever it is that is the bottom that there will be protection against the loss of quality when we get right down to where the prices can no longer be reduced.

Senator PACKWOOD. It is kind of a catch-22 situation though, because if you say we are not really sure if we can exactly measure quality, I hope the conclusion is, well, therefore, we should not put any limit on price.

Dr. FOREMAN. No, no. I am not making that argument at all. I am only saying we are prepared to move into a pro-competitive environment. I have seen no evidence, or not very much evidence, that the insurers in coming knocking to get a better price are willing to pay a premium for quality.

They do not come to us and say, you know, you are the big academic medical center, we will give you 25 percent more than your neighbors just because you do all these wonderful things. They say, your neighbors are offering this service to us at this price, you should be able to match it; and if you do not, we will take the business elsewhere. That is happening to us as it is happening in L.A.

I am concerned, as I think you should be, that we will get to a point when the water is squeezed out of the system and where the public needs some assurance that the price competitive environment will not bleed out the quality as well.

Senator PACKWOOD. Dr. Altman?

Dr. ALTMAN. Yes, I would like to take a crack at this question in a somewhat different way. Let us take our education system, our non-medical education system, where we have a relatively small number of academic institutions at a very high cost—and for the most part we would think of as high quality—and then we have a much greater distribution of educational institutions around the United States that are of lower cost, that do less research maybe and do quality education.

But we have allowed over a long period of time this differential, this higher education differential to exist. In health though, we have created a funding mechanism that has allowed our highest cost teaching institutions to be a much larger percentage of the total than we do in our non-medical education institutions.

I mentioned, for example, we have 4 percent of our institutions that are so-called major teaching hospitals, but they compose 14 percent of the beds. The question really from a societal point of view is, do we believe we have too many of these high cost beds in our system and that there is no question in my mind that if we go to an increasingly price sensitive system we will phase down the percentage of beds that are in those very high cost institutions.

I am not prepared to argue that that is not a good thing, particularly if we are as concerned as I am, and as I know you are in this committee about the total costs we are spending on our health care system.

But I am concerned that we do this price sensitivity in as equal or fair way as possible. Therefore, I have testified and PROPAC strongly supports the need for separating out some, if not most, of what we might think of as teaching costs. And then for the remainder allow a much more price sensitive marketplace.

But even in separating it out, it is not clear to me we ought to be separating out all of what we now pay for teaching. So I could see a world with fewer high cost teaching positions, supported by a combination of special education funds and then competitive pressures for this broad base of care.

Senator PACKWOOD. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Packwood.

Senator Rockefeller, patiently working on questions.

Senator ROCKEFELLER. Thank you, Mr. Chairman, but happily.

I want to just respond for a second to something that Senator Dole said and make a point from it. He said that—I forget exactly what it was about the markets working—but the next immediate

statement was that we cannot let the heavy hand of government come in and take this all over.

There are two extremes. On the one hand, you have free market; on the other hand, there is the United States Navy. I mean, the fact is that Medicare payment policies today distort the marketplace by putting the wrong incentives on training more and more subspecialists. That is a fact.

And Dr. Foreman, Dr. Schultze, Dr. Marks would not disagree with me on that. Medicare's hospital payment——

The CHAIRMAN. Could I just say that the transcripts do not record affirmative nods.

Dr. MARKS. We agree.

Senator ROCKEFELLER. So Medicare's hospital payment policies, which are government polices, ensure specialty residents, generate far greater patient care revenues than primary residents, which encourages hospitals to favor specialists and treat the most profitable DRGs. That is a fact. The government created that fact.

And the market is not working by definition, Mr. Chairman, if almost every State has significant areas of undeserved people, much less rural States like our own. I make that statement simply to say that one of the things that I hope, as we come down in the final months on this whole question of health care reform, is that we will do what is right.

The CHAIRMAN. We will do what is right?

Senator ROCKEFELLER. We will do what is right, what is the right thing to do.

The CHAIRMAN. Oh, if that is all we have to do, find out the fellow who knows and we will do it.

Senator ROCKEFELLER. Well, let me just give you an example. This is not on topic, but I am going to forgive myself. [Laughter.]

We had a discussion yesterday on community rating and alliances. And because of the Harry and Louise ads and, frankly, statements that say, if it is not free market that means it is totally run by the government and everybody hates the government, so obviously that must be a terrible thing. And people said, "Well, my people at home do not like alliances."

Well, of course, they do not like alliances because they are being told by Harry and Louise and the insurance industry that alliances are nothing but big government and nobody is telling them otherwise.

So if you look at the alternatives, which would be voluntary alliances or competing alliances or if you look at community rating areas, each of those has tremendously more regulatory administrative government—State Government, Federal Government—monitoring and reporting than does alliances.

Now that is a fact. Now we may choose because we are told by our town meetings that people do not trust alliances because Harry and Louise say that they are all government. But I want to make the statement that I hope and believe that in this committee where people have been working on health care for a long time, that we will do what is the best thing for the American system and not what we are—well, you understand my point.

Stuart Altman, you have testified that PROPAC generally supports the President's approach which is expressly designed to make

sure that academic health centers are viable in a reform market. I mean, let us leave no doubt about that—15 percent of all residents train in New York City. If we do not have academic health centers, the treasures like our research universities and non-medical research universities for medical training are absolutely essential. Nobody doubts that. None of that is in question.

Greater pools for their benefit, if that is what we must do, that is what we must do. We must make sure of that.

But in any event, actually giving teaching hospitals the tools to effectively compete in a managed care environment is going to be very important because managed care is beginning to tear apart academic health centers and their profitability.

Now we know that you have studied the issues relating to teaching hospitals and Medicare payment policies for a very, very long time. What would you say is the single most important thing we can do to protect teaching hospitals in health care reform?

Dr. ALTMAN. Two things. First, I think we should try to establish how much we want to pay for teaching in this country, recognizing that it will be an arbitrary number. There is no science here that will come up with the perfect number.

But we do need to decide that as a country. I think government has a very legitimate role to play in deciding what that number looks like. And then decide how to partition it among the various payers for care and then separate out the educational component as best we can from the patient care component.

As I said in my testimony, I think the President's approach is a very viable one, although it is not the only one. You could do it differently.

Senator ROCKEFELLER. Now you have not answered the way I thought you would, which I thought you would say, we should do it through an all payer pool.

Dr. ALTMAN. Well, that is what I think I said. I said we need to establish a mechanism that has all of the payers for patient care paying.

Senator ROCKEFELLER. All right.

Dr. ALTMAN. I just used different words.

Senator ROCKEFELLER. All right.

Dr. ALTMAN. I think I was saying the same thing.

Senator ROCKEFELLER. All right. So as you are aware, obviously the dollars from the administration's all payer pool are entitlement dollars. They are entitlement dollars. They are not discretionary. They are entitlement dollars.

So given that these dollars are guaranteed, entitlement dollars, going from the taxpayer to the protection of academic health centers, and as I indicate we can talk about making that a larger pool and I am inclined to think we probably have to do that, do you not think in exchange for that, for that guaranteed funding from taxpayers' dollars, which is an entitlement, it is appropriate for us only to pay for what we need, as a matter of government policy, in terms of types and numbers of physicians who we train?

Dr. ALTMAN. Yes and no. I am sorry to be so—I think it is appropriate to pay for what we need. I think the discussion before was whether it is the government that can always figure out what that number is.

What I was trying to say was, there are some values in allowing some flexibility in that system in terms of some call it market forces only because some forces other than a group getting together and divvying it up some other place. Maybe market forces give it more independent——

Senator ROCKEFELLER. Mr. Altman, if I would interrupt and say that generally what we need with some error for flexibility——

Dr. ALTMAN. Yes.

Senator ROCKEFELLER [continuing]. Generally what we need, the public should get what they, generally speaking, what they need and require.

Dr. ALTMAN. Yes. I would agree with that.

Senator ROCKEFELLER. All right.

Mr. Chairman, just one statement which really is not a question. In the 1960's——

The CHAIRMAN. We do not allow that around here, you know.

Senator ROCKEFELLER. Yes. [Laughter.]

Well, then I will not give it. This is just, I guess, my feeling on this. In the 1960's Congress sought to increase the overall physician supply. Thinking that would increase the number of primary care doctors. We believed that.

Enrollments increased and large numbers of international medical graduates entered the system. We were not predicting that would happen, but it happened. The physician-to-patient population ratio doubled, but the proportion to primary care residents decreased.

The bottom line is, we have found the financial and professional self-interest of teaching hospitals and training programs will be the main determiner of the kind of numbers of residents produced. It is not a hostile statement. I am simply saying that analytically.

It has been two decades since the Federal Graduate Medical Education National Advisory Committee was established, Mr. Chairman, which in 1980 then created COGME, the Council on Graduate Medical Education.

Since that time COGME has monitored but has not affected the supply and the distribution problems in our work force. I believe the Federal Government has been studying and monitoring this problem for too long, that we have been standing on the side lines watching this problem get worse. Academic health centers themselves are under severe pressure to survive if we do no Federal legislation whatsoever. This point has been made by others.

However, if we decide to fix this in health care reform, as I think we must, we have to redirect training dollars. We cannot continue to use public funds to subsidize the production of unneeded specialists, which drive up our health care bill, which is not an incidental subject.

That would be disastrous for our overall effort to contain costs in our system. Now I believe that. As I said before, New York trains 15 percent of all residents in this country. If we reduce slots, New York will certainly be affected and will be affected negatively.

I want, Mr. Chairman, and I will work very closely with Chairman Moynihan to help New York with its real service needs. I mean that and the Chairman knows that I mean that because I have told that to him privately as well.

The CHAIRMAN. I surely do.

Senator ROCKEFELLER. But I do not think that that means that New York needs to continue or other States—California or Texas—needs to continue to train the same amount and the same mix of residents which it does today. I think that the Chairman would probably agree with that. But a nod, either up or down is not recorded. [Laughter.]

I thank the Chairman and the panel for their attention.

The CHAIRMAN. We thank you, Senator, for your devotion to this subject which is remarkable. It reminds me of all I would want to say to this distinguished panel.

Dr. Foreman, you wanted to respond.

Dr. FOREMAN. Senator Rockefeller, permit me to disagree somewhat with respect to causes; and, therefore, with respect to cures. It is not our belief that the Medicare payment system to teaching hospitals has distorted the mix of specialists to generalists, but rather the incentives created for practice after training and the availability of training in any specialty that you would choose in America's teaching hospitals.

That is to say, we have, in fact, underwritten either explicitly or implicitly the cost of training in every specialty and permitted young physicians to take specialty training in almost anything they desire it for as long as they wish to make themselves into any kind of specialist they chose.

Senator ROCKEFELLER. Under an extraordinary amount, you would agree, of peer pressure and institutional pressure within the period of their residency and internships.

Dr. FOREMAN. I would agree that they received reality training while in programs of graduate medical education. That is, I believe that they came to understand that when they graduated from their training programs, that the life of a specialist—intellectually, professionally, and economically—was better than the life of a generalist and that they were encouraged by the whole system to seek specialty training.

That is not a new phenomenon, Senator. When I took my training almost 30 years ago, I was encouraged—and I was then a United States Public Health Service officer—I was encouraged by my training program to see subspecialty training because that was the way health care was evolving and we were advised as very young people that long ago, that to prepare one's self for the great new tomorrow one needed highly specialized skills.

But having said that, we have done everything we possibly could to encourage young physicians to become specialists by making life as a specialist very, very attractive. We now believe that the forces that are changing medical care are sending different signals back to young physicians.

In our community, primary care physicians have starting incomes which are now 20 percent higher than cardiologists. That is, you can be employed in New York City at a 20 percent premium as a generalist over what you can be employed as a cardiologist. It does not take long for that kind of information to get back into the halls of ivy and send the signal that the world is changing.

The AAMC does not oppose a regulatory solution to changing specialty mix or distribution. In fact, they favor it if over a reason-

able period of time the changes that we now see in the world around us do not move specialty choice in the direction we think it ought to go, which is to get 50 percent generalists.

We have only argued that we ought to give, set some national goals, and give the market several years time to work in this new environment and see whether or not we need to help it with regulation.

Senator ROCKEFELLER. Dr. Foreman, you know as well as I do that if we went to an OB/GYN that is now being included in primary care to a 55/45 split in terms of physician education, and we started that this year, it became effective this year, it would be the year 2040 before we would achieve that split in this country. You are aware of that?

Dr. FOREMAN. I am, sir.

Senator ROCKEFELLER. So, waiting for the market, you have to be a very patient man.

Dr. FOREMAN. I do not think that the market is going to work slowly, sir. I think it is going to work——

Senator ROCKEFELLER. I understand what you are saying. I understand that you are saying there are new pressures coming. And I understand the Kaiser-Permanente from the west, they are sucking up 85 percent of all pediatricians and they are paying them $125,000 and there are probably very few of them staying in Maine, they are all going out west.

Dr. FOREMAN. Yes, sir.

Senator ROCKEFELLER. I understand those forces are working, and they are working here and they are working there, but they are not working systemically.

I think it is not unreasonable for the government which funds so much of this and which has for so many years tried to make this into a system which has some systemic viability to it, not only in terms of the ratio and the incentives which you talk of, but also what actually happens as to the payment. For example, if you really are going to go to have physicians be primary care physicians in Camden-on-Gauley in southern West Virginia.

You cannot just give them a bus ticket and a box of candy. I mean, there has to be a reason for them to be there, which may mean that in some instances that those places will have to receive the payment, which is what Dr. Onion is indicating.

In other words, the system has to say that if you go there, if the teachers of medicine and the learners of medicine go to Camden-on-Gauley , the system rewards that and speaks to that. Not in all cases, but in some cases. You would agree that there has to be not just letting things happen at random as they will—managed care crowding in on you, you cannot meet their prices, et cetera, the whole question Dr. Marks was talking about $100,000 down to $60,000, we could not do it, but to do it in some more orderly fashion if we can with the help of public policy?

The CHAIRMAN. Dr. Marks? We have another hearing, but please comment.

Dr. MARKS. I just was going to say, Senator, fundamentally I agree with you completely. I just would recall, because I was a Dean of a medical school at the time, that it was the government

that was putting great pressure on us to increase production of medical students in the late 1960's and to shorten our curriculum.

Senator ROCKEFELLER. From NIH, right?

Dr. MARKS. Right. And I can say without trying to sound too—that we resisted it. And it was at a cost because medical schools were being given extra dollars and I remember a faculty meeting which almost ran me out of town because we were not taking the money because I thought it was the wrong way to go.

So I think there is a middle road here kind of thing. I think that the government absolutely has not only a role but an obligation to move in the directions which you are addressing. But I hope we can find a way legislatively to do it which does not lack some flexibility to recognize a very rapidly changing health care scene. There is no question in my mind.

Senator ROCKEFELLER. I agree with that.

Dr. MARKS. Thank you, Senator.

The CHAIRMAN. Well, on that note, on that happy note, we want to thank you gentlemen with greatest appreciation.

Senator PACKWOOD. A great panel.

The CHAIRMAN. A great panel said Senator Packwood. Could I just leave it by saying, since you mentioned 30 years ago, Dr. Foreman, 50 years ago I was in City College where I learned all about demystification, but I never thought it would reach the level which we have discussed—the great ministry of health care in the boldest terms of soybean futures.

People migrate to challenge, to mystery but it is something more than that. It is a healing profession in the end and we will pay very close attention to what you have told us. We thank you very much.

Dr. MARKS. We thank you, sir.

Dr. FOREMAN. We thank you.

Dr. ONION. Thank you.

Dr. SCHULTZE. Thank you.

Dr. ALTMAN. Thank you.

[Whereupon, at 12:18 p.m., the hearing was adjourned.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF STUART ALTMAN

Good morning, Mr. Chairman. I am Stuart Altman, Chairman of the Prospective Payment Assessment Commission (ProPAC). I am pleased to be here to discuss payment policies affecting teaching hospitals and academic health centers, and potential issues raised in the debate on health care reform. To focus on these issues, I will use the Health Security Act proposed by the President as an example.

Mr. Chairman, this nation's teaching hospitals fulfill a unique role in the provision of health care. In addition to providing routine patient care services, they provide care to patients with the most complex illnesses and frequently are the first hospitals to adopt new medical advances. Many of them also furnish inpatient as well as ambulatory care to the uninsured. In addition, they serve as an important training ground for our future health care providers. As a result of these functions, teaching facilities necessarily incur higher costs than similar non-teaching institutions.

As this Committee knows, the Medicare program currently reimburses teaching hospitals for the costs associated with medical education through two distinct payment adjustments. The indirect medical education (ME) adjustment recognizes the higher patient care costs in teaching hospitals. The graduate medical education (GME) payment reimburses hospitals for Medicare's share of costs associated with operating a residency training program. Many private payers also contribute to the reimbursement of ME and GME costs, although implicitly, through higher rates for patient care services.

The President's health care reform proposal recognizes the unique role that teaching hospitals play in our health care system, and that unless a new mechanism is found to pay for their legitimate higher costs, such institutions would be at a distinct competitive disadvantage in the much more price conscious world of competing managed care plans.

The President's proposal would create two new funds, the Academic Health Center Account and the Health Professions Workforce Account. Payments into these two funds would come in part from Medicare, out of what are now IME and GME payments, and in part from contributions on behalf of private payers through a surcharge on the regional and corporate alliances.

The Commission believes that the President's proposal would have important consequences for teaching hospitals and the patients they serve. In my testimony this morning, I will address three aspects of the proposal: the objectives that each of these funds is intended to accomplish, the need for a separate mechanism to compensate for the costs associated with teaching, and the importance of determining the appropriate level and distribution of these funds.

The Academic Health Center Account is designed to cover the extra costs of patient care incurred by teaching hospitals that are not routinely incurred by other facilities. These costs are not explicitly measured or reported, because they are related to the services teaching hospitals provide and the way that these services are provided, rather than directly allocated to specific activities.

Payments from the Health Professions Workforce Account would be intended to cover the more explicit institutional costs of graduate medical education. These costs are directly related to the training of physicians rather than the treatment of patients, and are borne to varying degrees by the hospitals and other settings in which the training is provided and by the other institutions or entities that are involved in training activities.

While the Commission supports the concept of these two accounts, it is concerned that the level of funding available from them be sufficient, and that the allocation method be appropriate, to compensate for these costs. Based on its own analysis of Medicare costs, the Commission believes that the total funding proposed for the Academic Health Center Account and the Health Professions Workforce Account is significantly less than would be needed to cover the combined patient care and training costs that are associated with teaching.

I now would like to briefly discuss each of the two payment mechanisms described in the President's proposal more specifically.

INDIRECT MEDICAL EDUCATION COSTS AND PAYMENTS

The Commission supports the general approach outlined by the President concerning teaching institutions. This approach would require teaching hospitals to compete with other hospitals for patients, through price and quality considerations. But it would allow teaching hospitals to compete more effectively by distinguishing between direct patient care costs and those related to their teaching mission. The additional patient care costs that are associated with their teaching function would be paid from the Academic Health Center Account. Some of these patient care costs include the reduced productivity of the faculty, uncompensated costs of clinical research, and higher costs associated with specialized treatment of exceptional cases. The available funds would be distributed by the Secretary of Health and Human Services based on total patient care revenue through a formula similar to the one used to determine Medicare's IME payment adjustment.

The total size of the Academic Health Center Account, including contributions from the regional and corporate alliances and Medicare, would be $3.1 billion in fiscal year 1996, increasing to $3.8 billion by the year 2000. Thereafter, the Account would grow at the rate of the general health care inflation factor, which is the rate of increase in the gross domestic product.

Mr. Chairman, the Commission supports the explicit recognition by all payers of the higher patient care costs in teaching institutions and the separation of payments for these costs from the basic price of care. We have several concerns, however, about the level and distribution of payments from the proposed Academic Health Center Account.

First, the amount to be distributed from the Account should adequately reflect the additional costs teaching institutions face. As part of our examination of the Medicare IME adjustment, we have analyzed the relationship between the intensity of hospital-based teaching activities and the costs of treating Medicare inpatients. Over the last several years in our annual March Report and Recommendations to the Congress, we have recommended that Medicare's IME adjustment be reduced because we believe that the current adjustment overcompensates teaching hospitals for the costs associated with treating Medicare patients. We reiterated that recommendation in our March 1994 report to Congress.

I would note that, while ProPAC has recommended a reduction in Medicare IME payments, our analysis would support a substantially higher level of total payments than is called for in the President's proposal. While we have not yet developed an estimate of overall hospital indirect medical education costs, our estimate of the portion of those costs that correspond to Medicare inpatient care is about 60 percent higher than that referred to in the Health Security Act.

This discrepancy reflects a basic disagreement about whether these payments ought to compensate only for the specific costs associated with physician training or for the cost differences associated with the broader role served by teaching facilities. We believe that the additional payments should cover the broader responsibilities of academic health centers, including clinical research, the adoption and application of technological advances and treatment regimens, and the treatment of more complex and difficult cases. In a very real sense, these costs are part of the total educational environment of the teaching institution. In the context of health reform, or in any price competitive market, these activities are not likely to be reflected adequately in the prices that payers are willing to pay for patient care services.

While the relationship between teaching and Medicare inpatient costs has been the subject of extensive examination, the relationship between teaching activities and the costs of treating all patients in hospital and particularly non-hospital settings is not known. More analysis is needed to ensure that the level of funding of the Account is appropriate to recognize these costs in all settings.

Our second major concern is that the distribution of payments from the Academic Health Center Account must be equitable and encourage the efficient operation of teaching institutions. It is important that the allocation of funds reflect the added costs of hospital ambulatory and outpatient care as well as inpatient services.

Finally, Mr. Chairman, we are concerned about how the proposed changes might affect access to the services these facilities provide for Medicare beneficiaries and others. This concern centers on two issues. If substantial reductions in the level of Medicare IME payments are made before an appropriately funded mechanism is implemented to replace these payments, the ability of teaching hospitals to continue to serve as America's flagship health facilities will be impaired.

Many teaching hospitals also provide services to a disproportionate share of low-income patients. These hospitals receive a disproportionate share (DSH) adjustment to their Medicare payment, in addition to the IME adjustment. Even with these additional payments, however, this subset of teaching hospitals is not performing as well financially as other hospitals.

Under the President's proposal, the Medicare DSH payment adjustment would be greatly reduced as universal coverage is phased-in. This, in combination with the changes in IME payments, would result in a substantial reduction in Medicare revenues for these hospitals. While it is true that universal coverage would offset some or even most of the proposed reduction in Medicare payments, the distribution of these payments will likely be different than the current flow of funds. Moreover, as discussed earlier, the introduction of universal coverage may be at variance with the timing of the Medicare payment reductions. Therefore, we strongly suggest that a more detailed analysis of the financial effects on the affected hospitals be conducted, and that these changes be evaluated before the new system is put into effect.

At a minimum, to ensure the financial viability of the institutions affected during the initial years of health care reform, the Commission believes that any reductions in payment adjustments should be implemented gradually and coordinated with the introduction of universal coverage and other reform payment initiatives.

GRADUATE MEDICAL EDUCATION COSTS AND PAYMENTS

As you know, Mr. Chairman, the Medicare program historically has provided teaching hospitals with a separate payment for Medicare's share of the direct costs associated with operating residency training programs. These costs include residents' salaries and benefits, faculty supervision, classroom space, program administration, and other related overhead expenses. Prior to 1985, hospitals were paid on a retrospective cost basis. Under current law, hospitals receive hospital-specific per resident payment amounts. These amounts are based on each hospital's 1984 audited per resident costs, updated annually for inflation.

The costs of training medical residents is not trivial. In 1990, total expenditures for the direct costs of graduate medical education were estimated to be about $5.4 billion. Medicare paid about $1.6 billion towards these costs; the remainder was paid indirectly by private payers through higher patient care payments.

The President's proposal would eliminate the current GME payment method for reimbursing for resident costs. Instead, both Medicare and the health care alliances would contribute to a Health Professions Workforce Account. The Secretary of Health and Human Services would allocate the Account funds to residency programs, based on the national average per resident cost in the 1992-1993 academic year and increased annually at the general economywide rate of inflation. Actual residency payments would be adjusted to reflect regional differences in residents' wages and other wage-related costs.

Initial funding for the Workforce Account would be set at $3.2 billion in fiscal year 1996, rising to $5.8 billion in 1999 and 2000. Thereafter, it would increase at the same rate as the growth in the gross domestic product.

The Commission believes it is appropriate for all payers to contribute explicitly to the funding of graduate medical education. The Commission also believes this funding should be consistent with national work force goals with respect to both the number of residents and their specialty distribution. It should also support training for physicians and certain non-physician medical personnel necessary to meet these goals.

The Commission also believes that payments for the direct costs of training should be made to the appropriate training program, whether it is based in a hospital inpatient, hospital outpatient, or ambulatory setting. There are several alternative approaches to accomplishing this. One, which has been tried in several locations including Massachusetts, is to have payments made to a separate entity in the area, which would then reallocate the funds to the appropriate settings in relation to their participation in the training effort and their relative costs.

Finally, the Commission believes that graduate medical education payments should be based on a national prospective per resident amount that is adjusted for appropriate differences in residency costs. The difficulty, as you well know, Mr. Chairman, is establishing an appropriate baseline amount and determining the ap-

propriate cost differences that merit adjustment. Medicare per resident cost data—which are the only data available—provide little help. A major reason is the lack of uniformity in the reporting of these costs. As a result, as you can see in Figure 1, reported per resident costs vary substantially across hospitals, from less than $10,000 to more than $200,000. Even after these data are audited, significant variation remains.

The problem is that per resident costs include not only resident salaries and benefits, but also other costs that are more difficult to quantify, such as faculty supervision and allocated overhead. These other items represent the majority of reported costs, and they also are the major reason for the increase in these costs. In 1990, for example, the average per resident GME cost was $74000–70 percent more than what was reported in 1984. Over this same period, resident salaries increased roughly at the rate of inflation, while the other costs increased much more rapidly. If all GME costs had risen at the rate of inflation over this period, per resident costs in 1990 would have been $56,000—equal to the Medicare per resident payment rate.

Much of the variation in resident costs across hospitals is due to overhead and supervision costs. Figure 2 compares the major components of per resident GME costs for hospitals with high, moderate-to-low, and low costs. While resident salaries were twice as high at the high cost hospitals compared with the low cost hospitals, other assigned costs were three times as high and overhead costs were four times as high.

ProPAC has also examined some of the reasons for the variation in per resident costs and has found geographic location to be a significant factor. As Figure 3 shows, reported per resident costs are much higher in the northeast than in the south central part of the country. A portion of the variation also is related to cost reporting practices and overhead allocations. It is important to note, however, that within these regions, and even within states and cities, a substantial amount of variation remains. One issue in establishing a baseline average per resident payment is determining the types of overhead and management costs that should be recognized as contributing to the costs of training residents. Another factor is the payment for faculty supervision.

Unfortunately, Mr. Chairman, the data we have on the costs of faculty supervision are not as reliable as we would like and, further, they can be very misleading. Hospitals differ greatly in their use of voluntary and hospital-employed staff. There is also a complex flow of funds among academic health centers, medical schools, hospitals, and faculty practice plans. In many cases, hospitals report a portion or all of the salaries of teaching physicians, even though these physicians may devote a considerable amount of their time to research and other activities that are not directly related to patient care.

It is important to recognize that teaching physicians also may be paid by Medicare under Part B as well as by other payers for the services residents are performing under their supervision. Since one physician may supervise several residents at the same time, these patient care revenues may be substantial. In some cases these payments may be part of the design of the total compensation package for teaching physicians. The policy issue is whether the total compensation package should be considered in teaching costs or only the portion that represents time that is actually spent teaching or supervising residents.

I must note, however, that in some hospitals, teaching physicians supervise the care furnished to people without insurance. In these cases, no third party payment is available for the physician component of the service. Universal coverage will provide a new source of payment to physicians, as well as hospitals, for the services they furnish. It is critical, however, that the changes in GME payments carefully be coordinated with coverage of the uninsured. Further, adequate funding should be available to assist hospitals that lose training positions as a result of changing manpower goals. Some of these institutions rely on residents to provide basic patient care, and the loss of these positions could increase their costs and adversely affect the care their patients receive.

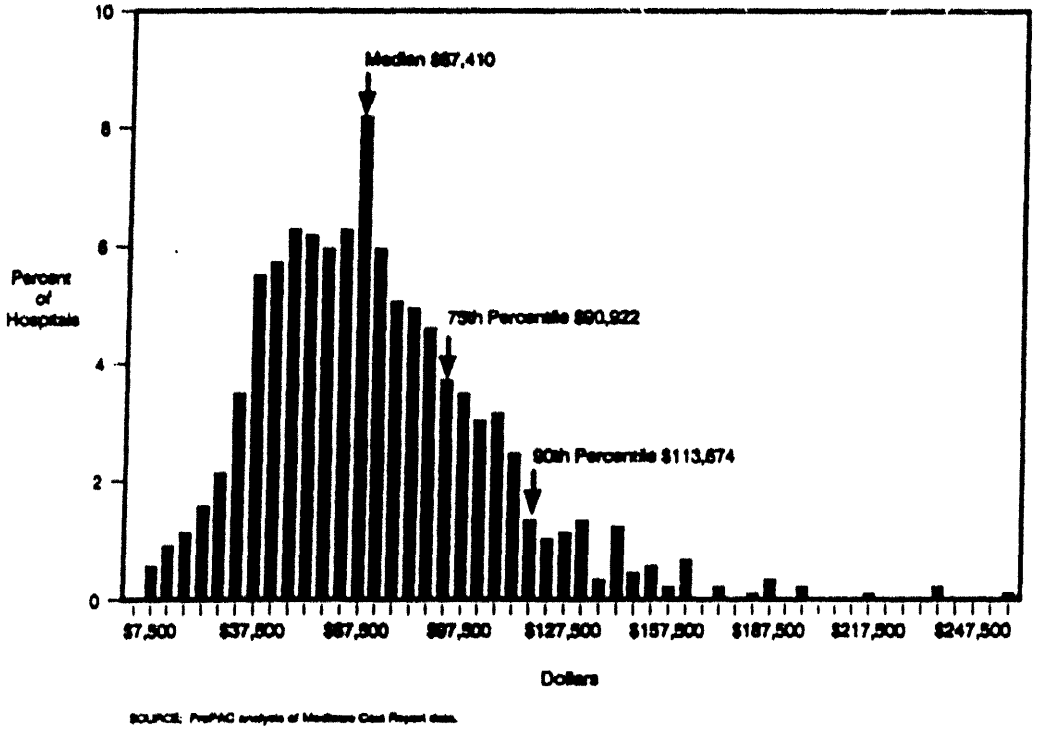
Mr. Chairman, while establishing a national baseline residency payment amount based on historical costs may be necessary initially, more analysis is needed to better understand the components of resident training costs to ensure that resident costs are appropriately compensated, without also compensating for incidental costs and historical inefficiencies.

CONCLUSION

The importance of teaching hospitals in this country is undisputed. Any proposals for health care reform should recognize the need to appropriately reimburse teaching hospitals for their unique functions. Changes to the current reimbursement

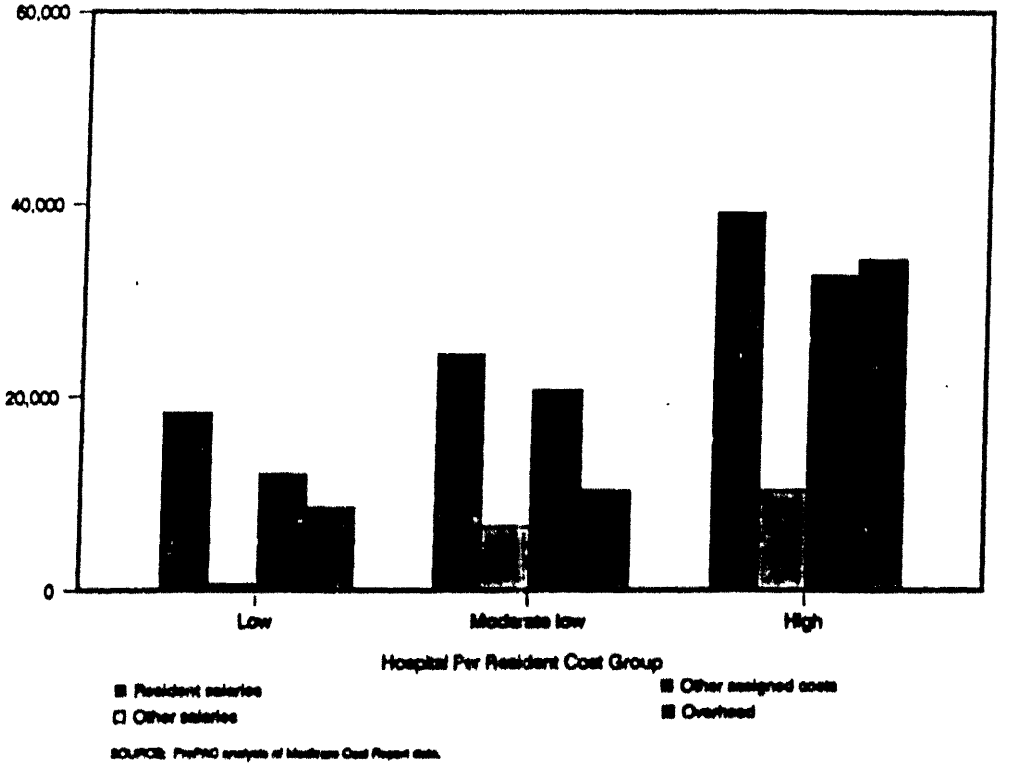
methods for these costs, therefore, should be implemented gradually and their effects carefully monitored.

Figure 1. Hospital Distribution of Per Resident Costs, 1990



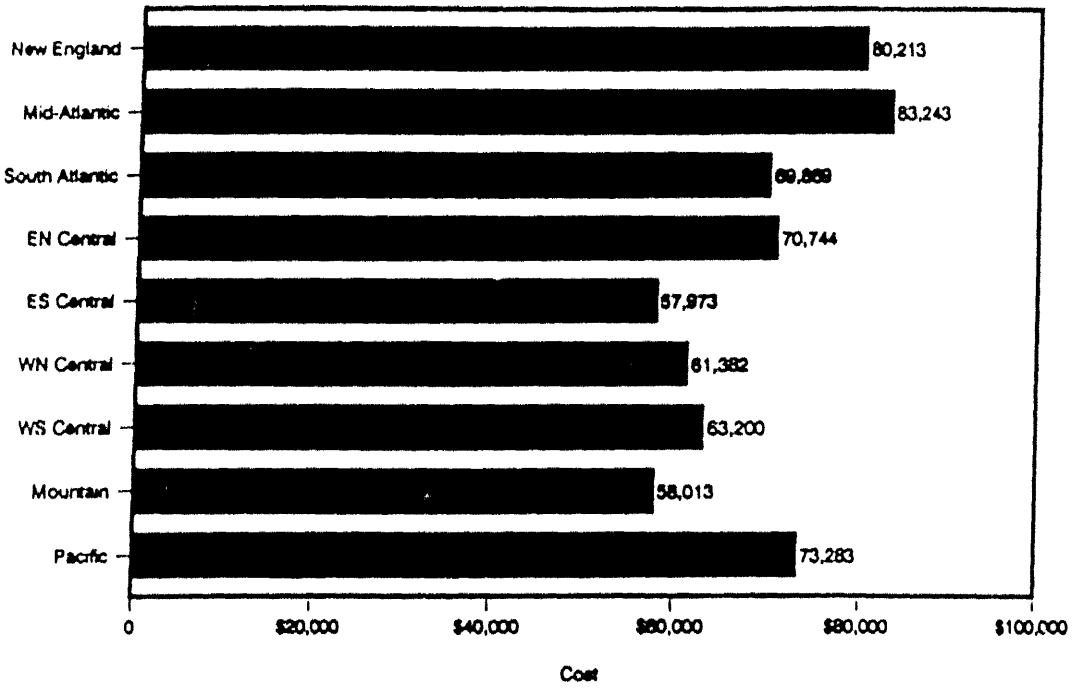
SOURCE: ProPAC analysis of Medicare Cost Report data.

Figure 2. Graduate Medical Education Cost Allocation By Total Per-Resident Cost Groups, 1990



SOURCE: ProPAC analysis of Medicare Cost Report data.

Figure 3. Average Per Resident Cost By Region, 1990



SOURCE: ProPAC analysis of Medicare cost reports

QUESTIONS FOR THE RECORD

Senator Dole. I noticed with interest that you did not mention foreign medical graduates.

If we are about to undertake a downsizing of the number of residency slots, should we reserve a number for U.S. educated physicians as compared to foreign trained physicians?

Dr. Altman. The Commission supports an approach that would set a limit on the number of residency positions. The size of this limit, however, likely would be larger than the total number of current mainland medical school graduates. Both mainland and foreign trained physicians would compete for the available positions. If the mainland trained graduates competed successfully for the positions, they could all find a slot. Given the strong preference for mainland graduates by most residency programs, I think this outcome is very likely. Therefore, at least initially, I would favor an approach that requires candidates to compete for positions rather than using an arbitrary formula.

Senator Dole. International medical students (IMG) fill approximately 21 percent of the residencies nationwide. It is my understanding that in New York state and in North Dakota they fill 42 percent of the residencies. If we are to limit the total number of residencies, what would you suggest with respect to these physicians? Who makes the choice between U.S. grads and foreign grads?

Dr. Altman. I believe that the various residency selection committees are in the best position to evaluate their needs and the qualifications of the candidates. With a total limit on residencies, some hospitals would lose slots. It is intended that these be specialty slots, not primary care, and graduates interested in specialty residencies may have to reconsider their choice. Some U.S. graduates, in particular, may have to reconsider their choice of a specialty career if they wish to obtain a residency position. In addition, it is anticipated that hospitals that relied on residents to provide care to the uninsured will have less need for these services as insurance coverage is expanded. Many of these hospitals currently rely on foreign medical graduates. The problem here, however, is not graduate medical education, but the lack of primary care physicians in underserved areas.

Senator Dole. You acknowledge in your testimony that teaching hospitals do incur higher costs because of their teaching responsibilities and because of the kind of patients they serve.

In your view, should we try and separate these costs and pay for them separately rather than through an adjustment like the IME adjustment?

Dr. Altman. For teaching hospitals to maintain their financial position in a more competitive market, I believe it is essential that the extra costs related to their special mission be recognized and paid for separately. The Medicare IME adjustment does that in the context of Medicare's rate setting system, and it also can be viewed as a separate payment. The more complicated issue is for private payers. I believe that all payers should contribute their share of the higher costs of maintaining teaching programs. The specific mechanism for doing this would depend on the type of health care reform proposal enacted. One approach is for all payers to contribute appropriately to a special fund, such as that contained in the President's proposal. There are other mechanisms, as well, that could be developed.

Senator Dole. Do I understand you to say that you support paying GME funds to organizations other than the teaching hospital? If so, who do you believe should organize these new entities and who decides if the organization is a fair one.

For example, what happens in a community like New York or Los Angeles where there are multiple schools and multiple facilities?

Dr. Altman. As we move to train more primary care physicians and as more and more services are provided outside of the hospital, the training of physicians should also move away from the hospital. The GME costs need to be recognized, regardless of whether they are incurred in or out of a hospital. Since there is a mechanism in place for approving residency programs, the payment policies should be consistent with this mechanism. I believe the teaching programs can best decide themselves how they wish to organize, in keeping with accreditation requirements. In many cases, this entity will continue to be a hospital as a component of the academic health center, or the medical school, as it is today. It is not uncommon now for academic medical centers to have affiliation agreements with a number of hospitals in the community, through which residents rotate. These agreements could be expanded to include providers in addition to hospitals. This approach is also successfully used by the Department of Veterans Affairs. It is possible that each medical school in New York or Los Angeles would choose to be the entity on behalf of the hospitals and other providers with which it has agreements. Alternatively, some major hospitals could be the entity, arranging for rotations outside the hospital. All of these approaches are consistent with the idea of consortia, proposed by Senator Chaffee.

Senator Dole. I don't believe I heard you comment directly on the proposal to cap the total number of residents and the distribution between primary care and specialty training.

Do you support Federal controls over this distribution?

Dr. Altman. I have been persuaded by the studies and expert opinion of others that we are training too many residents, but that an inadequate number of these are in primary care specialties. The approach to this problem, however, does not require the Federal government to regulate the number or the distribution of residents. Instead, I would recommend that the funding for GME be based on a limited number of residency slots and better allocation of primary and specialty positions. This has the advantage of maintaining a fiscal constraint on the system and providing financial incentives without putting fixed regulatory controls on the number of residency slots. I believe that a group of experts, such as a commission, should recommend national work force goals, including the number of residents and the distribution between primary care and specialty training. It is important, however, that the goals allow for some flexibility and be periodically reassessed and adjusted to meet changing circumstances. The private sector should also continue to set the standards for approval of residency programs, which also will affect the number and distribution of slots. This is an approach that has been used successfully over the years, relying on the best knowledge and expert opinion in the private sector. As Dr. Schultze pointed out, training programs are now recognizing the demands of the changing medical market place. The level of GME funding and the distribution of payments will provide financial incentives and should be consistent with these national work force goals. It is important to note that other policies, such as the relative level of fees for primary care and specialty physicians can also provide strong incentives to shape the supply and distribution of the physician work force.

Senator Grassley. Let me ask a more general question. Is the situation that Dr. Marks believes exists for the cancer centers happening more generally with the academic medical centers? That is, are the academic medical centers experiencing a loss of patients because organized delivery systems do not send their patients as readily to sophisticated academic centers?

Dr. Altman. I don't have any definite evidence one way or the other. I have been told, however, that to keep from losing patients, teaching hospitals in competitive markets now must agree to accept a payment that is similar to the payment to non-teaching hospitals. My solution for this problem is to provide an additional payment to teaching hospitals, through a fund or other mechanism, to recognize the extra costs that result from their teaching mission. With this separate payment, they should be expected to compete based on price and quality with other hospitals in their area.

Senator Grassley. Dr. Marks argued that "health plans should be required to permit the referral of their patients to designated specialty providers and centers of excellence."

May I have the comments of the other panelists on this suggestion?

Dr. Altman. I don't believe that such a requirement is necessary or that it would necessarily result in referral of the most appropriate patients. Competing health plans, which include physicians, will have strong incentives to ensure that their enrollees receive the services they need in the most appropriate settings. If the extra costs of teaching hospitals are recognized, as I discussed previously, then teaching hospitals should be able to compete based on price. They may also have the advantage of competing based on recognized excellence and the quality of care furnished. Further, it is well known that hospitals that specialize in complex procedures, provide care at less cost and at higher quality than hospitals that perform these procedures only infrequently. Another problem that must be addressed, however, is ensuring that the premiums health plans receive reflect the severity of illness and risk that the plans face in providing care to their enrollees. If premiums are not risk adjusted, then plans with people who are sicker than average will not be able to provide all the specialized care required.

Senator Grassley. I am very aware that teaching hospitals deliver care in a more costly manner because they deliver more specialized care. In an effort to ensure choice as well as preserve academic health centers, many centers would like to mandate that all health plans contract with these centers. However, in an effort to contain costs, approval of specialized care and experimental therapies could be denied. Could you comment?

Dr. Altman. I agree that a requirement to contract with teaching hospitals for specialized care may not lead to the desired result, for the same reasons I described in my response to the question on a requirement for referrals. Rather than requiring referrals to or contracts with teaching hospitals and specialty centers, health plans should be subject to an effective oversight of the quality of care they furnish to their enrollees. The subject of experimental therapies, however, is very different. These services need to be carefully controlled, and much more discussion of how to do this is necessary.

PREPARED STATEMENT OF SPENCER FOREMAN

Mr. Chairman and members of the committee, I am Spencer Foreman, M.D., Immediate Past Chairman of the Association of American Medical Colleges (AAMC) and President of the Montefiore Medical Center in Bronx, New York. The AAMC represents the nation's 126 accredited medical schools, approximately 400 major teaching hospitals, the faculty of these institutions through 92 constituent academic society members, and the more than 160,000 young men and women in medical training as students and residents. I am pleased to appear before you today to comment on three issues of particular interest to academic medicine that are part of the national health care reform debate: workforce planning and financing; medical school financing in an era of health care reform; and how the special missions and costs of teaching hospitals should be recognized in a competitive delivery environment.

The AAMC appreciates the leadership of the members of this committee and the administration in initiating legislation to extend universal comprehensive health coverage to all Americans while improving quality and constraining growth in health care costs. As early as 1969, the AAMC called for universal access to health care, and since then has advocated a number of other positions on reform of the overall system, including the need to: balance the provision of a basic benefits package with available resources; provide access to primary, preventive, and specialty care; support pluralistic financing systems with appropriate beneficiary cost sharing mechanisms; and develop planned community health care programs.

In June 1993, the association adopted a set of five goals and supporting principles that should guide health care reform. These goals are:

- giving all Americans the chance for a healthy life;
- providing universal access to health care;
- recognizing that once health care excellence is achieved, the necessary resources must be provided so that quality and capacity are maintained;
- instituting cost containment measures that do not compromise health care quality; and
- supporting the essential roles of medical and other health professional education and of biomedical, behavioral and health services research. (Appendix A provides a complete list of goals and principles.)

Health care reform will test the entire health care system, and academic medicine in particular will face special challenges. Medical schools, teaching hospitals and their faculties constitute the cornerstone of the health care system, as educators of physicians and other health professionals, as creators and evaluators of scientific knowledge and its transfer into practice for the benefit of society, and as major providers of primary, secondary and tertiary care in their local communities--often to indigent patients--and on regional, national and international levels. These special responsibilities are highly interdependent in both their missions and financing, increasing the costs and therefore the amount, that teaching physicians and teaching hospitals must receive for their services, making them vulnerable in a price conscious environment. Additionally, the contributions of academic medicine depend on multiple sources of financing, each of which is increasingly constrained at a time when changes in health care delivery are demanding that academic medicine undertake new initiatives and functions. If medical schools and teaching

hospitals are to play roles in sustaining the effectiveness of the health care system, health care reform must recognize and support the special roles these institutions have in society.

The AAMC is interested in many issues addressed in the legislative proposals before the committee, ranging from broad areas such as anti-trust, to more narrow concerns, such as the provision for contracting with academic health centers as described in the Health Security Act (HSA) (S. 1757). Many policies in the HSA and in other legislative proposals deserve enthusiastic support, ranging from reforming the Medicaid program to altering the malpractice system. The AAMC also notes that as part of health care reform many Congressional leaders, several of whom serve on this committee, have developed proposals to change the physician workforce and graduate medical education financing. Senators Rockefeller, Chafee, Breaux, Dole and Durenberger are sponsoring legislation to increase the number of generalist physicians as part of national health care reform, a basic goal on which we all agree.

But, to a degree not found in any other legislative proposal, the HSA recognizes and supports the critical missions of teaching physicians and teaching hospitals in the health care system. It also has an underlying policy requiring support for the missions of academic medicine from all insurers or sponsors of patient care programs. The level of financial support, the purposes for which the funds are intended, and how money is allocated are all matters that will be subject to debate. However, the AAMC wishes to emphasize the fundamental importance of the principle that all payers must support the education and training of the workforce as well as providing an environment in which education and clinical research can flourish. Our commitment to this principle will not waiver.

The HSA's comprehensive scope includes not only proposals to reform the physician and health professional workforce, but also proposals for academic health centers (AHCs), health research and public health initiatives, health programs of the Department of Veterans Affairs (VA), and hospitals serving vulnerable populations. Many of these provisions, which are crucial to the overall viability and quality of the health care system, are of special concern to academic medicine and the AAMC will pursue the opportunity to continue a dialogue in these areas. However, despite its breadth and attention to detail, the association must call to the attention of this committee and others that the HSA, which would strengthen the emerging price competitive market, potentially constitutes a severe threat to the financial viability of the nation's medical schools. Currently, the HSA makes no provision for revenue lost to medical schools, no provision for supporting costly new activities that they must undertake, and inadequate provision for a transition to a new and highly uncertain future. Before I explain why health care reform poses a threat to the nation's medical schools and the association's proposed approach to addressing the special needs of medical schools and teaching hospitals, I will describe the AAMC's recommendations on workforce planning and financing issues. The AAMC strongly supports the inclusion of these recommendations into any legislative proposal that this committee and the Congress considers as part of national health care reform.

Workforce Planning and Financing Recommendations

The Need for Physician Workforce Planning. The AAMC agrees with the need to train more physicians in the generalist disciplines and fewer physicians in the more highly focused specialties and subspecialties. These are the basic principles underlying the HSA and all other proposals

to reform the workforce and graduate medical education. Increasing access to the health care system for all Americans will require more generalist physicians. In 1992, the association called for a national goal of a majority of graduating medical students committing to generalist careers in family medicine, general internal medicine, and general pediatrics. The successful implementation of health care reform rests upon an adequate supply of well-trained health professionals in an appropriate specialty mix that addresses the health needs of the population.

The AAMC also recognizes the need for physician workforce monitoring at the national level. Most legislative proposals to reform graduate medical education, and statements of the Physician Payment Review Commission (PPRC), the Prospective Payment Assessment Commission (ProPAC), and the Council on Graduate Medical Education (COGME) call for the establishment of a national body to make recommendations on physician supply, medical education and related issues. The AAMC strongly supports the creation of a national physician workforce council, board or commission. Authorized in statute, the national council should be independent of the Department of Health and Human Services (DHHS); funded separately rather than from the workforce account; and staffed adequately to permit its effective operation. It should be composed predominantly of private citizens representing various constituencies with interests in physician education. As proposed in the Rockefeller/Durenberger bill (S.1315), the council's representation should specifically include a dean and a teaching hospital executive on its planned national board.

The Role of a National Council. The national council, as we see it, would monitor graduate medical education, improve the available data on physician workforce training, and identify national workforce goals. The AAMC believes that the council should assess physician workforce needs in aggregate and by specialty and should provide guidance to the medical education system for the total number and specialty mix of residency positions. The council should be charged with specifying workforce goals that relate training capacity to the need for practicing physicians and physicians trained for research.

Beginning January 1, 1996, we believe that the council should initiate a data collection process for workforce training to provide an analytic foundation for its projections. Data should be collected from entities such as teaching hospitals, medical schools, group practices or graduate medical education consortia that train physicians in residency programs. The council would be expected to analyze these and other types of relevant workforce data and hold public hearings. It also should be required to consider recommendations from independent educational organizations and associations as part of its deliberations.

The council would publish annual reports, assessing the evolving health care delivery system, workforce needs, and the progress made toward achieving national workforce goals. The reports should include analyses of the impact of changes in medical practice, delivery of services, and other factors on the supply, specialty mix, and distribution of physicians. The council also should monitor the effect of market forces and changes in the delivery system on the total number of physicians and the balance of generalists and specialists. In the context of these analyses, the council should set voluntary targets for the total number and specialty distribution of training positions. In identifying national goals, the council should make judgments regarding the appropriate physician-to-population and generalist physician-to-population ratios and the appropriate ratio of generalist-to-specialist training positions, including the specialties to be

defined as "primary care". Appropriate organizations should have the opportunity to review the council's research and report and to submit comments to the council prior to its publication.

The primary purpose of the council's report would be to provide its annual assessment of workforce needs in an evolving delivery system and whether adequate progress was being made toward achieving appropriate goals for the total number of residency positions and for the balance of generalist and specialist physicians. The council could conclude that market forces had begun, or could be reasonably anticipated, to change the number and specialty mix of the physician workforce in a manner consistent with national goals. Or the council could conclude that adequate progress had not been made and it could decide to implement a regulatory approach to physician training.

Whether market forces or regulation reshape the nation's workforce, the AAMC firmly believes that an all-payer national fund, separate from patient care revenue, must be established to fund the full costs of graduate medical education. Without an all-payer fund, the AAMC would consider a regulatory system for the physician workforce to be inappropriate.

If the council were to decide that the regulation of physician workforce training would be necessary, how a regulatory process would be implemented would need to be explored in greater depth. To this end, the council should be required to submit a special report, within eighteen to twenty-four months after passage of the legislation, to the five Congressional committees with jurisdiction over workforce issues and to the committees with jurisdiction over the Department of Veterans Affairs. It would describe how a regulatory system might work if it is needed at a future date and would make recommendations regarding the:

- appropriate total number of residency training positions and a proposed methodology for adjusting the total number;
- timetable for achieving the desired total number and specialty balance of residency training positions; and
- methodology for allocating positions by specialty.

Because this report would address complex, fundamental issues and would likely reveal unintended consequences of changing the physician workforce, the AAMC believes that the Congress should be given an opportunity to review the council's report and recommendations, receive public comment, and modify how a regulatory process, if needed, should be implemented.

The Impact of Delivery Reform on the Physician Workforce. The AAMC believes that a regulatory approach to physician workforce training may not be necessary. Changes in market forces already are shifting the balance of generalist and specialist physicians as incentive systems are restructured, and it appears likely this trend will continue. Changes in the practice environment, namely the increase in managed care arrangements, increases in physician reimbursement for primary care services, and mitigation of the "hassle factor" are also likely to affect medical students' career choice.

Although data on medical students' career choice from as recently as the graduating class of 1989 show a declining selection of the generalist specialties, more recent data give the AAMC and the academic medical community signs that 1993 medical school graduates have noticed the changes in the environment. Last year, for the first time in more than ten years, the percentage of medical school graduates indicating their intention to pursue certification in one of the generalist disciplines increased. Of graduating medical students, 19.3 percent indicated an intent to choose a generalist career in 1993 compared to 14.9 percent in 1991 and 14.6 percent in 1992.

Data from the National Residency Matching Program (NRMP), released on March 16, 1994, also are encouraging. The number of U.S. senior medical students who "matched" into family medicine residency programs reached a record high of 1,850 in 1994. This result continued the upswing that occurred in 1993, reversing a six-year decline, from 1987 to 1992, in the percentage of total applicants that matched into family medicine. It is more difficult to interpret the "match" data for the disciplines of internal medicine and pediatrics. Many applicants who match successfully in the first-year of the training programs in these two disciplines choose subspecialties at the end of their three-years of general training. Other individuals who enter internal medicine or pediatrics are satisfying first-year training requirements for other specialties, such as dermatology or anesthesiology. Nevertheless, the number of U.S. seniors who matched into "primary care track" internal medicine and pediatrics programs, a label that is self-designated by individual programs, continued to increase in 1994. Training institutions have responded to changing needs in the health care system. Almost one-quarter of all internal medicine programs now offer a specialty track dedicated to primary care training, and the number of first-year positions available to residents in primary care track internal medicine has increased 42 percent since 1990.

Because it is likely that a regulatory process would cause many unanticipated and unintended consequences, one way to limit the number of residents and shift the specialty mix would be to encourage voluntarism among the specialties before adopting a regulatory approach to workforce planning. As part of the initial findings to be included in its annual report, the national council, early in its operations, could designate national goals or targets for each specialty. With a data collection process already in place, the council could analyze data on residency training and publish the results. The academic community could then determine its own methods for reaching the goals. Transition payments could provide an incentive for hospitals to adjust their residency programs' size and specialty mix.

Whether the specialties could meet these targets in the current legal environment, however, is unclear. Particularly in the area of workforce planning, and in many other areas as well, where societal needs might be better and more efficiently met by a coordinated effort among academic institutions and health care organizations, the constraints of antitrust legislation and the uncertain parameters developed by the Federal Trade Commission and the Department of Justice need to be reconsidered and modified. Wherever institutions, professionals, or professional societies might be regarded as actual or potential economic competitors, the current state of the law often precludes private sector efforts, and forces constructive initiatives to be the sole province of government. Thus, to accomplish their objectives, proposals to reform the physician workforce and graduate medical education, including the HSA, must address legislatively the boundaries of antitrust law and its enforcement in the health care arena.

If the council concludes that market forces, voluntarism, and individual student preferences have not been effective in shifting the balance of generalist and specialist physicians and in achieving appropriate goals for the total number of residency positions, then the AAMC would support a regulatory approach to physician training under certain conditions. The national council could assume responsibility for authorizing payment from the existing all-payer fund to assure that national goals are met. Any regulatory approach also must address a methodology for establishing the total number and specialty mix of residency training positions through a process that allows for gradual change and is equitable in terms of how positions are allocated.

The Total Number and Specialty Distribution of Residency Positions. Some proposals to reform graduate medical education, most notably those of Senators Rockefeller and Breaux, PPRC and COGME, would limit the total number of residency positions to 110 percent of U.S. allopathic and osteopathic medical school graduates. While the association does not oppose a limit on the total number of residency positions, we do not believe it should be specified in statute. The AAMC believes that many unintended consequences could result from imposing a specific limit and urges that the national council be given the authority to determine the appropriate total number of training positions if a regulatory process is judged to be necessary.

Under a regulatory system, the AAMC would support an approach, such as the one described in the HSA, which would authorize (but not require) the national council to reduce the number of positions by a percentage that it would determine through analysis. We would expect that, as stated in the HSA, the total number of training positions would bear a relationship to the annual number of U.S. allopathic and osteopathic medical school graduates. We also believe that residency positions related to research training should receive special consideration in the workforce planning process. The national council should consider a variety of other factors in setting the aggregate number. The AAMC agrees with the administration and the proposals of Senators Rockefeller and Breaux that in designating the annual number of positions, it would be desirable to consider the current and future distribution of practicing physicians in urban and rural areas, the incidence and prevalence of diseases associated with particular specialties, and the need for health care services. But simply increasing the number of generalists won't solve the problem of the geographic maldistribution of physicians. The AAMC believes that a whole range of incentives aimed at individuals must be offered, such as offering bonus payments to practicing physicians as proposed in the HSA, and addressing the problems of isolation and spousal employment.

Although the AAMC recognizes that there is a need to adjust the size and specialty mix of the physician workforce, the training period for physicians is long. Any adjustments in aggregate and in specialty-specific training capacity should be carefully planned and coordinated so that the quality of the educational experience will not be diminished and that teaching hospitals and training programs will be able to adapt to the requirements of a regulatory system. The regulatory process would be the subject of the special report described earlier and would address among other factors a methodology for allocating positions by specialty. The association believes that the council should be given the flexibility to study and evaluate a variety of allocation approaches, including national, regional, local and "blended" or combination methods. If an allocation method is implemented, the council should consider the positions of independent and governmental organizations in making its allocation determinations. The council's annual allocation decisions should be binding unless the overall proposal is rejected by the Congress.

The AAMC believes that allocation decisions by specialty should be based on a variety of factors. Among the factors specified in the HSA are the historic geographic distribution of training programs, quality, underrepresented minority groups, and the recommendations of private health care and consumer organizations. The AAMC also supports considering underrepresented minority groups in position allocation decisions. The association has implemented an initiative aimed at increasing the number of underrepresented minorities who apply to medical school. Called 3000 X 2000, our goal is to have 3,000 individuals in underrepresented minority groups in the entering class that enrolls in U.S. medical schools in the year 2000.

Designing a regulatory system for physician workforce training will be difficult. Graduate medical education is complex. It is the period of formal education in clinical practice that begins with graduation from medical school and ends with the fulfillment of the requirements for certification in specialty or subspecialty practice. Each of 82 specialties and subspecialties has its own training requirements, and there are nearly 7,000 training programs.

Given the complexity of graduate medical education, any allocation system must be flexible. For example, some specialties or programs require residents to enroll first in a broad-based clinical year of training, often in internal medicine or pediatrics, before entering specialty training. Other trainees, about 6.5 percent of all first-year residents in 1992-93, may enter a first-year residency experience, often referred to as a transitional year, to obtain a broad-based clinical year because they may be undecided about their future discipline. How to count the first, and in some unusual cases a second, transitional year will become an important issue in how positions get allocated by specialty. Other trainees may not complete their training within the minimum required time because they train part-time, share a residency position, interrupt their training for childbearing or other reasons, or change the discipline in which they train. Any allocation methodology must be designed to accommodate these factors.

Allocating residency positions to reach a specified ratio of generalist-to-specialist physicians, as mandated in the Rockefeller/Durenberger bill (S.1315) would be difficult. A review of the concentration of specialties and location of training reveals some important points which can be understood by reviewing Tables 1-5 at the end of this testimony. Residency training is currently offered in 25 specialty and 57 subspecialty areas. While the majority of residents are concentrated in a relatively small number of specialties and states, the remaining residents are widely distributed. Table 1 shows that nearly one-half of all physicians in training are in the specialties of internal medicine, pediatrics and surgery. Table 3 shows that while 48 states have some residents in training, one-half of all residents are trained in seven states: New York, California, Pennsylvania, Texas, Illinois, Ohio and Massachusetts. Policy makers will have to consider carefully the impact of proposed policies on both the large concentrations as well as the broader distribution in designing an allocation system.

Timing and Implementation. The AAMC is concerned that the timetables for implementing physician workforce reform, as set forth in many of the legislative proposals, are too ambitious, and would not allow sufficient time for the national council to become fully operational. Senator Breaux's proposal would place the 110 percent limit mentioned earlier on the total number of residency positions beginning July 1, 1995. The HSA requires that training programs would have to be notified of their approval by July 1, 1997, and the Rockefeller/Durenberger proposal would restrict the aggregate number of training positions to the 110 percent limit as of 1998. If reform

legislation were signed into law in August 1994, the national council would have, from the date it was created (at best), slightly more than two years to establish and organize itself, adopt broad principles and policies for change, and make thousands of allocation decisions.

These "start-up" issues notwithstanding, the AAMC is concerned that proposals to restrict the number of training positions to 110 percent of U.S. allopathic and osteopathic medical school graduates by a specified date, such as 1995 or 1998, would cause significant disruption in the system. Table 6 shows that the total number of first-year residents is 140 percent of the number of U.S. graduates in 1993 (23,930/17,188), according to AAMC data. Reducing the number of first-year residency positions by about 5,000 would be extremely difficult to do within less than five years.

Table 6
Growth in First-Year Residents in ACGME Programs
by Medical School Origins, 1988-1993

	U.S. Medical School Graduates (1)		U.S. International Graduates (2)		Non-U.S. International Graduates (3)		TOTAL	
Year	Number	%	Number	%	Number	%	Number	%
1988	17,398	83.2%	1,288	6.2%	2,206	10.6%	20,892	100%
1989	17,516	80.6%	1,317	6.1%	2,893	13.3%	21,726	100%
1990	17,616	77.7%	1,425	6.3%	3,629	16.0%	22,670	100%
1991	17,066	77.1%	1,251	5.7%	3,815	17.2%	22,132	100%
1992	16,779	73.3%	1,184	5.2%	4,915	21.5%	22,878	100%
1993	17,188	71.8%	1,150	4.8%	5,592	23.4%	23,930	100%

(1) Graduates of the LCME-approved U.S. and Canadian medical schools and U.S. osteopathic schools of medicine. There were 100 Canadian graduates in ACGME residencies in 1992-93; other years include similar numbers.
(2) U.S. citizens who are graduates of foreign medical schools.
(3) Graduates of foreign medical schools who are not U.S. citizens.

SOURCE: Association of American Medical Colleges GME Tracking Census, SAIMS Database, 1993

Under a regulated system, the national council could establish a mechanism to reduce gradually the total number of residency positions beginning in academic year 1998-99. The initial decision, and a particularly difficult one, would be how to reduce the number of training positions across specialties. Any reduction should be phased-in over a period no shorter than five years so that sponsors of training programs and teaching sites could devise and implement their own strategies for adjusting their training program size and mix. The provision of a transition period would give institutions the flexibility to determine how to achieve the phase-down or closure of a training program as long as they achieved the goal by the end of a specified time period depending on the specialty. A series of annual decisions would cause significant disruption and uncertainty by requiring institutions to respond incrementally. The AAMC also recommends that transition funds should be available immediately to institutions on a flexible basis so that institutions could facilitate changes in the size of their training programs.

In its 1994 report to the Congress, the PPRC recommends that reducing the aggregate supply of physicians, by limiting overall residency positions, "should take priority over attainment of specialty goals." The following example shows the difficulty of trying to achieve the two objectives simultaneously. Table 7 below uses 1992-93 data to demonstrate how the number of generalist and specialist first-year positions would change if these limits were placed on the total number of residency positions. At the same time the council would adjust the specialty mix of first-year positions to a 55/45 generalist-to-specialist ratio, the council also would begin to reduce the total number of residents in 1998-99 for the first reduction over a five-year period (through 2002-03). Assuming a policy of first-year positions equal to 110 percent of U.S. allopathic and osteopathic medical school graduates, the national council would be placed in the position of advocating or directing an increase in the number of generalist positions, only to have to eliminate some of them later to achieve a reduction in the overall number of first-year residency positions. In this example, the overall limit is 18,660 positions, roughly the number of graduates of U.S. allopathic and osteopathic medical schools plus ten percent. This example assumes that the 110 percent goal of 18,660 first-year positions would be reached in 2002-03 through a gradual, annual reduction of about 850 positions over a five-year period beginning with the 1998-99 entering residency class.

Table 7
An Example of Adjusting Total First-Year Residency Training Positions: Reducing the Total Number to 110 Percent of 1992-93 Graduates While Maintaining a 55/45 Ratio of Generalists to Specialists

	Current (1992-93) Filled First-Year Positions	--	1998-99	1999-2000	2000-01	2001-02	2002-03
Total	22,905	--	22,056	21,207	20,358	19,509	18,660***
Generalists*	7,817**	--	12,131	11,664	11,197	10,730	10,263
Specialists	15,088	--	9,925	9,543	9,161	8,329	8,397
LCME + Osteo Grads + 10%	18,662	--					

*Generalists include residents in family medicine, general internal medicine, general pediatrics and obstetrics/gynecology.
**AAMC estimate of PGY-1 trainees likely to complete training as generalists; proportion applied to current PGY-1 data based on experience of recent years, i.e, outcomes at the conclusion of residency training.
***18,660 total positions in 2002-03 used in this example as the target reflect the recommendations of the Council on Graduate Medical Education and the Physician Payment Review Commission that the total number of positions be reduced to 110 percent of graduates of LCME and AOA approved medical schools.

Source: Association of American Medical Colleges GME Tracking Census, SAIMS Database, 1993.

The Role of Quality in Allocating Residency Positions. Some proposals to reform graduate medical education, most notably those of Senators Breaux and Durenberger (S.1579) and the PPRC, would expand the role of the accrediting bodies by requiring them to make recommendations on the quality of training programs to the national council. While the AAMC concurs that quality should be a major factor in the allocation process, the association has several concerns about the process for stratifying training programs by quality. One is that there would have to be a process in place by which new training programs could enter the system. In addition, there would need to be a process to address fluctuation in individual program quality across years. Educational quality is dynamic. The process and incentives must be in place to motivate the program to improve its quality continuously, rather than simply taking a snapshot of educational quality. Finally, one must make the distinction between the significant reductions in positions that are likely to occur in the first years after the proposed legislation is passed compared to the continuous monitoring of educational quality that will be needed in later years. The decision of whether to eliminate a training program entirely or whether merely to reduce the size of the existing program may require very different approaches.

A large number of professional organizations participate in graduate medical education to provide control over the quality of the training. They determine the standards to be met by each type of specialty training program and assess whether or not individual programs meet the standards. The Accreditation Council for Graduate Medical Education (ACGME) accredits over 7,000 graduate medical education programs in the United States. It is sponsored by five parent organizations, including the AAMC. The ACGME relies on residency review committees (RRCs) to perform the actual review of each training program. A RRC consists of representatives from the specialty appointed by the appropriate specialty certifying board, the American Medical Association, and in some instances, a national specialty society. Residency programs are accredited either by the ACGME upon recommendation of the RRC or by the RRC itself, if the ACGME has delegated authority to it.

Some policy makers have suggested that the ACGME or the American Osteopathic Association's Committee on Postdoctoral Training, which would be separate from the proposed national council, should assume the additional and sole responsibility of allocating positions on the basis of measures of educational quality. The association believes that the medical profession should judge the quality of its training programs, but it has several concerns about the ACGME's ability to differentiate and stratify training programs by educational quality. For example, it is unclear whether the ACGME has the information systems or methodology to quantify educational quality objectively beyond established minimum criteria without the development of very sophisticated new systems and methodologies. Ranking training programs could be highly subjective. In addition, the structure and resource level of the ACGME may be inadequate to undertake this role. Developing and implementing a mechanism to stratify programs by quality certainly would require more staff and financial resources than the ACGME currently has at its disposal. There also would be the need for sufficient time, more than would be provided under most proposals, to develop and test new data collection and evaluation systems.

It is also clear that, if the ACGME were to take on the role of ranking training programs by quality, it and its five sponsoring organizations would need significant legal protection. The ACGME currently relies almost wholly on contributed professional time, and is not structured

to command the resources to deal with the inevitable legal challenges to a ranking process that will accumulate over time.

The role of quality in the allocation process and the method of measuring program quality are difficult issues. While the AAMC's current position is that the ACGME should not assume responsibility for allocation or ranking, the association also recognizes that there are strong arguments favoring some greater level of participation by the ACGME in an allocation process. The AAMC and other sponsors of the ACGME are currently evaluating an ACGME proposal on how the ACGME could effectively and appropriately participate in allocation activities.

The Role of Graduate Medical Education Consortia. The AAMC strongly supports the formation of graduate medical education consortia as organizations to assure the continuity of medical education and to serve as the focal point for collaborative decision making and resource allocation regarding graduate (and undergraduate) medical education. In February 1994 the AAMC reaffirmed its support of a consortium as "represent[ing] an effective means of accomplishing the tasks and processes required for graduate medical education programs of the future." The association also believes that ideally one or more medical schools should participate in each consortium and should have a partnership role in assuring the quality and composition of the physician workforce.

The AAMC is about to release the results of a national study it conducted on existing consortia. Among the findings is that while consortia are promising innovations and are featured prominently in many proposals to reform graduate medical education, they are far from well-established. Existing consortia seem to be ideal vehicles for maintaining the pluralism and diversity of the current system of graduate medical education, but differ markedly in many respects, particularly regarding their structures and functions. Whether each consortium would have to meet identical workforce goals and how its governance is structured will be the focus of discussion. The AAMC is pleased that COGME is addressing many of the structural and governance issues that need to be debated, and looks forward to their report. In the meantime, the AAMC continues to encourage medical educators to form consortia and views the voluntary, provider-initiated demonstration projects as outlined in the Chafee/Dole bill (S.1770) as one approach that could be tried. These voluntary, provider-initiated demonstrations could be effective as a means of educating policy makers about what kinds of incentives and behaviors might affect workforce development in a positive way, making a regulatory approach unnecessary for the nation.

Physician Workforce Financing. Without funding contributions from all payers to a separate account for physician workforce training, reform of graduate medical education would be difficult to accomplish. Several proposals to reform graduate medical education rely solely on Medicare funding to achieve their objectives. The AAMC strongly supports proposals to create an all-payer fund for physician training costs, such as those made by the HSA and Senator Breaux. The association has long held the position that all payers should continue to provide their appropriate share of support for graduate medical education. Until recently, most sponsors have been able to cover the cost of medical education through explicit payments for these costs from the Medicare and some Medicaid programs, state and local government appropriations, and from higher charges paid by private insurers. The AAMC and its constituents recognized that governmental and third-party payers are becoming more price sensitive as they attempt to reign

in health care costs and limit their support of the educational mission. In 1993 the AAMC adopted the position that an all-payer fund for the financing of graduate medical education, separate from the patient care revenue, should be established.

The national all-payer fund should be funded adequately and it should reflect the total direct costs of graduate medical education. The pool should include not only residents' stipends and fringe benefits, but faculty supervision expense, applicable benefits, direct overhead costs such as the salaries and benefits of personnel assigned to the support and management of the graduate medical education office, and allocated overhead costs such as maintenance and electricity, and the effect of inflation. The Health Security Act is the only legislative proposal that identifies a specific dollar amount for the physician workforce account. As such, it provides the appropriate basis for addressing the adequacy of available funding. According to the HSA, the account would be funded at $3.2 billion in Calendar Year (CY) 1996, the first-year of implementation; $3.55 billion in CY 1997; $4.8 billion in CY 1998; and $5.8 billion in CY 1999 and CY 2000 (no inflation is provided between 1999 and 2000). The $5.8 billion in 1999 would be the equivalent of $4.8 billion in 1994 dollars. Currently the Medicare program pays about $1.7 billion for the direct costs of graduate medical education. After CY 2000, the $5.8 billion would be increased by the general health care inflation factor

The AAMC is concerned that, as currently specified, the amount of money in the HSA's workforce account is not adequate. According to preliminary calculations by the AAMC and others, the workforce account will require between $7-8 billion in the year 2000, which is the equivalent of $6.8 billion in 1994. It is our understanding that the lower funding level specified in the HSA results from an estimate using only the national average resident's stipend and fringe benefits and an estimated salary and fringe benefit amount for faculty supervision and no direct or allocated overhead costs. We also believe that the faculty salary portion of the per resident amount was calculated in a manner that differs from the approach described in the HSA. It is our understanding that the faculty salary portion was based on taking 10 percent (using a ratio of ten residents for every supervising faculty member which is far too high for many specialties) of the amount allowed by the National Institutes of Health for physicians' salaries ($125,000 per year). As specified in the HSA, the per resident payment rate should consider the "average costs of providing faculty supervision."

The HSA workforce account does not include financing for the 8,500 residency positions which are currently funded by the Department of Veterans Affairs. It also appears to exclude payments for podiatry, oral surgery or general dentistry residents, for whom the Medicare program currently pays its proportionate share. In addition, the dynamics of how the regional and corporate alliances would participate in financing these costs are not well understood, including how these entities contribute to the workforce account and at what level. The AAMC understands that there is an error in the bill in the level of funding provided in CY 1998, the first full-year of implementation. The account is currently funded at $1 billion less than the HSA proposes for full funding. A fully-funded workforce account of $5.8 billion in CY 1998, and updated for inflation in CY 1999, would be essential.

The Entity That Receives the Payment. To encourage the development of ambulatory training sites, innovation, and collaborative efforts, the AAMC believes that payments for the direct costs of graduate medical education should be made to the entity that incurs the cost of training. The

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AAMC does not support payments being awarded directly to training programs as proposed in the HSA and by ProPAC. The AAMC recognizes that the need for more and well-trained generalist physicians will require a transition from education in hospital inpatient settings to new training sites, such as outpatient clinics, physicians' offices and nursing homes. Because local circumstances and arrangements for graduate medical education are diverse, the entity that incurs the training cost may be a teaching hospital, medical school, consortium, or multi-specialty group practice. Any entity, including a graduate medical education consortium, could serve potentially as the fiscal intermediary in distributing payments across various training sites. Any of these entities that incur training costs could apply to receive payments from the national all-payer fund. An applicant, for example a consortium, should be required to:

- submit a written agreement, signed by all participants in the organization, which shows that all parties agree on the distribution of these payments, as specified in the application, and

- agree to submit additional documentation to demonstrate that the funds are being distributed in a manner agreed upon by all parties.

The data collection and monitoring process (described earlier) could serve as a mechanism for distributing payments from the national all-payer fund.

Payment Methodology. As mentioned earlier, the AAMC is concerned about the adequacy of a proposed payment which excludes direct overhead costs, such as malpractice costs, and the salaries and benefits of administrative and clerical support staff in the graduate medical education office, and allocated institutional overhead costs, such as costs for maintenance and utilities. The AAMC believes the level of payment should recognize all types of costs, including both types of overhead costs. In particular, direct overhead costs are legitimate educational costs that should be recognized and included in a payment system for graduate medical education.

The AAMC also is concerned about the use of a national average payment methodology, as described in the HSA and Senator Breaux's proposal, and its redistributional effect across institutions. The association supports the continuation of a payment method based on hospital-specific costs, as prescribed in the Rockefeller/Durenberger (S. 1315) and Chafee/Dole (S.1770) bills. The overall financing of teaching hospitals and medical schools often is driven by historic circumstances, which have led to certain costs, especially faculty costs, being borne by the medical school, or in some cases, the teaching hospital. The diversity of faculty costs is probably the most important reason for the variation in Medicare per resident payments. Additionally, there are legitimate differences in educational models depending on the specialty and the institution. Residency programs also may have unique histories and differences in the funding available to them, such as state or local government appropriations. While the HSA and Senator Breaux's proposal require the national average payment to be adjusted to reflect regional differences in wages and wage-related costs, these other structural factors would not be reflected in their proposed national average payment methodology, creating winners and losers inappropriately.

While the Physician Payment Review Commission restated its belief in its April 1994 report to the Congress that payments for graduate medical education should be set prospectively rather than

based on historical costs, it expressed concern about the administration's proposed methodology. The commission said that the "methodology may not recognize legitimate differences in the costs of training. The development of adjusters that acknowledge these variations warrants further attention."

At its January 20, 1994 meeting, the Prospective Payment Assessment Commission discussed recommendations on graduate medical education financing for its March 1994 report. The commission reviewed a staff analysis of graduate medical education costs and payments and noted the complexity of the distribution of these payments to hospitals. Chairman Stuart H. Altman, Ph.D., cautioned against moving to a national average payment methodology for residency costs without incorporating a number of adjustments in the payment system. Pointing to the commission's eleven-year experience with the prospective payment system--the first attempt by the federal government to standardize payments based on national averages--Dr. Altman noted how many adjustments had been added to the PPS over the years to achieve payment equity. ProPAC's preliminary analysis of graduate medical education costs found significant positive relationships between per resident costs and hospital size; its share of full-time equivalent residents in the outpatient setting; its share of costs related to faculty physicians' salaries; geographic region; location in a metropolitan statistical area; and area wages.

The AAMC believes that since the HSA imposes an overall limit on the amount available for workforce funding, other payment policy options, which would distribute the funds more equitably among training sites, should be explored. The AAMC recommends that the national council should be required to conduct a study, funded separately from the workforce account, to review the national payment method. The AAMC intends to pursue the development of alternative payment proposals that would recognize the significant diversity across institutions that participate in graduate medical education. We would be pleased to share our payment policy proposals with members of the committee and with the administration.

Medicare Participation and Transition to a National All-Payer Fund. Under the HSA, Medicare payments for the direct costs of graduate medical education would terminate for cost report periods beginning on or after October 1, 1995. The AAMC believes that separate Medicare payments should continue to flow to teaching hospitals in 1996 and 1997. The separate Medicare payments would be made using the current per resident methodology and the current payment level adjusted for inflation in 1996 and 1997 and would be made to teaching hospitals that now receive funds for direct graduate medical education regardless of whether the hospitals are in participating or nonparticipating states. In participating states, entities that receive Medicare support for direct graduate medical education would receive additional payments from the newly created, all-payer workforce account, which would contain the contributions of regional and corporate alliances. In nonparticipating states, entities would receive payments only from the Medicare program. Or if they served significant numbers of patients from participating states, the Secretary of the DHHS could make exceptions for additional payment from the all-payer fund. Beginning January 1, 1998, the first full-year of implementation, all entities would receive payments from the national all-payer fund to which the Medicare program would contribute its proportionate share. The transition between the end of Medicare payments for direct graduate medical education costs and the beginning of payments from the workforce account should be adjusted, depending on the hospital's fiscal year end and

its relationship to the start of the calendar year. No gap in available funding should occur as a result of the timing of the contributions to the all-payer fund.

The AAMC concurs with Senators Rockefeller, Durenberger, Chafee and Dole that Medicare payments should be available to non-hospital residency training sites. Current Medicare payment rules mandate that payments for direct graduate medical education costs be made only to hospitals. The association believes that the program rules should be modified to allow non-hospital, ambulatory training sites or organizations formed to train physicians, such as consortia, to receive payments based on a methodology developed by the council. Payments should be made to the entity that incurs the cost of training.

Transition Payments for Hospitals that Lose Residency Positions. The AAMC supports the HSA provision to make transition payments available to institutions that lose residency positions. However, the association is concerned about their timing and their adequacy. To encourage institutions to adjust the size and mix of their training programs, transition funds should be made available as soon as the national council is operative. The HSA now states that these payments would not be available until CY 1997. Additionally, there should be some flexibility in how these payments are used so that institutions could try different approaches. The AAMC also is concerned that because an institution could apply only one time to receive payments, it would be locked into a four-year period during which it could become even more disadvantaged if further reductions in positions were imposed after the institution's application. Additionally, because these payments would be determined using only the national average salary of a resident, they will not provide enough relief. Some hospitals may still be unable to attract highly skilled non-physician practitioners or community physicians as substitutes for residents, particularly in inner city areas. Further, highly skilled non-physician practitioners are paid more than residents and will require physician supervision. These additional costs are not included in the transition payment amount. If a hospital replaces residents with non-physician practitioners, the salaries and supervisory costs of these non-physician professionals become permanent, not transitional, costs to the institution.

Support for Graduate Nurse Education and Other Workforce Provisions. The AAMC supports many of the non-physician workforce proposals included in legislation to reform physician training. Funding for other health professionals-nursing and allied health--through the continuation of Medicare hospital payments, targeted grants, funds for physician training and distribution and through other authorized programs--should be maintained and enhanced. The AAMC believes that the levels of funding in the HSA, specifically the $200 million fund for graduate nurse training programs, and for other activities are appropriate and adequate.

How the costs of training general dentists, oral surgeons and podiatrists are paid under the HSA is not clear. Currently the Medicare program pays their costs through the per resident payment amount. The AAMC believes that the costs associated with these trainees should be paid from the workforce account and the level of the account should reflect their inclusion.

Academic Health Center Recommendations

The Academic Health Center Provision in the Health Security Act. Historically, the higher costs associated with the missions of academic medicine generally have been recognized and paid

for by private and public payers. Many private payers have paid higher rates to teaching physicians and teaching hospitals for patient care services. But in an environment of increasing price competition and escalating federal and state budget deficits, teaching physicians and teaching hospitals will not be able to obtain payments that reflect the higher costs associated with the academic missions.

The AAMC is particularly pleased that one proposal, the HSA, recognizes that the critical roles and additional missions of academic health centers and teaching hospitals increase their costs, making them non-competitive in a price sensitive environment. As introduced, the HSA would require the federal government to make payments to academic health centers and teaching hospitals to "assist eligible institutions with costs that are not routinely incurred by other entities in providing health services, but are incurred...by virtue of the academic nature of such institutions." The HSA defines an "academic health center" as an entity that operates a school of medicine or osteopathic medicine; operates or is affiliated with one or more other health professional training schools or programs; and operates or is affiliated with one or more teaching hospitals. A "teaching hospital" is a hospital that operates an approved physician training program.

An All-Payer Fund for Academic Health Centers. The AAMC strongly agrees with the HSA's underlying policy to require all insurers and sponsors of patient care programs to support the missions of academic medicine. The AAMC wishes to emphasize the importance of the fundamental principle that all payers must support not only educating and training the workforce, but providing an environment in which education, clinical research, and service to special populations can flourish.

But while the association is pleased that the HSA would create a separate fund for the costs associated with the academic mission, the proposal is unclear regarding the purpose and the rationale of the fund, and creates expectations that are not forthcoming in terms of what entity gets the payment. Much of the confusion arises from comparing this fund and its rationale with the Medicare IME adjustment and its purpose in the prospective payment system. The confusion is only compounded because the HSA calls for the elimination of the Medicare IME adjustment beginning in Federal FY 1996 and then would require the program to contribute to the academic health center account thereafter. However, the purpose of the academic health center account--reduced productivity of faculty, uncompensated costs of clinical research and exceptional costs of specialized treatment--differs from the broad rationale behind the Medicare IME adjustment for inpatient hospital costs.

The AAMC believes that in confusing the purpose and rationale of the fund, the HSA fails to account adequately for the costs of the academic mission. Policy makers should note that no health care reform proposal addresses the need to recognize and pay for the medical school costs associated with adapting to a price sensitive delivery system and accepting new and changing educational responsibilities. To remedy this shortcoming, the AAMC recommends that while the title of this section should remain, the Academic Health Center (AHC) section of the HSA (Title III, Subtitle B) should be re-drafted to create two funds. One fund constitute an all-payer pool to assist medical schools in meeting their academic responsibilities, including the education of high quality physicians, in an era of health care reform. The other fund would be an all-payer equivalent in purpose to the Medicare IME adjustment, and would make payments to teaching

hospitals to help "level the playing field," thus enabling them to compete in a price sensitive environment .

A Fund for Medical Schools. The AAMC is concerned about the ability of medical schools to maintain and enhance the support of physician education, particularly at a time when medical schools and teaching physicians are being called on to transform the medical education system from one that focuses on specialist training in hospital inpatient settings to a more expensive system of generalist training in ambulatory, non-hospital sites. The association calls for the creation of a separate fund to assist allopathic and osteopathic medical schools in meeting their academic responsibilities and in maintaining an infrastructure for education and research.

To a significant degree, medical schools, like teaching hospitals, finance educational and research activities through a complex system of cross-subsidization. Education, research and patient care exist as joint products. Directed by the medical school, undergraduate medical education in the clinical setting is not recognized explicitly by any payment system, but like other academic costs, a portion has been financed indirectly by clinical income. Undergraduate medical education is supported partially and directly by tuition and fees and state appropriations (primarily at public institutions). Table 8 on the following page shows that these sources of support accounted for 4.1 percent and 11.5 percent, respectively, of total medical school revenues in 1991-92.

Research is supported predominantly by federal grants and contracts, but state and local grants and contracts and the private sector also provide support. Philanthropies supplement these sources, but by themselves these funds cover only a portion of the costs of research. Hospitals also support medical schools by paying for services performed by their faculty and staff on behalf of the hospitals. Of total medical school revenue, reimbursements from hospitals have increased from 6.2 percent in 1980-81 to 11.4 percent in 1991-1992. Grants and contracts for specific types of medical services represented about 3.3 percent of total medical school revenue in 1991-92.

Education also depends on a system of nonpaid voluntary faculty drawn from the community. But as community physicians are forced to align with various health plans in integrated networks, their ability to "contribute" teaching services is being threatened. Medical schools, because of declining revenue, will not have the ability to compensate these physicians for the additional contributions to professional education asked of them.

The current educational and research output of the nation's medical schools relies on significant revenues from the delivery of medical services by the faculty of the school. Revenue from the clinical faculty practice plan constituted 32.4 percent of total medical school revenue in 1991-92; in 1980-81, only a decade earlier, medical service revenue contributed less than one-half this amount, 15.7 percent of the total.

Managed competition, the fundamental premise on which the HSA and Senator Breaux's proposals are based, will have a profound effect on the financing system of medical schools. For several reasons, medical schools will be unable to sustain the system undergirding the education and research missions. Pressures brought to bear on medical service costs will likely lead to declining contributions to the medical school from the faculty clinical practice, and less money will be available to support educational and research efforts at the school.

TABLE 8
REVENUES
U.S. MEDICAL SCHOOLS
(DOLLARS IN MILLIONS)

	1980-81		1991-92	
Fully Accredited Schools	116		126	
Number of Schools Reporting	123		126	
	Amount	% of Total	Amount	% of Total
GENERAL OPERATING REVENUES*				
Federal Appropriations	57	0.9%	105	0.5%
State & Local Government Apropriations	1,351	20.8%	2,662	11.5%
Appropriations	1,252	19.3%	2,523	10.9%
Subsidies	99	1.5%	139	0.6%
Recovery of Indirect Cost	445	6.9%	1,516	6.5%
Federal Government	409	6.3%	1,309	5.7%
State & Local Government	10	0.2%	32	0.1%
Non-Government	26	0.4%	175	0.8%
Medical Service Plans	1,020	15.7%	7,505	32.4%
Tuition and Fees	348	5.4%	955	4.1%
Endowment (1)	110	1.7%	401	1.7%
Gifts (2)	46	0.7%	509	2.2%
Parent University Funds	113	1.7%	208	0.9%
Reimbursements from Hospitals	404	6.2%	2,640	11.4%
Miscellaneous Sources	172	2.7%	957	4.1%
Total General Operating Revenues*	4,066	62.7%	17,458	75.4%
GRANTS AND CONTRACTS				
Research	1,340	20.7%	3,705	16.0%
Federal Government	1,098	16.9%	2,787	12.0%
State & Local Government	21	0.3%	101	0.4%
Non-Government	221	3.4%	817	3.5%
Teaching & Training	397	6.1%	533	2.3%
Federal Government	277	4.3%	317	1.4%
State & Local Government	35	0.5%	67	0.3%
Non-Government	85	1.3%	149	0.6%
Service & Multi-Purpose	491	7.6%	763	3.3%
Federal Government	124	1.9%	181	0.8%
State & Local Government	265	4.1%	382	1.6%
Non-Government	102	1.6%	220	1.0%
Research & Teaching/Training Programs at Affiliate Institutions	188	2.9%	688	3.0%
Total Grants and Contracts	2,416	37.3%	5,689	24.6%
TOTAL REVENUES	6,482	100.0%	23,147	100.0%

(1) Includes unrestricted and restricted endowment
(2) Includes one provisionally approved school
* Detail may not add due to rounding.

SOURCE: LCME Questionnaire, Part I-A, Section for Operational Studies.

The Medicare Part B proposals in the HSA, offered as FY 1995 budget savings to finance health care reform, are illustrative. Three proposals would particularly disadvantage physicians in teaching settings who routinely care for severely ill patients:

Limit Payments to High-Cost Medical Staffs. This proposal, effective in 1998, would establish limits on Medicare physician payments per inpatient hospital admission. At the beginning of each year, Medicare would establish a 15 percent withhold for medical staffs projected to be over the national limit of average relative value units (RVUs) adjusted for hospital case mix. After the end of each year, the Medicare program would compare the actual RVUs per admission per hospital to the limit for that year. For medical staffs above the limit, either none or only a portion of the withhold would be returned. Those medical staffs below the limit would receive their entire withhold. Projected savings for 1996-2000 are $2.320 billion.

The AAMC expects that this proposal would have a significant negative impact on teaching physicians. Although academic physicians provide substantial amounts of ambulatory care, they are predominantly inpatient providers, often delivering high cost, tertiary services and using new and sophisticated technology.

Reduce the Medicare Fee Schedule Conversion Factor by 3 Percent in 1995, Except Primary Care Services. This proposal would reduce the dollar amount that converts the RVUs into the payment amount for each service. Projected savings for 1995-2000 are estimated at $2.975 billion.

While the AAMC agrees with protecting payments for primary care services, equitable payment must be assured across specialty services as well. This proposal would likely reduce the ability of faculty in the non-primary care specialties to contribute the time necessary to teach the next generation of physicians.

Rates for Office Consultations. This proposal would increase payments for primary care services without changing Medicare spending, by reducing rates for office consultations and increasing fees for all office visits by 10 percent. The RVUs for office consultations would be redistributed to office visits.

This proposal would affect particularly subspecialist physicians in academic settings who tend to perform consultations more often than primary care physicians.

In addition to these proposed changes in the Medicare program, it is anticipated that competitive market forces will pressure academic physicians to accept capitated payments, discounted fee-for-service and other managed care arrangements which will offset any anticipated gains due to expanding insurance coverage. If adopted under the HSA as part of the 1995 Federal budget, these Medicare savings proposals together would further diminish the potential for the clinical practice plan to maintain its contribution to the medical school in support of its infrastructure costs.

Fundamental forces are causing the traditionally cross-subsidized products to rise to the surface, but the HSA has not provided assistance all arenas. The AAMC believes that a complete and adequate financing system for academic medicine must be provided through the creation of a separate fund for medical schools to which all public and private payers would contribute.

While the consequences of these changes in medical school financing are predictable, their magnitude is uncertain. The AAMC proposes a study by an independent analytic body, such as the Institute of Medicine, Physician Payment Review Commission, RAND or other similar organization, that considers the impact of health reform and market competition on medical school financing. The study, which should be completed by July 1, 1995, should determine the appropriate size and availability of the fund and the methodology for distributing the payments. The results of the study would be used to determine the level of funding for this account, and all payers would contribute to the fund beginning January 1, 1996, or whenever the all-payer system is established. Preliminary calculations by the AAMC estimate that a fund for medical schools should be between $1 and $1.5 billion.

The study should assess the impact of a price sensitive environment on medical school financing. It should identify ways in which the current system, particularly clinical practice, explicitly supports academic functions; quantify the ability of medical schools to finance their academic activities in a price competitive system, taking into account both the losses due to declining fees and service volume and gains due to universal coverage; and identify the costs of required educational innovations. The study also should examine the impact of teaching responsibilities on the productivity of faculty and the costs associated with transforming the medical education system from a hospital inpatient-based experience to one based on training in ambulatory, non-hospital sites, and the uncompensated costs of clinical research. The study should recommend a method for distributing the funds to medical schools, for example through grants or capitated payments.

The Medicare Indirect Medical Education (IME) Adjustment. Since the inception of the prospective payment system (PPS), Congress has recognized that the additional missions of teaching hospitals increase their costs and has supplemented their Medicare inpatient payments with the indirect medical education (IME) adjustment. While its label has led many to believe this adjustment to the Diagnosis-Related Group (DRG) payments compensates teaching hospitals solely for graduate medical education, its purpose is much broader. The Senate Finance Committee specifically identified the rationale behind the adjustment:

> This adjustment is provided in light of doubts...about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents...the adjustment for indirect medical education is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals (Senate Finance Committee Report, Number 98-23, March 11, 1983).

Some proposals to reform the health care system, notably those of Senators Breaux (S. 1579) and Wellstone (S.791), would eliminate altogether separate Medicare IME payments. The HSA would eliminate the IME adjustment to PPS payments, but then would require the Medicare program to contribute to an Academic Health Center account at a level that would be substantially less than the current adjustment. These policy makers maintain that the entire IME adjustment, or at least a significant portion of it, is currently intended to help defray uncompensated care costs. They argue that in a reformed health care system, in which there are fewer uninsured or underinsured individuals, teaching hospitals' burden of uncompensated care would be reduced, and would justify the elimination or significant reduction of IME payments.

While the academic medical community understands the need and commitment by the administration and the Congress to expand insurance coverage to all Americans without increasing the Federal budget deficit, the AAMC vigorously opposes any attempt to repeal the Medicare IME adjustment. The association has noted repeatedly that the purpose of the IME adjustment, as set forth in the above cited committee report language, is not to provide financing for uncompensated care, but to recognize factors that increase costs in teaching hospitals. Analysis by government and private researchers has consistently shown an empirical basis for a differential payment to teaching hospitals based on their true and legitimate costs. The justification for a special adjustment for these institutions traces back to the Medicare routine cost limits of the late 1970s and the inception of the PPS in 1983. Even when the health care system is reformed to provide comprehensive insurance coverage and access, legitimate cost differences between teaching and nonteaching hospitals will continue to exist.

In recent years, Congress and the Prospective Payment Assessment Commission have indicated that the level of the IME adjustment should reflect the broader mission and overall financial viability of teaching hospitals to assure access and quality of care for Medicare beneficiaries and other patients. Both bodies have indirectly considered uncompensated care losses in establishing the level of the IME adjustment. ProPAC has noted that the total margins of major teaching hospitals are historically lower than other hospital groups and that their overall financial viability, on average, tends to be more precarious than nonteaching hospitals. The commission has tried to assure "rough justice" of total margins among hospital groups. "Rough justice" refers to a policy objective of maintaining the overall financial viability of teaching hospitals as measured by total margins.

For these reasons, ProPAC has urged caution in implementing a precipitous drop in the IME adjustment, and has for several years recommended a gradual reduction of the IME adjustment to its empirical level, with the intent of making annual assessments of teaching hospital financial performance. For FY 1995 the commission has recommended that the adjustment be reduced from its current level of 7.7 percent to 7.0 percent for every 10 percent increase in a hospital's intern and resident-to-bed ratio (IRB). ProPAC's most recent analysis of hospital cost data shows a 5.2 percent difference in operating costs per discharge for each 10 percent increase in the IRB. Under ProPAC's "rough justice" concept, the difference between the current 7.7 percent IME adjustment and the analytically-determined estimate of 5.2 percent is a differential for the broader social goals of maintaining access and quality of care.

The AAMC believes that IME payments should be maintained at their current level, and vigorously opposes any attempt to reduce the current level of the IME adjustment in the absence of comprehensive health care reform legislation which provides insurance coverage to all Americans. A recent AAMC analysis of the importance of the IME adjustment to its member hospitals, shared with ProPAC commissioners, showed that 1993 PPS margins calculated with IME payments but without disproportionate share (DSH) payments, were negative 4 percent. Only after including DSH payments did the average PPS margin increase to a positive 7 percent. Noting this finding, the AAMC urges the Congress to consider carefully the impact of any reduction in the IME adjustment on the financial stability of the nation's teaching hospitals and their ability to assure access to quality care for Medicare beneficiaries and other patients.

Additionally, in its March 1994 report to the Congress, ProPAC "recommends the continuation of the indirect medical education adjustment to PPS payments until an alternative system of compensating appropriately for the higher costs of patient care in teaching institutions is fully operational." The AAMC strongly supports the ProPAC recommendation to continue IME payments to teaching hospitals during the transition to a new system when the Medicare program would begin to contribute its proportionate share to the teaching hospital fund.

With regard to a suggested technical change in the IME adjustment, the AAMC supports proposals made by Senators Rockefeller, Chafee, Dole and Durenberger (S.1315 and S. 1770) to modify the rules for counting residents for purposes of IME payments. The association agrees that the current IME payment rules, which allow only residents in the PPS-related units or outpatient department of the hospital to be counted for IME payment purposes, may be a disincentive to moving residents to non-hospital ambulatory training sites. OBRA 1993 which permits hospitals to count residents in hospital-owned community health centers subject to certain conditions is a positive step. However, the approaches outlined in these two proposals would change the counting rules appropriately to remove barriers to ambulatory training. In making this change, the Congress could allow hospitals to count residents in non-hospital ambulatory training sites for purposes of calculating the IRB in the payment formula, as long as the total number of residents counted by the hospital did not exceed the number it counts currently.

Payments to Teaching Hospitals. To pay for the higher patient care costs of teaching hospitals in an environment of increasing price competition, the AAMC proposes the creation of an all-payer fund for teaching hospitals that is fundamentally similar in purpose to the Medicare IME adjustment, which "levels the playing field" for teaching hospitals by recognizing legitimate differences in patient care costs due to severity of illness, complexity, specialized care and academic activities. The AAMC believes that the language in the HSA should be changed to state clearly that the purpose of the fund is to account for differences in hospital inpatient operating costs between teaching and nonteaching hospitals and that the payment should be made to any teaching hospital that has residents.

In its March 1994 report to the Congress ProPAC supports "the explicit recognition by all payers of the higher patient care costs teaching institutions incur," and recommends "such payments should be separated from patient care rates and paid through a fund similar to the Academic

Health Center Account proposed in the Health Security Act." However, ProPAC raises three concerns about the teaching hospital fund which the AAMC shares: the level of funding provided in the legislation; the methodology for distributing the payments; and how the funding might affect access to services that teaching hospitals provide to Medicare beneficiaries and other patients.

Level of the Teaching Hospital Fund. The AAMC is concerned that the all-payer AHC pool, which is based on inpatient and outpatient costs, is seriously underfunded at $3.8 billion in the year 2000. In 1994 dollars the all-payer pool would be $2.8 billion, if the HSA were implemented with its premium caps. In contrast, Medicare IME payments to teaching hospitals, which are for inpatient cost differences only, are expected to be about $4.2 billion in FY 1994. While the intent of this fund is to provide assistance to academic health centers and teaching hospitals in "leveling the playing field" so that they may compete on a price basis with non-teaching providers, the size of the fund is insufficient to narrow the gap to a level where teaching hospitals and teaching physicians could expect to compete reasonably.

The AAMC agrees with ProPAC's March 1994 recommendation that "the amount to be distributed through the account should adequately reflect the additional costs teaching institutions face." We also concur with the commission that only the relationship between teaching activity, as measured by the intern and resident-to-bed ratio (IRB), and the cost of caring for Medicare *inpatients* is well understood. Because further study is needed, the AAMC recommends that the level of the teaching hospital account should be based on the difference in *total* (all-payer) hospital *inpatient* costs between teaching and nonteaching hospitals. The association recommends that the Congress require an independent analytic body, such as the Prospective Payment Assessment Commission, to study the relationship of costs across the full range of ambulatory training settings to patient mix, severity of illness, and the resource requirements of educational sites. The study should assess possible modifications to the formula for determining the size and distribution of the fund. The report should be submitted to the Congress no later than July 1, 1997. If research findings demonstrate that changes in the level and methodology of the teaching hospital adjustment are warranted, then the appropriate recommendations should be made to the Congress for its consideration.

For several months the AAMC has been working with Lewin-VHI, Inc. to determine the methodology for calculating the appropriate size of the proposed fund for teaching hospitals. Using regression analysis of 1991 (PPS-8) cost data and a variety of different specifications, Lewin-VHI has calculated a range of dollar amounts for an all-payer fund based only on inpatient costs. Depending on the model used and other very important technical issues, such as how total cost per case is calculated, Lewin-VHI estimated that a fund for inpatient cost differences between teaching and nonteaching hospitals would have been between $4.8 and $7.3 billion in 1991. Trended forward to the year 2000, the fund would range from $9.2 to $13.9 billion without the premium caps mandated in the HSA, or under the premium caps, the fund would range from $8.3 to $12.5 billion by the year 2000.

Aside from some important technical issues, such as how the dependent variable (total cost per case) is adjusted to account for direct graduate medical education costs, the resulting range of estimates for the size of the teaching hospital fund depends on the variables included in the model to explain cost differences. Which variables are used in the model depends on its purpose. Some analysts maintain that a "fully specified" regression model, which includes all observed factors thought to affect costs, is the appropriate model to use because it results in a determination of the marginal cost of "pure" teaching activity. Those who argue for the "fully specified" model believe that hospital size as measured by the number of beds, for example, should be included in the model because the number of beds has been found to be an important factor in explaining cost differences among hospitals.

The AAMC believes that the "fully specified" model takes a too narrow view from a public policy perspective of the rationale for establishing a fund to level "the playing field" for teaching hospitals. Given the many and often unique characteristics and activities of teaching hospitals in addition to medical education, the AAMC supports the use of a "payment" model to estimate differences in costs between teaching and nonteaching hospitals. The "payment" model is a more restricted model which reflects the intended "level playing field" policy objective of the fund for teaching hospitals. It includes only those factors one would expect to be reflected in the market price for hospital services, such as wages and case mix. In our example mentioned above, the number of beds is not currently reflected in payment rates, and hospitals would not expect to be paid on that basis, so the AAMC believes it should be excluded from the model. When bed size is included in the model, it acts as a proxy for the additional costs of treating more severely ill patients beyond that reflected in the payment system.

The AAMC supports a "payment" model that takes into account only those factors related to cost differences that will be compensated and reflected in market prices. Discussions about the model and the appropriate explanatory variables to include in estimating the level of the fund for teaching hospitals will continue. But severity of illness will likely not be adequately adjusted for in a health plan's capitated payment to a teaching hospital, yet the cost of caring for that patient will be greater than at a nonteaching hospital. Teaching hospitals will bear the risk of severely ill patients in a competitive market, thus providing the rationale for an all-payer separate fund for teaching hospitals.

Distributing Payments from the Fund. Related to the level of funding is the basis on which payments will be made to teaching hospitals. Like ProPAC, the AAMC believes that the distribution of funds should be equitable, and that applying the Medicare IME adjustment to total patient revenue may not be the most appropriate way to distribute the funds. Because the available data on outpatient activities are not well understood, the AAMC believes that initially payments should be distributed based on total inpatient costs. The AAMC recommends that as part of its report to the Congress, the analytic body asked to study this account should assess possible modifications to the formula to address the scope of outpatient settings, the transition of service from inpatient to ambulatory settings and the impact on the IRB measure.

The AAMC believes that the methodology of using the IRB to distribute these dollars unfairly penalizes a teaching hospital, such as a psychiatric or rehabilitation hospital, that is not paid under the prospective payment system. Presumably its IRB is zero. One remedy to this oversight may be to calculate IRBs for these hospitals as if they were subject to the PPS.

Medicare Participation and Implementation of the Fund. The HSA would reduce substantially the IME payment formula from its current 7.7 percent to a rate of about 3.0 percent for every 10 percent increase in a hospital's IRB. Beginning October 1, 1995, the program would end IME payments to hospitals and contribute $2 billion to the AHC fund, about the equivalent of a 3.0 percent IME adjustment. Current Medicare IME payments are expected to be about $4.2 billion in Federal FY 1994. The AAMC strongly supports requiring the Medicare program to contribute to the all-payer AHC account at least at the equivalent rate of the statistical estimate for the IME adjustment in the PPS, even after universal coverage is achieved and a new system is fully operational. According to ProPAC's most recent analysis, the statistical estimate would be 5.2 percent for every 10 percent increase in the IRB. The association is unaware of any justifiable analytic basis for a reduction in the Medicare IME adjustment to a rate of 3 percent and views the proposed reduction as simply a mechanism for lowering Medicare's contribution to the AHC fund, thus reducing federal expenditures.

The AAMC is opposed to the elimination of the IME adjustment as of October 1, 1995. These Medicare funds, which are essential to assuring that Medicare beneficiaries and others have access to services provided by teaching hospitals, would be reduced and removed from the PPS and then redistributed without knowing the impact on teaching hospitals' financial status. As ProPAC explains in its March report, "a sharp reduction in the payments teaching hospitals receive from government payers may result in financial hardships for some of the nation's major hospitals. Constraints on payments from private payers may exacerbate the problem." The AAMC urges the Congress to reflect carefully on this consequence when considering any change in the level of the IME adjustment, particularly until a new system is fully operational and the effect of the new system on the financial viability of teaching hospitals can be determined.

Ensuring Access to Academic Health Centers. The HSA also recognizes the difficulty that academic health centers and teaching hospitals may have in maintaining a flow of patients in a price conscious environment that emphasizes lower cost care. The proposal requires health plans to enter into contracts with academic health centers so that their enrollees will have access to the specialized treatment expertise found in these institutions. The AAMC supports this provision in the HSA, but asks that the proposal be modified to reflect that academic providers, including teaching hospitals and their associated faculty physicians, should meet criteria established by the Secretary of the DHHS. These criteria should address both the parameters for selecting appropriate academic providers and the assurance of appropriate competitive payment. The association also believes that, in addition to specialized services, health plans should contract with academic providers for primary care, routine and preventive health care services. The opportunity for individuals in health plans to seek care from academic providers without incurring financial penalty should be maintained. If a truly level playing field has been established, academic providers should not be paid more than the competitive rate for similar services. The

association also supports the program of making discretionary grants for the establishment and operation of information and referral systems to improve access for residents of rural and urban communities. Eligible medical schools, teaching hospitals, faculty practices and other appropriate organizational entities, such as academic health centers, should be eligible to receive these grants directly to improve access. The Secretary of the DHHS should determine the eligibility criteria and should provide a unique funding stream for these grants.

Overall Adequacy of Financing for Academic Medicine in the HSA

The HSA recognizes that teaching hospitals and teaching physicians are unique national resources and that they have added societal responsibilities in the health care system. As previously explained, however, the AAMC believes that a complete and adequate financing system for the missions of academic medicine also must include a separate fund for medical schools to assist them in maintaining their education and research infrastructure. The association strongly supports the need to fund separately the spectrum of costs associated with the academic mission, including the costs of graduate medical education and other health professionals, and the special and unique patient care costs that make it difficult for these teaching physicians and teaching hospitals to compete in the current environment. We also agree that all payers should contribute to the financing of the three accounts.

Proponents of the HSA have argued that, if enacted, teaching hospitals would be better protected and more adequately financed than if the current situation were maintained. They compare the current level of Medicare payments for direct graduate medical education and indirect medical education costs-about $5.9 billion in FY 1994-to the $9.6 billion total amount that teaching hospitals would receive in the year 2000 under the HSA. In contrast, if the HSA with its premium caps were in place in 1994, the two pools would be funded at $7.6 billion ($4.8 billion for the workforce and $2.8 billion for the AHC accounts), containing in total about $1.7 billion in "new" contributions from payers other than Medicare. In addition, many believe that teaching hospitals will be able to "make up the difference" by commanding premium prices in the delivery system based on their service offerings and reputations.

While the total of these set-aside funds would exceed current Medicare spending for direct graduate medical education costs and the indirect medical education (IME) adjustment, this premise indicates an apparent misunderstanding of the current competitive environment and the level of support that the academic mission requires. The Medicare program supports only a portion of the academic mission. Data from hospitals belonging to the AAMC's Council of Teaching Hospitals show that Medicare payments cover only a range of 20 to 33 percent of the costs associated with the academic mission. The other 67 to 80 percent must be obtained from public and private payers who provide the balance of funding for these additional costs primarily through higher payments for services.

Historically, teaching hospitals and medical schools have financed their many functions through multiple streams of revenue. For example, in hospitals patient service revenues have supported graduate medical education and other academic activities; routine service revenues have supported

tertiary care patients; revenues from high volume services have supported low volume services; and payments from paying patients have supported charity care patients. However, during the past few years, as the overall costs of medical care have risen sharply, private health care payers have adopted payment systems--such as capitation, aggressive contracting and discounting--that restrict their payments to cover only goods and services they believe are necessary and of identifiable benefit to their enrollees. Costs associated with the education and research missions of teaching hospitals generally are not recognized by these payers.

The AAMC believes that the $9.6 billion currently specified in the HSA for the year 2000 for the all-payer workforce and academic health center accounts meets approximately 50-55 percent of the actual need. When the results of the recommended medical school study are completed, the percentage of needed funds provided by the $9.6 billion will be lower.

In addition to the overall level of funding, equally troubling is the tendency of some to view the two proposed pools as one aggregate amount. By combining and considering the two, actually three, separate accounts as one pool of dollars, legislators and policy makers may be misled in their conclusions about the adequacy of the funding in each pool. Viewing the separate accounts as one fund may mask a case of severe underfunding in one account or the other. That is, one account may cover a much smaller percentage of costs than the aggregate "average" percentage would suggest. The AAMC strongly believes that each account's purpose and funding adequacy should be considered on its own merit and that an analysis showing the percentage of costs that each fund covers should be disseminated. The Congress should remember that the two funds proposed in the HSA (or the three funds proposed by the AAMC) serve very different purposes and are distributed to different entities.

In a price competitive environment, there is pressure to identify the cross-subsidized products of medical schools and teaching hospitals. The AAMC believes that teaching hospitals and medical schools will no longer be able to "make up the shortfall" to fund the costs associated with their academic missions through higher charges to patients. Therefore, the financing of the funds must be adequate to ensure the continued financial viability of these institutions. The AAMC also believes that this new environment, which forces the exposure of cross-subsidized support, threatens the future financing of the nation's medical schools at a time when they are being asked to undertake new and costly initiatives. The AAMC strongly supports the creation of a third account for medical schools to assist them in meeting new challenges and opportunities.

Conclusion

Supporting academic medicine ensures its vital role as an international leader in education, research and patient care. Medical schools and their faculties educate fully trained physicians to meet the nation's health care needs. Teaching hospitals provide an environment for the conduct of biomedical and clinical research, serve as educational sites, and with their staff, work with academic physicians to deliver sophisticated patient care to all who need it. But academic institutions also need support to maintain their essential role in the health care system.

However, we must give considerable thought and attention to ensuring that any proposed changes, if enacted, are implemented effectively and financed adequately. While we have some concerns about these proposals, the AAMC generally support their overall objectives. We look forward to working with this committee and the administration to ensure the future of academic medicine and the nation's health care system. We can afford to do no less.

TABLE 1

NUMBER OF RESIDENTS AND FELLOWS
RANKED BY TOTAL TRAINEES BY SPECIALTY
1993

Specialty	No. of Residents	No. of Fellows	No. Physician in GME	% of Total	Cumulative %
Internal Medicine	19,962	10,581	30,543	30.9%	30.9%
Pediatrics	6,600	2,389	8,989	9.1%	40.0%
Surgery	7,832	886	8,718	8.8%	48.8%
Family Practice	6,925	539	7,464	7.6%	56.4%
Psychiatry	5,138	912	6,050	6.1%	62.5%
Anesthesiology	5,078	896	5,974	6.0%	68.6%
Obstetrics-Gynecology	4,665	620	5,285	5.3%	73.9%
Radiology	3,606	1,478	5,084	5.1%	79.0%
Orthopedic Surgery	2,752	583	3,335	3.4%	82.4%
Pathology	2,222	734	2,956	3.0%	85.4%
Emergency Medicine	2,024	354	2,378	2.4%	87.8%
Ophthalmology	1,476	332	1,808	1.8%	89.6%
Neurology	1,355	444	1,799	1.8%	91.5%
Transitional	1,589	--	1,589	1.6%	93.1%
Otolaryngology	819	403	1,222	1.2%	94.3%
Urology	911	246	1,157	1.2%	95.5%
Physical Medicine/Rehab.	993	118	1,111	1.1%	96.6%
Dermatology	708	261	969	1.0%	97.6%
Neurosurgery	630	224	854	0.9%	98.5%
Plastic Surgery	161	362	523	0.5%	99.0%
Thoracic Surgery	--	345	345	0.3%	99.3%
Preventive Medicine	235	57	292	0.3%	99.6%
Allergy/Immunology	--	169	169	0.2%	99.8%
Nuclear Medicine	90	45	135	0.1%	99.9%
Colon & Rectal Surgery	--	64	64	0.1%	100.0%
TOTAL	**75,771**	**23,042**	**98,813**	**100.0%**	

Source: Association of American Medical Colleges, GME Census, SAIMS Database, 1993

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TABLE 2

NUMBER OF FMGs IN GME
RANKED BY PERCENTAGE OF FMGs OF TOTAL TRAINEES BY SPECIALTY
1993

Specialty	No. of FMGs	No. Physician in GME	% of Total	% of Total FMGs
Nuclear Medicine	52	135	38.5%	0.2%
Internal Medicine	10,402	30,543	34.1%	49.8%
Pediatrics	2,787	8,989	31.0%	13.3%
Allergy/Immunology	52	169	30.8%	0.2%
Neurology	526	1,799	29.2%	2.5%
Pathology	819	2,956	27.7%	3.9%
Psychiatry	1,534	6,050	25.4%	7.3%
Family Practice	1,396	7,464	18.7%	6.7%
Transitional	293	1,589	18.4%	1.4%
Colon & Rectal Surgery	11	64	17.2%	0.1%
Anesthesiology	862	5,974	14.4%	4.1%
Preventive Medicine	36	292	12.3%	0.2%
Physical Medicine/Rehab.	110	1,111	9.9%	0.5%
Surgery	849	8,718	9.7%	4.1%
Neurosurgery	83	854	9.7%	0.4%
Thoracic Surgery	31	345	9.0%	0.1%
Plastic Surgery	37	523	7.1%	0.2%
Obstetrics-Gynecology	369	5,285	7.0%	1.8%
Ophthalmology	107	1,808	5.9%	0.5%
Radiology	269	5,084	5.3%	1.3%
Urology	59	1,157	5.1%	0.3%
Dermatology	43	969	4.4%	0.2%
Emergency Medicine	101	2,378	4.2%	0.5%
Otolaryngology	25	1,222	2.0%	0.1%
Orthopedic Surgery	49	3,335	1.5%	0.2%
TOTAL	20,902	98,813	21.2%	100.0%

Source: Association of American Medical Colleges, GME Census, SAIMS Database, 1993

TABLE 3
PHYSICIANS IN GME RANKED BY STATE, 1993

State	No. Physician in GME	% of Total	Cumulative %
New York	14,805	15.0%	15.0%
California	9,004	9.1%	24.1%
Pennsylvania	7,236	7.3%	31.4%
Texas	5,859	5.9%	37.3%
Illinois	5,530	5.6%	42.9%
Ohio	4,728	4.8%	47.7%
Massachusetts	4,433	4.5%	52.2%
Michigan	3,904	4.0%	56.2%
New Jersey	2,603	2.6%	58.8%
Maryland	2,491	2.5%	61.3%
Florida	2,413	2.4%	63.8%
Missouri	2,233	2.3%	66.0%
North Carolina	2,211	2.2%	68.3%
Minnesota	2,193	2.2%	70.5%
District of Columbia	2,179	2.2%	72.7%
Connecticut	1,878	1.9%	74.6%
Georgia	1,826	1.8%	76.4%
Tennessee	1,798	1.8%	78.3%
Virginia	1,751	1.8%	80.0%
Wisconsin	1,583	1.6%	81.6%
Louisiana	1,504	1.5%	83.1%
Washington	1,415	1.4%	84.6%
Indiana	1,162	1.2%	85.8%
Colorado	1,130	1.1%	86.9%
Alabama	1,002	1.0%	87.9%
Arizona	997	1.0%	88.9%
Kentucky	986	1.0%	89.9%
South Carolina	908	0.9%	90.8%
Iowa	846	0.9%	91.7%
Puerto Rico	779	0.8%	92.5%
Kansas	702	0.7%	93.2%
Oklahoma	683	0.7%	93.9%
Oregon	648	0.7%	94.5%
Rhode Island	576	0.6%	95.1%
Utah	560	0.6%	95.7%
Arkansas	534	0.5%	96.2%
Nebraska	499	0.5%	96.7%
West Virginia	496	0.5%	97.2%
Mississippi	432	0.4%	97.7%
Hawaii	430	0.4%	98.1%
New Mexico	386	0.4%	98.5%
Vermont	265	0.3%	98.8%
New Hampshire	238	0.2%	99.0%
Maine	214	0.2%	99.2%
Delaware	195	0.2%	99.4%
North Dakota	120	0.1%	99.5%
Nevada	112	0.1%	99.7%
South Dakota	85	0.1%	99.7%
Idaho	39	0.0%	99.8%
Wyoming	38	0.0%	99.8%
Montana	0	0.0%	99.8%
Alaska	0	0.0%	99.8%
Unidentified Military	174	0.2%	100.0%
TOTAL	**98,813**	**100.0%**	

Source: Association of American Medical Colleges, GME Census, SAMIS Database, 1993

TABLE 4
PHYSICIANS IN GME PER THOUSAND POPULATION BY STATE, 1993

State	No. Physicians in GME	Population	Phys. in GME per 1,000 population
District of Columbia	2,179	589,000	3.70
New York	14,805	18,119,000	0.82
Massachusetts	4,433	5,998,000	0.74
Pennsylvania	7,236	12,009,000	0.60
Rhode Island	576	1,005,000	0.57
Connecticut	1,878	3,281,000	0.57
Maryland	2,491	4,908,000	0.51
Minnesota	2,193	4,480,000	0.49
Illinois	5,530	11,631,000	0.48
Vermont	265	570,000	0.46
Missouri	2,233	5,193,000	0.43
Ohio	4,728	11,016,000	0.43
Michigan	3,904	9,437,000	0.41
Hawaii	430	1,160,000	0.37
Tennessee	1,798	5,024,000	0.36
Louisiana	1,504	4,287,000	0.35
New Jersey	2,603	7,789,000	0.33
Texas	5,859	17,656,000	0.33
Colorado	1,130	3,470,000	0.33
North Carolina	2,211	6,843,000	0.32
Wisconsin	1,583	5,007,000	0.32
Nebraska	499	1,606,000	0.31
Utah	560	1,813,000	0.31
Iowa	846	2,812,000	0.30
California	9,004	30,867,000	0.29
Delaware	195	689,000	0.28
Kansas	702	2,523,000	0.28
Washington	1,415	5,136,000	0.28
Virginia	1,751	6,377,000	0.27
West Virginia	496	1,812,000	0.27
Georgia	1,826	6,751,000	0.27
Kentucky	986	3,755,000	0.26
Arizona	997	3,832,000	0.26
South Carolina	908	3,603,000	0.25
New Mexico	386	1,581,000	0.24
Alabama	1,002	4,136,000	0.24
Arkansas	534	2,399,000	0.22
Oregon	648	2,977,000	0.22
New Hampshire	238	1,111,000	0.21
Oklahoma	683	3,212,000	0.21
Indiana	1,162	5,662,000	0.21
North Dakota	120	636,000	0.19
Florida	2,413	13,488,000	0.18
Maine	214	1,235,000	0.17
Mississippi	432	2,614,000	0.17
South Dakota	85	711,000	0.12
Nevada	112	1,327,000	0.08
Wyoming	38	466,000	0.08
Idaho	39	1,067,000	0.04
Montana	0	824,000	0
Alaska	0	568,000	0
Puerto Rico	779	–	–
Unidentified Military	174	–	–
TOTAL	**98,813**	**255,062,000**	0.39

Source: Association of American Medical Colleges, GME Census, SAIMS Database, 1993
Population Data: U.S. Bureau of the Census, Current Population Reports, 1992

TABLE 5
FMGs IN GME, RANKED BY % OF PHYSICIANS IN GME BY STATE, 1993

State	No. Physicians in GME	No. of FMGs	% FMGs of	% of Total FMGs in U.S.
New Jersey	2,603	1,377	52.9%	6.6%
North Dakota	120	50	41.7%	0.2%
New York	14,805	6,168	41.7%	29.5%
Nevada	112	40	35.7%	0.2%
Puerto Rico	779	269	34.5%	1.3%
Illinois	5,530	1,797	32.5%	8.6%
Michigan	3,904	1,154	29.6%	5.5%
Connecticut	1,878	549	29.2%	2.6%
West Virginia	496	121	24.4%	0.6%
Rhode Island	576	123	21.4%	0.6%
Pennsylvania	7,236	1,419	19.6%	6.3%
Wisconsin	1,583	306	19.3%	1.5%
Maryland	2,491	479	19.2%	2.3%
Ohio	4,728	908	19.2%	4.3%
District of Columbia	2,179	411	18.9%	2.0%
Florida	2,413	417	17.3%	2.0%
Missouri	2,233	367	16.4%	1.8%
Massachusetts	4,433	722	16.3%	3.5%
Oklahoma	683	107	15.7%	0.5%
Tennessee	1,798	275	15.3%	1.3%
Minnesota	2,193	323	14.7%	1.5%
Texas	5,859	845	14.4%	4.0%
South Dakota	85	11	12.9%	0.1%
Georgia	1,826	222	12.2%	1.1%
Indiana	1,162	139	12.0%	0.7%
Kentucky	986	113	11.5%	0.5%
Virginia	1,751	185	10.6%	0.9%
California	9,004	943	10.5%	4.5%
Iowa	846	81	9.6%	0.4%
Vermont	265	25	9.4%	0.1%
Nebraska	499	47	9.4%	0.2%
Maine	214	20	9.3%	0.1%
Delaware	195	18	9.2%	0.1%
Alabama	1,002	91	9.1%	0.4%
Kansas	702	63	9.0%	0.3%
Arkansas	534	45	8.4%	0.2%
Arizona	997	77	7.7%	0.4%
Hawaii	430	33	7.7%	0.2%
Mississippi	432	31	7.2%	0.1%
South Carolina	908	63	6.9%	0.3%
North Carolina	2,211	152	6.9%	0.7%
Louisiana	1,504	95	6.3%	0.5%
Utah	560	32	5.7%	0.2%
New Mexico	386	20	5.2%	0.1%
Idaho	39	2	5.1%	0.0%
Colorado	1,130	57	5.0%	0.3%
New Hampshire	238	12	5.0%	0.1%
Oregon	648	30	4.6%	0.1%
Washington	1,415	65	4.6%	0.3%
Wyoming	38	1	2.6%	0.0%
Montana	0	0	--	
Alaska	0	0	--	
Unidentified Military	174	2	1.1%	0.0%
TOTAL	**98,813**	**20,902**	**21.2%**	**100.0%**

Source: Association of American Medical Colleges, GME Census, SAIMS Database, 1993

RESPONSES OF DR. FOREMAN TO QUESTIONS SUBMITTED BY SENATOR DOLE

1.) **Given our interest in the development of health care training program consortia, I was intrigued by your comment that there could be problems with the anti-trust laws. Could you tell us more specifically the kinds of changes in the anti-trust laws that you would recommend?**

The AAMC favors the adoption of an exemption from anti-trust laws for the standard setting and standard enforcement activities of medical self-regulating entities as contained in S.1658, "The Health Care Anti-trust Improvement Act of 1993", introduced by Senators Hatch and Thurmond. The association urges the addition of an exemption for sponsors of graduate medical education (GME) training programs and for national organizations representing academic institutions, hospitals and health care organizations, and medical professionals.

The Federal Trade Commission (FTC) is oriented toward competition and is hostile to coordinated planning among institutions and organizations which is the medical profession's preferred approach to workforce issues. Professional associations and specialty societies representing the medical profession have experienced the close scrutiny of the FTC's Bureau of Competition over the past decade and a half. Within the past five years the American Medical Association (AMA), the Liaison Committee on Medical Education (LCME) and the Accreditation Council for Graduate Medical Education (ACGME), and over the longer period, virtually every medical specialty society has been the subject of non-public "informal investigations" by the FTC. These investigations are apparently premised on the perception that participation in standard-setting activities is likely to be motivated by economic self-interest and thus contrary to, not in service of, the public interest. No formal complaint has been issued but these investigations have been burdensome to the organizations and very costly in economic terms. More significant in the current context is the chilling effect that these investigations have had on the ability of these organizations to deliberate rationally about workforce issues. Meetings are burdened by the presence of lawyers who urge caution against considerations of possible excess of supply over need, thoughts of downsizing, coordination of services in a geographic area, and other similar issues.

In the association's view, fear of FTC scrutiny has led to paralysis of thought and action at the national and local levels. Often, actions appear to be undertaken based upon legal considerations rather than upon medical or service needs. In the future, it is anticipated that GME consortia will have an explicit objective of limiting opportunities for specialty training. Without an exemption, the FTC is likely to interpret this objective as anti-competitive and thus subject to challenge. Consequently, efforts to develop GME consortia is likely to be frustrated if there is no anti-trust relief.

There is, of course, an exemption from anti-trust liability for any action undertaken at the direction of the government. Thus, if the federal government establishes a national body to assign GME positions by specialty to each GME sponsor, there is little likelihood of an anti-trust issue. Short of that, however, efforts directed toward the same end will be subject to anti-trust scrutiny. These

would include local discussions between hospitals in the same community, because the FTC regards them as "competitors" and because GME programs certainly have economic implications. Limiting specialty, and increasing generalist, positions or agreeing to coordinate the assignment of all GME positions in the community through a coordinated action or a central authority -- i.e., establishment of consortia -- appear to be subject to challenge on anti-trust grounds by either federal agencies or by private action. The latter might be brought, for example, by disappointed applicants to GME programs that have been reduced in size

The AAMC believes an independent National Council should be established to study future workforce needs, set national workforce goals, and publish annual reports on the status of workforce needs. If the Council judges that market forces are ineffective in altering the ratio of generalists to specialists, it could recommend a regulatory approach, including an allocation method for aligning the size and composition of the physician workforce consistent with national policy goals. The Council should be required to consider commentary on the allocation method from educators before a regulatory mechanism is implemented. We believe that providing a safe harbor exemption from anti-trust laws for collaborative activities among sponsors of GME programs would facilitate the development of consortia Such a safe harbor could be modeled after the provisions in S 1658, along the following lines

Section 2. Exemption from Anti-trust Laws for Certain Competitive and Collaborative Activities

(a) Exemption Described -- An activity relating to the provision of health care services shall be exempt from anti-trust laws if--

1) The activity is within one of the categories of safe harbors described in Section 3

Section 3 Safe Harbors

The following activities are safe harbors for purposes of Section (2) (a)(1)

--Activities of Sponsors of Graduate Medical Education Training Programs and other organizations

(A) Any activity of a sponsor of a Graduate Medical Education Training Program that has as its objective, or one of its objectives, any of the following:

i. Increasing the number of generalists or reducing the number of specialist physicians trained

ii Attracting physicians to underserved rural or urban practice sites

iii. Providing more extensive training in meeting community health needs and preventive care

(B) Any activity of a national organization representing academic institutions, hospitals

and health care organizations or medical professionals directed toward the objectives specified in (A) i, ii, iii.

2.) I understand from your testimony that you oppose funds being directed away from the hospitals to other sites of training?

The AAMC does not oppose funds being directed away from hospitals to other sites of training. The AAMC concurs with Senators Dole, Chafee, Rockefeller, and Durenberger, that Medicare payments should be available to non-hospital residency training sites. Current Medicare payment rules mandate that payments for direct graduate medical education costs be made only to hospitals. The association believes that the program rules should be modified to allow non-hospital, ambulatory training sites or organizations formed to train physicians, such as consortia, to receive payments based on a methodology developed by the council.

To encourage the development of ambulatory training sites, innovation, and collaborative efforts, the AAMC believes that payments for the direct costs of graduate medical education should be made to the entity that incurs the cost of training. The AAMC does not support payments being awarded directly to training programs. The AAMC recognizes that the need for more and well-trained generalist physicians will require a transition from education in hospital inpatient settings to new training sites, such as outpatient clinics, physicians' offices and nursing homes. Because local circumstances and arrangements for graduate medical education are diverse, the entity that incurs the training cost may be a teaching hospital, medical school, consortium, or group practice. Any entity, including a graduate medical education consortium, could serve potentially as the fiscal intermediary in distributing payments across various training sites. Any of these entities that incur training costs could apply to receive payments from the national all-payer fund. A multi-entity applicant, for example a consortium, should be required to:

submit a written agreement, signed by all participants in the organization, which shows that all parties agree on the distribution of these payments, as specified in the application, and

agree to submit additional documentation to demonstrate that the funds are being distributed in a manner agreed upon by all parties.

The AAMC strongly supports the formation of graduate medical education consortia as organizations to assure the continuity of medical education and to serve as the focal point for collaborative decision making and resource allocation regarding graduate (and undergraduate) medical education. In February 1994 the AAMC reaffirmed its support of a consortium as "represent[ing] an effective means of accomplishing the tasks and processes required for graduate medical education programs of the future." The association also believes that ideally one or more medical schools should participate in each consortium and should have a partnership role in assuring the quality and composition of the physician workforce.

The AAMC recently released the results of a national study it conducted on existing consortia. [This study is included with the responses sent directly to Senators Dole and Grassley.] Among the findings is that while consortia are promising innovations and are featured prominently in

many proposals to reform graduate medical education, they are far from well-established. Existing consortia seem to be ideal vehicles for maintaining the pluralism and diversity of the current system of graduate medical education, but differ markedly in many respects, particularly regarding their structures and functions. Whether each consortium would have to meet identical workforce goals and how its governance is structured will be the focus of discussion. The AAMC is pleased that COGME is addressing many of the structural and governance issues that need to be debated, and looks forward to its report. In the meantime, the AAMC continues to encourage medical educators to form consortia and views the voluntary, provider-initiated demonstration projects as outlined in the Chafee/Dole bill (S.1770) as one approach that could be tried. These voluntary, provider-initiated demonstrations could be effective as a means of educating policy makers about what kinds of incentives and behaviors might affect workforce development in a positive way, making a regulatory approach unnecessary for the nation.

3.) **The fundamental question we are examining is why the Federal government should pay for the training costs of physicians and the costs that you incur in medical centers. Doctors make good money; hospitals have ways of billing for services. Why do we have a role?**

Currently the chief means of support for graduate medical education (GME) are teaching hospital revenues derived from services provided to patients. Many believe that the Medicare program is the only payer of graduate medical education costs because it makes explicit payments for its share of training costs. However, other payers support GME either through higher charges for hospital services or in some states through explicit Medicaid payments. This method of financing--reliance on hospital patient care revenue--has provided a significant degree of autonomy to physicians in training and teaching hospitals. However, increasing price competition in the health care delivery system has led many in the medical education community to question whether they can continue to support the additional costs of training physicians through higher charges and Medicare and/or Medicaid payments. Many have called for the creation a national fund for GME to which all payers would contribute.

The AAMC believes that the federal government's role in GME is to provide stability in funding for training programs. Society has been supporting residency training virtually since its inception, and with this support, medical educators have developed an educational system unsurpassed in the world. But quality programs can be developed and maintained across many years only by assuring some degree of predictability in the level of funding. Substantial fluctuations in the level of support for GME will likely preclude educational institutions from making long term commitments to training programs. The public benefits from stable and adequate support for GME.

For costs that medical centers incur, we believe the federal government has a role in ensuring the viability of medical centers as the cornerstone of the health care system. Without dedicated funding for the missions of education, research and medical care of severely ill patients, AAMC members will be unable to maintain their role as the cornerstone of the health care delivery system. Dedicated funding sources are essential to our responsibilities as educators of physicians and other professionals, as creators and evaluators of scientific knowledge and its transfer into the practice for the benefit of society, and as providers of the full range of patient care services. These additional missions result in higher costs relative to nonteaching hospitals.

Patient care is financed in teaching hospitals through a complex and delicate web of cross-subsidization. For example, charges for more routine services may subsidize treatments in sophisticated and costly intensive care units. At the same time, many health care payers are adopting payment methods that will allow them to spend their health care dollars "more wisely." These payers want to restrict their payments to only those services they believe are necessary and reasonable for the care of the patients for whom they are responsible and then negotiate the most favorable price they can for those services.

Along with increased efficiency, by establishing separate all-payer funds at the national level for teaching hospitals and medical schools, medical centers will be able to compete in the delivery system on a level playing field. The association has long held the position that all payers should continue to provide their appropriate share of support for graduate medical education. Until recently, most GME program sponsors have been able to cover the cost of medical education through explicit payments for these costs from the Medicare and some Medicaid programs, state and local government appropriations, and from higher charges paid by private insurers The AAMC and its constituents recognize that governmental and third-party payers are becoming more price sensitive as they attempt to reign in health care costs and limit their support of the educational mission In 1993 the AAMC adopted the position that an all-payer fund for the financing of graduate medical education, separate from the patient care revenue, should be established.

The national all-payer fund should be funded adequately and it should reflect the total direct costs of graduate medical education. The pool should include not only residents' stipends and fringe benefits, but faculty supervision expense, applicable benefits, direct overhead costs such as the salaries and benefits of personnel assigned to the support and management of the graduate medical education office, and allocated overhead costs such as maintenance and electricity, and the effect of inflation

If an all payer system is adopted in health care reform legislation, the AAMC believes that separate Medicare payments should continue to flow to teaching hospitals during the transition from the current system to a reformed delivery system The separate Medicare payments would be made using the current per resident methodology and the current payment level adjusted for inflation should be made to teaching hospitals that now receive funds for direct graduate medical education. Entities that receive Medicare support for direct graduate medical education would receive additional payments from the newly created, all-payer workforce account, which would contain the contributions from other payers The transition between the end of Medicare payments for direct graduate medical education costs and the beginning of payments from the workforce account should be adjusted, depending on the hospital's fiscal year end and its relationship to the start of the calendar year No gap in available funding should occur as a result of the timing of the contributions to the all-payer fund.

The AAMC strongly supports a policy requiring all insurers and sponsors of patient care programs to support the missions of academic medicine The AAMC wishes to emphasize the importance of the fundamental principle that all payers must support not only educating and training the workforce, but providing an environment in which education, clinical research, and service to special populations can flourish

4.) One of the things the AAMC seems to be seeking is new funds for medical schools versus the money we now spend for GME and IME. What do you intend to use the money for?

The attached AAMC Issue Brief on an ***All-Payer Fund In Support of the Academic Mission of Medical Schools*** sets forth our rationale and purpose of the fund

RESPONSES OF DR. FOREMAN A QUESTION SUBMITTED BY SENATOR GRASSLEY

5.) Are academic health centers experiencing a loss of patients because organized delivery systems do not send their patients as readily to sophisticated academic centers?

On an anecdotal basis a number of academic medical centers have indicated that they have experienced a loss of patients due to increasing restrictions on patient access.

There appear to be a number of reasons for these restrictions by organized delivery systems. These include:

- Concerns that academic centers cannot be cost competitive. In some cases this has led to exclusion, even from consideration by organized delivery systems, of potential participation in their network

- Fear by the organized delivery systems that inclusion of an academic medical center will lead to adverse risk selection. Because academic medical centers are believed to attract patients who have sophisticated medical needs, the inclusion of an academic medical center in the system would lead to a disproportionate number of such patients selecting such a system and placing them at a competitive disadvantage on average cost.

- A belief that there is a fundamental cultural clash between academic centers and organized delivery systems. While cultural differences clearly exist, there is little motivation or opportunity to deal with these differences due to exclusion from the networks activity

- If an academic center works more closely with one organized delivery system there is a potential reluctance to refer patients because this would benefit a 'competitor' Thus academic medical centers are constrained from serving the broad population base, a population base which is often needed in its entirety to maintain sufficient volume to be effective and efficient.

It also needs to be recognized that a decision by an organized delivery system that it prefers to keep all possible patient activity within their 'network' Thus, if a sufficient critical mass of enrollees is achieved they will establish various services internally. This limits referrals to academic medical centers to a smaller and smaller number of patients with increasingly serious problems This in turn increases their average cost and reinforces a presumption that academic medical centers cannot be cost effective. This type of 'downward spiral' in patient activity then threatens the ability to maintain educational and research programs due to inadequate patient populations and populations which are too skewed in their problems and pathology for a balanced educational experience

Issue Brief
All-Payer Fund In Support of
the Academic Mission of Medical Schools
June 6, 1994

Issue

Medical schools are challenged to make major changes in their educational programs at a time when their sources of support are threatened. The major change is a restructuring of the clinical education program for medical students, to include more experiences in community-based, outpatient settings. How medical schools can meet this new commitment and maintain existing programs, in the wake of fiscal pressures, constitutes their most pressing strategic concern.

Background

Medical schools are revising their educational programs to meet the challenges of health care reform, including a focus on community health and preventive care, medical student preparation for generalist practice, and outcomes research and the teaching of cost-effective medical care. The major change is the restructuring of clinical education for medical students, now underway, from programs based in hospital settings to those that rely more heavily on community-based, ambulatory settings, such as community clinics, HMOs, doctors' offices, and nursing homes.

Teaching in ambulatory settings requires a substantial increase in resources. The number of patients cared for by a teaching physician in an ambulatory setting in a given time period is severely curtailed when students participate in the patient care process. This loss in productivity is expressed in terms of lost revenues to the medical school from the professional services of its clinical faculty. It is also reflected in the demand of managed care organizations for payments in exchange for allowing students to train in their settings.

Even without the burden of teaching programs, medical school revenues derived from clinical faculty practice are expected to decline,with the increase in capitation, discounted fee structures, and other reimbursement mechanisms prevalent in managed care delivery systems. These financing changes affect most dramatically specialist and subspecialist physicians that predominate among medical school clinical faculty The fees generated by these faculty for their professional services cover not only much of their salaries, but also constitute a significant proportion of the funds available to the medical school for general academic purposes. Approximately one-third of all medical school revenues are derived from the medical faculty practice. Additionally, medical schools rely on community physicians to supplement their teaching programs, and currently do not provide any significant compensation to them. The clinical

faculties of many medical schools are already finding it difficult to support themselves, without compromising their teaching and research responsibilities. Moreover the willingness of community physicians to "volunteer" teaching services is also in jeopardy.

If universal coverage is achieved through health care reform legislation, it may ease one pressure on clinical faculty revenues -- the amount of uncompensated charity care that faculty physicians provide. Efficiency measures being implemented by faculty practices, and now demanded of all providers, will help as well. However, it is unlikely that the financial benefits of these changes will offset the expected loss in clinical revenues coupled with the added expenses of new educational initiatives.

There is, in addition, little expectation that the shortfall in support can be made up through other sources of funds. State and local government appropriations to medical schools are declining, with little prospect for turnaround. Tuition and fees paid by students are at maximum levels and, even now, consign students graduating from medical school with considerable debt and may discourage applications to medical schools by members of underrepresented groups.

The cost of medical student education is now borne, indirectly, by the beneficiaries of the health care system through payments for services. A reformed system that emphasizes price-competition and efficiency demands that a mechanism be found for beneficiaries of medical school programs to continue in their support.

Solution

A medical school fund must be created to finance the new initiatives required of allopathic and osteopathic medical schools to support the goals of health care reform. Estimates, which require additional refinement, indicate that this account should be funded annually at $1-1.5 billion. Payments from this fund should be directed to medical schools by a method to be developed in accordance with findings from an independent analytic study completed by July 1995.

PREPARED STATEMENT OF PAUL A. MARKS

We strongly support the need for health care reform to assure universal access for all necessary and appropriate health care including prevention, therapy, and rehabilitation. We support the need to assure that health insurance is portable and that no one is prevented from obtaining health insurance because of pre-existing conditions. We also strongly believe that to achieve these elements of health care reform in a manner that will be both effective and cost-sensitive, there is a need for malpractice legislative reform.

Even in the absence of health care reform legislation, dramatic changes have been occurring in the health care arena. Of particular concern to the federally-designated cancer centers, on whose behalf this statement is submitted, has been the growth of managed care and a resultant increase in the restriction of patient access. Patient access to these cancer centers has become more restricted because the managed care health plans tend to seek the least expensive providers with, in our judgment, inadequate regard to quality of care. We, therefore, strongly support health care reform legislation that guarantees access to federally-designated cancer centers and other specialized providers for individuals who need and want such care.

I turn now to three issues that this statement will address: 1) assuring patients guaranteed access to federally designated cancer centers in a reformed health care system; 2) providing for coverage of qualified clinical trials in the basic benefits package; and 3) assuring that the federally-designated freestanding cancer centers are not subjected to inappropriate payment methodologies.

ASSURING PATIENTS GUARANTEED ACCESS TO THE FEDERALLY-DESIGNATED CANCER CENTERS IN A REFORMED HEALTH CARE SYSTEM

The National Cancer Program was enacted by Congress in 1971 to improve the prevention, diagnosis, and treatment of cancer. An important element of the program has been the designation by the National Cancer Institute (NCI) of comprehensive and clinical cancer centers.

The NCI-designated cancer centers are the cornerstones for deepening the understanding of the causes and cures for cancer, for applying this knowledge to new approaches to prevention and more effective treatment, and for disseminating this knowledge nationally to physicians and community hospitals. These cancer centers have developed many of the major advances in cancer care.

The role of these national resources—and the continued success of the National Cancer Program—should not and need not be compromised by health care reform if their special missions are taken into account:

- *Patients in managed care programs must be guaranteed access to the NCI-designated cancer centers.*

  Cancer patients must be permitted to choose treatment at an NCI-designated cancer center without unreasonable economic barriers. Otherwise, the cancer centers could become available only to affluent patients.

  In addition, NCI-designated cancer centers should be treated as designated specialty providers. Managed care plans must inform enrollees of such a provision and allow the referral of their enrollees to these cancer centers.

- *The basic benefits package must cover treatment of cancer patients in qualified clinical trials that substitute for standard, and possibly less effective, therapy.*

  The customary exclusion of "investigational" services must not extend to qualified clinical trials involving cancer patients since the reasons for the exclusion do not apply to such trials. The benefits package should cover patient care provided in the course of treatment as required by the design of the trial.

- *Any rate-setting methodology must be designed to accommodate the atypical services and patients of these cancer centers.*

  The freestanding federally-designated cancer centers treat a disproportionate number of complex and severely ill patients and use particularly sophisticated techniques. Such care generally costs more and this must be recognized. Frequently, such care will be less costly in treating cancer if it effectively controls or cures the disease than would caring for patients with chronic, disseminated disease.

  Because of their atypical services and patients, current law affords nine freestanding cancer centers special status under the Medicare reimbursement system. Comparable status for both inpatient and outpatient services should be afforded the nine centers under any payment mechanisms adopted by states or health alliances.

THE CANCER CENTERS ARE NATIONAL RESOURCES

As part of the National Cancer Program, the NCI was directed to designate certain cancer centers to develop new and more effective approaches to diagnosis, treatment and prevention of cancers and introduce them into clinical practice.[1] These state-of-the-art programs of research and patient care offer the greatest possibilities for successfully reducing both the human and financial burden of cancers on our society. Research is the driving force that allows these cancer centers to innovate care which clearly is necessary because, today, we can effectively prevent few cancers and cure about 50 percent of all newly diagnosed cancers.

As the centers develop new methods for treating, preventing, and detecting cancer, they demonstrate their effectiveness through treatment of patients at the centers and disseminate information on these developments so that they can be incorporated into clinical practice throughout the country. Much of the progress made in understanding the biology of cancer and the treatment of this disease is directly attributable to the work done in these NCI-designated cancer centers.

The cancer centers have played pivotal roles in developing and advancing treatments for childhood leukemias which previously were often fatal and are now highly curable; developing techniques for the early detection of cancer; originating limb preservation techniques that minimize disability and disfigurement; developing bone marrow transplantation to cure previously untreatable cancers; achieving a better than 90 percent cure rate for early stage testicular cancer, the most common cancer in men between ages 20 and 40; markedly reducing mortality for cervical cancer; and perfecting ambulatory cancer treatment for large numbers of patients. The work continues, as the cancer centers innovate in such areas as prevention of cancers; early detection when the disease is most likely to be curable; gene therapy; and immunotherapy. The cancer centers' endeavors have contributed to the increasing number of survivable cancers and have enabled countless individuals to return to productive lives.

Health care reform must be undertaken in a manner that does not undermine the National Cancer Program nor deprive patients of access to these cancer centers.

ASSURING ACCESS UNDER MANAGED COMPETITION

Many health care reform proposals, including the President's, are intended to foster the development of managed care. In any expansion of managed care, extreme caution must be taken to assure that cancer patients are not denied the state-of-the-art treatment available primarily, and often only, at the NCI-designated cancer centers. These federally designated national resources must continue to be available to the general population and should not be limited to affluent patients who can afford high coinsurance payments or special insurance coverage.

Moreover, without a patient base with which to test promising new discoveries, the essential translation of treatment advances from laboratory bench to the patient's bedside will not occur: Without patients, the cancer centers would be unable to carry out their mission under the National Cancer Program in patient care, research and health professional training.

Therefore, any health care reform legislation must contain the following protections to assure access by cancer patients to the NCI-designated cancer centers—

- Any cancer patient enrolled in a managed care plan must be guaranteed the right to choose treatment at an NCI-designated cancer center without the obligation of excessive financial burden.
- Managed care plans would be required to provide information on NCI-designated cancer centers to enrollees of all plans.
- Health plans should be required to permit the referral of their patients to designated specialty providers and centers of excellence. This should be a state mandate—not a state option.
- NCI-designated cancer centers should automatically be considered to be designated specialty providers or centers of excellence.
- The referral to NCI-designated cancer centers should not be limited to in-state centers. Health plans should be required to permit the referral of their patients to an NCI-designated cancer center that can provide appropriate services regardless of location.

THE BASIC BENEFITS PACKAGE SHOULD COVER QUALIFIED CLINICAL TRIALS

A clinical trial on a new cancer therapy is initiated because of expert judgment, generally based on extensive pre-clinical and preliminary clinical evidence, that the

[1] 42 U.S.C. §§285a through 285a–3.

therapy is likely to be more effective than the therapy otherwise available. The trial is intended to establish the superiority of the new therapy definitively. Patients in trials can benefit since they may receive treatment that is substantially better than conventional treatment.

The NCI-designated cancer centers play major roles in conducting clinical trials of new methods to prevent and treat cancer. Through such trials, the cancer centers develop the standards of treatment that are eventually used by physicians and community hospitals throughout the nation.

Although approved clinical trials offer the possibility of superior treatment for cancer patients, insurers frequently deny coverage of the associated medical care, such as the hospital stay or physician visits, under policy or plan provisions excluding "investigational" or "experimental" treatment. By inappropriately invoking provisions designed to prevent payment for questionable or speculative treatments, insurers have adopted policies precluding reimbursement for state-of-the-art, advanced medical treatments that are frequently more effective and ultimately more cost-effective than those the insurers would readily pay for. Cancer becomes a great human and financial burden when it cannot be controlled, cured or, even better, prevented.

The National Cancer Institute agrees that health insurance should cover clinical trials and " . . . does not consider the research exclusion justifiable. For patients with life-threatening diseases for which standard therapy is inadequate or lacking altogether, participation in well-designed, closely monitored clinical trials represents best medical care for the patient. The NCI believes that clinical trials *are* standard therapy for cancer patients to whom a curative therapy cannot be offered. . . . For these reasons, we consider it appropriate for third-party carriers to reimburse patients for medical care costs of participating in scientifically valid clinical trials."[2]

The basic benefits package established in health care reform legislation must include coverage of the medical care associated with clinical trials provided to cancer patients if the trials have been approved by (1) HHS, NIH, or NCI; (2) the Food and Drug Administration, in the form of an investigational new drug exemption (IND); (3) the Department of Defense, the Department of Veterans Affairs; or (4) a qualified nongovernmental research entity as identified in the guidelines for NCI cancer center support grants.

Coverage of cancer clinical trials should not increase aggregate health care costs. Treatment of cancer patients through clinical trials is ordinarily a substitute therapy that is not necessarily more expensive than conventional therapy.

Administrative costs (e.g., data management) of the clinical trials should not be covered, but all patients care costs pursuant to the design of the trial should be covered.

THE NINE FREESTANDING CANCER CENTERS SHOULD BE PROTECTED FROM INAPPROPRIATE PAYMENT METHODOLOGIES

To carry out their mission under the National Cancer Program, the NCI-designated cancer centers treat a disproportionate number of severely ill patients, and they utilize sophisticated, state-of-the-art methods The centers are mandated under the National Cancer Program to help find a cure for cancers. This function cannot be accomplished without the development of new technology, and payment restrictions that act to suppress the development of new technologies at the centers would be contrary to their statutory function. The centers cannot fulfill their mission if they are paid on the same basis as community hospitals that treat an ordinary patient population with standard forms of treatment.

Most of the NCI-designated cancer centers are part of larger, diversified academic health centers; only nine are freestanding facilities including the three originally designated comprehensive cancer centers, M.D. Anderson, Houston; Roswell Park, Buffalo; and Memorial Sloan-Kettering, New York City.[3] As such, they are particularly vulnerable to any health care financing measures that do not take their unique characteristics of predominantly caring for cancer patients into account. Such a patient population has substantially higher levels of acuity and complexity of illness than would the patient mix of a general hospital facility. For that reason, Congress

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[2] Raub, William F. "Remedies and Costs of Difficulties Hampering Clinical Research." January 1989. (Submitted to the Senate Committee on Appropriations in response to S. Rep. No. 100–399.)

[3] The remaining six are: City of Hope National Medical Center, Duarte, CA; Dana-Farber Cancer Institute, Boston, MA; Fox Chase Cancer Center, Philadelphia, PA; Fred Hutchinson Cancer Research Center, Seattle, WA; Arthur G. James Cancer Hospital and Research Institute, Columbus, OH; Kenneth Norris Jr. Cancer Hospital, Los Angeles, CA.

determined that the Medicare diagnosis-related group (DRG) system was inappropriate for the nine centers.

By law, Medicare exempts the nine centers from the prospective payment system (PPS) for inpatient hospital services and instead pays them under a cost-reimbursement method.[4] Since PPS uses DRGs based on typical cases, Congress concluded that it would not be appropriate for the atypical services of, and patients treated by, the nine cancer centers.

In a June 1993 report, the Prospective Payment Assessment Commission (ProPAC) reconfirmed that the reasons for the statutory exemption continue to exist today.[5] The statutory exemption acknowledges the cancer centers' status as unique, state-of-the-art facilities with the most acutely ill cancer patient populations. Importantly, the exemption confirms that the existing cancer DRGs do not reflect the complexity of illnesses treated at the cancer centers, or the intensity of services provided.

If health care reform legislation allows or requires rate-setting, it should include special requirements governing the nine freestanding cancer centers comparable to the Medicare exemption.

As Congress recognized in exempting the nine freestanding centers from the Medicare prospective payment system, controls based on average cases or the experience of ordinary institutions, such as controls based on DRGs, would be completely inappropriate for these freestanding centers. Federal legislation should require a similar approach, with respect to both inpatient and outpatient services, for any rate-setting by states or regional alliances.

An appropriate rate-setting methodology would be based on the historical costs (e.g., average-per-patient costs) of each freestanding cancer center, updated to reflect inflation and any significant changes in the center's patient case-mix or services provided. Any such methodology should be subject to revision based on changes at each center. Rates must be established in a manner such as this if the nine freestanding cancer centers are to remain viable.

ALTERNATIVE STATE SYSTEMS

Some proposed health care reform plans would allow states to substitute their own reform and cost control plans for the national program. If this is permitted, the federal regulation should require states to adopt the protections and benefits package requirements specified above. The National Cancer Program is an important federal initiative that should not be thwarted by state regulation that does not adequately accommodate the NCI-designated cancer centers.

To ensure that the services of the NCI-designated cancer centers remain available to patients, and that these centers continue to provide complex, state-of-the-art care, it is essential that health care reform be structured to include the following elements:

- Patients in managed care plans suffering from cancer must be guaranteed access to the specialty services and treatment available at the NCI-designated cancer centers without overly burdensome financial penalties.
- All managed care plans should be required to provide information on NCI-designated cancer centers, and how to access their services, to their enrollees.
- The definition of an academic health center should include the freestanding NCI-designated cancer centers.
- NCI-designated cancer centers, including out-of-state centers, should be included as "designated specialty providers" to which health plans must allow the referral of their enrollees.
- Qualified clinical trials must be included in the basic benefits package.
- Rate-setting applicable to the nine freestanding cancer centers should be limited to an appropriate non-DRG methodology for both inpatient and outpatient services.
- Any alternative state system created under the health care reform legislation should be required to include comparable protections for the cancer centers and patients.

RESPONSES OF PAUL MARKS TO QUESTIONS FROM SENATOR DOLE

Question No. 1. The concerns that you cite regarding patient access to your very specialized facilities cannot be much different than the concerns of those who run rehabilitation hospitals or pediatric facilities.

[4] 42 U.S.C. §1395ww (d)(1)(B)(v).

[5] Prospective Payment Assessment Commission. "Medicare and the American Health Care System: Report to the Congress." June 1993. Pages 84–85.

Practically, how do we insure that patients have freedom to choose you? The managed care programs argue that if we force them to contract with any willing provider, we destroy their ability to truly manage the care they give.

Answer. First of all, it is important to know how patients have traditionally accessed facilities like ours. Historically, over 55% of the patients coming to the NCI-designated freestanding cancer centers are *self referred.* In other words, more than 55% of our patients, on their own volition, have chosen to come to our centers for treatment.

It is also important to point out that, under the National Cancer Act of 1971, the National Cancer Institute (NCI) has established a rigorous procedure for designating comprehensive and clinical cancer centers. In order to be designated, a center must meet high standards for clinical care, research and teaching.' There are forty such NCI-designated centers across the country of which nine are free-standing.

However, the most recent experience is that patients are frequently permitted to come to the NCI-designated cancer centers for "second opinion" and then are not permitted to stay for treatment. Virtually no patients enrolled in managed care plans that have contracted with the cancer centers are referred to the centers for treatment.

The point-of-service option would allow patients to self-refer to an NCI-designated cancer center. Legislation is also needed to establish out-of -pocket caps for co-payment and for premiums relative to point-of-service so that there are no overly burdensome financial barriers to enrollees in obtaining such plans.

Question No. 2. The issue of paying for service incident to the participation in a clinical trial has been a difficult one in the past.

What, if any, thought has been given to funding these costs as part of the research costs of the trial rather than through the insurance payments system?

Answer. Much thought has been given to your question and the answer is clear: the patient care component of clinical trials is an insurance issue and not a research grant funding mechanism issue.

It is important to review how clinical trials are currently reimbursed. The research costs of clinical trials (i.e., costs of special drugs; data management and administrative costs) are reimbursed by the sponsor (e.g., the National Cancer Institute (NCI), a pharmaceutical company, or the institution itself) of the trial.

The direct costs related to patient care (i.e., the hospital stay, physician visits and diagnostic tests) have traditionally been paid for by insurance companies under the "medically necessary and appropriate" clauses of the policies. The insurance language for exclusion of coverage for experimental therapies was always intended as a patient safety net so that patients would not be subjected to scientifically questionable therapies (e.g., laetrile).

However, beginning approximately two years ago, insurance companies, in order to contain costs, have begun to aggressively deny payment for the necessary patient care during clinical trials. In fact, a major insurer has in its health insurance policies explicitly excluded from reimbursement any patient care costs if the patient is enrolled in Phase I through IV trials.

Most of the health care reform proposals include patient care costs for health care enrollees on clinical trials in the standard benefits package. However, a better approach is found in separate bills introduced by Senators Breaux and Durenberger, and by Senator Chafee, both of which require coverage of all routine patient care costs according to the design of the study. If the study is peer-reviewed and is found to be appropriate, the patient care costs would be covered. There is no ambiguity in the language.

Another factor to keep in mind is that these costs are already part of our current health care system. A patient comes to our cancer center to have his or her cancer treated and possibly cured. They are not admitted solely for entry into a clinical trial. After admission, the patient may be subsequently eligible for inclusion in an ongoing clinical trial. Regardless, the patient receives the best therapy available for the particular cancer diagnosis.

To put this issue into a comparative context, approximately 3% of all cancer patients treated in the U.S. are on clinical trials. This 3% is concentrated in institutions like ours, where approximately 25% to 30% of our patients are on clinical trials.

RESPONSES OF PAUL MARKS TO QUESTIONS FROM SENATOR GRASSLEY

Question No. 1. **You stated in the introduction to your statement that managed care plans tend to restrict access to cancer centers by seeking the least expensive providers with inadequate regard for the quality of care.**

There has been testimony before this Committee to the effect that capitated managed care plans may have an incentive to underserve, in theory at least. But what evidence can you cite for your view that this is actually happening with respect to access to the cancer centers?

Answer. Our most recent experience is that patients may be permitted to come to the NCI-designated cancer centers for "second opinion," but they are frequently not permitted to stay for treatment. Virtually no patients enrolled in managed care plans that have contracted with the cancer centers are referred to the centers for treatment. For example, to be specific, there have been essentially no referrals from managed care plans to Memorial Sloan-Kettering Cancer Center (New York City) nor to M.D. Anderson (Houston). These two centers are the largest cancer care hospitals in the United States.

Question No. 2. Let me ask a more general question. Is the situation that Dr. Marks believes exists for the Cancer Centers happening more generally with the Academic Medical Centers? That is, are the academic medical centers experiencing a loss of patients because organized delivery systems do not send their patients as readily to sophisticated academic centers?

Answer. Yes, as indicated above.

Follow-Up

Dr. Marks argued that "health plans should be required to permit the referral of their patients to designated specialty providers and centers of excellence."

May I have the comments of the other panelists on this suggestion?

Answer. Not Applicable to Dr. Marks.

Question No. 3. I am very aware that teaching hospitals deliver care in a more costly manner because they deliver more specialized care. In an effort to ensure choice as well as preserve academic health centers, many centers would like to mandate that all health plans contract with these centers. However, in an effort to contain costs, approval of specialized care and experimental therapies could be denied. Could you comment?

Answer. I believe that Congress will have to take action to preserve this country's superior clinical research programs embodied in our academic health centers. In particular, Congress must make provisions that the mission of the National Cancer Program—furthering the knowledge of curative treatments for cancers—can continue in a reformed health care system. Congress can ensure guaranteed access to federally designated cancer centers for patients who need and desire such care and should provide coverage of patient care costs of qualified clinical trials in the standard benefits package.

PREPARED STATEMENT OF DANIEL K. ONION

I have been practicing, living, and advocating for primary care for 25 years.

I grew up in rural Vermont, and after graduating from Harvard College and Medical School, I did my residency training in internal medicine under Dr. Robert Petersdorf, in Seattle. Although I had been cared for as a child by family practitioners in Vermont, no one in Boston ever mentioned that breed of doctor, except in derogatory terms. In Seattle, I realized that my plans to be a cardiologist fit neither with what the country needed nor my image of a real doctor. I and others in our residency were supported by Dr. Petersdorf when we worked to create continuity of out-patient care over our three years of training. I was impressed by Dr. Ted Phillips who was recruited to Seattle to head the new family practice program, similar to ones that were being created then throughout the country. While still in Seattle, I helped create and teach the curriculum for the first three classes of MEDEX, one of the first physician assistant training programs in the country.

I obtained my Master's of Public Health and thereby learned a lot about health maintenance organizations. I then returned to northern New England to found a rural group practice of physicians in Farmington, Maine, which created an extensive community-oriented primary care program and Maine's first health maintenance organization. I helped write HMO enabling legislation in Maine. I began teaching in Maine's family practice residencies one or two half days a month and eventually became a member of the Maine-Dartmouth Family Practice Residency faculty in Augusta. I became that residency's director, despite not being family practice trained myself, in 1985.

Our program, since its inception in 1973, has graduated over 100 family practitioners, 2/3 of whom remain in practice in Maine. We have used both federal family practice training grants and private foundation grants as ways to develop the infrastructure to support our residents in training and our graduates in practice in Maine. Our faculty's modest research and publications deal primarily with clinical

and health service delivery issues. Each year, our residency serves as a training site for several dozen medical students from Dartmouth and other northeastern schools as well as for physician assistant and nurse practitioner students.

I chair the Maine primary care residency directors group which learned a lot about DME and IME as we successfully undertook a legislative project in Maine three years ago to allow expansion of our residencies.

1. Train more primary care physicians and fewer specialists by capping total residency positions at 110% plus or minus 10% of current American medical school graduate numbers and by establishing a target that 50% of these positions be in primary care by a specific date; control this at the national level.

We need to be training a substantially higher proportion of our current medical school graduates as primary care physicians ("real docs," not gatekeepers, a pejorative term invented by "partialists" or limited practice physicians), a substantially lower proportion as specialists, and stop exploiting international medical graduates as cheap resident labor in poor training programs.

I hope I needn't spend much time convincing you of the overall wisdom of these goals since they seem to be universally agreed upon by most of the current reform proposals. The Council on Graduate Medical Education, the American College of Physicians, the American Academy of Family Practice, the American Association of Medical Colleges, and the Physician Payment Review Commission all have referenced, articulate statements to this effect. But I would like to persuade you that you cannot rely on the marketplace to effect these goals. There should be deliberate congressional action to address the need to increase primary care residency positions and to decrease some specialty positions.

You have heard, I know, from Jack Colwill, the sad saga of primary care in this country over the last three decades while I have practiced. We now have only 1/3 of our physicians who are primary care docs, and 2/3 who are not. And that proportion has been declining rapidly, since only 15% of our medical school graduates have been going into primary care for the past several years, 1993 and 1994 have seen slight improvements perhaps thanks to the promise of the recent rhetoric and the natural inclination of medical school entrants to be real docs. HMO's staff at the inverse of this ratio. Most industrialized countries in the world average at least 50% of their physician work force in primary care.

If you allow continued unlimited training of high tech specialists, you will get, as you have now, lots of high tech medicine without comprehensive care. Just as, if all you have is a hammer, then everything will tend to look like a nail, so too, if gastroenterologists are paid $600/20 minute endoscopy procedure, then they will tend to feel everything needs to be scoped. So there is some heavy, painful cutting to be done.

I agree with the PPRC; I think that such cutting is best, most fairly and consistently done at the national level, not through local "consortia" which don't now exist and remind me of the old Health Systems Agencies on which I served. Our residency is very unique in that it is a consortium of two community hospitals and a medical school, but it took years to develop and the real medical school involvement is marginal at best.

It is fashionable to contend that we most need more primary care in rural and urban underserved areas. I think we definitely need it there where inadequate physician compensation, isolation, low prestige, excessive workload, and poor people with high social service needs have all been identified as contributing to health care access problems. But, those same problems, except for the last, exist in the more urban, affluent areas too; at least in Maine, we need lots more primary care everywhere. Right now specialists try to do that with their specialized hammers at great expense and generally poorly and inefficiently because of their lack of training. When the health insurance system for the Maine State employees changed last spring to a managed care plan which required assignment of a primary care doctor to each enrollee, 40% of the employees in Augusta, the State capital, had no "real doc" and the primary care system was overwhelmed.

2. Pay direct medical education (DME) monies directly to the residency program; pay the indirect medical education monies (IME) either directly to the residency or to the institutions in which the training takes place (hospitals, group practices, HMO's, community health centers, etc.) and inform the residency program of these amounts.

Primary care residencies are generally in weak political positions in their sponsoring institutions (usually hospitals) because of years without prestige and consequent inferiority complexes.

Residency directors are usually kept in the dark about DME and IME and are usually led to believe that they are lucky to be allowed to exist at all on whatever

handout they may be graciously given. Specialists, because of money, time and prestige, dominate medical staffs and hospital administrations.

Likewise, community hospitals, where much primary care and most family practice training takes place, have little influence with and rarely get any financial help from tertiary care centers and (even less often) medical schools.

For example, most medical schools require primary care clerkship experiences for their students but pay nothing for the training while still receiving and keeping tuition and capitation payments. Our residency provides such training for two Dartmouth and two or three additional students from other medical schools continuously (4+ student FTE's). We rent a house for the students, provide discounted meals, provide exam rooms and medical assistants to help them, and pay faculty physicians to directly supervise all their work, entirely at our expense. We do the same thing for physician assistant and nurse practitioner students as well. That is the norm; we have been met with incredulous, "impossible" responses when we ask for payment. Nevertheless we must participate in this training to recruit medical students and PA/NP's to primary care and to our area.

Even in my home community hospital, our primary care program has had to wait 15 years to get a new family practice center building to replace our current one which has literally been falling down for all 15 years.

So don't expect much to trickle down to primary care programs if you pay medical schools certainly, or tertiary care hospitals, or even community hospitals.

3. Because costly supervision and outpatient facilities are needed, it takes $100,000 per resident per year to train a primary care physician. The $55,000 per resident currently proposed is predominantly based on an average in-hospital training cost for specialists.

Annual resident salaries (for 80-hour weeks) average in the low 30's now with malpractice insurance ($9,000) health, life, and disability insurance travel mileage and other benefits, the direct cost is conservatively $45,000 per resident per year. Accreditation requirements and realistic teaching needs in primary care are for at least one FTE faculty (at least $140,000/year with malpractice and fringe, and rising fast) per 4 residents and in a good program the ratio is usually 1/3. One can legitimately bill in the faculty's name for patients cared for exclusively by faculty and those jointly seen with residents and students, and thus realize $25–35,000 per year per faculty (total direct supervision would defeat the purpose of the training program to produce competent, independent physicians). Substantial additional graduate medical education (GME) funding must accrue to the institution where the resident does his/her clinical training to support exam rooms, receptionists, social services, medical and nursing assistance, billing, and the whole panoply of primary care practice support made less efficient by the presence of neophytes. All this amounts to well over $25,000 per resident.

Annual Cost of Training a Primary Care Physician

Resident Stipend	$30,000
Fringe at 25%	7,500
Malpractice	9,000
Faculty cost at 3.5 residents/physician faculty	40,000
Faculty $ generation/resident	(10,000)
Practice related inefficiencies (fewer patients seen per room, per nurse, per receptionist etc)	25,000
Total cost per resident per year	$101,500

Whether this $ 100,000 is covered by DME and IME, or DME alone, doesn't matter as long as it flows to the residencies. Primary care residencies do care for a disproportionate share of the poor, disabled, and mentally ill all of whom have more complex problems, so one could argue for some IME, as it is currently defined, on this basis. It seems to me that IME now has more to do with supporting academic medical centers than residency training realities.

4. We need medical students exposed to primary care programs and more nurse practitioners and physician assistants to supplement primary care teams. Thus you should financially support medical student and PA/NP training which now result in hidden costs to primary care residencies and other primary care practices expected to provide free practice facilities and supervision for such students.

I believe that all the hoopla about the independent nursing practice is a "tempest in a teapot" because in my experience, real primary care physicians desperately need PA/NP's and vice versa. I frankly don't think any provider should be practicing

totally independently, but rat.her all should be forced into cooperative relationships. When you are up to your ears in alligators with sick patients and sharing responsibilities with other conscientious health care providers, you ask the others for advice and counsel on how to do the best job to make patients better; you are not concerned about practice boundaries, nor should you be. We all learn from each other as well as our patients.

Certainly PA/NP's need to be expected to provide or help physicians provide 24-hour coverage. Systems that set up independent nurse practices without real 24 hour coverage will break the backs of the few primary care physicians we have out there, if the NP patients then come to the primary care docs on nights and weekends.

Right now the support for PA/NP's training is minimal. There is no provision for student stipends during training, nor is there any money for precepting/teaching them during that training.

I don't know what the right way to do this is but I do know that the numbers we are producing are inadequate, and don't think the modest dollars that are being proposed are going to be adequate to expand physician assistant/nurse practitioner training to the level that we need if we are really going to deliver adequate primary care in this country.

Thank you for inviting my comments.

PREPARED STATEMENT OF RAYMOND G. SCHULTZE

Over the past 30 months, this country's healthcare delivery system has received unparalleled scrutiny and its multiple flaws have been detected. The Congress is now engaged in examining the details of the proposals that offer corrections to these flaws. While this activity proceeds within these halls, the healthcare system is undergoing dramatic and accelerating change in virtually all of its segments. The change is so profound that some observers have suggested the system has reached a discontinuity in its evolution. Discontinuities in any industry present a profound survival challenge to existing organizations. Indeed, the history of organizations in other industries facing similar changes teaches us that only a small fraction will manage to survive the transition. When those organizations are steeped in tradition, like the Universities of which we are a part, the challenge is particularly daunting.

The most immediate challenge is that our academic environment develop a innovative, flexible, competitive, business-oriented approach to clinical activities that historically have been in an environment of professional gentility. This transformation will require revolutionary rather than evolutionary change.

The changing delivery system brings a second revolution to academic medical centers. The new system will require far fewer medical specialists and sub-specialists than we have produced or are producing and the training of many more primary care physicians. However, our medical schools and academic medical centers are geared to the training of specialists not primary care physicians. Thus, our education and training activity must be retooled while we are simultaneously attempting to successfully adapt to the new delivery environment as a business entity.

Changes in California's healthcare delivery system have been ahead of most states. UCLA's academic medical center has been forced to deal with the new challenges for some time. What follows is a brief description of the events that shaped the challenges and our response to them.

BACKGROUND

Mission

The UCLA Medical Center's primary mission is to serve as the clinical laboratory for students and faculty of the UCLA School of Medicine. In the context of today's healthcare delivery system, the clinical laboratory includes both ambulatory and inpatient settings. In addition, we must attract patients to provide the primary and tertiary clinical experiences necessary for the education and training of medical students and residents. We also provide support for the clinical research and technology transfer activities of the faculty. Finally, with the UCLA Medical Group, we provide a full range of healthcare services to a broad spectrum of patients with a wide variety of clinical problems with an emphasis on the most complex. Some of these services are available only at centers like ours.

The successful accomplishment of our mission is directly dependent on our ability to succeed as part of our community's healthcare delivery system. Success is measured by maintenance of a sufficient share of the healthcare market so that our clinical programs are adequately populated and that we remain financially capable of

maintaining a highly professional, well trained staff and a state-of-the-art physical plant. Since less than 2% of our hospital budget comes from the State of California, we are dependent on the revenues earned through the care of our patients in the healthcare marketplace for our financial viability.

The Southern California Healthcare Environment

Southern California's healthcare market has been changing since 1983 when the State of California decided to purchase inpatient services for its Medi-Cal beneficiaries through a selective process that awarded contracts to the low cost provider. Insurance companies and the "Blues" were granted similar contracting privileges for all healthcare services rendered their beneficiaries. The salient effect of the selective contracting program was to introduce price competition into the healthcare market.

The past ten years has seen the health plan' component of the market place evolve in a predictable manner. Preferred provider organizations (PPOs) which contract for services on the basis of a discount from charges, grew most rapidly at first but are now have a declining market share. Health maintenance organizations (HMOs), which reimburse physicians on a capitated basis, are replacing PPOs because of their economic advantages. Growth in Medicare HMOs has been dramatic, and relatively soon, more than half of the Medi-Cal population will be in capitated programs as well. Traditional insurance plans, which pay providers on a fee for service basis, have all but disappeared.

The provider environment has also evolved. The dominant development in Southern California has been the evolution of multispecialty and primary care physician groups which provide care for patients under a contract arrangement with health plans. On the other hand, there has been less development of hospital alliances than in other parts of the country.

Insurance companies with PPO products contract with a selected number of medical groups on a discounted fee for service basis. The medical groups trade patient volume for price. Medical groups contract with HMOs to provide care to a population on a capitated fee basis and assume financial risk for this population either on a shared risk or full risk basis. In shared risk arrangements, the medical group is responsible for all outpatient costs and inpatient professional fees. The Health plan or a hospital assumes the risk for the cost of inpatient care. In full risk arrangements the medical group is responsible for the cost of all covered services in both the ambulatory and inpatient settings.

In the current environment, the organization that purchases healthcare, whether a medical group, state government, or a business, will use price as the most important criteria. For most of these organizations, there is an *a priori* assumption that the differences in the quality of care among licensed providers is not discernible. It follows that for readily available services the successful bidder is the low cost provider.

The future evolution of the healthcare delivery system in Southern California will see the continued development of physician groups. However, because these groups have limited access to capital, they will gradually become components of large fully integrated healthcare delivery systems. Ultimately competition between these systems will be less on price (which will be uniformly low) and more on quality.

UCLA'S RESPONSE TO ITS CHANGED ENVIRONMENT

Reduction of the hospital cost structure.

Southern California's price driven healthcare environment presents a major challenge for UCLA's Medical Center and Medical School. The region is awash in excess hospital beds and there are large numbers of highly skilled specialist physicians, many trained at UCLA or an affiliated program, who can, in the near term, effectively compete with the medical school's faculty. As a result of the provider surplus, a buyers market exists which has driven prices for professional and institutional services ever lower. The pressure on prices is not likely to ease until enough hospitals close and enough physicians leave practice to bring into alignment the supply of providers with the demand for services. Until that time arrives the UCLA clinical enterprise must find ways to compete in this price sensitive environment.

Since the prices for the services we provide must be competitive, we have worked hard to reduce our cost structure. From 1988 through 1991 annual reductions of between 2.5 and 7.5 percent in the budget of the Medical Center were achieved. In 1992 the UCLA Medical Center and Medical Group embarked on an effort to reduce the hospital operating budget by 28% over three to four years. This will require a reduction of $700 million in our "malleable" operating budget of $358 million. We expect to accomplish this task in three phases. Phase one planning calls for substantial restructuring of hospital operations and results in a $50.2 million reduction in

our cost structure. To date $30 million of the cuts have been implemented and the remaining $21.2 million will be implemented within six months.

Phase two of this effort will address the style of practice by physicians on our medical staff. By introducing care pathways fOr commonly encountered clinical problems and careful case management we expect to achieve an additional $25 million in savings. The use of clinical care pathways will be coupled with a careful measurement of outcomes in order to assure that the consensus driven treatment plans are optimized through a continuous improvement process. The final $25 million will be achieved in phase three through further restructuring efforts in a manner similar to those in phase one.

The effort to reduce costs is a broad based institutional undertaking stimulated by our competitive, highly price sensitive, healthcare environment. The effort has been characterized by high levels of creativity and innovation. It is unlikely that a regulatory process could stimulate a process of this quality and magnitude.

Cost and price reductions by the entire healthcare community have kept the rate of increase of healthcare costs in California to levels that are at or below the changes in the consumer price index. Indeed, it is entirely possible that unit healthcare costs for both government and business will actually decline in the next two or three years, and as more patients are cared for in HMOs, the volume of services provided may decline as well.

The maintenance of marketshare.

Achievement of low cost will not necessarily ensure that academic medical centers can accomplish their mission in the new environment. The challenge of attracting a sizable patient population that will ensure that the education, training and research missions can be fulfilled goes beyond price. We must build a system of care that guarantees that both our primary care and tertiary care programs have access to a sufficient share of our local and regional market.

In order to achieve the primary care base necessary to provide a clinical component of routine cases, UCLA has developed a capitated primary care practice on the campus around a cadre of family medicine, general internal medicine and general pediatrics faculty. We are also developing a network of primary care groups in our local market area. We expect this network will eventually serve 200,000 to 400,000 HMO enrollees.

The quality and breath of the tertiary care provided by the UCLA Medical School faculty and hospital staff has provided the basis for the distinguished reputation of the UCLA Medical Center. Our faculty, not unlike those of most medical schools developed over the past four to five decades, is highly specialized. In addition to providing tertiary care, the faculty carries out a comprehensive clinical research program. It is also their responsibility to train the next generation of tertiary care providers.

In order to provide the clinical base for this extensive activity we have signed over two hundred contracts with other healthcare organizations to provide all levels of tertiary care to members of their PPOs and HMOs. Some of these contracts represent "new products" designed specifically to meet the needs of the primary care and multispecialty medical groups in our healthcare market. For instance, we offer to provide, on a capitated basis, all tertiary services needed by the patients they care for under a capitation agreement. The advantage to the primary care or multispecialty group is that this arrangement transfers the financial risk of tertiary care to us and lowers their administrative costs. For the academic medical enterprise these contracts bring the broad range of clinical problems needed to ensure that our clinical training programs offer adequate experience and that our clinical research efforts can be successful.

ORGANIZATIONAL ISSUES

The challenges to the survival of academic medical centers inherent in the healthcare marketplace revolution may not be as daunting or dangerous as the challenges derived from the nature, tradition, history, and multiple mission orientation of our organizations themselves.

Adding a business culture to the academic environment.

The close association of academic medical centers and research universities has been highly productive. The university's faculty-directed reward systems, which emphasize individual effort and the independence and decentralization of programs have served the scientific efforts of medical schools well. Traditionally, university faculties have shunned management as something antithetical to the academic environment.

The previous healthcare environment was forgiving enough so that clinical activities could successfully exist in the academic environment. But the new environment demands that clinical activity be carried out in a highly coordinated and disciplined manner. Well integrated multispecialty and primary care medical groups will be the only ones that will succeed. The challenge to the members of the academic medical center community is to build and effectively operate such organizations despite their academic traditions.

Ailgning the organizational structure and incentives with its missions.

An organization faced with an intensely competitive environment must be able to focus on the means to achieve its mission. The mission must have clarity and there must be a vision that describes the means of achieving the organizations mission-related goals. For academic medical centers this task is complicated by the presence of three missions: research, education, and clinical service. While these three missions are related, the cognitive approaches to them and the means of achieving them are sufficiently different, that pursuing them simultaneously within the current organizational structure generates a considerable degree of organizational dissonance.

This burden of multiple missions must be turned into an advantage in order to succeed in the new healthcare environment . Our institutions must redefine the role of the academic clinical department visa vis the multispecialty group. We will have to recognize that the "triple threat academician" must be replaced by the specialist researcher and the generalist clinician. We will have to link our medical centers, ambulatory operations, multispecialty group practices and primary care networks into cohesive healthcare systems. Ultimately form must follow function and the lessons learned over the last four millennia about the values of the division of labor must be constructively applied to our endeavors.

The importance of these organizational issues is rapidly becoming apparent to the leaders of the various components of our academic medical centers. It is on their shoulders that the responsibility to bring about constructive change rests. Government, both federal and state, may need to moderate some of the new environmental conditions for a time to prevent unnecessary loss of some of these important organizations while these adaptive changes are made.

THE EDUCATIONAL REVOLUTION

The expansion of primary care training.

As noted previously, the changing delivery healthcare system brings about the need for a second revolution in academic medical centers. Current projections indicate that many fewer specialists will be required in the evolving clinical delivery system and that even now there are in many areas of the country a surplus of medical specialists in the vast majority of specialties. Our medical schools must begin training far more primary care specialist than we have in the past. Indeed, as the marketplace continues to mature, the demand for clinical training in the medical specialties can be expected to fall dramatically. However, most of our medical schools and academic medical centers are geared to the training of specialists not primary care physicians. Thus, our education and training activity must be retooled while we are simultaneously attempting to successfully adapt to the new delivery environment as a business entity.

At UCLA we are fortunate in that we have well established primary care training programs. However, in order to increase primary training even further, our Department of Medicine will cease training subspecialists beginning in 1995 except where the individual trained also makes a commitment to academic medicine by spending three years in basic or health services research. We are also prepared to retrain medical sub-specialists in primary care when there develops a demand for such training.

The changes we have embarked upon are both traumatic and substantial. However, we believe that we can be successful in meeting society's needs for both primary care physicians that will serve the evolving delivery system and sub-specialists that will carry forward the scholarship of discovery that will advance medical science.

Who will pay for education?

Education of healthcare professionals is expensive. There are the obvious direct-costs of supporting the trainee over the prolonged training period. However, since most clinical training is carried out in a "real world" setting and since the presence of the training process decreases the efficiency of the care process, there is a large additional cost of clinical education that while difficult to quantify, is real and must be met. Examples of identifiable training costs are the extra time it takes to perform operative and diagnostic procedures when trainees are involved and the longer

times that must be allotted to ambulatory patient visits when they are seen by a trainee supervised by a faculty member. On inpatient units, where trainees generally function as teams, major communication requirements reduce efficiencies and require higher staffing levels.

Over the past several decades the cost of medical education and training has been increasingly dependent on revenues generated by clinical activities of the medical school faculty and the teaching hospital. In the current competitive environment, however, hospital margins and the professional fee incomes of the medical school faculty are decreasing rapidly due to intense price competition. Thus, support for education from these sources is rapidly shrinking. This loss requires that a new source of funding be found.

At the present time only the Medicare program contributes directly to the support of education. In principle, all organizations that benefit from the educational activities of the academic medical centers should contribute to the costs of that activity. In our setting, it has become clear that in the developing competitive environment, contributions to the support of education will not be made by payer or non-teaching provider organizations on a voluntary basis. This issue will have to be resolved either in the reform legislation or if such legislation is not passed, in another legislative act. The twin educational funds, proposed by the AAMC, has our strong support.

CONCLUSION

The healthcare system in Southern California has changed dramatically over the past decade. The change continues at a rapid rate. There is accumulating evidence that Southern California is not an anomaly; rapid change in the healthcare systems of other regions of the country is occurring as well even before there is healthcare reform legislation.

The changes are characterized by (1) a shift to primary care, (2) the use of ambulatory rather than inpatient settings, (3) payment by capitation, per diem or per discharge rather than fee for service, and (4) the merger of smaller organizations into larger ones in order to gain economies of scale.

The healthcare organizations of the UCLA academic medical center have demonstrated that the competitive environment will stimulate appropriate adaptive responses although not without considerable organizational stress. Costs have been reduced. New contractual relationships have been developed. Educational programs have been redesigned. But many difficult issues remain to be resolved, many of them internal to the academic medical center itself. And still the healthcare environment keeps changing.

There is a need to recognize the educational product of academic medical centers and the costs incurred to produce that product. The AAMC's proposal is an acceptable solution.

Finally, it is worth re-emphasizing, that the healthcare system of the entire country is undergoing dramatic change. The legislation the Congress finally passes and the President signs will not change that fact. It is imperative that the legislation Congress passes supports and supplements the process of change without derailing it.

COMMUNICATIONS

STATEMENT OF THE AMERICAN HEART ASSOCIATION

The American Heart Association submits the following testimony on the funding of academic health centers, in response to S. 1757, the Health Security Act of 1993. The AHA is this nation's largest voluntary health organization dedicated to the reduction of disability and death from cardiovascular diseases, including heart attack and stroke. Annually, AHA's 56 affiliates nationwide coordinate the activities of about 3.7 million volunteers in carrying out this mission.

Despite progress, cardiovascular diseases, including heart attack and stroke, remain a major cause of disability and the No. 1 killer of men and women in the United States. More than 2,500 Americans die each day from cardiovascular diseases—a death every 34 seconds in this country. Heart attack, the single largest cause of death in this nation, kills about 5 times as many American women as breast cancer.

More than 1 in 5 Americans suffer from cardiovascular diseases at an estimated cost to this nation in 1994 of $128 billion in medical expenses and lost productivity. Stroke accounts for about $20 billion of this amount.

In light of the deadly and disabling impact of cardiovascular disease on our nation, the AHA has focused its efforts on working with Congress and the Administration to ensure that health care reform includes the necessary elements for research, prevention and effective treatment of cardiovascular diseases.

The position of the American Heart Association on health care reform has been guided by five principles on Access to Health Care, which the Association feels are critical to any health care reform package. The AHA principles are:

1. All residents of the U.S. should have access to quality medical care.
2. Universal coverage for basic medical care should be available.
3. Coverage for preventive care must be part of any access proposal.
4. Funds must be allocated for biomedical research, research training and clinical training.
5. The AHA should participate in the development of guidelines for appropriate patient care and should support research into methods to measure quality, outcomes and cost-effectiveness.

The American Heart Association does not endorse any one particular health care reform proposal. However, the AHA recognizes that many of its concerns are addressed in the Health Security Act of 1993.

The American Heart Association commends the Clinton Administration for emphasizing access to care in the Health Security Act. In particular, we support access to quality medical care, including appropriate medications and prevention programs, regardless of preexisting conditions. In addition, the AHA applauds the Clinton Administration's commitment to universal coverage of basic medical care, including preventive and cardiovascular care.

The AHA is pleased to find the strong emphasis in the Health Security Act on effective utilization of resources. We appreciate the support for the development of practice guidelines by professional groups with appropriate expertise. We are also pleased that Title V of the Act, Quality and Consumer Protection, would focus government resources on developing measures of treatment outcomes, through health services research to determine clinical effectiveness and cost effectiveness.

However, S. 1757, the Health Security Act, as currently drafted, would drastically reduce the ability of academic health centers to educate and train tomorrow's health care practitioners. By forcing "efficiency" through regulation of price competition, managed competition under the Health Security Act threatens to deprive academic health centers of patients and the lessons they bring. Patients are needed for education of students and physicians. Patient fees are critical for the support of the faculty and teachers. The patient fees are frequently used as well to support medical education and research.

Research conducted at academic health centers, including medical schools, affiliated hospitals, and other health training facilities such as schools of nursing, pharmacy and public health, is critical to AHA's mission. Academic health center research activities provide the scientific foundation for America's biomedical, biotechnological and pharmaceutical accomplishments. These centers also comprise outstanding health care practitioners who represent models of excellent patient care. Support for academic health centers is crucial to developing innovative approaches to the diagnosis, treatment and prevention of cardiovascular diseases, including heart attack and stroke.

Health care reform, by not providing adequate resources, poses a substantial threat to America's academic health centers. While largely unintentional, this threat reflects the conflict between creativity and efficiency. The goal of health care reform is swift and efficient health care delivery, but the mission of the academic health center is the education of health care practitioners and the creation of new knowledge to prevent and treat disease. The academic physician cannot be expected to treat patients as rapidly or as "efficiently" as the full-time clinical practitioner because at academic health centers the focus is both patient need and training.

Academic health centers depend on patient care dollars to supply needed funds for research and teaching, largely because traditional research and teaching support is diminishing despite increasing biomedical research costs. Endowment income and tuition, which paid a significant fraction of these costs up until World War II, now contributes a small and decreasing portion of the costs of maintaining the academic health centers. Direct funding for medical research, largely from the federal government through the National Institutes of Health and supplemented by such voluntary agencies as the American Heart Association, grew rapidly from the 1960s to the 1980s. But like endowment income and tuition, this source of funding has not kept up with rapidly expanding research needs. More recently, funding by the pharmaceutical industry is being reduced by pressures on the industry to lower the costs of drugs.

Managed health care, which relies on cost control through utilization review, is a major concern for academic health centers and their funding. Regulating service delivery through price competition threatens to deprive academic health centers of funds needed for research and education. Currently, patient derived income provides a major source of salary support for clinical faculty in medical schools. Additionally, a portion of the clinical revenues generated by university hospitals supports teaching and research. Unfortunately, the efficiencies demanded by managed care may no longer allow these options.

As we approach the end of the 20th century, it is useful to look back to its beginning, and to the Flexner Report which provided the impetus to develop academic health centers. At the end of the 19th Century, medical education was largely unregulated. The result was that many students were taught by individuals who had little understanding of the diseases about which they were teaching. The Flexner Report, commissioned to examine the poor standards that characterized American medical schools, at the end of the 19th century, recommended that future physicians learn both contemporary clinical practice from expert physicians and surgeons, and the scientific foundations for the prevention and treatment of disease.

The resulting integration of science into the medical curriculum was dramatically accelerated after World War II, when America made a strong commitment to science, and to scientific education. This explosion of knowledge has reduced the age-adjusted death rate from cardiovascular disease by 50 percent, and greatly reduced the suffering caused by heart disease and stroke. New discoveries offer hope of curing such diseases as muscular dystrophy and cystic fibrosis, once thought to be incurable, and preventing other diseases like heart attack and stroke—once viewed as an inevitable part of the aging process.

As noted in the Flexner Report, training our students only in current medical practice yields practitioners whose knowledge of medicine is incomplete and becomes obsolete within a few years of finishing training. Instead, we must train our students in current medical knowledge. We must also use the resources of the academic health center to provide the background to absorb and integrate the immense changes that will be incorporated into medical practice throughout their active lives—which for many will extend into the middle of the 21st century.

Academic health centers are an important national resource, developed through decades of human and financial investment. Like all medical facilities in an era of health care reform, they will become more efficient in the delivery of health care. However, the value of their notable research and education functions cannot be measured only in terms of efficiency. Academic health centers represent an important investment in our future. Clearly, whatever form health.care reform takes, support for the continued growth of this valuable national resource must be provided.

Our third Principle of Access to Health Care states that funds must be allocated for biomedical research, research tag and clinical tag. This principle has three major components:

- support for basic and clinical research at a level that allows reasonable growth;
- support for research training at a level that eliminates current downward trends in research manpower; and
- resources adequate to supply needed equipment and other types of scientific research infrastructure.

Academic health center funding, a major support for research training and maintenance of research infrastructure, is threatened by health care reform. The tremendous benefit that these institutions provide must be preserved. Academic health centers play a crucial role in our health system. The AHA is concerned that the Academic Health Centers are in danger, and if we lose their strength, this will have a major effect on the quality of health care Americans are able to receive in the 21st century.