REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 13-A-09

Subject: Medical Student Debt
(Resolutions 304, 313, and 320, A-08)

Presented by: Claudette E. Dalton, MD, Chair

Referred to: Reference Committee C
(Rodney G. Hood, MD, Chair)

This report combines the response to three resolutions, each of which was referred to the Board of Trustees.

Resolution 304 (A-08), “Medical Student Debt Crisis,” which was introduced by the Michigan Delegation, asks our American Medical Association to pursue long-term solutions to the student debt crisis by hiring an economic consulting firm to analyze the feasibility of novel solutions including: 1) competency-based curriculums that shorten the length of undergraduate education and medical school, 2) work-study opportunities, 3) paid rotating internships for fourth-year students who have passed initial licensing exams and have training equivalents of mid-level providers; 4) financial investment funds that match parental savings; 5) relief for dual degrees not covered by the National Institute of Health; 6) pursuit of Medicare funding for undergraduate medical education funding; and 7) implementing international medical student tuition models, among other viable options.

Resolution 313 (A-08), “Alternative Approaches to Dealing with Medical School Tuition Costs and Student Indebtedness,” which was submitted by the Pennsylvania Delegation, asks that our AMA though the Council on Medical Education and the Initiative to Transform Medical Education, study the applicability of novel models such as using endowment funds to lessen the impact of educational costs on medical students, develop policy recommendations, and suggest a work plan for how these models can be implemented by medical schools, with a report back at the 2009 Annual Meeting. Further, our AMA should work with stakeholders such as the Liaison Committee on Medical Education, Association of American Medical Colleges, and all US medical schools to implement solutions based on novel models such as using endowment funds to minimize student indebtedness, and provide an update on the status of these efforts at the 2010 Annual Meeting and periodically thereafter.

Resolution 320 (A-08), “Tax Deductibility of Medical Education,” which was introduced by the South Carolina Delegation, asks that our AMA advocate that payments for medical education tuition or medical education loans be deductible for US federal income tax purposes. Further, our AMA should continue to work to make medical education affordable for and accessible to all qualified and interested individuals.

The three resolutions ask that various strategies to reduce ultimate medical student debt be investigated. For purposes of this report, these have been grouped into the following general
categories: 1) opportunities to accrue less tuition through a shortened period of study or financial
support for dual-degree options; 2) scholarships and use of endowment funds to offset tuition
costs; 3) work-study opportunities; 4) tax deductibility of tuition and/or student loans; and 5)
federal/state funding for medical education. Current information related to each of these
categories, as well as any relevant AMA policy, will be described, followed by a discussion and
recommendations.

THE MEDICAL STUDENT DEBT CRISIS

Medical student debt continues to rise. Between 2000 and 2007, the mean medical school debt of
indebted graduates, as reported by medical schools, increased from $88,495 to $126,714. Table
1 illustrates the mean debt of graduates of public and private schools during that period.

<table>
<thead>
<tr>
<th>YEAR</th>
<th>PUBLIC SCHOOLS</th>
<th>PRIVATE SCHOOLS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean Debt</td>
<td>% Above $150,000</td>
</tr>
<tr>
<td>2000</td>
<td>$75,068</td>
<td>2.6%</td>
</tr>
<tr>
<td>2003</td>
<td>$90,025</td>
<td>6.4%</td>
</tr>
<tr>
<td>2007</td>
<td>$115,651</td>
<td>29.7%</td>
</tr>
</tbody>
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The rise in debt is mirrored by increases in tuition. Table 2 illustrates tuition for public and

<table>
<thead>
<tr>
<th>YEAR</th>
<th>PUBLIC SCHOOLS*</th>
<th>PRIVATE SCHOOLS**</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Constant 2007 $</td>
</tr>
<tr>
<td>2000</td>
<td>$11,535</td>
<td>$13,853</td>
</tr>
<tr>
<td>2003</td>
<td>$16,332</td>
<td>$18,356</td>
</tr>
<tr>
<td>2007</td>
<td>$23,065</td>
<td>$23,065</td>
</tr>
</tbody>
</table>

* Tuition for individuals defined as state residents
** Tuition for non-residents

Other factors besides tuition may affect debt, such as borrowing patterns based on such things as
interest rates for loan repayment.
STRATEGIES TO REDUCE DEBT

Accruing Less Tuition

Shortening the Total Length of Medical Education. Research illustrates a significant overall cost saving from reducing the length of training from four to three years. There are various models that could serve to decrease the overall length of training and, therefore, the total tuition that students must pay.

A number of medical schools that offer the option for a combined BA-MD program. Only some of these programs shorten the overall length of combined baccalaureate and medical education:

- 6 years total: 1 program
- 6-7 years total: 3 programs
- 7 years total: 14 programs
- 8 years total: 25 programs
- more than 8 years: 1 program

In Canada, there currently are 2 medical schools with a three-year curriculum. This experiment was attempted in the US in the late 1970s and 1980s. In the 125 medical schools during the 1978-1979 academic year, there were 7 where the regular curriculum was three years in length and an additional 16 that had a regular four-year curriculum with a three-year option. The three-year curriculum gradually disappeared in the US during the 1980s.

In the past, there were limited opportunities for combined medical school and residency training (3+3 programs) in internal medicine and family medicine that were approved by the respective medical specialty boards. These programs allowed medical students to complete some of the first-year residency curriculum during the fourth year of medical school. There is renewed interest in this option, especially in family medicine.

Decreasing the Cost of Combined Degree Programs. Resolution 304 asked that attempts be made to reduce the costs of combined degree programs. There is increasing ability for a medical student to obtain an additional degree while he/she is enrolled in MD studies. Data from the 2007-2008 Liaison Committee on Medical Education (LCME) Annual Medical School Questionnaire, which was sent to the deans of all 126 LCME-accredited medical schools with students enrolled and had a 100% response, showed the following availability of dual-degree programs:

- MS/MD program: 33 schools
- MD/PhD program: 108 schools
- MD/JD program: 23 schools
- MD/MPH program: 74 schools
- MD/MBA program: 51 schools

Typically, except for federally-funded or school-funded MD/PhD programs, the dual degree adds extra time to the length of training and includes the cost of the additional degree.

There are, however, some options to reduce the costs of an expanded curriculum. These include both scholarship support and integrating the program into the medical curriculum. These opportunities are especially the case for MD/MPH programs. For example, the Macy Foundation provides 12 scholarships annually to students enrolled in New York medical schools and Emory...
University defrays the cost of tuition and fees for 3 students per year. In some cases, the curriculum is organized so that the program can be completed during the 4 years of medical school.6

Scholarships/Use of Endowment Funds

AMA policy supports the availability of “financial aid opportunities, including scholarships and loan repayment programs” so that individuals “are not denied the ability to pursue medical education because of financial constraints” (Policy H-305.928 [3], AMA Policy Database). In addition, AMA policy states that medical schools “should have programs to assist students to limit their debt” including “making scholarship support available, counseling students about financial aid availability, and providing comprehensive debt management/financial planning counseling (Policy H-305.928, [6]).

Scholarships may be need-based or non need-based and come from a variety of sources internal or external to the medical school. In 2006-2007, medical schools reported that a total of 52,104 scholarships or grant awards were made to medical students (49,251 awards from internal or external sources without a service commitment and 2,943 awards from external sources with a service commitment).7 The total amount of scholarship/grant support without a service commitment was $423 million and total support with a service commitment was $68.6 million.7

As part of the total number of awards, medical students in that year received about 25,700 need-based scholarships from internal sources (with an average amount of about $7200) and about 4100 need-based scholarships from external sources (with an average award of about $5700). Both internal and external funding supports MD-PhD students (about 3,000 individuals funded from internal sources and 1,000 from NIH MSTP funding).7

One source of scholarship support is the endowment of the medical school an/or its parent university. For FY 2007, total endowment revenue for the 126 US medical schools with students enrolled was $1.55 billion, about 2% of total revenue (1.1% of total for public schools and 2.9% of revenue for private schools).8 In that year, medical schools also received a total of $1.8 billion in gifts (2.4% of total revenue). Gifts constituted 1.9% of revenue for public schools and 2.9% of revenue for private schools.8 Both endowment and gift revenue may be either restricted or unrestricted and may be used for multiple purposes, such as capitol needs, as well as scholarship support. While total endowment increased between FY 2005 and FY 2007,8 the current economic downturn has negatively affected the worth of endowments and the endowment income of many medical schools.

The availability of some categories of financial aid for medical students recently has increased. The American Recovery and Reinvestment Act (ARRA) of 2009 included $500 million for the National Health Service Corps and for Title VII and Title VIII of the Public Health Service Act.

Work-Study Opportunities

AMA Policy H-305.928 [8] states that:

Medical students should not be forced to jeopardize their education by the need to seek employment…Medical schools should have policies and procedures in place that allow for flexible scheduling in the case that medical students encounter financial difficulties that can be remedied only by employment. Medical schools should consider creating opportunities for paid employment for medical students.
Work-study is a relatively small component of financial aid funding. In 2006-2007, approximately 2200 medical students received funding from work-study programs, with an average award of about $2340. Of work-study awards, the vast majority were federally funded. For example, the Federal Work-Study Program provides wage subsidies to eligible employers who hire participating students.

**Repayment Policies and Tax Deductibility of Tuition and/or Student Loans**

There is comprehensive AMA policy related to increasing the availability of support and decreasing the costs of borrowing. This includes policies supporting extending deferment of repayment of educational program loans until the completion of residency training and allowing up to 10 years of forbearance (Policies H-305.961, H-305.965), opposing legislation that would make medical school scholarships or fellowships subject to federal income or social security taxes (Policy H-305.962, H-305.997), exempting amounts received under loan programs from income tax (Policies H-305.997, H-305.928, [7]), restoring the deductibility of student loan interest (Policy H-305.955), and informing students of all government loan opportunities (Policy H-295.869).

The recent reauthorization of the Higher Education Act and related legislation (the College Cost Reduction Act) resulted in elimination of the 20/220 pathway as of July 2009. The 20/220 pathway allowed medical school graduates in residency training to claim complete economic hardship deferment if their debt repayment was greater than 20% of their income and their income minus their debt burden was less than 220% of the federal poverty line. The 20/220 rule is being replaced by the Income Based Repayment (IBR) rule, which only allows complete economic hardship deferment if annual income is less than 150% of the federal poverty level. Otherwise it caps monthly payments at 15% of income exceeding 150% of the federal poverty level. Under IBR, it is unlikely that resident physicians will be able to qualify for economic hardship deferment. Instead, repayment begins within six months of graduation unless the resident chooses and is able to enter forbearance. Interest continues to accrue. There is a need to reduce the cost of borrowing, through, for example, the availability of low interest loans, so as to limit the ultimate amount that must be repaid.

Currently, student loan interest is tax deductible up to $2500 if conditions apply, for example, modified adjusted gross income is less than $70,000 (or $145,000 if filing jointly). There also is a tuition and fees tax deduction that can reduce the amount of income subject to tax up to $4000. This tuition and fees deduction is available to individuals who paid their own higher education expenses or paid for an eligible student. The tax deduction is only available to individuals with an adjusted gross income below $80,000 (or $160,000 if filing jointly).

**Federal/State Funding for Medical Education**

AMA policy supports stable funding for medical schools to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue (Policy H-305.928, [2]).

In FY 2007, state/local government and parent university appropriations accounted for an average of 5.8% of total medical school revenue (11.6% for public schools and 0.5% for private schools). With the current economic downturn, however, the current level of state funding for public schools is in jeopardy, and tuition increases are likely to be used to make up funding deficits. Federal funding for financial aid is available for selected categories of students, for example, MD/PhD students, National Health Service Corps and related service programs, and military
There also are state-funded scholarship and loan repayment programs available for students choosing specific specialties and agreeing to practice in underserved areas.

RECOMMENDATIONS

As recently described, until the economy improves there is unlikely to be broad-based new funding to generally offset increasing medical student debt; however, there have been some recent positive occurrences. Some existing and developing medical schools have used funds from new philanthropy or endowment to provide scholarships to all or a subset of students. There also has been increased funding in the ARRA for the National Health Service Corps for scholarship and loan repayment programs for students and resident physicians.

It is critical that ways be found to address the rising cost of medical education and the corresponding increasing level of debt that young physicians must carry. It is unlikely that one solution can be found that will address the needs of all schools and students. Therefore, the Council on Medical Education recommends that the following action plan be adopted in lieu of Resolutions 304, 313, and 320 (A-08) and that the remainder of this report be filed:

1. That our American Medical Association work with the Association of American Medical Colleges and other stakeholder groups to increase the amount of funding available through the National Health Service Corps and similar federal and state scholarship and loan repayment programs, and work to expand the scope of existing and new programs to allow the inclusion of physicians from other specialties (such as general surgery) that have been identified as in shortage in underserved areas. (Directive to Take Action)

2. That our AMA work with relevant stakeholder groups to study how fundraising efforts and existing endowment funds at medical schools and universities are being used to support financial aid programs for medical students and report back on successful models at the 2010 Interim Meeting. (Directive to Take Action)

3. That our AMA continue to monitor medical school finances and oppose state efforts to reduce medical school funding. (Directive to Take Action)

4. That our AMA encourage medical schools and other relevant stakeholders to plan, implement, and evaluate the success of innovative ways to reduce the length of training, such as combined BA/MD programs, combined medical school and residency programs, and combined degree programs that, as far as possible, do not add to either the length of training or to its cost. (Directive to Take Action)

5. That our AMA advocate for the following:
   - Expansion of existing and introduction of new public- and private-sector low interest loans;
   - Increased borrowing limits for existing federally-subsidized low-interest loans; and
   - Reinstatement of the economic hardship deferment qualification criterion known as the 20/220 pathway, and support alternative mechanisms that better address the financial needs of post-graduate trainees with educational debt;
• For equity among students in university settings, medical school tuition increases, if needed, should be based on a fixed-dollar amount as opposed to a university-wide percentage increase.

Fiscal Note: $4500 for staff time to conduct relevant studies and for advocacy activities.
REFERENCES


4. AAMC. Medical School Admission Requirements, 2009-2010. AAMC, Washington, DC.


9. AMA Medical Student Section Brief “Income Based Repayment.”

