AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 316
(N-21)

Introduced by: New York

Subject: Medical Education Debt Cancellation in the Face of a Physician Shortage During the COVID-19 Pandemic

Referred to: Reference Committee C

Whereas, There is a physician shortage facing our nation; and[i]

Whereas, The shortage is going to worsen since 2 of 5 current physicians will be 65 years or older and in retirement age this year; and[i]

Whereas, The shortage is amplified now during the COVID-19 pandemic, demonstrating now more than ever the need for a sufficient and robust physician workforce; and[i]

Whereas, An unprecedented number of physicians now plan to retire in the next year and many of whom are under 45 years old and therefore would be retiring earlier than expected by workforce shortage predictors due to COVID-19; and[ii]

Whereas, 8% of physicians surveyed across the United States have closed their practices during the pandemic, amounting to approximately 16,000 closed practices further exacerbating the shortage of healthcare providers; and[iii]

Whereas, The COVID-19 pandemic has placed immense financial strain on physicians across specialties who have reported loss of staff, lack of reimbursement, and closure of independent physician practices during the COVID-19 pandemic; and[iii,iv]

Whereas, Young physicians are expected to be part of the workforce for many years to come, yet the majority of healthcare workers (HCW) who died during the COVID-19 pandemic were under 60 years old with primary care physicians (PCPs) accounting for a disproportionate number of these HCW deaths; and[v,vi]

Whereas, Before the pandemic, the physician shortage in New York State (NYS) was already predicted to be between 2,500 and 17,000 by 2030; and[vii]

Whereas, During the pandemic, the shortage has been amplified in that New York City has had the highest COVID-19 death rate in the country with NYS accounting for the greatest number of HCW deaths in the USA; and[v,viii]

Whereas, 73% of medical students graduated with debt in 2020; and[ix]

Whereas, The cost of medical school has increased 129% in the past 20 years after adjusting for inflation, affecting newer generations of students and physicians substantially more than past ones; and[x]

Whereas, The average medical student debt is $207,003--an approximately 28% increase in the past 10 years--however, the average physician ultimately pays $365,000-$440,000 for an educational loan with interest; and[ix,x,xi]

Whereas, In the United States, 50% of low-income medical school graduates have educational debt that exceeds $100,000; and[x]

Whereas, The financial barrier to entry into medical school is significant in that over half of medical students belong to the top quintile of US household income, with 20-30% of students belonging to the top 5% of income; however, only less than 5% of students come from the lowest quintile of US household income; and[x]

Whereas, A recent study found that higher debt levels among medical students is more likely to motivate them to choose higher paying specialties than primary care specialties; and[xii]

Whereas, Higher burdens of educational debt has been demonstrated to cause residents to place greater emphasis on financial considerations when choosing a specialty; and[xiii]

Whereas, The COVID-19 pandemic is producing a secondary surge in primary care need that has been studied previously in natural disasters and has been shown to persist for years; and[xiv,xv]

Whereas, It is well-established that health inequities existed before the pandemic in that individuals with low socioeconomic status are more likely to also be from minority populations, and are more likely to have worse health outcomes; and[xvi]

Whereas, These inequities have now been exacerbated by the pandemic, with the heaviest burden of COVID-19 disease falling upon Black, Latinx, and immigrant communities; and[xvii]

Whereas, Over 27 million Americans have lost their employer-sponsored health insurance during the pandemic; thus, we will need more physicians now than ever before to address these disparities and rising needs in health care; and[xviii]

Whereas, 72% of physicians surveyed across specialties reported loss of income during the pandemic, with over half of these respondents reporting losses of 26% or more; and[iii]

Whereas, Policies modeled to include provisions for debt relief or increase in incomes were found by one study to be more likely to incentivize students to choose primary care physician specialties; and[xix]

Whereas, Current AMA policies support methods to alleviate debt burden but do not address debt cancellation specifically; and

Whereas, $50 billion of the initial CARES Act Provider Relief Fund were allocated to support the current healthcare system by giving hospitals and providers funding “to support health care-related expenses or lost revenue attributable to COVID-19...”; however, funding formulas based on market shares of Medicare costs and total patient revenue are most likely to bankrupt independent physicians, specifically primary care providers; and[xx,xxi]

Whereas, One study found that primary care internists whose medical education were funded through Public Service Loan Forgiveness and Federally Granted Loans were predicted to have

significantly less net present value than primary care internists who received military or private funding; and[xxii]

Whereas, Medical education debt has been shown to be a significant barrier for underrepresented minorities and low/middle income strata students to choose medicine for a career; and[xxii]

Whereas, A key strategy to address health needs of underserved communities involves recruiting students from these communities as they may be more likely to return to address local health needs; and[xxiii]

Whereas, One medical school has created a debt-free program for matriculated students and saw (1) an increase in applicants to supply the future physician workforce and (2) an increase in applicants from groups underrepresented in medicine to help address socioeconomic and racial/ethnic disparities in the medical workforce and in healthcare; and[xxiv]

Whereas, There is currently a student debt forgiveness resolution in the United States Senate to cancel $50,000 of student debt which will also apply to all medical students, training physicians, and early career physicians; and[xxv]

Whereas, Data suggests women and people of color will benefit most from such debt cancellation because they are most in need; therefore be it[xxv]

RESOLVED, That our American Medical Association study the issue of medical education debt cancellation and consider the opportunities for integration of this into a broader solution addressing debt for all medical students, physicians in training, and early career physicians. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 10/13/21

The topic of this resolution is currently under study by the Council on Medical Education.

AUTHOR'S STATEMENT OF PRIORITY

Students, training and attending docs are facing increasing amounts of administrative, regulatory and financial pressures that take a toll and cause increased rates of physician stress, demoralization, burnout and depression.
Data and experience show that physician stress and burnout result in reduced quality of care and reduced quality of patient-doc relationships and reduced patient satisfaction.
This loan forgiveness if achieved would reduce burdens on students and physicians and would contribute to reduced burnout and depression and mitigate reductions in quality of care that result from high levels of burnout.
Students and physicians need help now - this can't wait until the November AMA meetings.
Physician needs will be forgotten by the end of summer when we are projected to be near herd immunity.

RELEVANT AMA POLICY

Cares Act Equity and Loan Forgiveness in the Medicare Accelerated Payment Program D-305.953
In the setting of the COVID-19 pandemic, our AMA will advocate for additional financial relief for physicians to reduce medical school educational debt.
Citation: Res. 202, I-20

Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925
The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:
1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the “20/220 pathway,” and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes,

and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.
13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the "cost of attendance"; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to "lock in" a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.
15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.
16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.
17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.
18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.
19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.
20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician benefits the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the PSLF program qualifying status of the employer; (f) Advocate that the profit status of a physicians training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i)

Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.
21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.
22. Formulate a task force to look at undergraduate medical education training as it relates to career choice, and develop new polices and novel approaches to prevent debt from influencing specialty and subspecialty choice.
Citation: CME Report 05, I-18; Appended: Res. 953, I-18; Reaffirmation: A-19; Appended: Res. 316, A-19

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