



**Statement for the Record**  
**House Small Business Committee Hearing**  
**“The Doctor is Out: Rising Student Loan Debt and the Decline of the Small Medical Practice”**  
**Tracey L. Henry M.D. on behalf of the American College of Physicians**  
**June 12, 2019**

Thank you Chairwoman Velazquez and Ranking Member Chabot for this opportunity to share my views on behalf of the American College of Physicians on the impact of student loan debt on the medical profession. My name is Dr. Tracey L. Henry. I am a full-time practicing primary care physician and Assistant Professor of Medicine at Emory University School of Medicine. I also serve as the Assistant Health Director of the Grady Primary Care Center, the largest public hospital in the state of Georgia, serving a largely resource poor population (many of my patients are homeless, uninsured, or underinsured).

With 154,000 members, ACP is the largest medical specialty organization in the United States. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the care of adults across the spectrum from health to complex illness.

I have always envisioned a career in primary care and I am passionate about being a general internal medicine specialist. I love the depth and breadth of the relationships I have formed with my patients. I enjoy the problem solving and the complexity of my patient care, and helping my patients on their journey of health and well-being.

I have a heart for the medically underserved, stemming from health inequities I witnessed growing up.

Thus, my dream has always been to practice medicine in a medically underserved community. I was excited when I was offered a position to work for Emory at Grady Hospital. However, to my dismay, despite the patient population being medically underserved, I was unable to apply for the National Health Service Corp loan repayment program.

Grady Hospital is not designated a Health Professional Shortage Area, or HPSA. Because both Emory and Morehouse residents and fellows train there, we are not considered to have a “shortage” of physicians for our patient population. However, this is a shortcoming of the HPSA designation and ignores the challenges in treating our patient population and keeping good physicians in our system.

As much as I love working in my current practice, giving back to my community through medicine, community service and training our next generation of doctors; the burden of my student loan debt weighs on me heavily.

At the end of medical school, I can remember completing my financial aid exit interview and being told I owed well over the national average for the medical student loan debt of \$200,000 and now fast forward almost 10 years later, I owe nearly double that amount. My loans accrued a great deal of interest during my residency and fellowship, when I could not afford to pay on the principal. Despite my timely payments on my repayment program, my balance continues to rise even now post-training.

While I love where I work, my student loan debt may prevent me from being able to continue to do so in the future. Having physicians of color in clinical settings like mine is paramount, as research has shown that the clinical outcomes for people of color are better, when treated by a physician of color. A 2013 study from Columbia University's Mailman School of Public Health found that African American medical students had significantly higher anticipated debt and that it had implications for enrollment in medical school. When physicians like myself are financially constrained from working in these clinical settings, patients suffer.

My plan now is to pay off my student loan through the Public Service Loans Forgiveness program. Under the program, I must have 10 years, or 120, on-time student loan payments while working for a nonprofit or the government. However, this is a risky proposition. The current administration has proposed eliminating funding for the program. Even if funding continues, the vast majority of applications under the program have been rejected.

Sometimes my medical residents who really enjoy primary care struggle with the decision to choose it as a career. I hear from them concerns about things like administrative burdens, low reimbursement rates, and burnout. For those issues I can offer a rebuttal. However, if they mentioned their student loan debt to me, that is a harder sell. So in the end, I advise them to go with their heart and do what they enjoy, but I do so knowing that this is an issue I have not been able to solve for myself.

Even looking for a job in a different clinical setting might not be enough. Private practice is often not an option for many of my residents or myself. They finish training with minimal experience and knowledge of the business-side of medicine. The instability of starting and maintaining a private practice would not allow for the work-life balance that today's physicians value. To cover the overhead costs of running a practice, and to allow you to keep up with student loan payments, you would have to see an overwhelming number of patients in a day all of which doesn't balance the autonomy you get in a private practice setting.

The road remains difficult for general internal medicine specialists and other primary care physicians to pay off their medical student loan debt. However, I am hopeful that there are several steps that Congress can take to reduce student loan debt, and in turn, to encourage medical students to pursue careers in primary care.

On behalf of the American College of Physicians, I would like to share our support for H.R. 2441, the What You Can Do for Your Country Act, which would increase access to loan forgiveness for individuals who pursue careers in government service or in non-profit organizations. We also support increased funding for scholarships and loan repayment programs for primary care physicians through the National Health Service Corps and maintaining the loan programs under Title VII.

### **Primary Care Workforce Shortage**

At the same time primary care physicians are accumulating massive medical student loan debt, we are experiencing a primary care workforce shortage in this country. The demand for primary care in the United States is expected to grow at a rapid rate, while the nation's supply of primary care physicians is dwindling and interest of U.S. medical school graduates in pursuing careers in primary care specialties including internal medicine is steadily declining. The reasons behind this decline in primary care physician supply are multifaceted and complex. Key factors include the rapid rise in medical education debt, decreased income potential for primary care physicians, and increased administrative hassles that have caused great dissatisfaction with the current practice environment. Data from the Association of American Medical Colleges (AAMC) 2018 report show a shortfall of between 14,800 and 49,300 primary care physicians by 2030. Shortages already exist across the country. There are 6,708 primary care Health "Provider" Shortage Areas (designated by the Health Resources and Services Administration (HRSA) as having shortages of primary medical care, dental, or mental health "providers" and may be geographic (a county or service area), demographic (low income population), or institutional (comprehensive health center, federally qualified health center or other public facility).

With the enhancement of high-value primary care and the expansion of coverage, the supply of the primary care physician workforce will need to be increased. The nation needs workforce policies that include sufficient support to recruit and retain a supply of health professionals that meets the nation's health care needs and prioritizes physician specialties where millions of patients lack access, including internal medicine specialists, trained in comprehensive primary care and armed with the skills needed to treat an aging population with multiple chronic diseases.

### **Medical Education Debt and Impact on Physician Specialty Choice**

For most medical students, debt is a significant concern. According to a recent analysis published by the [AAMC](#) 76 percent of students graduate with debt. And, while that percentage has decreased in the last few years, those who do borrow for medical school face big loans, with the [median debt](#) at \$200,000 in 2018. The debt and the anticipation of that debt can influence a student's decision to pursue a career in medicine and in deciding what specialty to pursue.

The increase in medical school tuition is just one source of increasing debt burdens for medical students. Many students are entering medical school with more debt from educational loans for their undergraduate degrees. In addition, the interest that accrues over time on these loans and the new loans for medical school add to the total cost of student debt. Increasingly, many

medical students have children to support, which also contributes to the pressure of high levels of debt.

A heavy debt load is increasingly burdensome for students who choose careers in primary care medicine. Researchers at [Dartmouth Medical School](#) created a model of a young primary care physician's finances. Using the average starting salary for a U.S. primary care physician (\$130,000) and a medical school debt of \$162,500, a monthly budget for this hypothetical family physician or general internist was calculated.

The budget included about \$2,200 for loan payments, \$900 for retirement savings, \$1,700 for mortgage and other home expenses, \$2,000 for children's college savings, and another \$2,000 for other expenses. Unfortunately, at the end of the month, that budget left the new primary care doctor \$800 in the hole. By contrast, the same budgeting calculations showed that a new psychiatrist or radiologist would have a monthly surplus of more than \$600 or \$8,400, respectively.

Students with large debts are more likely to be influenced by debt in their career choices because the threshold for debt repayment is greater for primary care physicians, who typically earn an average of 30% to 50% less than specialists. Although studies of the impact of debt on student specialty choice have garnered mixed results, compelling evidence suggests that debt influences career decisions for certain students. [According to an American Medical Association Journal Report](#), "many factors influence the choice of a medical specialty, including educational opportunities, role models, lifestyle factors, debt levels, and anticipated income. Between 2007 and 2012, at least one-fourth of medical school graduates consistently reported that their level of educational debt had a strong or moderate influence on their choice of specialty. Unfortunately, rising debt appears to have a negative impact on choosing primary care as a specialty, with one study reporting an inverse relationship between the level of total education debt and the intention to enter primary care."

### **Support for Public Service Loan Forgiveness Programs to Reduce Medical Debt**

One way to ease the burden of high debt levels among primary care physicians is through the passage of legislation that would expand loan forgiveness of medical school debt through the Public Service Loan Forgiveness Program (PSLF). This program allows individuals to receive loan forgiveness for educational debt after ten years if they work for the government or a non-profit organization. Although Congress passed the PSLF in 2007, very few have been approved to receive loan forgiveness as millions of borrowers who believed that they qualified for forgiveness under this program were informed that they would not qualify since they were enrolled in the wrong type of repayment program. Congress passed legislation last year that funded loan relief for borrowers who were denied PSLF because they were in the wrong repayment program but many borrowers still have not received the loan forgiveness that they have earned.

ACP supports legislation introduced in this Congress to expand PSLF through **H.R. 2441, the What You Can Do for Your Country Act of 2019**. This legislation would allow all types of federal loans to qualify for loan forgiveness for eligible participants in the program, it would

ensure that the Department of Education provides public service and guidance concerning if individuals qualify for PSLF, and allow borrowers to receive a partial forgiveness benefit after five years of public service. This legislation would encourage primary care physicians to pursue careers working in government service and non-profits and relieve the financial pressure associated with carrying such high debt.

ACP also [supports](#) H.R. 1554, the **Resident Education Deferred Interest Act**, which allows for borrowers to qualify for interest-free deferment on their student loans while serving in a medical or dental internship or residency program. During residency training, physicians receive a stipend in acknowledgment of the patient care services they provide. However, medical residents receive far less income and typically work many more hours per week (up to 80 hours) than their counterparts with postgraduate degrees in other professions. Loan repayment in residency makes it even more difficult for physicians-in-training to start or support a family and leaves little discretionary income for products that will advance physicians' professional development (e.g., conferences or journal subscriptions). By deferring payment of interest and principal on medical student loans until after completion of postgraduate training, residents will have increased funds necessary for professional development and more of an opportunity for a reasonable lifestyle. This will reduce financial pressure for residents to moonlight to supplement their income. It will also better enable young physicians who want to enter primary care careers to do so with less pressure to enter a more lucrative specialty to pay off their student debts.

#### **Improve Recruitment, Training, and Retention of Primary Care Physicians**

Another way that Congress could address the misaligned incentives, such as medical school loan debt, that discourage students from going into primary care would be to support vital federal programs designed to ensure an adequate physician workforce.

ACP believes the federal government should create incentives for medical students to pursue careers in primary care and practice in areas of the nation with greatest need by developing or expanding programs that eliminate student debt for physicians who choose primary care, linked to a reasonable service obligation in the field, and creating incentives for these physicians to remain in underserved areas after completing their service obligation. Incentives should include: new loan repayment and medical school scholarship programs in exchange for primary care service in critical shortage health facilities, or in critical shortage areas of the country. Medical school scholarships and loan repayment programs in exchange for service in underserved areas for those pursuing careers in primary care are essential for those who are interested in careers in these critical but less remunerative specialties. Because of high student debt, many medical students who otherwise might consider going into office-based primary care may instead choose to go into subspecialties or other specialties that offer higher anticipated career earnings, allowing them to pay off their accumulated debt more rapidly. Such programs will ensure that new primary care physicians practice in areas of the country where they are needed the most. They are also necessary to ensure that opportunities for careers in primary care medicine continue to be available to the best-qualified candidates and are not restricted only to those with substantial financial wealth. The availability of these programs should be better publicized to prospective applicants.

**ACP supports maintaining Title VII Health Professions Student Loan Programs:** The Health Resources and Services Administration offers affordable student loan programs for students from disadvantaged backgrounds and those pursuing careers in primary care to ease the burden of obtaining a medical education. Title VII programs help ensure that the nation is equipped with a workforce that reflects the population it serves and improves access to care for those in need.

**We urge increased funding for National Health Service Corps (NHSC) scholarships and loan repayment programs.** The NHSC provides scholarships and loan forgiveness to 5,711 “providers” and has a field strength of 10,200 primary care medical, dental, and mental and behavioral health professionals training in rural, urban, and frontier communities (FY2017). In return, health care “providers” serve for a period of service in a Health Professional Shortage Area (HPSA). The NHSC services a vital purpose in helping to ease this workforce shortage through its scholarships and its loan forgiveness program that helps bring health care to those who need it most. More than 50,000 clinicians have served in the NHSC since its inception. From FY2011 through FY2017, the most recent year of final data available, the NHSC offered more than 39,000 loan repayment agreements and scholarship awards to individuals who agreed to serve for a minimum of two years in a HPSA. Today, nearly 10,200 NHSC members provide care to more than 11 million people. Though these numbers are substantial, it will likely not be enough to meet the soaring demand for primary care, and continued and stable funding is essential to the future of the program’s mission. The NHSC has faced a steep “primary-care cliff” in 2015, 2017, and now in 2019, in which funding completely drops off unless Congress acts to reauthorize it. This short-term funding situation is detrimental to the NHSC’s operations and its programs have suffered the consequences of lurching from one short-term funding authorization to another, lacking the needed stability of long-term funding and endangering physician training and patients in underserved communities. Accordingly, ACP believes that it is imperative that Congress reaches bipartisan agreement to reauthorize funding for the NHSC and other essential health programs over the long term.

The NHSC is key not only in providing primary care to underserved areas, but also in encouraging clinicians to pursue a career in primary care to help alleviate the primary care physician shortage. NHSC members greatly contribute to their communities by improving the health of the patients they serve. Most (55 percent) NHSC members continue to practice in underserved areas ten years after service. Another study found that six years after service, 26 percent of NHSC participants were located in the very same HPSA of their NHSC service, and 69 percent were in a HPSA location in general. Tuition debt impacts 72 percent of medical students, and they owe a median of \$180,000. With more resources, the NHSC can award more new applications and help medical students pay off debt while providing primary care. There is overwhelming interest and demand for NHSC programs, and with more funding, the NHSC could fill more primary care clinician needs. In FY2016, there were 2,275 applications for the scholarship program, yet only 205 awards were made. There were 7,203 applications for loan repayment and only 3,079 new awards. In 2018, 4,605 open NHSC positions could not be filled because NHSC field strength was not enough to meet the needs of every eligible NHSC site. Accordingly, the College calls on Congress not only to authorize NHSC funding for the long

term, but also to increase that funding significantly—essentially double the overall program funding level—to meet the demand that clearly exists. The NHSC needs a stable funding source to continue its efforts of providing primary care in underserved areas; future funding disruptions could mean that the NHSC cannot process new applications or service existing participants. With a doubling of resources, the NHSC could also increase its overall field strength of primary care clinicians, including physicians.

**We also support new practice-entry bonuses for scholarship or loan repayment award recipients who remain in underserved communities after completion of service obligation.**

ACP calls for the development of a practice-entry bonus for primary care physicians who have received scholarships or loan repayment awards in exchange for service in underserved facilities or areas as an incentive for them to continue to practice in an underserved community after fulfilling his/her obligation. This money could be used to help establish the physician in a new practice setting or purchase equipment or hire additional staff necessary to establish a patient-centered medical home

**Quality of Practice Life: Administrative Burdens and the Need for New Practice Models**

Although the accumulation of medical school debt is one factor that impacts the choice of physician specialties for medical students, it is also important for members of the Small Business Committee to examine how increasing administrative burdens diminish the attractiveness of careers in primary care. The complexity of the U.S. healthcare system has resulted in an excessive amount of unnecessary administrative tasks imposed on both physicians and patients. These administrative tasks divert physicians' time and focus away from patient care, are costly, can prevent patients from receiving timely and appropriate treatment, and significantly contribute to the burnout epidemic among physicians. A survey by the Medical Group Management Association – which included 426 doctors from group practices – found that 86 percent believe that regulatory burdens increased in the past year, and 79 percent believe that their overall burden under Medicare increased as well.

[ACP's Patients Before Paperwork](#) initiative outlines a cohesive framework for analyzing administrative tasks to better understand the source, intent, and impact of any given administrative task – providing the foundation for policy recommendations for revising, streamlining, or removing entirely burdensome administrative tasks. The framework and recommendations call attention to the untapped potential of electronic health records (EHRs) to improve care as well as provide a better understanding of the daily issues physicians face including prior authorization obstacles and irrelevant clinical documentation guidelines – all of which take away from patient care and can even result in administrative hassles and coverage issues for patients.

We believe that Members of the Small Business Committee should take action to reduce excessive administrative tasks that negatively impact physicians and their patients in a number of areas including:

- Improving the functionality of Electronic Health Records: Electronic Health Records (EHRs) are meant to house critical data about a patient's health and should facilitate the

ability of clinicians to access the data they need to make the best medical decisions for their patients. EHRs should be able to effectively communicate with one another (i.e. interoperability), and function effectively in their own right (i.e. operability). In reality, EHRs lack standards that are needed for systems to be able to talk to each other in a way that is meaningful.

- **Prior Authorization:** On a daily basis, clinicians are often required to seek approval from a patient’s health insurer in order to prescribe a certain medication, known as “prior authorization.” This process involves varying forms, data elements, and submission mechanisms and forces the clinician to enter unnecessary data in the EHR or perform duplicative tasks outside of the clinical workflow. Moreover, prior authorization rules are imposed by payers and vary by state with local regulatory requirements affecting and complicating how prior authorization is deployed. This often inhibits clinical decision making at the point of care and creates unnecessary burden. Ideally, the need for prior authorization would decrease as the health care system continues to evolve to a more widespread value-based payment system, particularly for clinicians participating in risk-bearing alternative payment models. A great first step toward the ideal would be for public and private payers and EHR vendors to accept the same clinical definitions for data elements and report formats, and to work transparently with all necessary stakeholders, so that health IT could be programmed to generate and send the necessary prior-authorization criteria automatically.
- **Clinical Documentation:** The primary goal of EHR-generated documentation should be concise, history-rich notes that reflect the information gathered and are used to develop an impression, a diagnostic and/or treatment plan, and recommended follow-up. EHRs should facilitate attainment of these goals in the most efficient manner possible without losing the humanistic elements of the record that support ongoing relationships between patients and their physicians. That patient narrative is being lost as a result of overly complex and burdensome clinical document requirements.

We continue to partner with CMS to reduce administrative burdens for physicians through its [Patients Over Paperwork](#) initiative to streamline regulations to significantly cut the “red tape” that weighs down our healthcare system and takes physicians time away from patients. Just last week, CMS issued a [Request For Information](#) (RFI) seeking new ideas from the public on how to meet these goals and we look forward to sharing our thoughts with CMS to reduce administrative burdens.

**We urge the Congress to pass the following measure to decrease the number of administrative burdens and allow physicians to spend more time with their patients:**

- **Improving Seniors Timely Access to Care Act of 2019 (H.R. 3107):** This legislation would streamline the process for prior authorization approval by requiring electronic prior authorizations transmissions in Medicare Advantage.



### **Advance New Payment Models**

We appreciate that the Small Business Committee included the “Decline of the Small Practice” in the title of this hearing to examine how student loan debt is making it more difficult for physicians to invest in the technology and infrastructure to meet the needs of their practice. We are pleased that CMS is moving in the right direction to reinvigorate small practices through the creation of new payment and delivery models to support the role of care provided by primary care physicians. Earlier this year the Department of Health and Human Services announced the creation of two new payment models, known as [Primary Care First](#) and Direct Contracting. These models are intended to recognize the value of primary care physicians in our health care system by offering sustainable and predictable prospective monthly payments to practices, to reduce administrative burdens for clinicians, to increase the quality of care for patients, and to allow practices and their physicians to share in savings from keeping patients healthy and out of the hospital whenever possible.

There are elements of the PCF model that suggest that CMS is on the right track to building models that will improve patient care and that will support the work of primary care physicians. It provides a variety of payment models that will support internal medicine and primary care practices, from smaller and independent practices to larger integrated ones; it includes a range of risk options available to practices, and it could potentially reduce administrative burdens that would allow physicians to spend more time with their patients.

However, a lot of details related to risk adjustment, attribution, and financial benchmarking are still missing that may determine how many physicians and practices will seek to participate. Also, unless other payers join Medicare in supporting the PCF model, practices may not experience the reduction in administrative burdens and predictable revenue that CMS anticipates. Presumably, CMS will be releasing such information soon, prior to the enrollment period it intends to begin this fall. As CMS moves forward with the development of new care models, we urge the continued creation of new Advanced APM’s that include multiple payers so that all patients, not just Medicare beneficiaries, may benefit from the innovations and improvements to patient care that these models may provide. This will also allow those practices that voluntarily support these innovative care delivery system reform models to focus on a unified set of metrics and goals, allowing them to focus on truly improving patient care in key strategic areas and get back to delivering patient care, rather than juggling dozens of sets of varying reporting metrics.

Although there is great potential that these models will revitalize the practice of primary care physicians, we believe the success and viability of these models will depend on the extent that they are supported by payers in addition to Medicare and Medicaid, are adequately adjusted for differences in the risk and health status of patients seen by each practice, are provided predictable and adequate payments to support and sustain practices (especially smaller independent ones), are appropriately scaled for the financial risk expected of a practice, are provided meaningful and timely data to support improvement, and are truly able to reduce administrative tasks and costs, among other things. ACP will continue to evaluate the new

payment and delivery models based on such considerations, and we look forward to working with CMS and to continue advocating for ways to support the value of primary care for physicians and for all patients across the health care system.

**Conclusion**

We appreciate the Small Business Committee giving us this opportunity to address how small businesses such as physician office practices are impacted by the rising accumulation of student loan debt. We look forward to continuing this discussion with members of this Committee and urge the enactment of policies outlined in this statement to remedy this problem in the 116<sup>th</sup> Congress.