THE DOCTOR IS OUT. RISING STUDENT LOAN DEBT AND THE DECLINE OF THE SMALL MEDICAL PRACTICE

HEARING

BEFORE THE

COMMITTEE ON SMALL BUSINESS
UNITED STATES
HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTEENTH CONGRESS

FIRST SESSION

HEARING HELD
JUNE 12, 2019

Small Business Committee Document Number 116–027
Available via the GPO Website: www.govinfo.gov

U.S. GOVERNMENT PUBLISHING OFFICE
36–714 WASHINGTON : 2019

HOUSE COMMITTEE ON SMALL BUSINESS

NYDIA VELÁZQUEZ, New York, *Chairwoman*
ABBY FINKENAUER, Iowa
JARED GOLDEN, Maine
ANDY KIM, New Jersey
JASON CROW, Colorado
SHARICE DAVIDS, Kansas
JUDY CHU, California
MARC VEASEY, Texas
DWIGHT EVANS, Pennsylvania
BRAD SCHNEIDER, Illinois
ADRIANO ESPAILLAT, New York
ANTONIO DELGADO, New York
CHRISSY HOULAHAN, Pennsylvania
ANGIE CRAIG, Minnesota
STEVE CHABOT, Ohio, *Ranking Member*
AUMUA AMATA COLEMAN RADEWAGEN, American Samoa, *Vice Ranking Member*
TRENT KELLY, Mississippi
TROY BALDERSON, Ohio
KEVIN HERN, Oklahoma
JIM HAGEDORN, Minnesota
PETE STAUBER, Minnesota
TIM BURCHETT, Tennessee
ROSS SPANO, Florida
JOHN JOYCE, Pennsylvania

ADAM MINEHARDT, *Majority Staff Director*
MELISSA JUNG, *Majority Deputy Staff Director and Chief Counsel*
KEVIN FITZPATRICK, *Staff Director*

CONTENTS

OPENING STATEMENTS

WITNESSES

APPENDIX

THE DOCTOR IS OUT. RISING STUDENT LOAN DEBT AND THE DECLINE OF THE SMALL MEDICAL PRACTICE

WEDNESDAY, JUNE 12, 2019

HOUSE OF REPRESENTATIVES,
COMMITTEE ON SMALL BUSINESS,
Washington, DC.

The committee met, pursuant to call, at 11:32 a.m., in Room 2360, Rayburn House Office Building. Hon. Nydia Velázquez [chairwoman of the Committee] presiding.

Present: Representatives Velázquez, Finkenauer, Kim, Davids, Chu, Schneider, Delgado, Craig, Chabot, Hern, Hagedorn, and Joyce.

Chairwoman VELÁZQUEZ. Good morning. The committee will come to order.

I want to thank everyone for joining us this morning, and I want to especially thank the witnesses for being here today.

Today, over 40 million Americans are burdened by student loans, and as a nation, mounting student debt now stands at nearly $1.5 trillion. Over the past 30 years, the cost of higher education at public 4-year institutions has skyrocketed, increasing by 213 percent from 1988.

So, as we begin this hearing, let us acknowledge that this is nothing short of a national crisis. Back home in New York, I have seen how it affects young people in my district who may be taking on multiple jobs to make their student loan payments only to be compounded by steep costs of living and a tough job market.

Today, student loan debt is now the second highest consumer debt category, higher than both credit card debt and auto loans and only behind home mortgage debt. This reality has produced a series of ripple effects throughout our economy, including a decline in entrepreneurship.

As we often talk about on this committee, starting a business is not without risk to the entrepreneur. And as we search for ways to minimize this risk, we must look at how the burden of what can feel like insurmountable student loan bills affects new business formation.

Which brings me to the purpose of today's hearing where we will be focusing on how the student debt crisis is affecting our medical students and their career decisions. We will examine how student loans push doctors away from starting their own practice, especially in rural and underserved communities.

Since the late 1980s, medical school tuition has increased 650 percent. According to the American Medical Association, the average medical student graduated with a loan burden of over $170,000 in 2014. Starting a private medical practice already comes with its own challenges like making payroll, finding affordable access to capital, securing a physical location, just to name a few.

Combine this with massive student loan bills, and it is no wonder why many doctors are deterred from pursuing the great American Dream, to own and operate their own business. At large health care providers, doctors can afford to worry less about administrative costs, making payroll, advertising, or human resource issues. And a stable paycheck is often there to help them pay down their loans. For many medical professionals leaving school with heavy debt, these circumstances may encourage them to choose a large health network over opening their own practice.

And the evidence for this is not just anecdotal. Annual reports by industry have highlighted the slow decline in the number of private practices among medical professionals, and an increase in the numbers employed by large providers. But this trend also leaves many communities at a disadvantage without the health care providers they need. In underserved and rural communities, medical professionals are needed more than ever to care for an aging population. Yet, fewer and fewer students are choosing to serve these areas.

By 2030, the Association of American Medical Colleges expects the workforce shortage to expand to over 100,000 doctors nationwide. The greatest need will be for primary care physicians, who are relied upon in every corner of our country to keep ourselves and our families healthy.

Yet, rising student loan debt for medical professionals is making this problem far worse by forcing those in the medical profession to choose more highly paid, specialized fields to offset their student loan payments.

One way to combat this growing problem is to empower small practices to fill the gaps and provide the necessary care. Make no mistake, incentivizing doctors to open local practices in rural and underserved communities is both a small business issue and a public health one. Addressing these issues requires us to have an honest conversation about the rising cost of education in this country, how young people will pay for it, and what to do about the millions of Americans already saddled with record high student loan debt.

There are many issues surrounding this discussion, and we must acknowledge its complexity. But I hope this hearing not only sheds light on the burden of student debt in this sector but helps us to reach serious solutions that can empower small businesses, medical professionals, and the communities they serve.

With that, I thank each of the witnesses for joining us today, and I look forward to your testimony.

I now would like to yield to Ranking Member Chabot for his opening statement.

Mr. CHABOT. Thank you, Madam Chair.

I am sure many of us have found ourselves celebrating the recent graduation of family or friends over these past several weeks. This joyous occasion marks an important milestone for students shoul-

dering years of intense study and challenging examinations. Graduation day is a triumph, and I would like to take this opportunity to applaud all of our recent graduates and graduate them on their achievement.

While some recent graduates may be rejoicing on such a day, others may already be counting down the days and dollars until their first student loan repayment. It is no secret that graduate programs, like medical school, come with a premium price tag. There are some programs in place that make that task a little more palatable. The Federal Government offers a number of student loan programs and repayment plans with terms more generous actually than the private sector lenders. Over the years, the Federal Government has amended its student loan programs to include increased advantages for graduate and professional students, like those enrolled in medical school.

The result is that the Federal Government is paying far more upfront compared to the amount that they will eventually obtain back from the borrower and that, of course, means that the Federal taxpayers pick up the difference.

The Department of Education indicates the Agency will lose $28.70 on each $100 in debt wrapped up in these loan repayment plans. Due to the popularity of these programs and repayment options, we have seen Federal loan volume increase dramatically, thus Federal spending in this area has also increased substantially. The Congressional Budget Office projects that the Federal Student Loan Program will run a deficit of more than $31 billion over the next decade with significantly less than projected revenue coming in from direct federal loans. Additionally, a Department of Education Office Inspector General audit revealed that between fiscal years 2011 and 2015, the cost of the Federal repayment programs ballooned from $1.5 billion to $11.5 billion.

It is undeniable that medical practitioners play an indispensable role within our communities. Small medical practices, particularly those operating in underserved areas, are vital to ensuring the health and well-being of Americans who otherwise would not have access to health care.

That said, given the over $22 trillion debt our nation faces, I think it is important that we carefully study this issue and clearly understand whether student debt is a significant factor in determining a physician's decision to start or join a small medical practice or if there are other reasons why a graduate may decide to choose a different career path. And if student debt is a significant factor in these decisions, we should also look at how often physicians are taking advantage of existing repayment programs before creating new ones. As part of that review, I think we need to understand why existing programs are either underutilized or inadequate for medical practitioners or whether changes to the existing student loan systems can help to alleviate these problems.

Of course, as policymakers, we must balance the need to be proper stewards of taxpayer dollars, while also encouraging the growth and success of our future healthcare professionals. To accomplish this task we must ensure that our Federal student aid system is efficient, effective, and fair.

Madam Chairwoman, I thank you, and I yield back my time.

Chairwoman VELÁZQUEZ. Thank you, Mr. Chabot. The gentleman yields back.

And if committee members have an opening statement prepared, we would ask that they be submitted for the record.

I would like to take a minute to explain the timing rules. Each witness gets 5 minutes to testify and the members get 5 minutes for questioning. There is a lighting system to assist you. The green light will be on when you begin, and the yellow light comes on when you have 1 minute remaining. The red light comes on when you are out of time, and we ask that you stay within the timeframe to the best of your ability.

I would now like to recognize Ms. Abby Finkenauer from Iowa's 1st District to introduce our first witness.

Ms. FINKENAUER. Thank you, Madam Chair. And thank you all for being here today. It is my honor, actually, to get to introduce our first witness, Dr. Sandra Norby from Des Moines, Iowa.

States like Iowa face unique challenges in supporting the small medical practices. We need to serve our patients and grow our economy. I am delighted to welcome an expert from my home state who can uplift these challenges and offer solutions. Many talented providers, even those from Iowa leave for big cities because they simply cannot make enough money locally. Healthcare professionals who stay in Iowa suffer from low reimbursements and have difficulty staying in business. For some providers who are struggling to pay off their massive student loans, practicing in rural and underserved areas is difficult or nearly impossible. I look forward to hearing Dr. Norby's perspective on what Congress can be doing to solve these issues and shore up our rural healthcare workforce. Dr. Norby is a founder and CEO of HomeTown Physical Therapy. She received her bachelor of science in exercise science and athletic training and masters in physical therapy from the University of Iowa. In May 2016, she earned her doctor of physical therapy from the University of Montana. She is currently serving as president of the Private Practice section of the American Physical Therapy Association.

Dr. Norby, welcome to Washington, and thank you so much for taking your time today to be here with us and offering so much to us here on this Committee. Thank you.

Chairwoman VELÁZQUEZ. Thank you, Ms. Finkenauer.

And our second witness is Dr. Lauren Wiese. Dr. Wiese attended Villanova University on a full academic scholarship and graduated in 2011 with a degree in chemical engineering and business. She went on to attend the Rutgers School of Dental Medicine. She is currently in her third and final year of orthodontic residency at the University of Maryland, where she was selected by her co-residents as the Chief Resident this year. She also successfully defended her master's thesis in April and will be graduating at the end of June with a master's degree in biomedical sciences and a certificate in orthodontics. An early congratulations to you.

Welcome, Dr. Wiese.

Our third witness is Dr. Tracey Henry. Dr. Henry is a general internist in the Division of General Medicine and Geriatrics, where she provides primary care to the underserved population in Atlanta, Georgia. She is an attending physician for inpatient teaching

services at Grady Memorial Hospital and assistant medical director and supervising attending in the primary care center. Dr. Henry earned her MS in neuroscience at Tulane University, MD at Georgetown University, and MPH from Johns Hopkins University in health systems and policy and a certificate in finance and management. She now serves on the American College of Physicians National Health and Public Policy Committee and the National Board of Medical Examiners, including their Diversity and Inclusion Taskforce. She is also an assistant professor at Emory University School of Medicine.

Welcome, Dr. Henry.

I would now like to yield to our Ranking Member, Mr. Chabot, to introduce our final witness.

Mr. CHABOT. Thank you, Madam Chair.

Our final witness is Jason Delisle, who is a Resident Fellow at the American Enterprise Institute, where he works on higher education financing issues with an emphasis on student loan programs. Mr. Delisle is returning to Capitol Hill today having served in the past in the Office of Representative Thomas Petri and then as an Analyst for the U.S. Senate Committee on Budget where he studied the history and mechanics of Federal student loans and other financial aid policies. Mr. Delisle has also testified on several occasions before the Education and Labor Committee. Before joining American Enterprise Institute, Mr. Delisle was the Director of the Federal Education Budget Project at New America, where he worked to improve the quality of public information on Federal funding for education and supported the advancement of well-targeted Federal education policies.

Thank you for your participation, Mr. Delisle, and we look forward to hearing your testimony as we do hearing the testimony of all the witnesses.

And I yield back.

Chairwoman VELÁZQUEZ. Thank you. The gentleman yields back.

Ms. Sandra Norby, you are now recognized for 5 minutes.

STATEMENTS OF SANDRA NORBY, PT, DPT, CEO, HOMETOWN PHYSICAL THERAPY, LLC; DR. LAUREN WIESE, ORTHODONTIC RESIDENT, UNIVERSITY OF MARYLAND SCHOOL OF DENTISTRY; DR. TRACEY L. HENRY, MD, MPH, MS, FACP; ASSISTANT PROFESSOR OF MEDICINE, EMORY UNIVERSITY SCHOOL OF MEDICINE; ASSISTANT HEALTH DIRECTOR, GRADY PRIMARY CARE CENTER; JASON DELISLE, RESIDENT FELLOW, AMERICAN ENTERPRISE INSTITUTE

STATEMENT OF SANDRA NORBY

Ms. NORBY. Thank you.

Chairwoman Velázquez, Ranking Member Chabot, and members of the House Committee on Small Business. My name is Dr. Sandra Norby and I am a physical therapist and CEO of HomeTown Physical Therapy in Des Moines, Iowa. On behalf of the American Physical Therapy Association (APTA) and the Private Practice Section of APTA, I thank you for the opportunity to provide testimony on the impact that rising student loan debt has on small practices.

Today, I will share with you my perspective on how small medical practices, including physical therapy clinics, struggle to recruit and retain good talent and the significant role that student debt plays in this challenge.

My small business consists of five clinics in rural Iowa with 25 employees. When we opened our doors 13 years ago, we named our business HomeTown Physical Therapy because it represented our desire not only to be part of the local community and economy, but also to hire individuals who had grown up in Iowa's small towns, hometown people who had gone away to school, earned their degrees and developed expertise, but who wanted to come back to their hometown to practice.

One of my clinics is in Lake Mills, Iowa. A recent graduate from the Mayo Clinic College of Physical Therapy and Rehabilitation is engaged to be married to a farmer who lives 15 miles outside of town. They plan to live and work on that farm. But she is struggling to find a job locally that will compensate her enough so that she can also pay her student loans. My clinic in that town is in high demand and we treat a variety of patient populations. The patients we treat run the gamut from the student-athlete recovering from a concussion, the farmer with low back pain due to long hours in the combine, to seniors receiving or recovering from joint replacement.

Forty-five percent of our patients there are Medicare beneficiaries and the need for services for our seniors is growing with the graying of rural America. While our patient load is high, it is not yet high enough to pay a second additional full-time physical therapist. We are currently in negotiation to determine whether or not I can bring her on board and pay her enough of a salary to cover her loans.

I knew the risks and opportunities of starting a small business, and the variables that come into play when running a small business in a rural area. But one variable stands out that continues to have a growing impact on the ability to recruit and retain staff and keep my business open is the impact of student loan debt.

The challenges that small practices face in rural areas in recruiting and retaining providers has been highlighted by the current opioid crisis, the critical need for increased access to nonpharmacological options. However, recruiting therapists, especially those who have expertise in pain management is a challenge given the competition for higher paying salaries offered in urban and suburban areas.

There is no easy fix or silver bullet to the complex problem of student debt. There are two immediate policy solutions highlighted in my written testimony that both APTA and the private practice section strongly support that would alleviate the burden of student debt on small practices' ability to recruit and retain recent grads.

One that I would like to highlight is enactment of H.R. 2802, the Physical Therapist Workforce and Patient Access Act of 2019. This bipartisan legislation, introduced by Reps Diana DeGette and John Shimkus, would allow physical therapists to participate in the National Health Service Corps Loan Repayment program. I am grateful for the opportunity to thank Chairwoman Velázquez in person for her co-sponsorship of this legislation.

Policy solutions that assist practices in recruiting and retaining graduates with student debt to Iowa and to other rural and underserved communities not only makes sense for small business, they assist in improving public health.

I truly appreciate the Committee's interest in addressing the student loan burden of providers who are willing and eager to be a part of the engine of the local economy, working in a small business and practice in rural and underserved areas.

I look forward to working with the Committee, and I am happy to answer any questions you may have.

Chairwoman VELAZQUEZ. Thank you, Ms. Norby.

Dr. Wiese, you are now recognized for 5 minutes.

STATEMENT OF LAURA WIESE

Dr. WIESE. Good morning, Chairwoman Velázquez and Ranking Member Chabot. On behalf of the American Association of Orthodontists, thank you for having me here today.

I am honored to share my story about how my student debt burden has greatly changed the plans I have for the future, as well as that of my family.

I am currently a third-year orthodontic resident at the University of Maryland in Baltimore and will be graduating at the end of the month. Among other reasons, a dental career enticed me because of the ability to own a practice. Throughout all of my education, I think I made sound financial decisions. I attended college on a full tuition scholarship and worked as a server, intern, and teaching resident assistant along the way. Rather than attending a private dental school, I stayed in-state and borrowed from my parents to help pay for the first 2 years. I lived very frugally, always had roommates, and never borrowed up to the full cost of attendance which is currently $92,000 at my dental school.

During my last year of dental school, I worked at satellite location and lived with my parents. My academic success allowed me to pursue a specialty residency program, but dental residencies are unlike medical residencies in that the majority are unpaid and charge tuition. With the Match program for residency, I also had less control over which program I could attend, and thus, the cost of tuition as well.

Although it is a state school, the tuition is still expensive and I had to borrow in excess to help pay my living expenses. Furthermore, my program forbade us from working or moonlighting as a dentist during residency. So I worked part-time as a cater waiter, applied for scholarships, returned excess loan money, and educated myself on student debt. My husband and I share a 2007 Subaru and limit most of our vacations to staying with family and friends.

Even with these money saving strategies and help from my parents, I am still terrified to face my $411,000 in student loans with interest accumulating by the day at rates, some of which are over 7 percent.

As I have been searching for jobs, my husband is seriously considering a career change. Although we were delighted when he was accepted into both medical and dental schools, we are carefully considering what it would mean to more than double our existing debt. On the outside, a two-doctor household sounds like it would be

more than comfortable, but the reality is that we would face financial ramifications of this decision for the next 15 to 20 years.

Most people think that I might be living the high life after I graduate, but the reality is that I am 30 years old, newly married, moving back in with my parents this summer, and will delay practice ownership and starting a family in order to save money and pay down my student debt. I never imagined the emotional struggles my husband and I would face in making decisions due to my debt burden.

While I have seriously considered many employment options, including in rural Wisconsin, I am now primarily focused on corporate dental offices which offer increased compensation to new graduates and other benefits such as health insurance. While this could be a somewhat satisfying employment opportunity, it is certainly a different experience than many of the orthodontists I know who helped inspire my career path.

I would love to pursue my initial goal of business ownership but the thought of taking out a large business loan in light of my own student debt and that which my husband may take on in the coming years is really paralyzing for us. With the median income for orthodontists at $200,000 annually, realistically, I will not be in any position to own a practice for the next 10 or 15 years, especially if we start a family and I begin saving for my own retirement.

Of my $411,000 in student loans, I have $256,000 in Federal loans which have already accumulated $35,000 in unpaid interest. With the aggressive standard 10-year repayment plan, my monthly payment will be $3,300, not including that which I will pay to my parents as well. Overall, on what was initially $256,000, I will pay over $100,000 in interest, which is about 40 percent of the principal.

Many of us consider refinancing the loans with private lenders to reduce the interest rates but then we lose out on the protections and flexibility of the Federal loans. Even though I am scared to pay my debt, I know plenty of others who have over $600,000 in student debt. Many young orthodontists, including most of my classmates, will be forced to face this harsh reality that they may need to follow a more corporate dental path long-term in lieu of following their dreams of becoming a small business owner and actively participating in their community.

Again, thank you for having me here today to speak on this important topic. While I understand higher education policy is not within this Committee's jurisdiction, as a medical professional, I look forward to working with you on solutions that will ensure owning a small business practice is still within reach for mine and future generations.

I would be happy to answer any questions you may have.

Chairwoman VELAZQUEZ. Thank you, Dr. Wiese.

Dr. Henry, you are now recognized for 5 minutes.

STATEMENT OF TRACEY L. HENRY

Dr. HENRY. Thank you, Chairwoman Velázquez 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 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, where many of my patients are homeless, uninsured, or underinsured.

ACP is the largest medical specialty organization in the United States with 154,000 members, including internal medicine specialists, internal medicine subspecialists, medical students, residents, and fellows.

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

My dream has always been to practice medicine in a medically underserved community stemming from the health inequities that I witnessed growing up. So I was excited when I was offered a position to work at Emory at Grady. 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 because Grady is not a designated health professional shortage area (HPSA).

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

At the end of medical school, I can remember completing my financial aid interview and being told I owe well over the national median for medical student loan debt, which was $200,000. And now fast-forward almost 10 years later, I owe more than double that amount. You see, my loans accrued a great deal of interest during my residency and fellowship when I could not afford to pay on the principal. And despite my timely payments on my repayment program since then, my balance continues to rise.

While I find great joy in my work, my student loan debt may prevent me from being able to continue to do so in the future. Further, having physicians of color in clinical settings like mine is paramount, as research has shown that health outcomes for people of color are better when treated by another physician of color. When physicians like myself are financially constrained from working in these clinical settings, our patients suffer.

My plan now is to pay off my student loans through the Public Service Loan Forgiveness program. Under this 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 as the current administration has proposed eliminating funding for this program. And even if this funding continues, the vast majority of applications under the program have been rejected.

Sometimes my medical students, who really enjoy primary care, struggle with the decision to choose it as a career. I hear from them concerns like administrative burdens, low reimbursement

rates, and even burnout. For all of those issues I can offer a rebuttal. But when they mention student loan debt to me, that is a harder sell. So in the end, I advise them to go with their heart, do what they enjoy, but I do so cautiously knowing that this is an issue that I have not yet been able to solve for myself.

Even looking for a job in a different clinical setting may 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 that many of today's physicians value. And to cover the overhead costs of running a practice, and to also keep up on those student loan payments, you would have to see an overwhelming number of patients a day.

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

So on behalf of the American College of Physicians, I would like to share with you our support of H.R. 2441, the What You Can Do for Your Country Act, which would allow increased access to loan forgiveness for individuals who pursue careers in government or non-profit organizations.

Thank you for this opportunity to share my views.

Chairwoman VELAZQUEZ. Thank you, Dr. Henry.

And Mr. Delisle, you are now recognized for 5 minutes.

STATEMENT OF JASON DELISLE

Mr. DELISLE. Thank you, Chairman Velázquez, and Ranking Member Chabot, and members of the Committee. Thank you for the opportunity to testify today about student loans and debt burdens among graduate and professional students, particularly those who pursue medical professions.

I should tell you at the outset, my testimony today represents my own views and not those of the American Enterprise Institute, which does not take any institutional positions.

So at the outset I should say also that I think the premise of this hearing is right on one dimension. When I look at the data and statistics from the Department of Education, the big increases in student debt are in the graduate and professional space, particularly medical school. We hear a lot about college affordability and student debt with respect to that. Really, the big change has been among the most advanced degrees. And I should also point out that when we are talking about graduate professional debt, it is almost entirely Federal student loans. The Federal Government lends unlimited money to people who want to pursue graduate and professional programs, including medical students. So whatever the institution charges, and including all living expenses, the students can take that out. Basically, no questions asked. So the institution and the medical school is totally in the driver seat. They can set their price wherever they want and the student has access to student loans through the Federal Government.

But I sort of disagree a little bit with one of the other premises here that the Federal Government has not done enough to allow doctors to afford their student loans, or that student loans is sort of the culprit here in preventing them from opening their own practice.

There is a program that has been available since 2009 called Income-Based Repayment. It allows anyone with a Federal student loan to cap their payments at 10 percent of discretionary income regardless of how much debt they have. So if you have $400,000 in loans, or $100,000 in loans, your payment is the same regardless of how much debt you have and what the interest rate is. And after 20 years of payments in this program, your debt is forgiven. So taxpayers have to sort of eat the cost of the loan. And this program, I actually think this allows doctors who have high debts but want to pursue different careers, an affordable monthly payment. So I am a little bit suspicious that the loans are sort of the bad guy in driving the whole decision here about whether or not to open a private practice. The loan should be affordable because of this program.

But I also want to note that the Income-Based Repayment program is sort of a ticking time bomb. You heard some testimony today about the amount of debt that these borrowers have, hundreds of thousands of dollars. In my testimony, in Figures 2, 3, and 4, I show the projected amount of debt that they are going to have forgiven. It is hundreds of thousands of dollars. So this is a big problem, right, because here we have people who are some of the highest earners in this country. Dr. Wiese talked about median salary of $200,000, and we are going to have taxpayers forgive their debt. That seems like sort of misallocation of resources. Highest paid individuals receiving hundreds of thousands of dollars from the Federal Government.

And the Income-Based Repayment program, the Department of Education tells us 68 percent of the people enrolled in it pursued graduate and professional degrees. So these are not people who enrolled and dropped out of their community college. They are people with very, very advanced degrees and very high earning potential. The Department of Education also projects that people using income-based repayment, most of them on average will earn $100,000 or more while using the program.

And so to wrap up, I do want to mention something, and Dr. Henry mentioned it as well, the Public Service Loan Forgiveness Program. I mentioned Income-Based Repayment, you can have your debt forgiven after 20 years of payments. But if you work in any nonprofit job, virtually any nonprofit job or any government job, you have your debt forgiven after just 10 years of payments. The benefits for a doctor in this case would be absolutely enormous. The projected amount of debt forgiven for a typical doctor would be about $200,000 in the Public Service Loan Forgiveness if they have a typical level of debt, which is less than you have heard about today.

But, you know here is the curious thing with respect to the premise of this hearing. The premise is we are concerned that doctors are not opening their own practice. Well, could you receive public service loan forgiveness if you opened your own practice? No,

it is not a nonprofit. It is not a governmental entity. So here we have a government program that is supposed to be doing good things and providing huge disincentives for people to open their own practice, which I think is the problem that the Committee at least today is interested in solving.

So when I look at the sort of landscape of student loans, I am really hard pressed to think that we do not have enough government money in this program. If anything, we have too much. I have some recommendations on how to reign it in. And I think that we even have so much that it is working at cross purposes with some things that the Committee has identified as good outcomes, like people opening their own practices.

That concludes my testimony. And I look forward to answering any questions that you may have.

Chairwoman VELAZQUEZ. Thank you, Mr. Delisle.

I will now start asking questions, and recognize myself for 5 minutes.

I would like to share with Mr. Delisle that the Student Loan Forgiveness Program rejects 90 percent of applicants. So, and do you know what? It is very difficult for us to do oversight. It is very difficult for any committee, especially and particularly Education and Labor to assess where we are. This is a very complex issue. You heard the powerful stories that have been shared today, but we cannot, as policymakers, decide what is the best way to proceed when the Department of Education does not provide the documents that have been requested. So, and then you have the high percentage of applicants that have been rejected.

Ms. Norby, in your testimony you outlined the extensive efforts you make to recruit medical professionals to your community. Can you explain in greater detail how high student loans have affected your ability to attract, hire, and retain employees?

Ms. NORBY. Yes, I will. Thank you for that question.

We recently lost a physical therapist in one of our clinics due to marriage and having to move away. She had a relatively short engagement of 6 months, so we had about 6 months to try to find a replacement physical therapist for her. During that time we had two applicants, and that reflects the ability for people to want to move to a rural area compared to my peers in urban areas that get 10 to 15 applicants for an open position. We were able to hire someone who was leaving suburban Chicago to move back to rural Iowa to be closer to her sister. So that is an example of the difficulty of being able to fill open spots that we have.

Chairwoman VELAZQUEZ. Thank you.

Dr. Wiese, as we have heard, student loan debt can be a factor in determining where you live, what specialty is chosen, future retirement, and when you cross major life milestones. Dr. Wiese, as an incoming orthodontist entering the field, how has student debt influenced your decisions?

Dr. WIESE. Thank you for your question.

I think student debt has really influenced both my decisions as well as my husband's. I looked into possibly moving into a more rural location and just given the situation that we would be put in with my marriage and having to possibly travel back and forth, the income did not seem to support that at all. It has also impacted

what my husband is able to do with his career, and I think even though our median income sounds like it is high as the single earner in a household and paying back for my debt, as well as possibly my husband's debt, paying off our living expenses, starting to save for retirement since I have missed out on about 7 years of retirement savings, then it has definitely made it difficult for us. And as I was saying, I am looking primarily at working for a possible corporation because they can provide a little bit increased compensation for us and really have put on the table being able to start a business at all in the next probably 10 or 15 years.

Chairwoman VELAZQUEZ. Thank you.

Ms. Tracey, Dr. Henry, one of my top priorities is making sure we are providing the right incentives to encourage business formation, especially in rural and underserved parts of the country. With that in mind, I introduced the Supporting America's Young Entrepreneurs Act of 2019. This bill will cancel $20,000 of student loan debt for the founder of a small business startup in an economically distressed area. Do you think programs like the National Health Service Corps, coupled with legislation I just outlined, could encourage more medical professionals to start a small business in medically underserved areas?

Dr. HENRY. Thank you for that question, Chairwoman Velázquez.

Yes, definitely. I think that particular bill that you mentioned, canceling $20,000 of debt, coupled with the National Health Service Corps, would be more of an incentive to work in an underserved area. But I would add to that strengthening programs like National Health Service Corps, there are proven programs, we need more funding for those, and we also need to recruit more students, residents, and fellows from medically underserved areas and rural areas because studies have shown that you are more likely to work and train in those areas if you are from those areas.

Chairwoman VELAZQUEZ. Dr. Wiese or Dr. Henry or Ms. Norby, are you aware of any other, I know that you mentioned some piece of legislation, but do you know or can you suggest any other piece of legislation that is being submitted here, introduced that you support?

Ms. NORBY. The American Physical Therapy Association is working on a policy recommendation on workforce diversity that is a collaborative effort between APTA, AOTA, and ASHA, that would provide scholarships for students that are ethnically diverse for inclusion and to be able to help offset some of their student loan debt. And Congressman Bobby Rush from Illinois will be the lead sponsor on that.

Chairwoman VELÁZQUEZ. Thank you.

Dr. HENRY. Yes. And I have two other pieces of legislation. H.R. 2441, the What Can You Do for Your Country Act, which will increase access to loan forgiveness for individuals who pursue careers in government service or nonprofit organizations. And then also the REDI Act or the Resident Education Deferred Interest Act, which is H.R. 1554. This legislation allows borrowers to qualify for interest-free deferment on their student loans while serving in a medical or dental internship or residency program.

Chairwoman VELAZQUEZ. Thank you. My time has expired.

I now recognize Mr. Chabot.

Mr. CHABOT. Thank you, Madam Chair.

I think that probably we all agree that the amount of tuition that is owed is incredibly huge and a huge drain on the people that have it hanging over their heads and their families, and it is startling. What is it, a trillion and a half or something like that?

Chairwoman VELAZQUEZ. 1.5. Mm-hmm.

Mr. CHABOT. It is just huge.

Now, the Federal Government in recent decades has played a much bigger role in funding universities and education and all the rest.

And let me ask you this, Mr. Delisle. You mentioned, for example, that the Federal Government gives basically unlimited loans. You can get not only the tuition, but I guess housing and books and all that stuff. You can kind of max it out and obviously that drives up the cost. And you said 90 percent are the Federal Government loans right now. And the universities, and I think this is one of the key things, key points I wanted to make, if you look at how tuition has gone up in recent years compared to other things, it seems like they have gone up a lot more percentage-wise. Is one of the reasons for that because the Federal Government is so involved and we are kind of dishing out so much money to universities, for example, through student loan programs and a whole range of other things that we are essentially enabling the universities to continue to raise this tuition and then therefore, people who can take out these loans for everything do that because they want a career and they want to do something good for themselves or families and their communities, and so it is a vicious cycle and where does it end?

Mr. DELISLE. Yeah, well, so ironically, some of the research says, no, at least not for medical school. It is not actually driving up the price. And the sort of theory for this, the reason why, is the med school students are such good prospects in the job market that they would be able to secure loans without the government money. Because the earnings, the promise of the earnings and the earnings level is so high that private lenders would make loans to them anyway. So it really is not sort of what sort of the economists would call a sort of credit-constrained market. But, that does not mean that there are not sort of downsides and negative consequences to the policy. So this Income-Based Repayment program that I am talking about, the loan forgiveness benefit in it, which is primarily going to graduate and professional students, this program, when it first started in 2009, cost about a billion a year. Now it costs 14 billion a year. That is a huge change in just a relatively short period of time, and this is the cost of this loan forgiveness. So whether or not the unlimited availability of loans is driving up tuition, we know that it is definitely driving up costs for taxpayers. We can see that in the data from the Department of Education.

Mr. CHABOT. Thank you.

Dr. Wiese, let me ask you a question. You had indicated, and it sounded like you made every effort to be frugal and responsible, and you ended up still with $400,000-plus in debt hanging over your head and with your husband also considering a similar career, so perhaps as you indicated, doubling that, yet you indicated some of the folks, your colleagues, have even larger debts. You said you

did not max out all that. You were being responsible and working and trying to make ends meet. The other folks have even more. Is that why, the difference because they took full advantage and put it all on debt?

Dr. WIESE. Thank you for your question.

I am not sure that they maybe took full advantage of the system. I think that some of them were maybe not in as ideal of a situation as I was with being able to live with my parents and have additional support provided to me so I think for some of them maybe they were only accepted into one particular residency program and so they had to go there and then they had to live there. And if they did not know anyone there, depending on the cost of living in that area, they also had to take out additional loans for that as well. So I do not even think any of them really maxed out the cost of attendance as they were perhaps able to do but I think they still, even with trying to save a little bit, had to take out more and maybe attended more expensive schools as well.

Mr. CHABOT. Okay. Thank you very much.

I have got such short time left I am going to yield back at this time.

Chairwoman VELÁZQUEZ. Thank you. I really appreciate it.

So they called votes, and what I am going to do, we have enough time to recognize the gentlelady from Iowa, Ms. Finkenauer for 5 minutes.

Ms. FINKENAUER. Thank you. And thank you again everybody for being here today. And as a 30-year-old who is also still paying off student loans myself, first generation college grad, I grew up in rural Iowa, so much of what has been said today I hear it and I get it and it is still personal to me and a lot of my friends back in Iowa as well who I have seen move away because they could not afford the opportunity to come back home and have the jobs that pay well enough then to pay off the student loans that they are also sitting with because, you know, again, they were in different situations where like myself, my parents could not pay for college and so, you know, we are struggling.

And so, it is something that we need to continue to keep focus on and I have a very specific question for Ms. Norby, and also the folks here on the panel as well, if you would like to comment.

One of the things I would like to try to figure out here is if there are ways to incentivize folks to be able to move back to rural areas and start their careers and start their families while also paying off those student loans, and I do not know if there is any appetite at all or what you guys might think would be helpful if there are ways to start incentivizing folks who are from areas or who would move to areas that its population has either remained stagnant or has lost population in certain years when right now there is a lot of national conversation about repayment of student loan debt, all of that. And if we are going to go down that road, I would like to maybe see it focused first on where we could have the most bang for our buck if that makes sense and just kind of curious about your take on that and if you think that may or may not be a good idea or helpful in states like Iowa or Wisconsin or in our rural areas.

Ms. NORBY. Thank you for the question.

I definitely see the positive of physical therapists to be able to have some of that student loan repayment, and as I was listening to the other witnesses, it reminded me that as an entrepreneur, I had to go to banks to get money to start our practices. Right? And two of our clinics we went through the SBA loan process as well. Even though my student loan debt has been paid off for many, many years, I am a co-signor for my three sons on their student loan, and even though my credit score is good, I have a negative impact on my credit score because their student loan debt comes up on my credit search.

Ms. FINKENAUER. Yep.

Ms. NORBY. So then I was able to secure a small business loan but the rate that the bank loaned it to me was at a higher percentage. So I think about our company and we are trying to be a legacy company and encourage people that join our company to become partners so that they can continue the clinic when we decide to retire, and they need to go for a small business loan as well. And if they have high student loan debt, their affordability of doing that is not going to happen.

Ms. FINKENAUER. Yeah. Yeah, thank you.

Dr. WIESE. Thank you again for your question. And just to add a little bit to that, I think in my specialty we have difficulty qualifying for some of the programs that are in place to be able to go back to some rural areas. So I think just kind of putting those systems in place for some specialists as well would be helpful. Also, possibly consider refinancing within the Federal program for people who do go to these locations and even a little bit of a reduction in the interest rates on the loans that we do pay now to possibly go back and work in those places.

Ms. FINKENAUER. That is an interesting way to look at it, too. I appreciate that.

Dr. WIESE. Thank you.

Dr. HENRY. I also would like to add that redefining, how you define the health professional shortage areas. So I work in a medically underserved community, but because we have two large training programs there in the city of Atlanta, in my area they consider it not a health professional shortage area because they are counting all the trainees and not actually practicing clinicians. And so maybe changing that would also enable more people to come back to those underserved communities.

Ms. FINKENAUER. Great. Thank you.

And I know I have to hurry here, but one more thing.

Iowa is one of the lowest reimbursement states in the country for Medicare reimbursements, and I have heard from a lot of folks that that is one of the biggest reasons why we are lacking in rural providers and desperately need folks in our state and other rural areas who deal with the same situation.

Ms. Norby, could you just touch on that specifically of how that may be helpful to attracting folk and how that low Medicare reimbursement rates are also affecting folks being able to pay off their students loans if they are a physician?

Ms. NORBY. That is a very good question.

You have to be very nimble as a small business owner to be able to survive in that kind of environment, and yes, Iowa is actually the lowest paid for the Medicare reimbursement as well.

But there are people that want to come back and treat their neighbors and their friends, and it is being creative and finding resources that the small business can open and survive within that community.

Ms. FINKENAUER. Thank you. I appreciate it.

And Madam Chair, I yield back.

Chairwoman VELAZQUEZ. The gentlelady yields back.

And I will recognize Mr. Hern from Oklahoma, Ranking Member of the Subcommittee on Economic Growth, Tax, and Capital Access for 5 minutes.

Mr. HERN. Thank you, Madam Chairwoman, Ranking Member Chabot, and our witnesses for being here today testifying on rising student loan debt and the effects it has on small medical practice.

Like probably most people in this room, I had student debts that I had to pay off over the years but, you know, it was interesting that my colleague from Iowa brought up about the Medicare reimbursement. I also sit on Budget and we just had a Committee hearing 2 weeks ago with the deputy director of the CBO, the nonpartisan, you know, kind of guru of all things, and we talked about Medicare for all which would further lower the reimbursement rates, which really should have you all up in arms even discussing that. And it would further exacerbate the problems of trying to repay the loans for those of you who are currently in the medical field or working around it.

Student loan debt is a topic that resonates with most Americans. And as the Federal Reserve recently reported as we have talked about $1.5 trillion, only second to mortgages held by Americans and growing every day. However, as dire as the student loan situation may seem, several generous Federal loan repayment programs currently exist, including some of them disproportionately advantage the highest earners who accrue the most amount of debt.

I would love to ask you a lot of questions, but I have an expert sitting right next to me who has done exactly what you all are talking about, and my colleague from Pennsylvania, Dr. Joyce, who he and his wife own a practice together who are both doctors.

So I am going to yield the balance of my time, Madam Chairwoman, to Dr. Joyce.

Mr. JOYCE. Thank you, Madam Chairwoman.

Dr. Norby, Dr. Wiese, Dr. Henry, Mr. Delisle, thank you for being here.

I, too, have been inducted as a fellow in the American College of Physicians after doing a primary care residency in Johns Hopkins in general internal medicine. With my wife, I opened a small business in rural south central Pennsylvania, but prior to that I did additional training at Johns Hopkins in dermatology. So my terminal degree occurred when I was 32 years old. I finished with significant debt. I recognize that. We worked hard together. We did not have all the luxuries in life. I had no referral as far as the ability to pay those loans back, but I did. I did not defer on one of those.

I feel your pain. I know that in Pennsylvania we are grossly underserved by primary care physicians, particularly in the 10 coun-

ties that I represent in south central Pennsylvania. I know that the students who come back to our areas often are over half a million dollars in debt. I realize that many of them stay in the large metropolitan areas because they can make more money. I realizes that the Medicare reimbursement rate is something that definitely needs to be addressed. And when Representative Finkenauer brought that up, I will take that off of my discussion point. But I will want to mention to you that it is absolutely important that we support legislation such as H.R. 1554, the REDI Act, which would allow students to defer interest—what you have talked to us about—to defer interest on their student loans until the completion of their medical residency or their dental residency programs. This is important. This is a bipartisan bill with strong support on both sides of the aisle which could have an immediate impact, which could have an impact in primary care physicians returning to the areas where they grew up as you have pointed out to us. It is so happy to have these people, to welcome them back into their communities. I would welcome the ability to work with my colleagues to try to advance this bill.

But it is also something Mr. Delisle pointed out. We have to note that student debt is far from the only barrier that prevents private practice for doctors today. The major structural impact is the reimbursement under Medicare for procedures which can occur much higher in hospital settings versus in the doctor's office. This has driven, and is driving, many private practices to sell their private practices to hospital systems. It discourages individuals from entering into private practice.

My questions are more comments here today. We are advocates. We are bipartisan advocates. Our Chairwoman, our Ranking Member, we understand the importance of having physicians in private practice. I leave with the overwhelming encouragement that every republican and democrat work together to sponsor, to pass the REDI Act, H.R. 1554, and the importance of that for encouraging medical practices in the rural communities.

Thank you. Thank you, Madam Chairwoman. I will yield back the rest of my time.

Chairwoman VELÁZQUEZ. Dr. Joyce yields back. And thank you so much for your powerful statement and being able to shed light into this issue given the fact that you are a doctor.

The committee stands in recess, and we are coming back after votes.

We stand in recess. Thank you.

[Recess]

Ms. DAVIDS. The Committee will now come to order.

I would like to now recognize myself for 5 minutes of questioning.

Thank you to all the witnesses for being here and to Mr. Hagedorn for returning.

So many people in my district—I represent the Kansas 3rd Congressional District—are struggling with student loans. I know because I am one of them. I know we have heard that from a few members here today. I personally understand how stressful it can be to deal with the burden of student loan debt. That is why I have cosponsored legislation like the Empower Participation and Repay-

ment Act of 2019, which incentivizes employers and expands tax exclusions to help pay off your student loans.

How much student loan debt you have should not be the first thing that you are thinking about, or that physicians particularly are thinking about when deciding where to live, where to practice, how to practice. And with the looming physician shortage that I have heard a lot about, I know it is necessary for us to discuss the issue of rising medical student loan debt and its effect on small medical practices.

Physician shortfalls affect healthcare access and outcomes across the country. But even more so, it impacts underserved and rural areas. I am especially concerned about the decreasing number of physicians who are choosing to practice primary care due to their burdensome student loan debt.

The American Academy of Family Physicians, which is headquartered in the district that I represent in Lenexa, anticipates an outside shortage of primary care physicians by 2013, as compared to other specialties.

So the first question I would like to ask is, Dr. Henry, the Public Service Loan Forgiveness program has turned down 99 percent of the program applicants as of 2018. How is this from your point of view affecting the medical field, particularly primary care and internal medicine physicians like yourself?

Dr. HENRY. Thank you for your question, Ms. Davids.

It is greatly affecting our field. As I mentioned in my testimony, I work with internal medicine resident physicians and currently about 80 percent of our internal medicine residents specialize, and of that 20 percent, 10 are hospitalists and then that is left with just 10 going into primary care. And a big part of that is the student loan debt burden. When they think about becoming a specialist, or being a primary care physician, you make anywhere from 30 to 50 percent less than as a specialist, and so when they are factoring in that they need to be able to pay back their loans in a timely fashion, they choose a specialty over primary care.

And particularly for myself, without the Public Service Loan Forgiveness or programs like that, it would prohibit physicians like me from going into those areas.

Ms. DAVIDS. I would invite any of the other panelists if you want to follow up on that before I ask my next question.

No? Okay.

Mr. DELISLE. I would just add that the high rates of denial in the Public Service Loan Forgiveness program has come from the facts that the rules that Congress put in place around it to actually limit who can get the loan forgiveness as a way to save money. And so you have to have the right kind of loans and you have to be making regular payments. And so I think what we are seeing is that as people apply for it, they are sort of surprised to learn of these very complicated rules that were put into place when it was created. So it is not as if people are being denied in error. It seems to me that they are actually being denied for the actual reasons that exist in the program. But many of that is going to disappear into the future because as of 2010, everybody has the right kind of loans to qualify for Public Service Loan Forgiveness.

Ms. DAVIDS. Thank you. I appreciate that. I might follow up with you for some additional information about that.

I guess I would like to know whether or not the Public Service Loan Forgiveness program further, you know, would elimination of that program further exacerbate or some of these policy changes increase accessibility and help ensure that high-need areas have primary care physicians and that people are not making different choices based on that.

Dr. HENRY. Yes, thank you. Without the Public Service Loan Program, a medical degree would be increasingly out of reach to physicians like myself who contribute to the diversity of the healthcare workforce and are committed to increasing the healthcare, working to meet the healthcare needs of a medically underserved population.

Ms. DAVIDS. Thank you. So I will not ask any more questions.

I will yield back and would like to recognize Rep Hagedorn for 5 minutes to ask questions.

Mr. HAGEDORN. Thank you, Madam Chair.

I represent the 1st District of Minnesota, the southern part of Minnesota. A lot of rural areas. And so we are continuously working with folks and trying to make sure that people who live in underserved and rural areas have access to timely quality medical care, making sure that we can lure physicians in there as best as possible, and have some incentives if needed. I recently testified in front of the HHS Labor Subcommittee and said that I support a grant program that would allow doctors to go into rural areas and to practice there. I happened to be joined that day by three students at the Mayo Clinic who happened to be just in town on that kind of an issue and they wanted to be both doctors and researchers. Ando so whatever we can do in these areas I am sympathetic and supportive.

I also do not begrudge folks who get into the profession of medicine who over time are accomplished and make money. You take great risks. You put a lot of time into it and you should be rewarded for your talents. You are saving lives, you are improving lives, and doing wonderful things and we never want to discourage that. The same way in our system, I do not think we ever want to discourage medical technology, prescription drug advances and things of that nature. The United States is the envy of the world when it comes to medical care, and we need to preserve that.

One of the things I think that will be helpful in the future, legislation that we are working on we should be introducing soon, we will look for support in a bipartisan fashion, is the concept of letting you pay back education loans, letting everyone pay back education loans with pretax dollars. That seems to me just common sense.

I was at the Houston County Fair many years ago. I was campaigning and somebody walked up and said how come we cannot use pretax dollars to pay back these education loans? I said, well, I do not know. It just makes sense. We should get on that. So that is one of the things that we are working on in Congress.

Many of you have talked about the concept of physicians going into underserved areas and trying to open up practices, and that is important. But I think what you will find is based upon my

interactions in southern Minnesota is just as important as paying back debt and things of that nature, you have some government regulations to deal with that drive up your costs. You have all sorts of impediments as being small business people that drive up your costs and make it very difficult.

And one of the things that we have to look at is this concept of single payer. Medicare for all. A lot of people are pushing that. They think it is going to be some panacea. I disagree, particularly for physicians who want to have their own practice or those that want to serve in rural areas. Fifty cent on the dollar reimbursement does not sustain the model of our hospitals and our fine institutions of medicine in rural areas. If you want to pay back your loans, you need to make money. And when the Federal Government comes with 50 cent on a dollar reimbursement, you are going to have a tough time.

Now, I brought up a few things, and I will start here, and please just respond to anything I have said.

Ms. NORBY. Thank you. We live in Okoboji. We are close to your district.

Mr. HAGEDORN. Well, you can always move.

Ms. NORBY. There we go.

Mr. HAGEDORN. Right into Minnesota.

Ms. NORBY. One thing that I was thinking of when you were stating your statement was as a physical therapist, we completely embrace the fact that we need our primary care physicians as well in our communities. I need to go see my primary care physician at times as well and do not want to drive over an hour to do that.

One thing that I touched upon was the opioid epidemic. And physical therapists, we are the muscular skeletal experts in the field and we have something called direct access. So you, if you woke up and you could not stand up straight and your back hurt, you could call your physical therapist and get in that same day and actually receive treatment that would solve the cause of the problem. And so working collaboratively with the other healthcare professionals that would be attracted to those underserved areas is really one of our main goals.

Mr. HAGEDORN. Thank you.

Dr. WIESE. Thank you very much for your comments, and I appreciate them. Something that touched me I think was being able to use pretax dollars to pay for some of those student loans, and I think we very much support that idea. It would be fantastic and going along with that I know in the Senate there is a bipartisan act called the Student Loan Tax Elimination Act of 2019 to eliminate the origination fees of Federal loans, and I think that kind of goes along with using pretax dollars. I think it all kind of just adds up, any little areas where we can focus on reducing that would be of very great help.

Mr. HAGEDORN. Thank you.

Ma'am? Doctor?

Dr. HENRY. Yes, thank you also for your comments. I also agree with the idea of being able to pay back our loans with pretax dollars. In fact, anecdotally, when I called my lender I asked, so how are you figuring this amount out? Why am I paying nearly 25 percent of my take home pay on student loans, and then they said

they use your total AGI, adjusted gross income, and then they use some sort of numbers. But when I pay my loans back, I am paying after taxes. And so the take home pay, 25 percent after taxes is not enough to start and maintain a private practice. So I think that idea that you guys are bringing up in Congress would be perfect.

Mr. HAGEDORN. The concept would be you have to go work for the money, earn it, and then at least you could pay back those loans with it.

I guess we have run out of time for our last witness unless you want to give them one minute.

Ms. DAVIDS. I think that would be——

Mr. HAGEDORN. Would that be okay?

Ms. DAVIDS. Yes. Go ahead. Go ahead and answer.

Mr. DELISLE. Well, yeah, I think that, you know, paying the loans back with pretax dollars, I mean, I think one of the issues that we are starting to see in the Federal Student Loan Program is it has been layered on over and over and over again with different benefits and bells and whistles, and it really is. You can see that is proving very frustrating for people who are using the program.

So I would actually sort of argue in the opposite. I would make the system simpler and make the benefits very clear and transparent rather than multiple ones that are sort of hard for people to understand.

Mr. HAGEDORN. Thank you. I appreciate your testimony. It is nice to see you today.

Ms. DAVIDS. The gentleman yields back.

And I would like to now recognize Rep Judy Chu, who is the Chairwoman of the Subcommittee on Investigations, Oversight, and Regulations.

Ms. CHU. Thank you so much.

Dr. Wiese, in 2011, Congress passed the Budget Control Act, which drastically cut government spending and included a measure to strip graduate students of their eligibility to receive subsidized Federal loans. So since 2015, I have introduced the Post-Grad Act, a bill which would reinstate subsidized Federal loans for graduate students, and I will be reintroducing that bill soon. If enacted, it would allow graduate students in medical fields to complete their studies without interest accumulating on their loans.

You mentioned the burden that you have experienced from your loans accumulating interest during your schooling and residency. Do you believe that if you loans were subsidized you would be in a better position to open a private practice or work in underserved areas?

Dr. WIESE. Thank you very much for your question, and I absolutely agree with that. I think it is a fantastic idea to bring back the subsidized graduate student loans so that that interest does not continue to accrue while you are in training and unable to pay down the principal or the interest on those loans. We get a lot of communication from our loan servicers recommending to pay down on the interest and we are just unable to do that. There is really no other source of income besides our student loans, so I think that would greatly help us and going along with that with the REDI Act

I think is fantastic to be able to defer the loan payments while in residency as well. Thank you.

Ms. CHU. Thank you for that.

Dr. Henry, House Democrats last Congress passed the Aim Higher Act, a comprehensive reauthorization of the Higher Education Act, and included in that bill was a proposal to extend Pell Grant eligibility from 12 to 14 semesters and allow students to apply their unused Pell eligibility to their graduate studies. Right now, students who do not use all 12 semesters of their Pell eligibility as undergraduates are ineligible to receive the rest of the grant as graduate students, but the Aim Higher Act would enable a student who receives a Pell grant for 8 semesters for their bachelor's degree to use their final 6 semesters of eligibility during graduate school.

Do you believe this change would increase the number of students from low-income backgrounds that are able to pursue medical degrees at schools like Emory University?

Dr. HENRY. Yes. Thank you for the question.

Definitely. I was a Pell Grant recipient for my undergraduate education, and it was not until my graduate education that I started accruing private loans and loans that are unsubsidized. So being able to transfer that money over from undergraduate to your graduate degree will definitely enable people from communities like mine to pursue a medical degree, and from private universities like Emory University.

Ms. CHU. Well, thank you for that.

And just to continue on, I am one of two psychologists in Congress, so I feel this issue very keenly. And I wanted to ask about the shortage, Dr. Henry, of mental health professionals across the country. According to the Department of Health and Human Services, nearly 7,000 mental health practitioners are needed across the U.S. My legislation, H.R. 2958, the Increasing Access to Mental Health in Schools Act would reduce the cost of post-graduate education for mental health professionals that work in high-need schools and it would help address the shortage of mental health resources for students. But the need goes far beyond schools.

Can you talk about the long-term effects in communities that have a shortage of medical professionals, including mental health providers?

Dr. HENRY. Yes, thank you for that question.

Actually, I work in an integrated care setting where we are moving towards integrated practices, meaning mental health and substance abuse in our primary care setting at Grady Hospital. As an internal medicine doctor, I am working very closely with our psychologists, with the social workers, and also with their training programs to work together to help alleviate that shortage.

One answer to the shortage is actually training up, working together and training up our primary care physicians because most of the patients that we see who meet the diagnosed criterion for a mental health disorder, we refer them out. Only a third actually see a psychologist or psychiatrist, a mental health professional. So I think if we work together with collaborative care, it would actually help to address some of that shortage because we can provide more of that in the primary care setting.

Ms. CHU. Very good.

And Dr. Norby, as a small business owner, you know of the financial pressures involved with a private practice and yet we see many hospitals acquiring private practices. Do you believe that rising student loan debt has created an incentive for independent providers to sell their practices to hospitals?

Ms. NORBY. Yes, I very much agree with that. And I would be remiss to not say thank you for cosponsoring H.R. 2802 before I answer your question.

We see that a lot in consolidation as well in physical therapy practices, more of a corporate purchasing of the practices, which has caused restraints on the ability for a physical therapist to really practice to the full extent of their license.

Ms. CHU. Thank you. I yield back.

Ms. DAVIDS. Thank you. The gentlelady yields back.

Well, thank you very much. I am sure the entire Committee here would like to thank all the witnesses for taking the time out of their schedules to be here with us today.

As Chairwoman Velázquez said earlier, student debt is having an economic impact on all of our communities. Those that are just starting college or are on their way to the workforce, all understand the obstacles and burden that student debt has on life decisions. Whether it is trying to decide on a specialty or where to practice, student debt has weighed heavily on medical professionals and their ability to enter into private practice. This is why we must take the necessary steps to address the rising costs of education and student loan debt, particularly in health care, so that Americans can receive the care they deserve.

I look forward to working with my colleagues on both sides of the aisle to address this very important issue.

I would ask unanimous consent that members have 5 legislative days to submit statements and supporting materials for the record.

Without objection, so ordered.

And if there is no further business that comes before the Committee, we are adjourned. Thank you.

[Whereupon, at 1:22 p.m., the Committee was adjourned.]

[Ms. Sandra Norby did not submit her QFR's in a timely manner.]

APPENDIX

Testimony before the United States House of Representatives
Committee on Small Business

Hearing on "The Doctor is Out. Rising Student Loan Debt and the Decline of the Small Medical Practice."

June 12, 2019

Statement of Sandra Norby, PT, DPT
Chief Executive Officer, HomeTown Physical Therapy, LLC

On behalf of
The American Physical Therapy Association (APTA)
Private Practice Section of APTA

Chairwoman Velazquez, Ranking Member Chabot, and Members of the House Committee on Small Business:

My name is Dr. Sandra Norby, and I am a physical therapist and CEO of HomeTown Physical Therapy in Des Moines, Iowa. On behalf of the American Physical Therapy Association (APTA), and the Private Practice Section of APTA, I thank you for the opportunity to provide testimony on the impact that rising student loan debt has on small practices, the local economy, and by extension the local community. Today I will share with you my perspective on how small medical practices, including physical therapy clinics, struggle to recruit and retain good talent—and the significant role that student loan debt plays in that challenge.

Background

My small business consists of 5 clinics in Iowa, located in communities with populations ranging from 500 to 9,000. When we opened our doors 13 years ago, we named our business "Home Town Physical Therapy" because it represented our desire not only to be a part of the local economy and community, but also to hire individuals who had grown up in Iowa's small towns—hometown people who had gone away to school, earned their degrees and developed expertise, but who wanted to be able to come back to their hometown to practice. We know that when someone who grew up locally is able to return, they often do so with the intent of giving back to the community in a variety of ways—as a little league coach, sitting on the board of a local nonprofit or town council, or as a member of the local Kiwanis chapter, for example.

Practicing in small rural communities, as I do, my colleagues and I are often the only physical therapists in the local area. We do our best to meet the therapy needs of our communities; in some cases hiring an additional physical therapist would be the only way to truly achieve that goal. The combined financial constraints of the salaries we can afford to pay and what early-career doctors of physical therapy need to make in order to pay down their student loans can often be a roadblock. The compensation offered in urban and suburban areas are usually higher,

covering more than the cost of living and student loan payments. Additionally, most physical therapy schools are in big cities, and most people want to continue to live in cities and have access to all that they offer. The result is that we private practice owners have a hard time recruiting physical therapists to rural communities.

One of my clinics is in Lake Mills, Iowa, not far from the district of Congresswoman Finkenauer, who sits on this committee. A recent graduate from the Mayo Clinic College of Physical Therapy and Rehabilitation (which is in the district of Congressman Jim Hagedorn, who also sits on this committee) is engaged to marry a farmer who lives 15 minutes outside of Lake Mills. They plan to live and work on that farm, but she is struggling to find a job locally that will compensate her enough so that she can also pay her student loans. My clinic in that town is in high demand; but not high enough to pay a second (or additional) full-time physical therapist. We are currently in negotiations to determine whether or not I could bring her on board and pay her enough of a salary to cover her loans.

The challenges that I face as a practice owner in rural Iowa are not unique. Along with being CEO of HomeTown Physical Therapy, I also serve as president of the Private Practice Section (PPS) of the American Physical Therapy Association. The Private Practice Section comprises 4,019 physical therapists nationwide who own, operate, or work in a private practice setting. As I have spoken to my fellow private practice owners from across the country, they too have spent many sleepless nights worrying about their practice and the patients they serve—can they maintain their staff with declining reimbursement? How will they recruit and fill vacant positions? Will they ever be fully staffed, or are 80-hour work weeks going to be the norm forever?

Being a small-practice owner, I knew the risks and opportunities of starting a small business, and the variables—many out of my control—that come into play when running a small practice in a rural area. But one variable stands out that continues to have a growing impact on the ability to recruit and retain staff and keep my business open—the impact of student loan debt.

Education and Student Debt

Over the years, I have found my work as a physical therapist to be rewarding and fulfilling. Physical therapists play a unique role in society in prevention, wellness, fitness, health promotion, and management of disease and disability by serving as a dynamic bridge between health and health services delivery for individuals across the age span. While physical therapists are experts in rehabilitation and habilitation, we also have the expertise and the opportunity to help individuals improve overall health and prevent the need for avoidable health care services.

All PTs must earn a degree from an accredited physical therapist doctoral program before taking and passing a national licensure exam that permits them to practice. Physical therapists are educated through doctoral programs accredited by the Commission on Accreditation in Physical Therapy Education. State licensure is required in each state in which a PT practices. The doctoral education programs for PTs are comprehensive and prepare physical therapists to meet the needs of society.

However, this rigorous educational preparation, as for most highly skilled health care professionals, comes at a significant financial cost. According to the results of a 2017 survey[1] of the PT profession, 43% of PTs had undergraduate debt, and 87% had PT school debt. On average, students had $107,000 for PT program debt alone, and $124,000 for undergraduate and PT program debt combined. For those with loan debt, 33% indicated that it affected where they practice, and 32% indicated that it impacted the type of practice they sought. The median current full-time annual income for PTs at their primary position was $70,000, with 24% reported having other paid employment in addition to their primary position. That financial burden manifests itself in a number of ways beyond just salary requirements. In some cases one employer might be more appealing than another because the health care premium paid by the employer is more comprehensive. That could be the margin for the employee who needs to pay their student loans. Additionally, as small-business owners, we cannot afford to give sign-on bonuses like larger

[1] American Physical Therapy Association Student Debt Survey 2017.

hospitals can. These are just a few examples of the hurdles we face as small-business owners trying to recruit talented physical therapists to join our clinics and care for our communities.

The burden of student debt also impacts the urban-rural divide. The Bureau of Labor Statistics notes that many physical therapists live in urban and suburban areas, creating maldistribution of physical therapists throughout the country. This exodus from rural areas is particularly acute among new grads, who are leaving rural areas due the impact of student debt. In the January 28, 2019, Federal Reserve Issue Brief[2] titled "Rural Brain Drain: Examining Millennial Migration Patterns and Student Loan Debt" the authors' key findings were that individuals with student loan debt are less likely to remain in rural areas than are those without it. Furthermore, individuals in the highest quartile of outstanding student loan balances are the most likely to leave rural areas. Within the period of study, rural individuals who move to metro areas fare better than those who stay in rural areas across several financial and economic measures, including student loan delinquency rates and balance reduction.

Student debt does not impact existing small businesses only; it also extends to the formation and growth of *future* small businesses. Researchers at the Federal Reserve Bank of Philadelphia and Pennsylvania State studied[3] the relationship between student debt and small-business formation and found "a significant and economically meaningful" link: more student debt led to fewer small businesses being formed. I have spoken to many new PT grads who dream of opening up their own small practice someday but fear that those dreams will not become reality, as taking on small-business loans in addition to their existing student debt is simply not possible.

Finally, student debt is also impacting the ability of smaller practices to recruit graduates who reflect the diverse patient population that we serve. The impact of student debt on under-

[2] Tabit PJ, Winters J. Rural Brain Drain: Examining Millennial Migration Patterns and Student Loan Debt. US Federal Reserve. *Consumer & Community in Context.* 2019; January 28.
[3] Ambrose BW, Cordell L, Ma S. The Impact of Student Loan Debt on Small Business Formation. *SSRN.* 2015; July 15. http://dx.doi.org/10.2139/ssrn.2417676.

represented individuals in the profession—whether those of ethnic or racial minorities, or with disabilities, or from disadvantaged backgrounds—continues to be a major concern. The desire and determination of small practices to be inclusive and reflective of our patients is met by the stark reality of the burden that student debt disproportionally has on underrepresented individuals entering the profession.

The Impact of the Opioid Crisis on Rural Small Practices and Public Health

The challenges that small practices face in rural areas in recruiting and retaining providers has been highlighted by the current opioid crisis. According to the Centers for Disease Control and Prevention, rural Americans are more vulnerable to prescription painkiller abuse and overdoses, and the rate of opioid-related overdose deaths in nonmetropolitan counties is 45% higher than in metro counties. There is a critical need for increased access to nonpharmacological options for the prevention, treatment, and management of pain. However, recruiting therapists, especially those who have expertise in the prevention and management of pain, is a challenge, given the competition from higher-paying salaries offered in urban and suburban areas.

Recommended Policy Solutions

There is no easy fix or silver bullet to the complex problem of student debt. The physical therapy profession is currently exploring options and ideas for new models of education to meet the needs of future students of physical therapy and their patients. In addition, APTA is committed to providing resources and information to help students, prospective students, and recent grads make the best financial decisions possible when it comes to their education. In 2017 APTA launched its Financial Solutions Center to help those in the physical therapy profession deepen their knowledge of education debt and finances.

However, there are 2 immediate policy solutions that APTA and the Private Practice Section strongly support that would alleviate the burden of student debt on small practices' ability to recruit and retain recent grads.

First is enactment of H.R. 2802, the Physical Therapist Workforce and Patient Access Act of 2019. This bipartisan legislation, introduced by Reps Diana DeGette (D-CO) and John Shimkus (R-IL), would allow physical therapists to participate in the National Health Service Corps (NHSC) Loan Repayment Program. I am grateful for the opportunity to thank Chairwoman Velazquez in person for her co-sponsorship of this legislation.

The NHSC addresses the health needs of more than 11.4 million underserved individuals across the nation. The program allows for the placement of certain health care professionals in areas designated as a health care professional shortage area (HPSA). In exchange for serving at least 2 years in these areas, eligible health professionals are provided up to $50,000 toward the cost of their education. Loan repayment awards are made based on the HPSA score of the site and on the loan repayment program participant's characteristics—their dedication to serving the primary care needs of their patients. The NHSC has not only served as a pipeline for providers in underserved areas but has successfully retained many of its providers. For example, in 2018 nearly 80% continued to practice in a HPSA for at least 1 year after their service commitment ended.

Currently, there is no rehabilitative care component in the NHSC, and physical therapists are not eligible to participate in the program. My daughter in currently studying to be a doctor of osteopathic medicine; she is planning to use the NHSC loan repayment program so that she may practice in a rural area. I am truly excited for her and for the community she will serve, but I must admit that I am also jealous because physical therapists are not able to participate in the program.

I believe that including physical therapists in the NHSC Loan Repayment Program will improve functional outcomes and save costs by increasing access to critical rehabilitation services. Adding physical therapists to the NHSC will also ensure that individuals in underserved communities have access to nonpharmacological options for the prevention, treatment, and management of pain. If I were able to advertise that my clinic was in a HPSA and that the recruit would be eligible for the NHSC loan repayment program, I am sure I would be a more appealing

employer.

Second, APTA along with the American Occupational Therapy Association and the American Speech-Language-Hearing Association, are committed to ensuring that we are recruiting providers who reflect the diversity of the patient populations we serve, while addressing student debt. Legislation will soon be introduced in the House to provide student scholarships or stipends for individuals underrepresented in the professions of physical therapy, occupational therapy, audiology, and speech-language pathology, including racial and ethnic minorities and those from disadvantaged backgrounds.

Policy solutions that assist practices in recruiting and retaining graduates with student debt for rural Iowa, and other rural and underserved communities, makes sense for small business, while also improving public health, whether it be increasing access to nonpharmacological options for pain management, preventing and treating injuries from falls in older adults, ensuring that pediatric patients with development disabilities get the care and service that they need, or providing rehab for the injured farmer who just needs to get back to work.

Conclusion

I truly appreciate the committee's interest in addressing the student loan burden of providers who are willing and eager to be a part of the engine of the local economy—working in a small business—and practice in rural and underserved areas. Your efforts can go a long way toward improving access to care. I look forward to working with the committee, and I am happy to answer any questions you may have.

United States House of Representatives
Committee on Small Business

"The Doctor is Out. Rising Student Loan Debt and the Decline of the Small Medical Practice"
Wednesday, June 12, 2019
Testimony by Dr. Lauren Wiese

Introduction

Good morning. Chairwoman Velázquez and Ranking Member Chabot, on behalf of the American Association of Orthodontists, thank you for having me here today. The AAO is the oldest and largest dental specialty professional association in the world. The AAO and its 9,600 U.S. members are dedicated to advancing the art and science of orthodontics and dentofacial orthopedics, improving the health of the public by promoting quality orthodontic care, and supporting the successful practice of orthodontics. It is really that third goal for which I am here today.

Background and Education

I have been very fortunate in my life in terms of academic and personal success and am honored to be able to share my story about how my student debt burden has greatly changed the plans I have for my future as well as that of my family. I am currently a third-year orthodontic resident at the University of Maryland in Baltimore and will be graduating at the end of the month. After graduating from high school, I attended Villanova University on a full-tuition academic scholarship and graduated in 2011 with degrees in Chemical Engineering and Business. While studying engineering, I became interested in dentistry and was drawn to the ability to make a difference in the lives of my patients using my own hands and artistic nature while also having the opportunity to own a small business. My father is a small business owner and while his business is unrelated to healthcare, growing up I saw the advantages of being your own boss and community involvement that this path affords.

At the time, dentistry seemed an ideal career path for me to pursue my goals, including that of business ownership. So after college, in 2012, I began dental school at my state school, the Rutgers School of Dental Medicine in New Jersey. I was accepted into private schools, such as the University of Pennsylvania, but the cost of attendance at the time would have been almost double that of Rutgers University. I excelled in dental school and graduated first in my class in 2016; my academic record allowed me to pursue an orthodontic specialty and I ultimately matched at the University of Maryland School of Dentistry, a three-year residency program for orthodontics.

As I am completing the final year of my residency, I have spent the last few months looking for jobs, considering more remote areas like Wisconsin, where I would have loved to serve the population, as well as more populated areas in New Jersey and Connecticut. My husband, who has been working since graduation from college, has been considering a career change for the last few years and gained acceptances into both medical and dental schools this year. In considering his opportunities, as well as my employment opportunities, we are trying to solidify our plans, but have had great difficulty determining which options make the most financial sense for us. While I would love to pursue my initial goal of owning a business by buying into an existing practice, purchasing a practice, or starting my own practice; the thought of taking out a large business loan in light of my own student loan debt -- in addition to that which my husband may take on in the coming years -- is paralyzing for us.

Student Debt and Loan Burden

While neither of my parents are doctors or dentists, I was lucky they had worked very hard and saved well and were able to provide loans to me for the first two years of dental school. Tuition, fees, and my health insurance through the school added up to bills of almost $55,000 for each year. Taking into account living expenses during the first two years as well, my parents

loaned me about $120,000, which will be paid back to them in the coming years in addition to my federal loans. I had saved all throughout high school and college by working as a server at various restaurants; and as a teaching assistant, resident assistant, and intern at an engineering company during my college years. I used the money I had saved from these jobs to help with general living expenses during dental school to minimize my student loans.

I started to borrow from the federal government in the way of student loans at the beginning of my third year of dental school. I am very lucky that I was able to delay borrowing for so long, as I can only imagine how much greater my debt burden would be with the additional loans and years of interest accumulation. I think I understood my commitment in the way almost any student in their mid-twenties would; I did not quite understand what this would mean for me in terms of monthly loan payments after finishing school but had faith that I would do well as a dentist and would have no problem paying off the loans. That was the attitude that most dental students had at the time, and this outlook was confirmed many times to us by dentists working at the school and in our personal lives. Something I did not totally understand at the time was that many of the dentist mentors I spoke to, even those only a few years older than I, graduated at a time when the debt burden of school was much more manageable. While in school, it gave me solace to know that the majority of my dental school friends were in similar situations, and some even had loans from college that would need to be paid off as well, and others were starting families or supporting their existing families; compared to others, I often felt I was in a better financial situation. What I did not anticipate was the emotional struggles my husband and I would face in making decisions due to the debt, such as when we would be able to start a family or whether he would be able to also pursue his dreams.

Dental residencies are unlike medical residencies in that the majority of dental residencies are tuition-based. During my 3-year orthodontic residency, my 1st year tuition and

fees were approximately $35,000 during each of the two semesters (out-of-state tuition) and approximately $25,000 for each semester for the 2nd and 3rd years (in-state tuition); in other words, about $70,000 the first year and $50,000 for each of the last two years of residency. I had to borrow from the federal government in excess of these amounts to help pay my living expenses. Furthermore, my program in particular forbade us from working/moonlighting in the dental field in any capacity during residency. I am still unclear on the reasons for this, but it was disappointing that not only would we be taking out a large amount of student loans for residency, but then also not be allowed to work nights and weekends as a dentist to help pay for the extra education.

Including the loan from my parents, my total amount of indebtedness upon my graduation from residency is $411,714. From the time I started taking out federal student loans during my third year of dental school in the summer of 2014, up until my last disbursement during residency in February of 2019, I have accumulated a total of $152,257 in Stafford Loans with interest rates between 5.4-6.6% and $139,457 in Graduate Plus Loans with interest rates between 6.3-7.6%. This is a total of $291,714 in federal student loan debt, of which $35,688 is unpaid interest.

My student loans have been in deferment throughout my residency. We receive many emails from the loan servicer advising us on the importance of making payments while in school and paying down the interest on the loans while in deferment. I absolutely understand the benefit of this, but I do not understand where the additional money would come from; I have had to borrow money for almost everything over the last couple of years and by no means have extra laying around to pay down interest. If I had any extra or borrowed too much, then I made it a point to return it via the loan servicer, which credits back any accumulated interest to my account.

My loans will go into repayment six months after I graduate, so I will officially need to start payments in January 2020. I have selected the standard 10-year repayment plan, a more aggressive plan, which will require monthly payments of $3,295. Including interest, my total repayment amount will be $395,426, not including the $120,000 I will pay my parents. Due to the interest accumulated and capitalized, even with the most aggressive payment plan, I will pay over $100,000 on what was initially $256,000 (not including accumulated interest while I have been in school). While some people advocate for slowly paying off the student loans, seeing the tremendous amount of interest that would be paid is devastating. I come from a more aggressive train of thought and prefer to pay off the debt as quickly as possible so that I am then able to take on other business ventures without so much risk. In the meantime, however, paying the loans off aggressively makes it very difficult, if not impossible, to purchase or start a private practice during that time, not to mention start a family or support my spouse going back to school.

There are other loan repayment options, but in orthodontics, I was unable to find any employment opportunities that would quality for Public Service Loan Forgiveness (PSLF) and other similar programs. There is also quite a bit of uncertainty regarding the future of these programs.

After working for about six months, my plan is to refinance my loans with a private lender to reduce my interest rates. Unfortunately, this also involves risk because with private loans, I will lose out on the protections and flexibility of federal loans in the event I am unable to continue making regular loan payments.

Impact of Student Loans on Life

Most people think that orthodontists and other medical specialists make boatloads of money and can afford a huge house, fancy car, second vacation home, and so on. It may be true that our initial salaries are greater than average, but the reality is after taxes are paid, a significant

portion of our incomes are allocated towards paying back our student loans. We also have to make up for the lost years of retirement savings while we were in school, and some of us are barely able to scrape by and eat healthy meals, let alone save for the future. I personally have saved very little for retirement, so I am already about seven years behind in savings and have lost the important time value of money during that time. It is also a time in our lives when life gets expensive since we are nearing the age when the biological clock starts ticking and we cannot wait too much longer to try to start a family.

Considering my own loan burden as well as the possible future loan burden for my husband, our student debt impacts our lives on personal, professional, and emotional levels. My initial dream was to own my own practice and run a small business, but we are not in any position to be able to do this any time soon, likely not for the next 10-15 years.

The reality of my life is that I am 30 years old, newly married, and planning for my husband and I to move back in with my parents this summer to save money. Between my husband and I, we have one car; a 2007 Subaru Impreza that I plan to drive as long as possible until the maintenance costs become too expensive, and even after that we will probably purchase a used Toyota or Honda. Most of my vacations consist of visiting family and friends and staying with them to help decrease the costs. Any other vacations we take are usually bought via Groupon or some other cost-saving website after extensive research.

My husband and I were delighted when he was accepted into both medical and dental schools, but with careful financial contemplation, we must consider what it would mean to more than double our existing debt. On the outside, a two-doctor household sounds like it would be more than comfortable, but the reality is that we would face financial ramifications of this decision for the next 15-20 years, causing both short- and long-term problems.

As we are facing this very difficult decision for my husband's career path, I am also facing the difficult choice of buying or starting a practice within the next couple of years or working for a Dental Service Organization for a longer period of time to allow me to repay my student loans. Due to the financial burden, I have primarily been considering employment opportunities at corporate Dental Service Organizations; which offer more support in the way of increased compensation to new graduates and other benefits such as health insurance. While this could be a somewhat satisfying employment opportunity, it is certainly a different experience than many of the orthodontists I know who inspired my career path; they own their own practice and are able to greatly contribute to and serve their communities in similar manners as other small businesses.

On a personal level, my student debt is going to impact when my husband and I will plan to start a family. Few of the employment opportunities I have seen offer paid time off or maternity leave. With my husband in school, my job would be our only source of income, making it virtually impossible to start a family while he is in school for the next four years.

Similarly, my husband and I will have to make difficult relocation decisions about where to live and practice. It will be very important for us to live in a lower cost of living area, so that we can afford to pay our student loans and also contribute to retirement and provide for our family. With my student loan debt in mind and a willingness to serve in areas of need, I searched for jobs in remote areas, such as Wisconsin, and found the increased compensation in rural Wisconsin was not great enough to offset the travel expenses for me to visit my husband in the locations he was accepted into school.

Others Face a Greater Burden

The current total cost of attendance, which includes living expenses, for one year of dental school at the Rutgers School of Dental Medicine is $92,252 as an in-state student. The

current total cost of attendance for one year of my orthodontic residency at the University of Maryland as an in-state student is $84,754. At these rates, four years of dental school and three years of residency could cost over $600,000. Imagine going to a private school or paying the greatly increased out-of-state tuition for all of those years, as well as the amount of accumulated and capitalized interest. It is easy to see how student loan debt can spiral out of control, especially when the median orthodontist salary is quoted at $208,000. It could take an entire lifetime to get out of debt.

Indeed, a 2018 AAO survey of its members found that orthodontists on average now graduate with approximately $428,150 in student loan debt. More than one-quarter (26%) of respondents had or expected to have $600,000 or more in debt by the end of their orthodontic residency. Like me, many respondents said their student loan debt affected their plans for practicing (78%) and other life plans (85%). What's more troubling is that approximately 40% are unsure they would have chosen to enter the profession given their current amount of student loans.

I am so lucky that I could attend college for free, attend an in-state dental school, and attend a state school for residency (becoming in-state after one year). I never borrowed up to the cost of attendance and kept my cost of living very low. I worked part time throughout all of school as a cater waiter to earn a little extra for living expenses, employed extremely thrifty savings strategies, applied for any scholarships possible (and was awarded quite a few), returned loan money when I had excess, educated myself on student debt, and maintained an overall firm grasp on my financial situation. Even with these strategies and help from my parents, I am still terrified to face my $411,714 in student loans, with interest accumulating by the day.

Some of my classmates were not so lucky and have loans from college, private loans from post-baccalaureate programs, federal loans for a private dental school, and federal loans for

residency as well. This debt burden can amount to over $750,000. When two of these dental specialists decide to marry, they are indebted over $1.5 million, a number I cannot truly fathom ever repaying. To consider taking on additional debt to purchase or start a practice is almost inconceivable and I am unsure whether any banks would feel comfortable in lending to someone with so much debt already. Many young orthodontists, including most of my classmates, will be forced to face this harsh reality that they may need to follow a more corporate dental route long-term in lieu of following their dreams of opening a practice or purchasing one and becoming a small business owner.

Conclusion

Again, thank you for inviting me here today to speak on this important topic. While I understand higher education policy is not within this Committee's jurisdiction, as a medical professional, I look forward to working with you on solutions that will ensure owning a small business practice is still within reach for mine and future generations. I would be happy to answer any questions you may have.

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 20007, 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 116th Congress.

AMERICAN ENTERPRISE INSTITUTE

Statement before the House Committee on Small Business
On The Doctor is Out: Rising Student Loan Debt and the Decline of the Small Medical Practice

Borrowing for Medical School

Assessing the Benefits in the Federal Student Loan Program for Health Professionals

Jason D. Delisle
Resident Fellow

June 12, 2019

Introduction

Chairwoman Velazquez, Ranking Member Chabot, and members of the committee, thank you for the opportunity to testify about student loans and debt burdens among graduate and professional students, particularly those in medical professions. My testimony today focuses on broad trends in student debt and repayment patterns across a range of degree programs to provide the committee with a general understanding of the student loan landscape. I also discuss limited statistics on medical school tuition and debt increases in recent years to speak more directly to the topic of today's hearing. The testimony also addresses the federal Income-Based Repayment program, which has allowed high-debt, high-income borrowers to reduce their repayment burdens at substantial cost to the government. A related program, Public Service Loan Forgiveness, can provide large taxpayer-funded incentives to doctors who *do not* open their own practices and instead work for non-profit entities. To conclude, I suggest reforms to these programs and explain how an accountability system for federal student loans would help ensure colleges align their prices with graduates' expected earnings.

The federal government's Direct Loan program dominates the student loan market, now issuing 90 percent of all loans made across the country. Students pursuing everything from short-term certificates to graduate programs and medical degrees collectively receive nearly $100 billion in loans every year at terms more generous than most private lenders would offer.

The federal role in higher education lending has grown ever since lawmakers enacted the first loan program under the National Defense Education Act of 1958. The Higher Education Act of 1965 expanded access to loans to more colleges and students through the Guaranteed Student Loan Program, but benefits were restricted to students from low-income families. In 1980, Congress created a loan program for parents of undergraduates (Parent PLUS), and then in 1992, eliminated annual and lifetime borrowing limits for those loans. That year, lawmakers also authorized the Unsubsidized Stafford Loan program, which allows all undergraduate students to borrow federal loans regardless of their financial circumstances. In 2006, Congress created the Grad PLUS loan program, which removed limits on the amount that graduate and professional students can borrow from the government.[1]

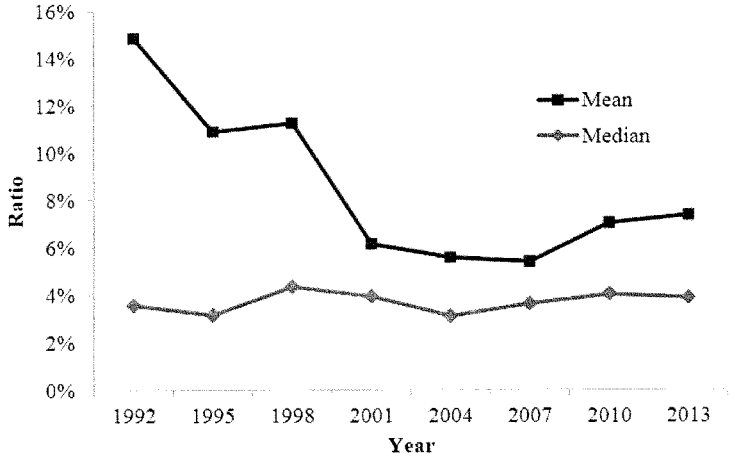
This expansion, along with rising college costs and increasing student enrollments, has led to a rapid increase in the stock of outstanding debt in recent years. The amount of outstanding federal student loans was $595 billion in 2004 (in 2019 dollars). By 2015, it had more than doubled to $1.3 trillion. Today, the amount of outstanding student loan debt is $1.5 trillion.[2] As a result, student loans have become a major source of worry among policymakers and the public.

Does Rising Debt Signal Rising Burdens?

The rapid rise in total outstanding debt has led some to conclude that students' monthly repayment burdens have increased at a similar rate. The data show a much more complicated picture.

One Brookings Institution study from 2014 shows that repayment burdens for households with student debt have remained surprisingly constant for decades.[3] The authors found that borrowers' monthly loan payments relative to their household earnings have remained steady at about 4 percent (median). There are, of course, limitations to these data and the analysis, but it is noteworthy how little the increase in outstanding debt has affected the amount that individual borrowers' pay each month. The authors suggest that the increase in outstanding debt reflects the fact that more students are pursuing a postsecondary credential. They also suggest that to the extent debt burdens have increased at the household level, incomes have also increased enough to offset the higher debt loads. In other words, rising student debt in the aggregate is not synonymous with rising debt burdens at the household level.

Figure 1. Monthly Household Student Loan Payment-to-Income Ratios 1992-2013

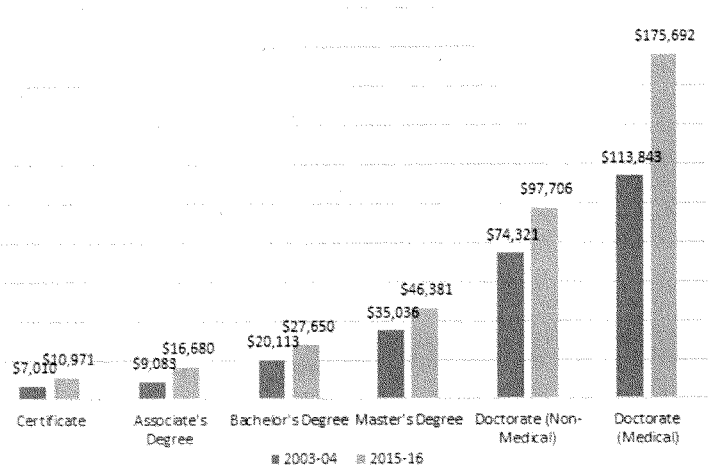


Notes: Based on households age 20-40 with education debt, wage income of at least $1,000 (in 2010 dollars), and that were making positive monthly payments.
Source: Elizabeth J. Akers and Matthew M. Chingos, Student Loan Update: A First Look at the 2013 Survey of Consumer Finances, Brookings Institute, September 2014, www.brookings.edu/wp-content/uploads/2016/06/Student-Loan-Update_Sept-2014.pdf.

Debt Has Increased Most for Graduate and Professional Degrees

Data from the U.S. Department of Education help illustrate another misconception about rising student debt. While popular narratives tend to focus on rising debt at the undergraduate level, data from the Department of Education show that graduate and professional degrees have seen larger increases in student indebtedness. Those who borrow for doctoral degree programs (which includes medical programs) have seen some of the largest increases in median debt. In 2004, borrowers who completed a doctoral degree program had accumulated $79,160 in debt. By 2016, students earning those degrees had borrowed $124,441 (figures are in 2017 dollars). In fact, debt for graduate and professional degrees makes up approximately 40 percent of the total outstanding stock of debt.[4] Figure 2 details the changes between the 2003–04 and 2015–16 academic year for students who completed a degree program that year and borrowed federal student loans at any point. In the case of graduate and professional students, estimates include loans incurred during undergraduate and graduate studies (the numbers are only slightly higher if non-federal loans are included).

Figure 2. Median Cumulative Federal Loans Upon Completion, changes between 2004 and 2016



Notes: Estimates are in 2017 dollars and exclude interest. Master's and doctoral degree debt estimates include both undergraduate and graduate loans. Doctorate (Medical) includes medicine, osteopathic medicine, dentistry, chiropractic, pharmacy, optometry, and podiatry degrees. Doctorate (Non-Medical) includes all other doctoral degrees.
Source: Author's calculations based on National Center for Education Statistics, National Postsecondary Student Aid Survey 2004, 2016.

This same data source shows debt levels among students pursuing medical education. However, the sample size for these students is relatively small. With that limitation in mind, the data suggest that students in medical school borrow more on average. Among those who take loans, annual borrowing for this group of students was $51,845 in 2016, up from $41,595 in 2004 (both figures are in 2017 dollars). Nearly all of the increase occurred between the 2011–12 and 2015–16 academic years, suggesting that rapidly rising debt loads are a more recent phenomenon for medical students. However, the data do not show an increase in the incidence of borrowing. About three quarters of medical students borrow each year, a share that has remained constant since 2004.[5]

Statistics about borrowing understate medical students' debt burdens because during residency, a borrower's income is usually not high enough that she would be able to make payments that cover the accruing interest. It is not unusual for a medical student to accrue tens of thousands of dollars in interest during residency, adding to the total amount owed.

The increase in borrowing for medical programs has coincided with a large increase in tuition at medical colleges. Here again nearly all of the change occurs between the 2011–12 and 2015–16 academic years. Median tuition and fees after grants and scholarships are netted out has held fairly steady at about $20,000 per year between 2004 and 2012. In 2016 tuition and fees jump net of aid jump to $36,360. (All figures are in 2017 dollars).[6] This suggests that a major factor in the increase in debt is a response to the sharp spike in tuition and fees that medical colleges charge. The reasons for such price increases are beyond the scope of my expertise but I would urge the committee to redirect concerns over rising debt to rising tuition prices. To the extent that unaffordable student debts have affected small medical practices, the proximate cause of the problem is likely to be the pricing practices of medical colleges.

Income-Based Repayment

Student debt burdens, especially among graduate and professional students and those with loans from medical school, must be understood in the context of the federal Income-Based Repayment (IBR) program. Under the most recent version of IBR, which Congress and the Obama administration enacted in 2010 and made available to all new federal student loan borrowers beginning in July 2014, borrowers pay only 10 percent of their discretionary income toward the loan. Discretionary income is defined as all income in excess of 150 percent of the poverty guidelines adjusted by household size. After a 20-year repayment period, any remaining balance is forgiven. These payment terms apply regardless of the amount a student borrows and there is no limit to the amount a borrower can have forgiven.

IBR provides medical students a powerful tool to manage their debt as it allows them to make affordable payments even when their incomes are relatively low, particularly during residency. For example, Figure 3 shows that a typical medical school graduate with $200,000 in debt and a $55,000 income during residency would be required to make monthly payments starting at $307 while using IBR, substantially less than the amount he would owe under a fixed 10-year repayment term (though additional interest accumulates under IBR due to low payments during this period). His payments would later rise with his income when he is fully employed, but they are always set at 10 percent of his discretionary income. This is an important benefit to consider given that the premise of today's hearing is that doctors cannot afford to open their own practices because of unaffordable student debt. The IBR program should largely eliminate debt burden as a deciding factor in that type of career decision.

Figure 3. Loan Repayment for Hypothetical Medical Student with $200,000 Initial Balance

Repayment Plan	Years in Repayment	Monthly Payment (Residency)	Monthly Payment	Total Payment	Balance Forgiven
Income-Based Repayment	20	$307	$1,422-$2,271	$401,191	$0
Public Service Loan Forgiveness for Income-Based Repayment	10	$307	$1,422-$2,271	$146,628	$182,867
Standard 10-Year Repayment	10	$2,271	$2,271	$272,515	$0

Notes: Sample repayment estimates based on $200,000 loan balance with 6.5% interest rate upon completion of medical school. Assumes $55,000 salary for three years of residency and $190,000 starting salary following residency with 4% annual growth, one-person household.
Source: Author's calculation.

Here I will note that a typical doctor is likely to fully repay her student loans before she reaches the 20-year loan forgiveness term under IBR (Figure 3). That is based on my analysis of information from the American Association of Medical Colleges.[7] IBR simply allows these borrowers to smooth out their payments over that time period.

The story changes for borrowers with above-average debts or those with below-average incomes. For example, Figure 4 shows that a medical student who graduates with $300,000 in student loans stands to have $265,771 forgiven after 20 years of payments in IBR.[8] Moreover, his total payments are only about $21,000 more in nominal terms despite borrowing $100,000 more. In one sense, that is how IBR was intended to work. But in another sense, the program allows students to borrow more but make the same payments as someone who borrows less, with taxpayers making up the difference.

Figure 4. Loan Repayment for Hypothetical Medical Student with $300,000 Initial Balance

Repayment Plan	Years in Repayment	Monthly Payment (Residency)	Monthly Payment	Total Payment	Balance Forgiven
Income-Based Repayment	20	$307	$1,422-$2,744	$422,507	$265,771
Public Service Loan Forgiveness for Income-Based Repayment	10	$307	$1,422-$2,744	$146,628	$348,372
Standard 10-Year Repayment	10	$3,406	$3,406	$408,773	$0

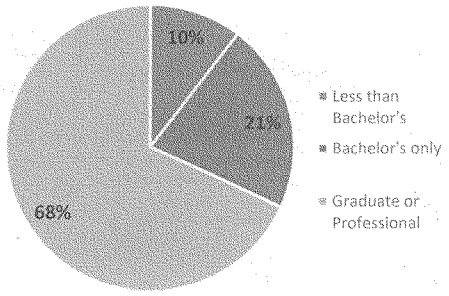
Notes: Sample repayment estimates based on $300,000 loan balance with 6.5% interest rate upon completion of medical school. Assumes $55,000 salary for three years of residency and $190,000 starting salary following residency with 4% annual growth, one-person household.
Source: Author's calculation.

The program can also provide six-figure government benefits to some of the highest earning professionals in the country. This issue was raised last year by a *Wall Street Journal* article that profiled an orthodontist earning $225,000 a year who was using IBR and on track to have much of his debt forgiven (he borrowed $600,000).[9]

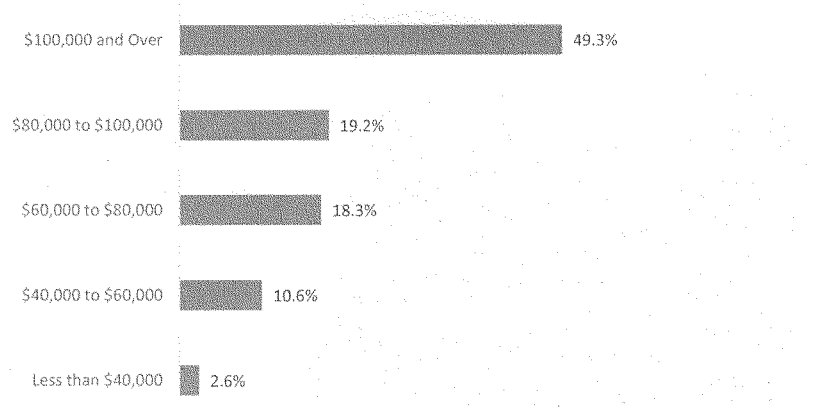
Such cases may look like outliers, but statistics from the Department of Education offer clear evidence that IBR's benefits are skewed toward high-debt, high-income borrowers with graduate and professional degrees. 68 percent of the students who are expected to use IBR borrowed for a graduate or professional degree (Figure 5), and nearly half of them are expected to earn $100,000 or more during their repayment period (Figure 6).[10] The cost to taxpayers for this program has increased from $1 billion annually in 2009 to over $14 billion today.[11]

These statistics suggest that the IBR program is providing more than just a safety net for borrowers. It has become a defacto tuition-assistance program for high-income borrowers with graduate degrees, a group that includes those in the medical professions.

Figure 5. Degree Level of Borrowers Projected to Use Income-Based Repayment for Federal Student Loans



Source: Author's calculation using US Department of Education Projections for 2017 cohort.
Figure 6. Household Incomes of Graduate School Borrowers Projected to Use Income-Based Repayment for Federal Student Loans



Source: Author's calculation using US Department of Education Projections for 2017 cohort.

Public Service Loan Forgiveness: A Disincentive to Open a Small Practice

The Public Service Loan Forgiveness (PSLF) program allows borrowers using IBR and work in government or non-profit jobs to have their debt forgiven much earlier than other borrowers -- and therefore receive a substantially larger benefit. PSLF provides tax-free loan forgiveness of any outstanding debt after a borrower makes 10 years of qualifying monthly payments. And like IBR, there is no limit to the amount that can be forgiven.

Unlike loan forgiveness programs that target specific professions, PSLF defines public service occupations so broadly that it encompasses a quarter of the U.S. workforce.[12] Eligible employment includes any position at a federal, state, or local government entity, or non-profit organization with a 501(c)(3) designation, or another non-profit organization that does not have 501(c)(3) status but provides emergency management, public safety, or law enforcement services; health services; education or library services; school-based services; public interest law services; early childhood education; or public services for individuals with disabilities and the elderly.[13]

As shown in Figures 3 and 4, medical school borrowers with $200,000 and $300,000 in debt would repay substantially less under PSLF's 10-year loan forgiveness term than under IBR's 20-year term. In total, PSLF reduces the borrower's cumulative payments by over $200,000 (in nominal terms).

This is relevant to today's hearing because it shows that a doctor who works at a non-profit hospital stands to receive a $200,000 bonus from taxpayers. Whereas a doctor who opens her own private practice does not qualify for this bonus. By definition, her practice would not meet the terms of an eligible employer under PSLF, as it is a for-profit entity. The disparate treatment results despite the fact that the doctor operating her own practice may be performing the same job as the doctor at the non-profit hospital and may even earn less than him. Nevertheless, in the eyes of the federal government, only the doctor at the non-profit hospital is providing a public service. The PSLF program, in short, can provide a powerful incentive for doctors to seek employment at PSLF-eligible organizations and a *disincentive* to open their own private practices.

Solutions

I conclude by offering a few solutions to the aforementioned problems. First, the best way to address the overly generous and poorly targeted benefits of the IBR program is to increase the length of time that high-debt borrowers are required to pay before qualifying for loan forgiveness. The current 20-year term is too short relative to how much borrowers must repay if they have high balances. One virtue of this approach is it maintains the income-based payment feature, meaning that borrowers never make payments that exceed 10 percent of their discretionary income. Both the Obama and Trump administrations have endorsed a longer repayment term for borrowers who attended school beyond a 4-year degree, proposing 25 and 30 year repayment terms, respectively.[14] Ideally, the term would be based on amount borrowed rather than the type of credential a borrower seeks or holds.

Second, the Public Service Loan Forgiveness program should be eliminated. Borrowers who wish to pursue these jobs can still benefit from affordable payments under IBR and have their debts forgiven under the same terms as borrowers working in other fields *who have the same debt-to-income* profiles. In other words, this approach treats all borrowers equally if they have the same incomes and debt levels. Lawmakers could then use the savings this generates, over $2 billion annually according to the Congressional Budget Office, to provide direct income subsidies to individuals in professions they deem in need of taxpayer-funded wage subsidies.[15]

Finally, one of the overarching problems implicit in this hearing's focus is that the price that universities are charging for many graduate and professional programs, including many in medical fields, are out of line with the incomes borrowers expect to earn. Put another way, these programs offer an insufficient return on investment for borrowers, taxpayers, or both. Borrowers and taxpayers therefore need some protection from such overpriced credentials, and universities need more incentives to better align their prices with labor market outcomes.

Lawmakers can provide those protections and incentives by using federal resources to collect and publish information on tuition prices, borrowing, and graduate earnings at each program. This effort is already underway through the Department of Education's College Scorecard and President Trump's executive order, but lawmakers can help the effort by ensuring that the Department has the resources necessary to carry out the task and that all federal agencies share the necessary data.[16]

Lawmakers could go further than providing information on prices, debt, and earnings. They could adopt an accountability system that penalizes programs at universities where graduate earnings are not high enough to justify the prices it charges, or ones where a high share of students stand to qualify for loan forgiveness under IBR. The penalty could be loss of access to the federal student loan program or assessment of risk-sharing fines in the case of unpaid loans.

That concludes my testimony today. I look forward to answering any questions that the members of the committee may have.

Citations

[1] Deficit Reduction Act of 2005, P.L. 109-171, www.congress.gov/bill/109th-congress/senate-bill/1932.
[2] Estimates adjusted for inflation. Office of Federal Student Aid, "Federal Student Loan Portfolio Summary," US Department of Education, https://studentaid.ed.gov/sa/sites/default/files/fsawg/datacenter/library/PortfolioSummary.xls
[3] Elizabeth J. Akers and Matthew M. Chingos, *Student Loan Update: A First Look at the 2013 Survey of Consumer Finances*, Brookings Institute, September 2014, www.brookings.edu/wp-content/uploads/2016/06/Student-Loan-Update_Sept-2014.pdf.
[4] Author's calculation based on annual loan issuance; 40% of debt issued in the federal loan program is for graduate and professional degrees. Congressional Budget Office, "CBO May 2019 Baseline," www.cbo.gov/system/files/2019-05/51310-2019-05-studentloan.pdf.
[5] Author's calculations based on National Center for Education Statistics, National Postsecondary Student Aid Survey 2004, 2008, 2012, 2016.
[6] Author's calculations based on National Center for Education Statistics, National Postsecondary Student Aid Survey 2004, 2008, 2012, 2016.
[7] American Association of Medical Colleges, "Medical Student Education: Debt, Costs, and Loan Repayment Fact Card," October 2018, https://store.aamc.org/downloadable/download/sample/sample_id/240/.
[8] Ibid.
[9] Josh Mitchell, "Mike Meru Has $1 Million in Student Loans. How Did That Happen?" *Wall Street Journal*, May 25, 2018, www.wsj.com/articles/mike-meru-has-1-million-in-student-loans-how-did-that-happen-1527252975.
[10] Ibid.
[11] Author's calculation using president's budget appendix for the Department of Education, FY2011 through 2020.
[12] Government Accountability Office, *Federal Student Loans: Education Could Do More to Help Ensure Borrowers Are Aware of Repayment and Forgiveness Options*, August 2015, www.gao.gov/assets/680/672136.pdf.
[13] Office of Federal Student Aid, "Public Service Loan Forgiveness Program," US Department of Education, http://studentaid.ed.gov/repay-loans/forgiveness-cancellation/charts/public-service.
[14] The White House, "Budget of the US Government: Fiscal Year 2015 Appendix," Executive Office of the President, www.govinfo.gov/content/pkg/BUDGET-2015-APP/pdf/BUDGET-2015-APP.pdf; and US Department of Education, "President's FY 2020 Budget Request for the U.S. Department of Education," www2.ed.gov/about/overview/budget/budget20/justifications/index.html.
[15] Congressional Budget Office, "Federal Education Programs—CBO's Estimate of the President's Fiscal Year 2020 Budget," May 9, 2019, www.cbo.gov/system/files/2019-05/55207-education.pdf.
[16] US Department of Education, "College Scorecard," https://collegescorecard.ed.gov/; The White House, "Executive Order on Improving Free Inquiry, Transparency, and Accountability at Colleges and Universities" Executive Office of the President, March 21, 2019, www.whitehouse.gov/presidential-actions/executive-order-improving-free-inquiry-transparency-accountability-colleges-universities/.

Questions for the Record From Rep. Spano to all witnesses
06/12/19 Hearing

- *Thank you all for making the trip to Washington to speak with us today. I firmly believe it is impossible to make good policy without practical application, and hearing your stories not only helps us know we are on the right track, but to also find new and effective policies to implement. You being here makes a difference. Thank you for your service.*

- *It is clear that student loan debt is a huge cost problem for medical practitioners, but I am also curious if small medical practices have had other issues remaining profitable. Since many of you all have been practicing medicine for years, and all have you have been long involved in the medical industry, I am curious if you have seen an impact from ObamaCare on small medical practices. In your opinion do you believe ObamaCare is in part responsible for the decline in small medical practices? If so can you expound on why that may be the case?*

Lauren Wiese:

I cannot personally comment on the impact of the Affordable Care Act (ACA) on small medical practices, because I am completing the final year of my orthodontic residency and have not started practicing. My understanding is that my colleagues support many aspects of the ACA, including expanding care to vulnerable populations. There are, however, other aspects of the law that have placed pressure on orthodontists and their patients, including the cap on annual contributions to flexible spending accounts (FSAs) and the 2.3 percent excise tax on medical device manufacturers and importers.

Under current law, the inflation-adjusted cap on FSA contributions is $2,700. This is lower than the substantial out-of-pocket healthcare costs that the average family may face, and does not recognize the proportionally larger costs of larger families. That is why the American Association of Orthodontists (AAO) supports bipartisan legislation, known as the Responsible Additions and Increases to Sustain Employee (RAISE) Health Benefits Act (H.R. 1366 / S. 503), which would: (1) increase the cap on contributions to $5,000 per year; (2) allow families to contribute an additional $500 for each dependent after the first two dependents; and (3) eliminate restrictions on carrying forward unused funds into the following year.

Additionally, alongside nearly all other professional medical societies, the AAO has long supported repealing the ACA's medical device tax. The device tax has exacerbated pressures on small business providers and patients, during a time when many are struggling with rising healthcare costs. The AAO believes that small business providers, such as orthodontists, should not be forced to choose between absorbing the cost or passing the cost to their patients.

Tracey Henry, MD Responses

Questions for the Record From Rep. Spano to all witnesses
06/12/19 Hearing

- *Thank you all for making the trip to Washington to speak with us today. I firmly believe it is impossible to make good policy without practical application, and hearing your stories not only helps us know we are on the right track, but to also find new and effective policies to implement. You being here makes a difference. Thank you for your service.*

- *It is clear that student loan debt is a huge cost problem for medical practitioners, but I am also curious if small medical practices have had other issues remaining profitable. Since many of you all have been practicing medicine for years, and all have you have been long involved in the medical industry, I am curious if you have seen an impact from ObamaCare on small medical practices. In your opinion do you believe ObamaCare is in part responsible for the decline in small medical practices? If so can you expound on why that may be the case?*

Dr. Henry's response - No I have not personally seen an impact from Obama Care on small medical practices. I have for the last few years worked in a large academic medical center.

Dr. Henry's response - No the decline of the small medical practices or private practices began far before the implementation of the ACA. The decline of private practices have to do more with the attrition rate of primary care physicians not being balance by the decrease in the amount of clinicians choosing private practice after their completing their medical training. Payment models favor value over volume and quality and safety which require more time, money, staff and technology for the busy clinician which is often easier in a larger practice setting to spread the costs. It is easier to satisfy payment reforms and demonstrate improvement in health outcomes when in larger practice settings. New doctors with the burden of student loan debt, lack of training in the business of medicine and who value work life balance are choosing in most cases to become employed physicians.

Questions for the Record From Rep. Spano to all witnesses
06/12/19 Hearing

- *Thank you all for making the trip to Washington to speak with us today. I firmly believe it is impossible to make good policy without practical application, and hearing your stories not only helps us know we are on the right track, but to also find new and effective policies to implement. You being here makes a difference. Thank you for your service.*

Thank you for inviting me to testify. It was a pleasure speaking with the committee.

- *It is clear that student loan debt is a huge cost problem for medical practitioners, but I am also curious if small medical practices have had other issues remaining profitable. Since many of you all have been practicing medicine for years, and all have you have been long involved in the medical industry, I am curious if you have seen an impact from ObamaCare on small medical practices. In your opinion do you believe ObamaCare is in part responsible for the decline in small medical practices? If so can you expound on why that may be the case?*

As an expert on student loans and higher education finance, this question is outside my area of expertise. Accordingly, I would not be comfortable opining on this subject.

AMERICAN ACADEMY of DERMATOLOGY | ASSOCIATION

1445 New York Ave., NW, Suite 800
Washington, DC 20005-2134

MAIN: (202) 842-3555
FAX: (202) 842-4355
www.aad.org

U.S House of Representatives
Committee on Small Business

Hearing on "The Doctor is Out. Rising Student Loan Debt and the Decline of the Small Medical Practice."

June 12, 2019

American Academy of Dermatology Association

Statement for the Record

Chairwoman Velázquez and Ranking Member Chabot, on behalf of the American Academy of Dermatology Association (Academy), which represents more than 13,800 dermatologists nationwide, thank you for your leadership in convening the hearing on "The Doctor is Out. Rising Student Loan Debt and the Decline of the Small Medical Practice." The Academy is committed to excellence in the medical and surgical treatment of skin disease; advocating high standards in clinical practice, education and research in dermatology, and supporting and enhancing patient care to enhance the burden of disease. Dermatologists diagnose and treat more than 3,000 diseases, including skin cancer, psoriasis, immunologic diseases and many genetic disorders. One in four Americans suffers or will suffer from a skin disease. As dermatologists at the forefront of the fight against skin cancer and treating numerous skin diseases, the Academy is pleased to submit the following statement for your consideration.

The Academy applauds you for raising awareness about the impact that student debt has on physician practice structure and career choice. Student loan debt, coupled with other factors such as increased administrative burdens, is changing practice models in specialties across the country, and dermatology is no different.

Dermatologists train for four to five years post-medical school and have between $155,000 and $200,000 in debt at the end of training, which is an increase of 34% in just five years. In a 2018 survey of the Academy's residents and young physicians, student debt ranked among the top three concerns when making career decisions. In recent years, practice trends in dermatology have moved away from solo practice ownership to group practice with less than half of dermatologists having an ownership stake in the practice. A decline in fellowship training in pediatric dermatology and dermatopathology has also occurred in recent years. These practice shifts of increased consolidation and decline in subspecialties can have broad negative ramifications for the health care system. We look forward to working with you to ease the student debt burden on our nation's health care providers and allow providers to make career choices that are right for them and the patients they wish to serve.

Reform of student loan repayment is needed to address the rising debt health care providers are incurring and its repercussions. The Academy supports the "Resident Education Deferred Interest Act" (H.R. 1554), which would allow for deferment on student loan payments for those training in medical or dental residencies. This legislation is an important part of student loan repayment reform, as it would save physicians and dentists in residency thousands of dollars in interest. Providing interest accrual relief during residency would make the concepts of opening practices in underserved areas or entering into subspecialties attractive and affordable to residents.

Again, the Academy appreciates the Committee holding this hearing, and the Committee's efforts to address the impact student loan debt has on health care providers. Please feel free to contact Michelle Mathy, the Academy's Assistant Director, Political and Congressional Affairs, at mmathy@aad.org or (202) 609-6333 if you have any questions or if we can provide additional information.

AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

Statement of the

American Academy of Family Physicians

Submitted for the Record to the

U.S. House Committee on Small Business

Hearing: "The Doctor is Out. Rising Student Loan Debt and the Decline of the Small Medical Practice"

June 12, 2019

AAFP Headquarters
11400 Tomahawk Creek Pkwy
Leawood, KS 66211-2680
800.274.2237 • 913.906.6000
fp@aafp.org

AAFP Washington Office
1133 Connecticut Avenue, NW, Ste. 1100
Washington, DC 20036-1011
202.232.9033 • Fax: 202.232.9044
capitol@aafp.org

The American Academy of Family Physicians (AAFP), which represents 134,600 physicians and medical students nationwide, is grateful for this opportunity to submit a statement for the record to the House Committee on Small Business on the impact of medical student debt on small medical practices and the choice of family medicine as a specialty.

Family physicians conduct approximately one in five of the total medical office visits in the United States per year—more than any other specialty. They deliver care in more than 90 percent of U.S. counties—in frontier, rural, suburban and urban areas. They practice in a variety of professional arrangements, including privately owned solo practices as well as large multi-specialty integrated systems and public health agencies.

Family physicians provide comprehensive, evidence-based, and cost-effective primary care dedicated to improving the health of patients, families, and communities. Family medicine's cornerstone is an ongoing and personal patient-physician relationship where the family physician serves as the hub of each patient's integrated care team. More Americans depend on family physicians than on any other medical specialty.

In recognition of the importance of family physicians to patients across America, the AAFP promotes the expansion of the workforce needed to ensure that all Americans have access to a primary care medical homes. Consequently, because the debt incurred by pursuing medical training (including undergraduate medical school and residency) serves as a barrier to choosing family medicine, the AAFP supports efforts that assist in reducing that debt burden. Medical student debt relief may be a significant contributing factor in family medicine career choice.

Medical Student Debt

With the median annual tuition for medical students now exceeding $32,000 at public medical schools and $50,000 at private institutions, rising educational costs and a resulting increase in student debt have emerged as significant barriers for primary care physicians entering the profession. Research[i] published in 2018 by the Association of American Medical Colleges (AAMC) indicated 75 percent of medical school students

graduate with debt and 32 percent enter medical school already carrying educational debt. The median medical school debt was reported at $200,000. Sixteen percent of 2018 medical school graduates carried more than $300,000 in educational debt.

Student Debt Impact on Specialty and Practice

Student debt is a major concern among medical students when determining a medical specialty and type of practice. According to a recent article[ii] from the *Journal of the American Board of Family Medicine*, "We now have good evidence that debt influences at least some medical students to choose high-income specialties rather than primary care careers. Students with more debt weigh their income potential more heavily when making career plans, and they are more likely to switch their preference for a primary care career to a high-income specialty career over the course of medical school. In a large, retrospective study of 136,232 physicians, those who had graduated from public schools with more than $100,000 of debt (2010 dollars) were less likely to practice family medicine." The same article[iii] noted the findings of a qualitative study that students described their debt as making them "feel more cynical, less altruistic, and entitled to a high income. High debt has also been correlated with callousness, stress, suicidal thoughts, failing medical licensing exams, and leaving or being dismissed from medical school."

Indeed, a number of survey studies demonstrate that students who choose family medicine value income and "lifestyle" less than their peers. In choosing to become family physicians, they "viewed this as a career that offered economic security, even if it would not support extravagant luxury. But evidence is emerging that some students with high debt do not think of family medicine as a feasible choice for them. High-income specialization is viewed as the financially secure career path."[iv]

An analysis of the relationship between student debt and primary care practice published in the *Annals of Family Medicine* concluded that "(h)igh educational debt deters graduates of public medical schools from choosing primary care, but does not appear to influence private school graduates in the same way. Students from relatively lower

income families are more strongly influenced by debt. Reducing debt of selected medical students may be effective in promoting a larger primary care physician workforce."[v] A study[vi] by the Robert Graham Center funded by the Josiah Macy, Jr. Foundation showed specialty income at graduation had a greater influence on a graduate's decision to choose family medicine versus debt at graduation. Researchers found the income gap was a significant factor in students' eventual practice location and specialty. "Medical Group Management Association data on physician income show that the income gap has grown steadily since 1979 such that the difference between diagnostic radiology or orthopedic surgery and primary care was $250,000 in 2005. This gap reduced the odds of students' choice of primary care or family medicine by nearly half. It reduced the odds of working in an FQHC or RHC by 30%, and of practicing in a rural area by almost 20%. The association between this income gap and most of these outcomes is stronger than debt at graduation."[vii]

Primary Care Physician Shortage

Due to the economic burden of medical school, the American health care system will see a shortage of primary care physicians. According to an Association of American Medical Colleges report,[viii] "We continue to project that physician demand will grow faster than supply, leading to a projected total physician shortfall of between 46,900 and 121,900 physicians by 2032, including a primary care physician shortage of 21,000 to 55,200 physicians and a non-primary care specialty shortage of 24,800 to 65,800 physicians (which includes a 14,300 to 23,400 shortfall of surgical specialties in 2032)."

In addition to physician shortages, rural areas may be more greatly affected. Currently, AAFP member census data[ix] shows that 71 percent of our members are employed, and that 17 percent of our members work in rural areas. According to a recent survey[x] published by Merritt Hawkins, "more than 90 percent of new physicians said they would rather be employed than on their own in an independent practice." The survey found that among those seeking employment, 43 percent would prefer to work with a hospital. However, the survey also found that only two percent of final-year medical residents said they want to work as a solo practitioner. The survey also found that in towns of 10,000 people or fewer, only 1 percent of medical residents expressed an interest in

establishing a practice there, while 2 percent of residents expressed a desire to practice in towns with 25,000 people or fewer. The majority of new physicians, 65 percent, said they prefer to practice in cities with 250,000 or more people. According to the survey, international medical graduates appeared to be more amenable to practicing in rural areas than U.S. medical school graduates.

To meet this challenge, the AAFP has called for expanded funding for federal loan and scholarship programs that target family medicine and primary care. We also support the deferment of interest and principal payments on medical student loans until after completion of postgraduate training as proposed in the *Resident Education Deferred Interest Act* (HR 1554). We further recommend the interest on medical student loans be deductible on federal tax returns regardless of income.

The AAFP also continues to support the National Health Service Corps (NHSC), which offers scholarships or loan repayment as incentives for physicians to enter primary care settings that serve Americans in rural and underserved areas. By addressing medical school debt burdens, the NHSC helps ensure wider access to both health care and medical education opportunities.

To help support the education and training of more medical students choosing family medicine and supporting them in practice in a variety of settings following residency training, the AAFP calls for expanded funding for federal loan programs targeted to support family medicine and primary care, allowing the deferment of interest and principal payments on medical student loans until after completion of postgraduate training, and allowing the tax-deductibility of interest on principal payment for such loans. The AAFP recommends the development of innovative programs that promote direct and indirect medical training debt relief for family medicine and primary care.

The AAFP appreciates the Committee's interest in the impact that medical student debt is having on our nation's family physician workforce. We look forward to working with you in support of policy initiatives that will help pave the way for building a strong family physician workforce.

[i] AAMC Analysis in Brief. Vol 18, No 4-September 2018.
https://www.aamc.org/download/492284/data/september2018anexplorationoftherecentdeclineinthepercentageofu..pdf
[ii] The Journal of the American Board of Family Medicine March 2016, 29 (2) 177-179; DOI: https://doi.org/10.3122/jabfm.2016.02.160034
[iii] Ibid.
[iv] Ibid.
[v] Ann Fam Med November/December 2014 vol. 12 no. 6 542-549 http://www.annfammed.org/content/12/6/542.full
[vi] Specialty and Geographic Distribution of the Physician Workforce: What Influences Medical Student & Resident Choices? Robert Graham Center
https://www.graham-center.org/content/dam/rgc/documents/publications-reports/monographs-books/Specialty-geography-compressed.pdf
[vii] Ibid.
[viii] https://aamc-black.global.ssl.fastly.net/production/media/filer_public/31/13/3113ee5c-a038-4c16-89af-294a69826650/2019_update_-_the_complexities_of_physician_supply_and_demand_-_projections_from_2017-2032.pdf
[ix] AAFP Member Profile 2018 https://www.aafp.org/dam/AAFP/documents/about_us/strategic_partnerships/common/2018-member-profile.pdf
[x]2019 Survey Final-Year Medical Residents. Merritt Hawkins
https://www.merritthawkins.com/uploadedFiles/MerrittHawkins_Final_Year_Medical_Residents_Survey_2019.pdf

ADA American Dental Association®

STATEMENT OF THE

AMERICAN DENTAL ASSOCIATION
TO THE
COMMITTEE ON SMALL BUSINESS
UNITED STATES HOUSE OF REPRESENTATIVES

ON

THE IMPACT OF STUDENT DEBT ON THE SMALL DENTAL PRACTICE

SUBMITTED BY

DR. RAYMOND JARVIS
CHAIR OF THE NEW DENTIST COMMITTEE
AMERICAN DENTAL ASSOCIATION

June 12, 2019

Washington Office: 1111 14th Street NW Washington DC 20005 (202) 898-2400

I am Dr. Raymond Jarvis, a practicing dentist in Shreveport, Louisiana and chair of the American Dental Association's New Dentist Committee. On behalf of the American Dental Association, I am submitting this statement for the record about the impact educational debt is having on the small dental practice.

Can you imagine starting out your career owing more than you might pay for a house in some places? Can you imagine how such a debt would shape your early career decisions?

Dental student debt has been increasing for decades, even after adjusting for inflation. It has risen to the point that 85 percent of 2017 dental school seniors graduated owing an average of $287,000 student loan debt.[1,2]

To put this in perspective, these same students would have graduated in 1975 owing nearly $63,000. 1985 graduates would have left school owing more than $126,000. And 1995 graduates would have been starting their careers owing almost $179,000, just in student loans.

According to the American Dental Association's Health Policy Institute, fewer dentists are operating as solo practice owners than ever before. In 1999,[3] 65% of dentists were solo practitioners, compared with just 50.6% in 2017.

In my case, I entered dental school with the dream of being a small business owner, where I could practice where I wanted, control my own work day and take pride in a

business that was mine to care for and grow. I also wanted to control my own professional destiny and have enough to get best care for my two young children.

Four years later, I graduated from dental school owing more than $180,000 in student loans. The weight of my debt was such that my dream of being a small business owner seemed out of reach. I knew that the corporate setting was not for me.

Fortunately, I found a business partner that was willing to loan me the money I needed to join his practice. I certainly bring home enough income to support my business and student loans, but that has only become comfortably manageable in the past few years. Many of my colleagues struggle with paying off their student loans. For many of us, our student loan debt levels hold us back from taking the leap into small practice ownership.

One way to get the student debt crisis under control is for Congress to reauthorize the Higher Education Act—and do so in a way that will help alleviate the alarming levels of student debt. The vast majority of dental students use federal student loans to finance their dental education. Even marginal changes, like lowering the interest rates on these loans, allowing dentists and medical residents to defer the accrual of interest on their loans while they are in their residencies and allowing them to be financed whenever interest rates are lower, would be a step in the right direction.

We are submitting with this statement with a list of principles for reauthorizing the Higher Education Act and information on other student loan and higher education related legislation we support. These proposals won't keep students out of debt, but

they will help (at least marginally) offset the more than $287,000 that most new dentists owe at graduation. We hope that Congress will act on this legislation soon.

Reducing a new dentist's early career debt, even marginally, can be a sound economic investment. One dental practice contributes more than $1.7 million dollars to the economy, and the profession overall contributes over $272 billion. The faster you can move a practice to the point of needing to hire new workers, the faster the economy will grow. That is why it is so important for Congress to get this financial crisis under control.

I would like to thank the committee for this opportunity to submit a statement for the record about how postgraduate student debt is affecting the health care marketplace. We appreciate your commitment to ending this financial crisis that is affecting our states, our towns and our communities.

---

[1] Annual American Dental Education Association Survey of Dental School Seniors, 2017 Graduating Class: Table 10. Level of 2017 graduating seniors' educational debt by type of school.

[2] Annual American Dental Education Association Survey of Dental School Seniors, 2017 Graduating Class: Table 8. Average amount of educational debt of graduating seniors by all schools combined and by type of school, 1990 and 1996-2017.

Narratives from New Dentists on the Effect that Student Debt Has Had on Their Career Choices

These narratives were provided by current and past representatives from the American Dental Association's New Dentist Committee. They are the personal stories of those dentist members and should not be considered official policy positions by the American Dental Association

Raymond Jarvis, D.D.S., Chair of the American Dental Association's New Dentist Committee

My name is Dr. Raymond Jarvis and I am a practicing dentist in Shreveport, Louisiana. I received my D.D.S. from Louisiana State University Health School of Dentistry in 2010. Upon graduation, I joined with my business partner in 2010 and we co-own the business. We employ 10 people and see an average of 200 patients per week. I am an active member of the American Dental Association (ADA) and I am proud to serve as the Chair of the New Dentist Committee at the ADA. Our Committee of 17 members from across the country advises the ADA Board of Trustees on the needs, wants and concerns of dentists who are less than 10 years out of dental school. I can tell you that the number one issue that we hear about is student debt.

I consider myself to be lucky in terms of my own personal debt load and achievements. I graduated with $180,000 worth of student loan debt, and although that may seem high, the most recent dental school graduates have an average debt of just over $287,000. Tuition varies across the country and this number, being an average, is much lower than what many experience. In fact, 40% of the 2018 dental school graduates report student debt above $300,000. By the way, this would mean a monthly payment of $3,907, using a 10 year loan term. And the debt is further compounded for dentists who decide to specialize, like in pediatrics or oral surgery. My colleagues who have this much debt have told me that debt has greatly affected their practice choice decisions.

Many enter into the corporate dental practice world because the burden of their debt deters them from wanting to take on the additional capital debt required to purchase a practice. Again, I was lucky that I found a business partner that was willing to enter into a partnership in which he would provide me with the loan I needed to join him in his practice. I pay off that loan and my student loans with monthly payments. This affects my net income greatly and I bring home less than I might otherwise if I worked in a corporate or larger practice setting. I made this choice because I had always envisioned myself as a small business owner where I could control my own work day and take pride in a business that was mine to care for and grow. I also wanted to ensure that I could control my own professional destiny and had stability so that I could best care for my future family – I now have two young children.

Owning a small business was always my goal – and many of my colleagues share this dream as well. In part, because of the desire to return back home and contribute to your chosen community. Our business is taking care of the people around us, our neighbors and friends, and dentists are often seen as community leaders because of this.

It's also important to note that many dentists start their careers as employees – working for another small or large dental office. And many of us may hold 2 or 3 jobs, working at a couple different offices or as adjunct faculty at the dental school. We contribute to the small business community as employees as well.

And some new graduates – about 17% of new dentists - may decide to enter a corporate practice, and this is okay too. There are a lot of options today and everyone has their own path. But what I find the most difficult to hear is when a new dentist tells me that opening their own practice is not possible – or is significantly delayed – because of the hindrance of debt. That they are afraid to take on the burden of a small business loan or that they simply don't have the flexibility in their finances to even get started.

They do not even have the opportunity to feel the satisfaction that I feel every day working in and operating my own business because I was able to make that choice.

And as our population becomes more diverse, it is increasingly important to ensure that we are inclusive to all people who want to pursue the wonderful profession of dentistry. And as they enter into dental school and assume the hundreds of thousands dollars of debt – we should be able to say – yes, you can open your own business and serve the patients in your community in the way in which you want to do so. And when it comes time to change, you can find a buyer as well. With the increasing student debt load and little provisions for relief, I am concerned that we are limiting our profession and our impact on our communities.

In addition to my own perspective on this issue, other members of the New Dentist Committee have included their narratives below on how student loan debt may affect their practice model choices in the start of their careers. I, along with other members of the New Dentist Committee want to applaud the House Small Business Committee for holding this hearing. We would be happy to work with the Committee members and staff to explore legislative ways that we can mitigate the student loan debt burden of our profession so that we can choose to continue to be a profession of proud small businessmen and women nationwide.

I have also included the ADA and American Student Dental Association one-pager on our positions on higher education and student loan debt, as well as a one-pager that illustrates the positive economic impact that a dental practice will have on its local community and nationwide.

Thank you for holding this important hearing and for reviewing mine and my colleagues' narratives on this issue.

Thank you,
Raymond Jarvis, D.D.S.
Chair, ADA New Dentist Committee
Shreveport, LA

Dr. Brooke Fukuoka, 11th District representative, ADA New Dentist Committee

When I finished dental school I did a residency and an externship. My passion is treating patients who have special needs. I had great training and I was excited to enter the real world where this skill would be valued and put to use.... Little did I know my dream was not realistic for a new graduate. I had over $200,000 in student debt that needed paid off. I had three choices: I could get a job that paid well, I could get a job that had loan repayment, or I could make income based payments and allow the mountain of debt to grow into an even more crushing number.

Looking at my target population, a job that paid well was out of the question. Anyone with access to Medicaid rates, overhead costs, and a calculator could see that math wouldn't work out in my favor.

I looked to my next option, a job with loan repayment. Unfortunately, because adults who have developmental disabilities and intellectual disabilities are not designated as a MUP, a practice of that nature would not qualify for National Health Service Corps Loan Repayment. I contacted them, wrote emails, and tried my best to have them reconsider. I searched for other options for loan repayment if I had a special care clinic and had no luck.

Stuck between what I wanted to do, open a clinic that focuses on treating patients who have special needs, and what I had to do, pay back my loans, I took a job at a health center where I could be paid on salary and have loan repayment.

It is an excellent health center and I am proud of what they do, however- my career satisfaction was low. I saw people who needed my services, those who needed my advanced training, who needed a special care clinic, but I was unable to provide what they needed. In 2015 I started a side practice to at least meet some of their needs. As this practice evolves my career sanctification is improving. This year I lost my loan repayment because my hours are less with the health center and more in my practice. It is hard. My family has made personal cutbacks so that I could follow my dream in Special Care.

I am on the path to building my dream, but it shouldn't take this long. The longer I go without access to certain treatment options for this population, the less confident I become in some of my skills. There are a couple of things I will be seeking re-training for before I implement. People who have special needs are the most underserved people in our community, and there are people like me who want to serve them, but first we have to climb out from under a mountain of debt.

I have scaled part of this mountain, I am far from the top, but I am lucky and have a husband who supports me so we have gotten to a manageable level. Some are not as lucky and have to settle for much longer. This issue does not only effect the new dentists coming out with large debt concerns, it effects the underserved populations we can't afford to treat.

Thank You,
Brooke MO Fukuoka, D.M.D.
ADA New Dentist Committee Representative 11th District
(Alaska, Idaho, Montana, Oregon, Washington)
Jerome, ID

Dr. Daniel W. Hall, District 16 Representative, ADA New Dentist Committee

I am a proud South Carolinian who is a product of both public and private educational institutions. I attended public school until college, where I was able to earn a full scholarship to Wofford College, a private undergrad institution, in Spartanburg, SC. Following Wofford, I enrolled in the Medical University of South Carolina's College of Dental Medicine. Unlike the private education I received at Wofford, there was little to no scholarship or tuition assistance available for Dental School, even though it is a public institution.

I chose my career, and I chose the institutions I attended. No one forced me into the debt I now carry. But what I did not understand was that in addition to the tuition, room, and board I was borrowing money for, I was also accruing interest that would total nearly $70,000 during the four years I was in Dental School. Add to that educational expenses, and I left my public state dental school with over $400,000 of debt. I hadn't lived extravagantly. No boat purchase, no ski vacations, no new car payments: I went to class, learned, and graduated.

I elected to participate in a General Practice Residency rather than enter private practice immediately following graduation. In spite of living in Columbia, SC apart from my wife for a year, which required a second set of living expenses, I began paying on my loans after the standard six month grace period.

It has taken me 4 years of payments, refinancing the loans with an education specialist, and adjusting my life goals to now have my debt at a mere $375,153.43, with a lowered interest rate of 5.3% rather than the 6.9% that the loans initially carried.

With debt like this, I had to delay my dream of practice ownership in a rural community until this past August. The office I purchased required an investment of $27,000 from our personal savings, which may not seem like a lot in D.C., but in South Carolina that's serious money to a couple recently married, out of school, and who just bought a house.

We have invested in the future of our family by choosing a profession that is rewarding and meaningful to our rural community. But the debt I carry has limited my ability to improve the office for the betterment of my patients and has delayed my wife and I having children.

I am frustrated that while we have planned and worked for the future we want, the income we earn is taxed heavily before it can be applied to our student loans. Tuition interest is deductible on the 1040 tax form, schedule 1, line 33, but only up to $2,500 per year per tax return if your household modified adjusted gross income is less than $135,000 for a couple married filing jointly. The deduction is phased out as income increases, leading to total loss of the deduction for modified adjusted gross incomes greater than $165,000. A similar scenario is true for single, head of household tax returns, with phase out of the deduction beginning at $65,000 and total loss at $80,000. This threshold applies to all career fields that require higher education: engineers, physician assistants, nurses, pharmacists, physicians, and yes, dentists.

This calculation fails to consider your "real income" once student loans, which were necessary to achieve this income, are factored in. So the benefit that exists to encourage self-improvement through education is useless once you achieve your goal due to the income cap and the $2,500 allowed deduction should you even qualify for participation in this deduction. For reference, I anticipate paying $19,673.16 in interest alone this year, and I will not be able to claim any amount of this deduction.

I am not asking for anything for free. I value the American Dream and the hard work it takes to improve your station in life. What I and others are asking for is sensible student loan reform that lessens the burden on those who seek to improve themselves and their communities through higher education. We work hard, we are taxed hard, and we vote hard. Instead of encouraging dependence on government programs and the Welfare State, why not invest in America's future by supporting those who invest in themselves.

Daniel W. Hall, D.M.D.
ADA New Dentist Committee, 16th District (North Carolina, South Carolina, Virginia).
Williamston, South Carolina

Dr. Lindsey J. Yates, past ADA New Dentist Committee member

I went to a state university for undergrad and came out with zero loans due to scholarships and help from my parents. I went to a state university for dental school, and came out with close to $170,000 in student loans, all federally subsidized and unsubsidized, no private. This is a pittance compared to the average dental student debt burden, and compared to many of my friends whose student loan burdens are nearing $500,000.

I was required to do a one-year residency in order to obtain my dental license, taking a significant salary hit my first year out of school, compared to graduates who went right into private practice. I completed my general practice residency in Chicago. During my time in dental school and residency, I discovered that my passions within the profession of dentistry were public health and teaching, both of which are among the lowest paid positions within dentistry. Due to the Great Recession, it was difficult to find any job as a dentist; most private practice owners had problems filing their own chairs, let alone having

enough patient volume to justify needing an associate. I found full-time work at a multi-disciplinary not-for-profit health center working 6 days a week. I worked there for 6 years, and eventually directed the dental department. I loved my work, and I was grateful for it. I found great fulfillment providing low-cost, much-needed dental care to the many underserved populations in Chicago. These were patients without insurance or Medicaid coverage, patients whom many other dentists refused to treat. Despite our not-for-profit health center having a great HPSA score, because the other numerous rules for public service loan forgiveness were so onerous, I was not able to qualify for loan forgiveness during my time working there. I also started teaching part-time at a residency at a local hospital; I used my vacation time at my full-time job so I could carve out time for teaching. I loved giving back to the profession which gave me so much. It was truly exciting seeing the growth and development of the dental residents during their year in the program, and I credit this experience with jumpstarting my career in dental education.

My loans were in deferment/forbearance while in residency, and once I started working, I opted for the minimum monthly payment (close to $1100 per month) because that is all I could afford to pay working on a not-for-profit salary. Because of my student loan burden, I put off buying a car, buying a house, and having a child. The loans for the last two years of my dental school education have a fixed interest rate of 6.8% and are not permitted to be consolidated, meanwhile I can finance a car at 0% interest, and a mortgage at 3.4% interest. I drove my car for 13 years until it no longer worked, and I had my son a month before my 30th birthday. I went back to work when he was 10 weeks old; paying for daycare was a challenge, but my husband and I cut back in other areas of our spending and made it work. As it was, I knew we had to put off having a second child for at least 5 years until our son entered kindergarten, because we could not afford to have two children in daycare at the same time. As my son grew, we began to think about where he would attend kindergarten. We tried to buy an apartment, but found we could not afford any home in a good public school district. We could afford to live in areas of the city which saw much more violent crime and had poorly-rated school districts, but decided we did not want to take that risk. We explored private school options, but it was so cost-prohibitive, we would have had to decide between sending him to private school and having a second child. I did not want to give up my work in public health dentistry, abandon my values and my calling, just to so I could work in private practice and earn a higher salary, nor did I want the regret of having an only child simply because I sought to educate myself and chose an altruistic profession. After 2 years of exploring all the options, we made the difficult decision to leave Chicago and move to Denver due to its much lower cost of living. In Colorado, I am able to continue treating underserved populations and working in dental education, and also afford a modest car and modest house in a good public school district and safe neighborhood. It only took uprooting my family from a city we loved and moving across the country to make it work. This is the true effect that high tuition costs and high interest rates for student loans have on people's lives. I make the joke, although it is really not funny at all, that I will be done paying back my loans when I turn 55 years old, and then I will finally have money to save to retirement. How is it that a dentist and a business professional, both working full-time, and their one young son, can't make it work financially in an American city? If we can't, who can?

Lindsey J. Yates D.D.S
Denver, Colorado

ADA Dentist and Student Lobby Day

ADA | ASDA

Student Loan Programs and the Higher Education Act

The Higher Education Act (HEA), which provides the statutory authority for most federal student loan programs to operate, is *several* years overdue for reauthorization. The American Dental Association (ADA) and the American Student Dental Association (ASDA) urge you reauthorize the HEA as soon as possible. We also urge you to alleviate the exorbitant amounts of dental student debt by adhering to the following principles.

1. Protect the Direct Unsubsidized Stafford Loan (Direct Loan) and Grad PLUS loan programs for graduate and professional degree students.

2. Reinstate eligibility for graduate and professional degree students to use federal Direct *Subsidized* Stafford Loans, which is currently available to undergraduates only.

3. Lower the interest rate caps and the total amount of interest that can accrue and compound on Direct and Grad PLUS loans.

4. Extend the deferment period and halt the accrual of interest while a dentist is completing a medical/dental internship or residency, as provided in H.R. 1554, the Resident Education Deferred Interest Act (or REDI Act).

5. Permit federal graduate student loans to be refinanced whenever interest rates are lower and economic conditions are more favorable.

6. Lower the administrative fees and simplify (and add more transparency to) the federal graduate student loan application process.

7. Remove the barriers for individuals to take advantage of the Public Service Loan Forgiveness program, which forgives any remaining student debt after ten years of payments and qualifying public service.

8. Permit those with private graduate student loans to take advantage of federal student loan forgiveness programs.

9. Encourage institutions of higher education and lenders to offer training to help students make informed decisions about how to finance their graduate education.

10. Encourage collaborative approaches to handling borrowers who fail (or are at risk of failing) to fully repay their federal student loan(s) in the required time period.

Most dental students rely on federal student loans to finance their dental education. In 2017, over two-thirds (66.9 percent) of graduating dental school seniors reported using Direct Loans to pay for dental school and, to a lesser extent, Grad PLUS Loans (65.1 percent).[1] The default rate on dental student loans is extremely low, making them good investments for the federal government. In fact, most dentists pay back their loans much faster than other federal loan recipients.[2]

Unfortunately, educational debt is making the move from dental school to Main Street a daunting endeavor. In 2017, 84.5 percent of dental school seniors graduated with an average educational debt of $287,331.[3],[4] This catastrophic level of student debt is sometimes exacerbated by the interest rates on Direct Loans taken out on or after July 1, 2013, which could reach as high as 9.5 percent, depending on the prevailing interest on 10-year Treasury notes plus 3.6 percent.[5],[6]

ADA Dentist and Student Lobby Day

ADA | ASDA

It is an uphill battle for a highly indebted young dentist to establish a career in an economy where over 50 percent of practicing dentists own or are partnered in a small business.[7] Lenders view early career individuals who are almost $288,000 in debt as a higher credit risk, which makes it more difficult to invest in a group practice. The same is true for any highly indebted person trying to obtain a car or home loan, or even a credit card.

As a matter of public policy, reducing a new dentist's early career debt, even marginally, is a sound economic investment. For an early career dentist, a lower debt burden will make banks more open to lending funds to invest in a group practice and make other high value purchases. Moreover, a lower debt burden will remove barriers for those wanting to pursue careers in public service, teaching, research and administration early in their careers.

Again, the ADA and ASDA urge you reauthorize the Higher Education Act as soon as possible with the above principles intact.

Information
Megan Mortimer
Congressional Lobbyist
American Dental Association
mortimerm@ada.org
202.898.2402

1 Annual ADEA Survey of Dental School Seniors, 2017 Graduating Class: Table 13. Type of loans reported by 2017 graduating seniors, by percentage of respondents (N=4,888).

2 "Health care & medical students who graduate with a large amount of debt are less likely to default on their student loans," *National Journal Research*, 2018.

3 Annual American Dental Education Association Survey of Dental School Seniors, 2017 Graduating Class: Table 10. Level of 2017 graduating seniors' educational debt by type of school.

4 Annual American Dental Education Association Survey of Dental School Seniors, 2017 Graduating Class: Table 11. Average graduating educational debt of 1996-2017 graduates with debt, by type of school.

5 20 U.S.C. § 1087e.

6 The interest rate on Direct Loans taken out between July 1, 2006 and June 30, 2013, is fixed by law at 6.8 percent.

7 ADA Health Policy Institute Survey of Dental Practice (1999-2009) and Distribution of Dentists Survey (2010-2017).

ADA Dentist and Student Lobby Day

ADA | ASDA

Resident Education Deferred Interest (REDI) Act

H.R. 1554

The American Dental Association (ADA) and the American Student Dental Association (ASDA) urge you to cosponsor the "Resident Education Deferred Interest" (REDI) Act, H.R. 1554, a bill that would amend the Higher Education Act of 1965 to allow borrowers to defer their student loans interest-free while they are serving a medical or dental internship or residency program. This bipartisan bill was introduced by Representative Brian Babin (R-TX), who is also one of our dentist members of Congress.

Currently, medical and dental residents accrue interest on their graduate loans while they are in school and residency – even if they qualify for deferment or forbearance due to their inability to make payments.

A dentist in a four-year residency program, for example, who has an average of $287,000 in unsubsidized student loans after completing dental or medical school at the current average graduate loan interest rate of 6 percent, **will pay more than $75,000 of additional interest over those four years.**

For those dentists who choose to enter a residency program, significant student debt coupled with very low pay make it difficult for them to begin repaying their student debt right away.

Furthermore, the elimination of subsidized graduate loans combined with higher student loan interest rates have resulted in a significant increase in student loan debt for medical and dental professionals, making it challenging for them to consider serving in underserved areas or in faculty or research positions.

The REDI Act would allow all medical and dental residents to qualify for deferment and allow all of their loans – both subsidized and unsubsidized – to accrue interest-free during this time period.

The ADA and ASDA are requesting that you cosponsor the REDI Act, H.R. 1554.

Information:
Ms. Megan Mortimer
Congressional Lobbyist
American Dental Association
mortimerm@ada.org
202.898.2402

ADA Dentist and Student Lobby Day

ADA | ASDA

Student Loan Refinancing Act

H.R. 2186

The American Dental Association (ADA) and the American Student Dental Association (ASDA) urge you to cosponsor the "Student Loan Refinancing Act" (H.R. 2186), introduced by Rep. Mark Pocan (D-WI) and Rep Glenn Grothman (R-WI). This bill would allow individuals to refinance their federal student loans to take advantage of lower interest rates at any time the rates are more favorable due to improved economic conditions.

As a result of the Student Loan Certainty Act of 2013, federal student loan interest rates are tied to financial markets. Interest rates are determined each year and could reach as high as 9.5 percent, depending on the prevailing interest on 10-year Treasury notes plus 3.6 percent.

In 2017, 84.5 percent of dental school seniors graduated with an average educational debt of $287,331.[1,2]

Most dental students rely on federal student loans to finance their dental education. In 2017, over two-thirds (66.9 percent) of graduating dental school seniors reported using Direct Loans to pay for dental school and, to a lesser extent, Grad PLUS Loans (65.1 percent).[3]

H.R. 2186 would allow new dentists to refinance their federal Direct Loans, Direct PLUS Loans, and Direct Consolidation Loans at any time during the life of the loans, enabling them to take advantage of lower interest rates during more favorable economic conditions. Moreover, refinanced rates would be fixed, protecting them from interest rate hikes when economic conditions worsen.

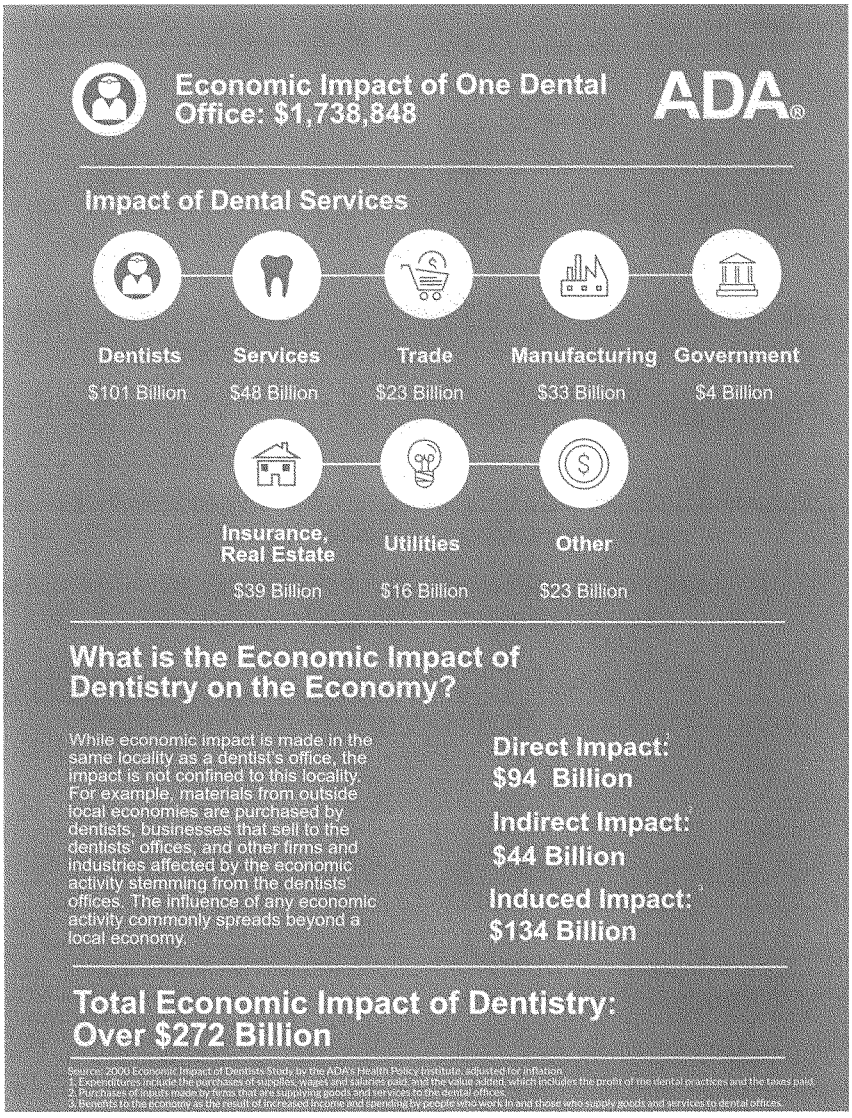
The ADA and ASDA are requesting that you cosponsor the Student Loan Refinancing Act, H.R. 2186.

Information:
Ms. Megan Mortimer
Congressional Lobbyist
American Dental Association
mortimerm@ada.org
202.898.2402

1 Annual American Dental Education Association Survey of Dental School Seniors, 2017 Graduating Class: Table 10. Level of 2017 graduating seniors' educational debt by type of school.

2 Annual American Dental Education Association Survey of Dental School Seniors, 2017 Graduating Class: Table 11. Average graduating educational debt of 1996-2017 graduates with debt, by type of school.

3 Annual ADEA Survey of Dental School Seniors, 2017 Graduating Class: Table 13. Type of loans reported by 2017 graduating seniors, by percentage of respondents (N=4,888).


Economic Impact of One Dental Office: $1,738,848
ADA®
Impact of Dental Services
Dentists
$101 Billion
Services
$48 Billion
Trade
$23 Billion
Manufacturing
$33 Billion
Government
$4 Billion
Insurance, Real Estate
$39 Billion
Utilities
$16 Billion
Other
$23 Billion
What is the Economic Impact of Dentistry on the Economy?
While economic impact is made in the same locality as a dentist's office, the impact is not confined to this locality. For example, materials from outside local economies are purchased by dentists, businesses that sell to the dentists' offices, and other firms and industries affected by the economic activity stemming from the dentists' offices. The influence of any economic activity commonly spreads beyond a local economy.
Direct Impact: $94 Billion
Indirect Impact: $44 Billion
Induced Impact: $134 Billion
Total Economic Impact of Dentistry: Over $272 Billion
Source: 2000 Economic Impact of Dentists Study, by the ADA's Health Policy Institute, adjusted for inflation
1. Expenditures include the purchases of supplies, wages and salaries paid, and the value added, which includes the profit of the dental practices and the taxes paid.
2. Purchases of inputs made by firms that are supplying goods and services to the dental offices.
3. Benefits to the economy as the result of increased income and spending by people who work in and those who supply goods and services to dental offices.

Statement for the Record Submitted by the Association of American Medical Colleges (AAMC) to the House of Representatives Committee on Small Business: "The Doctor is Out. Rising Student Loan Debt and the Decline of the Small Medical Practice" Submitted June 11, 2019

The Association of American Medical Colleges (AAMC) appreciates the opportunity to submit this statement for the record for the House Committee on Small Business June 12 hearing, "The Doctor is Out. Rising Student Loan Debt and the Decline of the Small Medical Practice." The AAMC applauds the Committee for shedding light on physician workforce challenges and the need to improve access to health care in our nation's underserved communities.

While medical education remains an excellent financial investment, the country faces a critical shortage of primary care and specialty physicians that may impact physician recruitment. The need for more physicians will be felt everywhere, but rural and historically underserved areas may experience the shortages more acutely. The AAMC highlights the following federal programs, among other factors, to help recruit physicians to health professional shortage areas: Public Service Loan Forgiveness (PSLF), the National Health Service Corps (NHSC), and the Conrad State 30 J-1 visa waiver program.

The AAMC is a not-for-profit association representing all 154 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and more than 80 academic societies. Through these institutions and organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals and their more than 173,000 full-time faculty members, 89,000 medical students, 129,000 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

Medical Education Remains an Excellent Investment

Medical education, while expensive, is an excellent financial investment for students. About three quarters of medical students use loans to finance their education. AAMC data shows that students graduate from medical school with a median debt of $200,000 and only 0.5% of students accumulate education debts over $500,000. However, numerous studies demonstrate that physicians repay their student loans, and default rates for medical school graduates are exceedingly low.

According to a 2013 AAMC study using financial planning software to model realistic household finance data, recent medical school graduates with the median amount of education debt can enter primary care, raise a family, live in an expensive urban area, and repay their debt within 10 years without incurring additional debt. However, heavily indebted primary care

graduates must plan repayment and lifestyle choices carefully and strategically.[1] Institutional aid, Health Resources and Services Administration (HRSA) scholarships and loans, and the Department of Education income-driven repayment caps, among other programs, can make educational debt more manageable. Programs like these also help promote a diverse and culturally competent health care workforce.

Medical education debt can be compounded by the unique repayment challenges of medical residency training and higher federal student loan interest rates for graduate and professional students. While the Department of Education income-driven repayment plans make monthly loan payments affordable for any occupation and salary, interest on student loans continues to grow during residency. For the average $200,000 graduating debt, total repayment over a physician's career ranges from $365,000 to $440,000 under sample repayment scenarios.[2] In recent years, federal loan? policy changes have made graduate and professional study less accessible and more costly, particularly for underrepresented, low-income, and first-generation students. For example, eliminating the in-school interest subsidy on graduate and professional student loans is estimated to increase repayment costs between $10,000 and $20,000 over the life of their loans.

The AAMC is particularly concerned about recent proposals to eliminate GradPLUS loans that allow medical students to borrow up to the full cost of attendance. Forty-seven percent of medical students currently rely on GradPLUS for medical school. Eliminating GradPLUS will have a disproportionate impact on the neediest borrowers and non-traditional students, forcing them to take out private student loans with less favorable terms to fully finance their education. A shift to the private market is an additional barrier for medical students, especially for borrowers with low credit, and creates multiple loan payments during residency training.

Moreover, GradPLUS, due to its higher interest rates and lower default rates (2% for all GradPLUS borrowers), has been a mutually beneficial use of limited federal resources. Contrary to recent criticism, a new analysis confirms, "There is no evidence to suggest the introduction and existence of the GradPLUS program has caused a significant increase in the cost of graduate and professional education. Concerns about higher education costs inflating, specifically at the graduate and professional level, because of readily available federal funds (the so-called Bennett hypothesis), are not supported by data." [3]

Factors Influencing Physician Career Choices

A number of factors influence physician career choices: work-life balance expectations, geographic preferences, mentorship during training, income potential, regulatory complexity, administrative burden, and cost of practice — to name a few. The AAMC annually surveys medical school graduates regarding the influence of various factors on specialty choice. The results of that survey consistently indicate that education debt and/or potential income play a

[1] "Can Medical Students Afford to Choose Primary Care? An Economic Analysis of Physician Education Debt Repayment", January 2013, https://journals.lww.com/academicmedicine/Fulltext/2013/01000/Can_Medical_Students_Afford_to_Choose_Primary.15.aspx

[2] AAMC Debt Fact Card, October 2018 https://store.aamc.org/downloadable/download/sample/samlple_id/240/

[3] Examining Grad PLUS: Value and Cost, April 2019 https://www.accesslex.org/resources/examining-grad-plus

relatively minor role in specialty choice.[4] Additionally, analysis of graduating debt levels across specialties shows little variance. In fact, a review of the academic literature shows little to no connection between economic factors such as debt/income potential and specialty choice.[5] Conversely, important factors in a student's specialty choice? includes personal interest in a specialty's content and/or level of patient care, desire for the "controllable lifestyle" offered by some specialties, and the influence of a role model in a specialty. Other central factors are the applicants' academic qualifications and the competitiveness of the residency program to which they are applying to.

The significant regulatory and administrative requirements that physicians must comply with on a daily basis also impact their decisions regarding whether to work in small private practices. Physicians spend a significant amount of their time on administrative tasks that are associated with clinician burnout, such as prior authorizations, performance measures and reporting, and electronic health record documentation, which has limited their time for direct patient care. Small practices may not have the financial ability to incorporate essential 21st century technology into their practices, nor the staffing and the infrastructure to support the changes to workflow needed for sustainable practice, including reporting requirements for quality measurement programs (e.g. the Merit-based Incentive Payment System), obtaining prior authorizations and claims submissions. It is also challenging for small practices to negotiate with commercial payers to receive adequate payment for their services. As a result of these challenges, an increasing number of physicians are choosing to work as employees in larger practices.

Exceptions to this trend include so-called "direct primary care" models, whereby physicians accept a small panel of patients, each of whom pays a fixed fee annually, and may incur additional charges for services that they are expected to pay for out of pocket. These practices typically establish a business model around a very spartan staffing structure (often just the physician with a single staff member), non-participation in 3rd party reimbursements, and closed panels to limit the workload and ensure access to those patients enrolled. As such, these models are not generalizable to the vast majority of the U.S population nor to most physicians in practice.

A 2019 American Medical Association Policy Research Perspective characterized the trend away from physician self-employment as follows:

> In the research that examined shifts away from ownership and solo practice in the 1980s and early 1990s it was said, "if current trends persist, a majority of physicians will be employees in the very near future" (Kletke, Emmons, and Gillis, 1996). Given that only now has the point been reached where the number of employed physicians exceeds the number of owner physicians, caution should be taken in assuming current trends will continue indefinitely. One motivation given for the shifts toward larger practices (which typically have a higher employee to owner ratio) during the 1980s and 1990s was the desire to slow health care spending growth. Notably, in the current health care

[4] AAMC Graduate Questionnaire, July 2018, https://www.aamc.org/download/490454/data/2018gqallschoolssummaryreport.pdf

[5] "Is Medical Student Choice of a Primary Care Residency Influenced by Debt?," October 2006, http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1868367.

> system, the ability to participate in new models of care (e.g., accountable care organizations) and the related goals of improving efficiency in the delivery of health care, reducing spending growth, and improving quality are factors in practice consolidation and integration with hospital systems. Just as shifts in physician practice arrangements stalled after the early 1990s, should evolving models of care not deliver on their theoretical savings or improvements, that might put a break on consolidation.[6]

Workforce trends may also play a factor in career decisions, and will also increase competition as the country faces a shortage of physicians. The AAMC projects that the United States will see a shortage of up to 122,000 physicians by 2032, in both primary care (between 21,100 and 55,200) and specialty care (between 24,800 and 65,800). In light of these shortages, underserved communities increasingly rely on federally-supported recruitment incentives, such as PSLF, NHSC, and Conrad 30 to help meet growing health care demand.

Public Service Loan Forgiveness (PSLF)

Since its enactment in 2007, the purpose of the Department of Education PSLF program has been to encourage graduates to pursue careers that benefit communities in need by providing student loan forgiveness after making loanpayments for 10 years. Through an annual survey of graduating medical students, AAMC has witnessed the success of PSLF. Now, roughly one-third of respondents indicate an interest in pursuing PSLF.

The AAMC is concerned that recent proposals that exclude physicians from PSLF or eliminate the program outright will undermine non-profit medical facilities that use PSLF as a provider recruitment incentive. It would also contradict the original intent of the program. The Higher Education Act, as amended, defines "public service" to include "public health," and lists for example "full-time professionals engaged in health care practitioner occupations and health care support occupations." Under this definition, we believe solo practitioners in underserved communities should qualify as public service.

In medicine, public service can include both primary care and specialty disciplines — family medicine physicians at community health centers, emergency medicine physicians at inner-city hospitals, or surgeons at VA medical centers. Though required for licensure, medical residency training is also a significant public service. Medical residents work with their supervisory physicians at teaching hospitals who:

- help care for the nation's underserved and extend the reach of attending physicians to these vulnerable populations (including Medicare patients);
- provide indispensable patient care services, such as neonatal intensive care units (NICUs), burn units, and trauma centers, and a variety of other services provided almost exclusively at teaching hospitals; and
- deliver charity care to patients who cannot afford it.

[6] AMA Policy Research Perspectives, May 2019 https://www.ama-assn.org/system/files/2019-05/prp-fewer-owners-benchmark-survey-2018.pdf

Furthermore, education is a critical component of teaching hospitals' not-for-profit missions that qualify these institutions as eligible PSLF employers.

PSLF is often criticized as expensive, but in reality physicians and other graduate/professional students pay a higher interest rate on federal student loans to offset the added costs of repayment and forgiveness associated with higher debt. Over the next ten years, the Congressional Budget Office estimates the Department of Education will profit $26.5 billion from graduate and professional federal students loans compared to spending $43.7 billion on undergraduate federal student loans.[7] In fact, the AAMC estimates that for every medical student that spends 10 years in public service to participate in PSLF, the cost is offset by just two medical students who do not. Furthermore, doctors in public service will earn approximately $315,000 less over those first 10 years than their private sector counterparts.

The value of PSLF to underserved communities in need of health care services cannot be underestimated. As Congress considers reauthorization of the Higher Education Act, AAMC urges preservation of the PSLF program.

National Health Service Corps (NHSC)

The NHSC is widely recognized — both in Washington and in the underserved areas it helps — as a success on many fronts. The simple, yet historically effective design of scholarship and loan repayment in exchange for primary care service in underserved communities:

- improves access to health care for rural and urban medically underserved Americans;
- increases state investments in recruiting health professionals;
- provides incentives for practitioners to enter primary care;
- reduces the financial burden that the cost of health professions education places on new practitioners; and
- helps promote access to health professions education for students from all backgrounds.

Importantly, the NHSC includes providers at solo or group private practices in rural, urban, or tribal communities with limited access to care. Given its success in improving the distribution of the primary care workforce, the AAMC supports the NHSC to help improve access to health care in underserved communities.

The AAMC echoes the Friends of the NHSC in calling for a doubling of the NHSC field strength to eliminate Health Professions Shortage Areas nationwide. For FY 2020, we recommend a total of $475 million for the NHSC, including both annual appropriations and reauthorizing the NHSC mandatory fund beyond FY 2019. This $60 million (15%) increase is the first stage of a five-year systematic doubling of the NHSC to meet the needs of underserved communities.

[7] CBO Baseline Projections for the Student Loan Program, April 2018, https://www.cbo.gov/system/files?file=2018-06/51310-2018-04-studentloan.pdf

State Conrad 30 J-1 Visa Waiver Program

Graduates of international medical schools or "international medical graduates" (IMGs) are a substantial part of GME, totaling approximately one-quarter of physicians entering the U.S. workforce. Roughly 7,000 positions in the 2019 National Residency Match were filled by graduates of international medical schools, over 55 percent of whom are not U.S. citizens.[8] The Conrad State 30 J-1 visa waiver program ("Conrad 30") enables state agencies to recruit these physicians to underserved areas for at least three years.

State agencies have some discretion in shaping their Conrad 30 programs to address states' priorities and some latitude in determining what specialties are needed, provided that they demonstrate, according to their own criteria, shortages in the specialties they recruit. Currently, non-primary care specialties constitute approximately half of Conrad 30 waivers requested by state agencies. These patterns suggest that IMGs not only help address primary care needs, but also fill deficits in specialty care as well.

In the last 15 years, over 15,000 physicians practiced in rural and underserved communities in nearly every state under the Conrad 30 program.[9] To put this into context, nationwide, Conrad 30 programs recruit physicians to underserved areas at levels comparable to the NHSC. In fact, Conrad 30 programs historically have out-performed the NHSC, which is limited by its annual funding. Because the NHSC recruits practitioners through scholarships and loan repayment, the Conrad 30 program accomplishes a similar goal at a lesser cost to the government.

In addition to increasing U.S. physician recruitment through NHSC and PSLF, the AAMC endorses the bipartisan Conrad State 30 and Physician Access Act (S. 948, H.R. 2141) to reauthorize and expand Conrad 30, among other improvements to the physician immigration system. To help underserved communities recruit physicians, this bill would:

- Allow the program to expand beyond 30 slots if certain nationwide thresholds are met;
- Create three new Conrad 30 slots per state to be used by academic medical centers;
- Allow "dual intent" for J-1 visa physicians seeking graduate medical education; and
- Establish new employment protections and a streamlined pathway to a green card for participants.

As the United States faces an unprecedented shortage of physicians, Conrad 30 has been a highly successful program for underserved communities to recruit both primary care and specialty physicians after they complete their medical residency training. We applaud this bipartisan reauthorization for recognizing immigrating physicians as a critical element of our nation's health care infrastructure, and we support the expansion of Conrad 30 to help overcome hurdles that have stymied growth of the physician workforce.

---

[8] National Resident Matching Program, April 2019, https://mk0nrmpcikgb8jxyd19h.kinstacdn.com/wp-content/uploads/2019/04/NRMP-Results-and-Data-2019_04112019_final.pdf

[9] U.S. Senator Susan Collins, March 2019, https://www.klobuchar.senate.gov/public/index.cfm/2019/3/klobuchar-collins-rosen-introduce-bipartisan-legislation-to-increase-number-of-doctors-in-rural-and-other-medically-underserved-areas

Federal Investments in the Physician Workforce

In addition to the loan repayment programs discussed by the Committee at this hearing, the AAMC also strongly supports the HRSA diversity pipeline and workforce development programs and legislation to end the two-decade freeze on Medicare support for graduate medical education.

The NHSC, PSLF, and Conrad 30 programs play an important role in addressing primary care needs in underserved communities. However, the size and breadth of projected physician workforce shortages, including both primary care and specialty care, cannot be solved by recruitment alone. The major factor driving demand for physicians continues to be a growing, aging population. According to the U.S. Census Bureau, the nation's population is estimated to grow by more than 10% by 2032, with those over age 65 increasing by 48%. The resulting shortage of primary care and specialty physicians holds true despite a projected increase in the number of physician assistants and nurse practitioners and even in the presence of emerging health care delivery efforts to address overall population health.

With the demand for physicians simply outstripping our expected supply, we must advance a multifaceted strategy to ensure that Americans have access to the care they need when they need it. The AAMC strongly supports the bipartisan Resident Physician Shortage Reduction Act of 2019 (H.R. 1763, S. 348) as a critical component of any comprehensive workforce strategy to strengthen the physician workforce in both primary and specialty care by lifting the current freeze to support 3,000 new residency positions each year for the next five years.

The AAMC also supports HRSA's Title VII health professions and Title VIII nursing workforce development programs, which are structured to allow grantees to test educational innovations, respond to changing delivery systems and models of care, and address timely health threats in their communities. Titles VII and VIII programs emphasize interprofessional education and training in community-based settings, by bringing together knowledge and skills across disciplines to provide effective, efficient and coordinated care. Now more than ever support is needed for Title VII and Title VIII programs that improve the supply, distribution, and diversity of the workforce – to ensure health professionals are prepared to address the health care challenges of today and the future.

We applaud the Committee for highlighting these important health care issues and hope that Congress will increase funding for HRSA workforce development and prioritize legislation to end the freeze on Medicare support. While rural and historically underserved areas may experience the shortages more acutely, the need for more physicians will be felt everywhere unless lawmakers act now.

Oral and maxillofacial surgeons:
The experts in face, mouth and jaw surgery®

American Association of Oral and Maxillofacial Surgeons

9700 W. Bryn Mawr Ave.
Rosemont, IL 60018-5701

847-678-6200
800-822-6637
fax 847-678-6286

AAOMS.org

A. Thomas Indresano, DMD, FACS
President

Scott Farrell, MBA, CPA
Executive Director

June 12, 2019

The Honorable Nydia Velazquez
Chair
House Committee on Small Business
2361 Rayburn HOB
Washington, DC 20515

The Honorable Steve Chabot
Ranking Member
House Committee on Small Business
2069 Rayburn HOB
Washington, DC 20515

Dear Chairwoman Velazquez & Ranking Member Chabot:

On behalf of the American Association of Oral and Maxillofacial Surgeons (AAOMS), I thank you for holding today's hearing entitled "The Doctor is Out. Rising Student Loan Debt and the Decline of the Small Medical Practice." AAOMS has serious concerns about the future of our specialty should the student debt crisis continue to grow and become even more unsustainable. Thank you for raising awareness about this important issue. We look forward to working with you to ease the student debt burden on our nation's health care providers.

Oral and maxillofacial surgery (OMS) residents must complete a minimum four-year, hospital-based residency in addition to their undergraduate and dental degrees. Nearly 40 percent also earn a medical degree or complete a fellowship-training program. This extended residency program can lead to unsustainable debt loads after graduation and during residency. A recent survey of OMS residents revealed that more than half of our residents who were surveyed expect to have $300,000 or more in student loan debt by the time they complete residency. A quarter of those anticipate $500,000 or more in debt. In addition, 76 percent have student loans with an interest rate of 6 percent or more, which continues to compound even if loans are in deferment or forbearance. More than 50 percent indicated their debt is a determining factor for where and how they practice, potentially deterring decisions to practice in rural or underserved areas or join the academic or research communities instead of private practice.

The debilitating cost of repayment undoubtedly influences financial decisions and choices of young OMSs and impacts the broader economy. Nearly 40 percent stated their debt has influenced their decision to start a family and 50 percent delayed buying a home. We believe a smart solution for Congress to pursue to help curtail the student debt crisis for medical and dental students can be found in HR 1554, the "Resident Education Deferred Interest (REDI) Act." The legislation – introduced by Rep. Brian Babin – would allow for deferment on student loan payments for those training in medical or dental residencies. During that deferment period, no interest would accrue. The bill has garnered widespread bipartisan support, and we believe it provides a common-sense approach to curtailing student debt by not penalizing medical and dental students during their residency.

Those who undertake several years of residency with very low pay are often unable to begin repaying student debt immediately. As a result, they qualify to have their payments halted during residency through the deferment or forbearance processes, but they continue to accrue interest that is added to their balance. The REDI Act would save physicians and dentists in residency thousands of dollars in interest. Providing interest accrual relief during residency also would make the concepts of opening practices in underserved areas or entering faculty or research more attractive and affordable to residents.

This legislation is needed because due to passage of the Balanced Budget Act of 2011, graduate students are no longer eligible for federal subsidized Stafford loans. Therefore, medical and dental residents accrue interest on their graduate loans while they are in school and residency – even if they qualify for deferment or forbearance due to their inability to make payments. An OMS going through a four-year residency program who averages $350,000 in unsubsidized student loans after completing dental school at the current average graduate loan interest rate of 6 percent will pay more than **$90,000 of additional interest over those four years of residency.** This figure will climb for the nearly 40 percent of OMSs enrolled in programs that allow them to obtain both a dental and a medical degree.

AAOMS strongly endorses the REDI Act and thanks the Committee for bringing the issue of medical and dental student loan debt the attention it deserves. There is no question that if Congress does not act to curtail student debt among healthcare professionals, we will see a decline in small medical and dental practices, faculty physicians and dentists and rural and underserved area providers.

Please contact Jeanne Tuerk, manager of the AAOMS Department of Governmental Affairs, at 800-822-6637 or jtuerk@aaoms.org for additional information.

Sincerely,

A. Thomas Indresano DMD, FACS

A. Thomas Indresano, DMD, FACS
AAOMS President