

THE MATCH MONOPOLY: EVALUATING THE MEDICAL RESIDENCY ANTITRUST EXEMPTION

HEARING

BEFORE THE

SUBCOMMITTEE ON THE ADMINISTRATIVE STATE,
REGULATORY REFORM, AND ANTITRUST

COMMITTEE ON THE JUDICIARY

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**THE MATCH MONOPOLY:
EVALUATING THE MEDICAL RESIDENCY
ANTITRUST EXEMPTION**

Wednesday, May 14, 2025

HOUSE OF REPRESENTATIVES

SUBCOMMITTEE ON THE ADMINISTRATIVE STATE,
REGULATORY REFORM, AND ANTITRUST

COMMITTEE ON THE JUDICIARY

Washington, DC

The Subcommittee met, pursuant to notice, at 11:04 a.m., in Room 2141, Rayburn House Office Building, the Hon. Scott Fitzgerald [Chair of the Subcommittee] presiding.

Present: Representatives Fitzgerald, Issa, Cline, Hageman, Schmidt, Nadler, Correa, Garcia, Lofgren, and Johnson.

Also present: Representative Onder.

Mr. FITZGERALD. The Subcommittee will come to order. Without objection, the Chair is authorized to declare a recess at any time.

We welcome everyone to today's hearing on medical residency antitrust exemption.

I will now recognize myself for an opening statement. Before I do that, I want to waive on, we have one Member, Mr. Onder, Dr. Onder, who will be waiving on to today's hearing.

Without objection, Mr. Onder will be permitted to participate in this hearing to question the witnesses if a Member yields him time for that purpose.

When America's future doctors apply for residency, they enter a closed market controlled by a single accreditation monopoly. The Accreditation Council for Graduate Medical Education (ACGME), and the centralized hiring system called the MATCH, quote, "the MATCH, together those two gatekeepers dictate who trains, where they train, and at what wage."

Through mountains of red tape, the ACGME alone decides which programs survive and how they operate. Because most opportunities are filled through the MATCH, the algorithm wields unrivaled power over resident hiring. Twenty-three years ago, residents tried to challenge this setup under America's antitrust laws. They argued that the ACGME and MATCH, and the programs operating under them, colluded to restrict slots, limit choice, and keep wages low. Before the case could be heard Congress hightailed to the hos-

pital lobby and slid an antitrust exemption for a graduate medical resident MATCHing programs into the unrelated pension bills.

As a result, there's no competition now, and it decides the fate of more than 50,000 residents and fellows each year. Applicants cannot negotiate pay. They must accept whatever slot the algorithm hands them or whatever terms they are given.

The command-and-control model eliminates competition and flattens salaries. Last year, the average first-year resident earned just \$66,000. That's roughly \$60,000 less than a physician assistant or a \$100,000 less than a nurse practitioner, despite working long hours and holding more advanced credentials.

The MATCH monopoly doesn't just pinch paychecks, it worsens the doctor shortage. Each cycle, thousands of graduates fail to match with the program. Last year alone, 8,869 applicants, about one in five were left without a slot. Because every State requires a residency to become a licensed doctor, those unmatched doctors can get a license or board certification. Thus, the MATCH acts as a bottleneck for the training of American physicians precisely when we need more doctors—not fewer. This oppressive process discourages smart young students from pursuing medical degrees. The squeeze also comes as America's population ages and demands more care.

Today, over 77 million people already live in areas with a shortage of primary care doctors. That figure is projected to climb sharply in the years ahead. As a result of the monopoly power given to the teaching hospitals, our future doctors are not choosing primary care. Instead, they're turning to more specialized medicine hoping to more quickly recoup their investment with the higher salary in specialized practices like orthopedics, cardiology, and anesthesiology.

According to Medscape's 2024 Physician Compensation Report, the average salary for a primary care physician in the United States is \$277,000. By contrast, specialists earn an average of over \$394,000. This leaves our communities with fewer family doctors, longer waiting times, and a decreased level of care.

A second chokepoint is the ACGME's accreditation monopoly. The ACGME is the sole gatekeeper for the residency program approval in the United States. Without its blessing, programs lose access to billions of dollars in Medicare, Medicaid funding. Doctors must graduate from an ACGME accredited program to practice medicine. The organization uses that leverage to impose one-size-fits-all rules that crush community hospitals and rural programs. Many small rural residency programs have closed their doors under the weight of the costly mandates. When programs close, residents lose positions, and patients lose access to care.

Two decades after Congress granted the carveout for this system, the market is more conclusive and less competitive than ever. Resident wages are completely stagnant. America is producing fewer practicing doctors even as demand for affordable high-quality care grows at a rapid pace.

Today's hearing asks a simple question: Will the next generation of physicians train in a free market or under a government-sanctioned monopoly? Today's witnesses know this system firsthand. Their testimony will help the Committee understand the medical

residency market and confront the anticompetitive fallout of the ACGME and the MATCH and their special interest exemption.

I want to thank each witness for appearing before us today and look forward to your insights.

I'll now recognize the Ranking Member, Mr. Nadler, for an opening statement.

Mr. NADLER. Thank you, Mr. Chair.

Mr. Chair, it's a little difficult to take seriously a hearing that Republicans bill as an effort to improve healthcare in this country when their colleagues in other Committees are busy gutting Medicaid and other programs, which will have a devastating impact on the health of millions of Americans.

Apparently, Republicans think what really ails our healthcare system is that lower incomes Americans, people with disabilities, and children have too much healthcare. That is the only explanation because, of course, it couldn't just be a cynical ploy to fund massive tax cuts for billionaires on the backs of the most vulnerable among us.

These same Republicans who claim they want to, quote, "Make America Healthy Again," have remained silent while the Trump Administration systematically dismantles our entire public health infrastructure.

Under the leadership of America's No. 1 vaccine skeptic and conspiracy theory promoter, Robert Kennedy, Jr., the Department of Health and Human Services has fired more than 20,000 experts, eliminated entire agencies, deleted important datasets and public health tracking tools, and cut or threatened to cut billions of dollars in grants for scientific research.

At the same time, the administration is waging an ideological war on institutions, such as universities and the National Institutes of Health, that develop the groundbreaking research that underpins most medical advances.

The NIH alone has suffered a \$1.8 billion cut and, by some estimates, as much as \$2.7 billion. That will undoubtedly set back research into cancer treatments, infectious disease prevention, and much more by many years.

Meanwhile, Republicans cheer as the Administration's immigration policies chase out foreign-born students and researchers and send a clear message to anyone abroad who might wish to bring their talents and innovation to our country, "You are not welcome."

Taking collectively, these actions represent a dramatic effort to undermine, destroy, and limit healthcare research; access to critical health data; and access to care. The impact of these cuts will likely fall most deeply on marginalized communities, but we will all suffer the consequences.

That is why today's hearing on the National Residency Matching Program seems beside the point. The healthcare system is facing an outright assault from the Trump Administration, and yet we are being called on to examine the Residency Matching Program.

This is not to say that there are no issues related to the MATCH worth exploring in due course. Any valid criticisms of the program warrant appropriate consideration, whether they concern salary, hours, working conditions, or other matters that call out for refinement.

As part of that revisiting, we can account for collectively bargaining, which has led to approximately 20 percent of the resident physician workforce becoming unionized. We should also recognize that the MATCH provides an effective system for placing more than 40,000 doctors a year across more than 6,500 residency programs and tracks throughout every region of the country that suits the needs of both students and hospitals alike.

It's important to remember that the MATCH was created in 1952 to solve problems in the placement process that were created by unfettered market competition. Before the MATCH was instituted, residency programs competed with each other to make offers earlier and earlier so as to preempt other programs. This resulted in students receiving limited time offers as early as the beginning of their junior year of medical school when they had limited exposure to clinical practice, before they had done rotations. Attempts to delay the matching process by withholding student information until senior year led to exploiting offers with extremely short fuses. This system served no one, and the MATCH was created to address these market breakdowns.

Over 70 years later, it is still largely working as intended, avoiding what would otherwise be chaos even as the needs of candidates and residency programs have evolved.

While no system is perfect, many of the Republicans' criticisms simply do not hold up under careful scrutiny. For example, Republicans have taken aim at foreign doctors who enter the MATCH, arguing that they are displacing American students, but statistics show that 99 percent of all U.S. medical school graduates enter residency or full-time practice in the country within six years of graduation. There is simply little evidence to suggest that foreign medical school graduates are taking slots from U.S. residents.

Rather than scapegoating immigrants, Republicans could address a real issue, the need for additional residency slots overall. That would take an investment in new funding from the Federal Government, and we have already seen where the Republicans priorities lie.

Finally, if the majority wishes to address flaws in the healthcare system, they need only look at the important work this Subcommittee did under Democratic leadership. We examined issues related to consolidation and market concentration across the healthcare industry, and we passed several pieces of legislation addressing the rising cost of prescription drugs. Many of these issues had bipartisan support, and there's much we can do together. Instead, Republicans want to distract us from their disastrous healthcare policies with a hearing on a minor issue. We can do better.

I appreciate our witnesses for appearing today. I look forward to hearing from them. I yield back the balance of my time.

Mr. FITZGERALD. The gentleman yields back. Without objection, all other opening statements will be included in the record.

We'll now introduce today's witnesses.

Dr. James Lin. Dr. Lin is a Clinical Professor of geriatric medicine at the Lake Erie College of Osteopathic Medicine, and the President of the LECOM Institute for Successful Living. His practice focuses on geriatrics, internal medicine, and primary care.

Mr. Sherman Marek. Mr. Marek is the Founder of Principal Attorney at Marek Health Law, a Chicago-based firm that focuses on representing medical residents and disputes with teaching hospitals through internal appeals, administrative proceedings, direct negotiations, mediation, and litigation. Over the past 25 years, he and his firm have represented more than 1,000 medical residents nationwide.

Mr. Thomas Miller. Mr. Miller is a resident fellow in the health policy studies at the American Enterprise Institute where he focuses on regulatory barriers through choice and competition, market-based alternatives, healthcare litigation, and the political economy of healthcare reform. He previously served as a senior health economist with the Joint Economic Committee and as a senior lecturing fellow at Duke University School of Law.

Dr. William Feldman. Dr. Feldman is an Assistant Professor of Medicine at Harvard Medical School and Brigham and Women's Hospital. Dr. Feldman's research focuses on drug pricing, FDA regulation, and pharmaceutical policy.

We welcome our witnesses and thank them for appearing today. We'll begin by swearing you in. Would you please rise and raise your right hand?

Do you swear or affirm under penalty of perjury that the testimony you are about to give is true and correct to the best of your knowledge, information, and belief, so help you God?

Let the record reflect that the witnesses have answered in the affirmative.

Thank you. You can be seated. Please note that your written testimony will be entered into the record in its entirety. Accordingly, we ask that you summarize your testimony in five minutes.

Dr. Lin, you may begin.

STATEMENT OF DR. JAMES LIN

Dr. LIN. Thank you, Mr. Chair, and Ranking Member Nadler, and the Members of the Committee. Thank you for the opportunity to testify today on a matter of critical and national concern: The increasingly detrimental impact of the Accreditation Council for Graduate Medical Education, otherwise known as ACGME, standards on the sustainability of medical residency fellowship programs in rural and underserved areas.

LECOM Graduate Medical Education, which has trained over 693 residents since 1977, stands as a case study in how a rigid and monopolistic accreditation system is undermining the health infrastructure of America's smaller communities. Despite a proven track record of producing competent board-certified physicians, 417 of whom remain in practice within a 100-mile radius of Erie, Pennsylvania, our programs are being dismantled, not due to deficiencies in quality but due to arbitrary, urban-centric, inflexible accreditation policies.

ACGME is a sole accrediting body for graduate medical education in the U.S., influencing over 16–18 billion in Federal and institutional investment. Yet, its governance is dominated by faculty from major academic centers. As a result, the accreditation criteria are designed for high-resource university hospitals, not for the realities of rural health systems.

Programs have closed due to faculty departure tied to vaccination mandates, our general surgery program in Elmira, New York; inflexible geographic limitations on training sites despite affiliation with top-tier hospitals, LECOM Orthopedic Program; requirement of redundancies that ignores consortium models, punishing programs for sheer training infrastructure; excessive initiative cost, even when programs have no active residents. This rigidity stifles innovation, penalizes lean and effective community models, and directly contributes to the loss of training pathways for future physicians.

The LECOM Orthopedic Surgical Residency Program, despite positive outcomes, premier training partnerships, and high board pass rates, the orthopedic surgery program was closed due to inflexibility rules about program mix and rotation supervision. This displaced residents, disrupted their careers, and stripped Erie County of essential orthopedic care.

The LECOM Internal Medicine Residency Program, this is a longstanding program that was closed following an unresolved hotline complaint, despite an internal and legal review finding no merit. Its closure cascaded into a termination of our gastroenterology and pulmonary fellowship, eliminating critical pipeline for specialty care.

Since 2020, the number of withdrawn or closed program has increased dramatically, many in rural areas. The ACGME one-size-fits-all model disproportionately harms smaller institutions and thoroughly qualified health centers. Programs have been denied probationary periods or closed outright sometimes by Zoom meetings with no room for remediation.

Critical specialties like psychiatry, cardiology, obstetrics, and surgery are being lost in precisely the regions that need them most.

The loss of residency program directly reduced patient access today and in the future. Without local training opportunities, DO candidates face increasing exclusion from competitive specialties due to documented disparities in the MATCH.

Moreover, rural systems and urban underserved are left with workforce shortages, longer waiting times, and higher recruitment costs. Even Federal efforts are thwarted. Despite winning a rural residency planning grant from HRSA, our psychiatry program was denied rural track status by ACGME due to a rigid and outdated definition of “rural” in direct conflict with other Federal agencies like CMS and USDA.

Some proposed solutions: (1) Revise accreditation criteria, modernize standard to allow flexibility in rural and consortium-based models.

(2) Diversity review committees ensure rural osteopathic educators have a voice in shaping specialty standard.

(3) Create an alternative accreditor, promote innovative training track models specifically designed for rural and urban underserved areas. Streamline administrative burden. Shift focus from bureaucratic checklists to actual outcomes and training and patient care. Protect Federal investments. Align ACGME definition with Federal and rural health policy to avoid undermining HRSA support initiative.

The current ACGME model, while well-intentioned, has created systemic barriers that disproportionately harm rural communities, limit innovations, and suppress diversity in physician pipelines.

We urge Congress and CMS to take action, whether through oversight, reform, or the creation of an alternative accreditation pathway to ensure rural America is not left behind. We can no longer allow bureaucratic rigidity to dictate where and how the next generation of doctors are trained. The health of millions in rural and urban underserved regions depend on a more inclusive and responsive system. Thank you.

[The prepared statement of Dr. Lin follows:]

Testimony of James Lin, President, Institute for Successful Living

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Testimony of James Lin, President, Institute for Successful Living

1. Systemic Issues with ACGME Accreditation Standards

1.1 - Program Closures Tied to Arbitrary or Burdensome Requirements

Vaccination Mandate Fallout

The termination of the General Surgery Program Director at Arnot Ogden Medical Center—due to noncompliance with the COVID-19 vaccination mandate—triggered a cascade of challenges that ultimately led to the program's closure. His departure created an immediate faculty shortage, leaving the residency unable to meet ACGME requirements for faculty oversight and supervision. Despite efforts to stabilize the program, this led to loss of ACGME accreditation for this vital rural training program.

The closure not only disrupted resident education but also deprived the surrounding community of much-needed surgical care and workforce development.

Resident-Survey Over-Weighting

The closure of the Cardiology Fellowship at Arnot Ogden Medical Center highlights the unintended consequences of over-reliance on Resident Survey scores—particularly during the extraordinary disruptions caused by the COVID-19 pandemic. Although the program held initial accreditation, it was given no opportunity to appeal before its closure. During the height of the pandemic, federal and state mandates halted all elective cardiac procedures, leaving fellows without access to essential training opportunities such as catheterizations. Understandably, survey responses reflected frustration with the lack of procedural exposure—yet these circumstances were entirely beyond the program's control.

This decision had far-reaching consequences. The loss of the fellowship program has severely impacted cardiology recruitment in this already underserved rural region. Without a pipeline of trained specialists, the area continues to face critical shortages in cardiac care—contributing to delays in diagnosis, treatment, and ultimately, poorer health outcomes for the community.

Administrative Burden Without Residents

ACGME requirements mandate that all accredited programs—regardless of resident enrollment—maintain full administrative staffing and support. For small or emerging residency and fellowship programs, particularly those in underserved rural and urban areas, these fixed costs quickly become unsustainable. As a result, several programs across the country have preemptively closed, recognizing that they could not continue to meet increasingly rigid standards.

A notable example is the Ophthalmology residency at St. John's Episcopal Hospital in Far Rockaway, New York—a medically underserved urban community. This program had operated successfully for over a decade under American Osteopathic Association accreditation without citations. However, following the transition to ACGME oversight, the program voluntarily closed in 2024, unable to align with the new administrative and structural expectations despite a long history of training competent physicians.

Testimony of James Lin, President, Institute for Successful Living

Similarly, the Endocrinology Fellowship at Arnot Ogden Medical Center faced insurmountable challenges meeting ACGME criteria and chose to voluntarily close. This decision, made in the absence of regulatory flexibility, has only intensified the region's shortage of endocrinologists—further limiting access to specialty care in the local population.

These closures underscore a critical need for nuanced, scalable accreditation models that support—not stifle—small programs serving high-need communities.

1.2 - Cost-Prohibitive and Arbitrary Accreditation Requirements

Geographic Restrictions

The LECOM Orthopedic Surgery Residency Program was prohibited from continuing its affiliation with Cincinnati Children's Hospital and Allegheny General Hospital in Pittsburgh as approved training sites due to ACGME-imposed distance restrictions. While both institutions are nationally recognized for excellence in orthopedic and subspecialty training, the ACGME standards prohibit rotations beyond a certain mileage radius from the primary training site—regardless of the clinical value, patient diversity, or educational benefit they offer. This restriction significantly hindered the program's ability to provide residents with exposure to high-volume, high-complexity cases that are not readily available at smaller or rural facilities.

Within 10 miles from LECOM's program, UPMC Hamot houses a historically allopathic orthopedic surgery residency program and sends their residents to Pittsburgh for rotations. This program has not been closed by the ACGME.

Mandatory Base Hospital Program Mix

The LECOM Orthopedic Surgery Residency Program received a citation on the grounds that the sponsoring institution did not have its own General Surgery, Pediatrics, and Internal Medicine residency programs—despite the fact that these foundational clinical experiences were fully addressed through established rotations at accredited consortium partner sites. This rigid interpretation of institutional requirements failed to acknowledge the strength, quality, and oversight of the training provided through these affiliated programs. The residents received comprehensive exposure to core disciplines, meeting both educational and ACGME competency requirements through structured, well-supervised clinical experiences at partner institutions. Penalizing the program for not duplicating services already available through the consortium undermines the collaborative training models that are often essential for smaller institutions and rural medical centers. It also raises critical concerns about equity in accreditation, particularly for community-based programs committed to innovation and resource sharing in graduate medical education.

Again, within 10 miles from LECOM's program, UPMC Hamot houses a historically allopathic orthopedic surgery residency program and relies on affiliated sites in Pittsburgh for General Surgery, Pediatrics, and Internal Medicine. This program has not been closed by the ACGME.

1.3 - Post Merger Discrimination Against DOs in Competitive Specialties

Testimony of James Lin, President, Institute for Successful Living

Since the AOA-ACGME merger, the disparities in MATCH outcomes for D.O. students have worsened, especially in competitive specialties.

Competitive Specialties

According to the NRMP's 2024 *Charting Outcomes in the Match* for U.S. D.O. MS-4 students, match rates for D.O. applicants in highly competitive specialties remain significantly lower compared to their M.D. counterparts. For instance, in specialties such as Dermatology, Neurosurgery, Orthopedic Surgery, and Vascular Surgery, D.O. applicants face substantial challenges in securing residency positions. These disparities are attributed to factors like program preferences, limited availability of positions, and historical biases.

Primary Care Specialties

In contrast, D.O. applicants have more comparable match rates in primary care fields. The NRMP's 2024 data indicates that D.O. MS-4 students had match rates of approximately 91% in Family Medicine, 89% in Internal Medicine, and 88% in Pediatrics. These higher match rates are partly due to a greater number of available positions and a growing emphasis on addressing primary care shortages across the United States.

These statistics highlight the ongoing challenges D.O. students face in certain specialties, underscoring the need for continued efforts to promote equity in residency selection processes.

1.4- Loss of Community-Based and Rural Programs

Community hospitals—especially those in rural and underserved areas—are being disproportionately affected by rigid ACGME accreditation standards that fail to accommodate the realities of their clinical environments. These hospitals often operate with limited financial and educational resources, face significant challenges in recruiting and retaining qualified faculty, and serve patient populations with lower volumes and narrower case diversity. While these factors reflect the logistical constraints of their geography and mission—not deficiencies in quality—the current accreditation framework does not sufficiently account for such context.

As a result, many community-based residency and fellowship programs are being forced to make an impossible choice: invest resources they do not have to meet urban-centric standards or voluntarily withdraw their accreditation. According to ACGME data, 42 programs closed or were withdrawn during the 2021–2022 academic year, and that number rose to 64 in 2022–2023, signaling an alarming upward trend. In 2019–2020 alone, 102 programs closed or withdrew, many of them smaller, community-based programs unable to align with increasingly complex requirements.

This pattern reveals a critical flaw in the system: accreditation standards intended to ensure quality are, in practice, undermining access to graduate medical education in the very areas where workforce shortages are most severe. Without greater flexibility, technical assistance, and resource investment, community hospitals will continue to lose vital training programs—further widening the gap in physician access for rural and underserved populations.

Testimony of James Lin, President, Institute for Successful Living**1.5 - Detrimental Impact on Patient Access and Affordability**

The ACGME framework has become increasingly inflexible—creating systemic obstacles that hinder innovation and penalize institutions committed to serving marginalized populations.

Discouraging Growth in High-Need Areas

ACGME's current model imposes uniform expectations without acknowledging the adaptive strategies required in resource-constrained environments. Hospitals in rural and medically underserved areas often have the clinical volume, patient diversity, and community support necessary to train competent physicians. Yet, the inflexible application of structural requirements—such as specific numbers of core faculty, on-site specialties, or administrative infrastructure—creates a hostile environment for program sustainability and growth.

This is not a matter of educational quality but of feasibility. Many institutions are forced to choose between overextending limited resources or exiting graduate medical education altogether. In both scenarios, the result is the same: fewer residency slots where they are most urgently needed.

Costly Compliance Structures with Diminished Educational Return

The administrative load imposed by ACGME's compliance infrastructure has escalated dramatically in recent years. Even efficient, outcomes-focused programs must invest disproportionately in bureaucratic functions: detailed logs, policy manuals, and performance dashboards that satisfy paper compliance but do little to enhance educational quality or patient care.

The real-world effect is a redirection of funds away from bedside teaching, simulation training, and recruitment initiatives—and into layers of oversight that are often misaligned with the operational realities of smaller institutions. In effect, the system punishes lean, high-functioning programs for not mimicking the structure of large academic centers.

Overrepresentation of Academic Powerhouses on Review Committees

Perhaps most concerning is how the standards themselves are shaped. The Review Committees responsible for setting specialty-specific requirements are often dominated by faculty from large academic medical centers. This skews the expectations toward models that reflect high-resource, university-based training—models that are unattainable or irrelevant for community hospitals and emerging consortia.

The consequence is not merely administrative friction; it's a narrowing of what is considered "acceptable" training. Programs rooted in real-world, community-based care delivery—where future physicians are desperately needed—are being systematically excluded before they can even begin. This is especially true in specialties like orthopedics and general surgery, where the startup burden is high and the national need is urgent.

Testimony of James Lin, President, Institute for Successful Living

End Result: Workforce Disparities and Worsening Health Access

When residency and fellowship programs are stifled or shuttered by these structural misalignments, the pipeline of trained specialists shrinks. This is not an abstract concern—it translates directly into fewer doctors in the operating room, longer referral wait times, delayed diagnoses, and worse health outcomes. Communities that already suffer from provider shortages are pushed further to the margins, not because of educational inadequacy, but because of accreditation inflexibility.

1.6 - Barriers to Innovation and Rural Track Expansion

On May 24, 2024, LECOM Graduate Medical Education was awarded the prestigious Rural Residency Planning and Development (RRPD) Grant from the Health Resources and Services Administration (HRSA) - a competitive federal initiative aimed at strengthening the rural healthcare workforce. This award recognized our institution's strategic plan to expand psychiatry residency training through our rural affiliates, Corry Memorial Hospital and Corry Counseling of LECOM Health.

To receive this federal award, we underwent a rigorous vetting process. We substantiated—through both the HRSA Rural Health Grants Analyzer and the U.S. Department of Agriculture's Road Ruggedness Scale—that our clinical training sites meet the federal definition of rurality. These facilities are located in non-urban settings with no population centers exceeding 50,000 residents. In full alignment with HRSA's guidance, our curriculum ensures that over 50% of resident training occurs in rural settings, a requirement clearly depicted in our submitted block diagrams.

Despite meeting and exceeding federal rural health standards, the ACGME denied our request for Rural Track Program (RTP) designation—based solely on a geographic technicality. The ACGME's rural definition relies exclusively on whether a training site's street address lies outside of a Core-Based Statistical Area (CBSA), a restrictive criterion that ignores more nuanced and federally accepted definitions of rurality used by HRSA, CMS, and USDA. This decision dismisses the reality that Corry Memorial and Corry Counseling operate in precisely the kind of medically underserved areas that federal policy is attempting to support.

This denial represents a missed opportunity to train desperately needed behavioral health professionals in rural communities that face persistent provider shortages and worsening mental health disparities. Our Psychiatry Rural Track Residency was designed to do exactly what ACGME claims to prioritize: expand access to care, address health inequities, and strengthen the physician workforce in high-need areas.

1.7 - Barrier to Enhanced Education

One of the most innovative and forward-thinking components of LECOM Graduate Medical Education was the integration of a Master's degree in Medical Education as a core requirement for all residents. Far beyond traditional curriculum, this academic element was deliberately crafted to cultivate the next generation of clinician-educators—individuals equipped not only to deliver exceptional patient care but also to

Testimony of James Lin, President, Institute for Successful Living

lead, mentor, and teach within academic medicine. The feedback from residents was overwhelmingly positive; many shared that this experience significantly enhanced their confidence, teaching acumen, and ability to mentor medical students and peers.

Despite these clear professional benefits and the program's intent to foster leadership and scholarship, the ACGME issued a citation to the Internal Medicine Program. Their concern centered on the perception that the additional academic workload could disrupt the expected balance within the clinical learning environment. While well-being and workload are vital considerations, the residents themselves viewed the program as an investment in their long-term growth and success.

Testimony of James Lin, President, Institute for Successful Living

2. LECOM Orthopedic Surgery Residency Program Closure

The Orthopedic Residency program accreditation was withdrawn on 2/1/2024. Residents were allowed to finish their current academic year. PGY-4 were allowed to finish their 5th and final year of residency at LECOM GME. The other PGYs were required to find new residency placements.

The ACGME Committee raised concerns about the viability of the primary site given the absence of general surgery and internal medicine residencies, the lack of direct supervisory continuity by the program director during away rotations, and the potential impacts on resident well-being due to frequent rotational transitions.

LECOM Graduate Medical Education (GME) has consistently prioritized the quality and depth of its clinical training experiences in the orthopedic surgery program, a commitment clearly reflected in the overwhelmingly positive feedback from residents regarding their rotations at both Allegheny Health Network and Cincinnati Children's Hospital. These premier institutions provided invaluable exposure to a wide spectrum of complex orthopedic cases, offering residents the opportunity to refine their surgical skills and broaden their clinical knowledge in real-world, high-volume environments.

To further support this immersive learning experience, LECOM GME ensured that residents were provided with housing accommodation during these away rotations, removing barriers and reinforcing our dedication to both their education and well-being. The diverse case mix and high standards of care encountered at these sites not only enriched the residents' training but also played a pivotal role in preparing them to become confident, capable, and highly sought-after orthopedic surgeons.

The success of this training model is evident in our outcomes: Since 2011, 52 of our orthopedic surgery graduates have gone on to secure fellowship positions or assume attending physician roles. Additionally, nearly every resident since 2019 has successfully passed both the clinical and written components of the American Osteopathic Association Board Exam—demonstrating the strength of our academic foundation and the caliber of our graduates.

The closure of the Orthopedic Surgery residency program by the ACGME had significant consequences for both the residents and the Erie County community. The residents, many of whom had deep ties to the region, were forced to seek alternative programs across the country to complete their training and education. This abrupt transition caused considerable hardship, including disruptions to their personal lives, professional development, and financial stability. In addition to the challenges faced by the residents, Erie County lost a critical healthcare asset.

The residency program had long provided essential orthopedic care to the region's population - particularly vulnerable and underserved groups. Residents played a key role in patient care delivery, supporting local hospitals and clinics. With the program's closure, access to orthopedic services in the community has diminished, creating a gap in care and placing increased pressure on remaining healthcare providers.

Testimony of James Lin, President, Institute for Successful Living

3. LECOM Internal Medicine Residency Program Closure

The LECOM GME Internal Medicine program has a long-standing history, having been established in 1977. Over the decades, 146 residents have benefited from graduate medical education clinical training and educational opportunities in Internal Medicine and its subspecialties.

In March 2022, the Accreditation Council for Graduate Medical Education (ACGME) made the decision to withdraw the program's accreditation following a complaint submitted to the ACGME Hotline by a resident. The Sponsoring Institution engaged internal experts, legal counsel and outside counsel with over 30 years of experience in labor law and reviewed the complaint step by step and closed it as unfounded. Despite this comprehensive and conclusive investigation, the ACGME proceeded to close the program.

The closure of the LECOM GME Internal Medicine program had a profound impact on both the institution and the broader Erie County community. The decision disrupted the career paths of numerous residents who had committed years to their medical training. Many were required to secure placement in other residency programs to complete their education—on short notice—while navigating complex processes such as licensing, credentialing, and relocation.

For fellowship programs, the ACGME requires the base residency program. Therefore, loss of the Internal Medicine Residency resulted in the closure of the Gastroenterology Fellowship and the Pulmonology/Critical Care Fellowship.

The ripple effects of the program's closure were deeply felt throughout Erie County. The Internal Medicine residents played a critical role in the delivery of patient care across hospitals, outpatient clinics, and underserved communities in the region. Their abrupt removal from the healthcare workforce placed strain on local health systems and reduced access to care, particularly for vulnerable populations.

In addition to the immediate loss of clinical support, the closure disrupted a key pipeline for retaining physicians in the Erie area. Many former graduates of the program had chosen to remain in the region to practice, contributing to the long-term stability of Erie County's healthcare infrastructure. The program's elimination represents not only an educational loss but also a challenge to meeting future healthcare needs in the community.

Testimony of James Lin, President, Institute for Successful Living

4. Community & Workforce Impact

When residencies close, access to care now and in the future is impacted. Since 1977, 693 residents and fellows have completed training at LECOM Medical Center (formerly Millcreek Community Hospital), and 417 still practice within 100 miles of Erie, Pennsylvania. Eliminating accredited slots severs this pipeline, pushing graduates to seek fellowships or jobs elsewhere. The effect is especially pronounced for D.O. candidates, who depend on community-based programs as gateways into competitive specialties that can be hard to access at large academic centers. Without local training pathways, rural health systems confront a shrinking applicant pool, steeper recruitment costs, and prolonged vacancies in key services—challenges that ultimately erode continuity of care and community health outcomes.

Mr. FITZGERALD. Thank you, Dr. Lin.
Mr. Marek, you're now recognized for five minutes.

STATEMENT OF SHERMAN MAREK

Mr. MAREK. Thank you. Good morning, Chair Fitzgerald. There we go. Good morning, Chair Fitzgerald, Ranking Member Nadler, and the Members of the Subcommittee. Thank you for the opportunity to testify today.

My name is Sherman Marek, and I support the repeal of the 2004 MATCH Antitrust Exemption. It was engineered to stop a lawsuit I filed in 2002 on behalf of medical residents. I have since represented more than 1,000 residents in disputes with their hospitals. I witnessed daily the harm caused by the exemption to residents, to patients, to taxpayers, to rural hospitals, and to the medically underserved public nationwide.

In my view, formed now over decades, the exemption protects market distortions, undermines free market principles, limits personal freedom and choice, prevents normal employment negotiations, shields wage suppression, and contributes to the nationwide physician shortage.

The MATCH is and always has been operated by hospitals for hospitals. It assigns each resident to a single program for the duration of residency. The system, including an unspoken ban on transfers, traps the residents there in that position for 3–5 years. Residents are not free to leave. Even in cases of unsafe working conditions, inadequate pay, incompatible supervisors, or a family or medical emergency, or simply changes in personal preference. Anyone who leaves or is terminated is blacklisted and denied a position anywhere. There are very few second chances.

There is no freedom and no flexibility in the system. Residents who leave their program generally lose their entire career in medicine—their entire career in medicine.

Correspondingly, taxpayers generally lose their entire investment in that resident. Medicare pays hospitals \$150,000–\$180,000 annually for each one. The public loses someone who would otherwise help reduce the physician shortage. That was not a sustainable system 20 years ago and is even less sustainable now.

These were the anticompetitive restraints we challenged in the 2002 *Jung* case. We won the opening rounds, and the judge ruled our claims viable under the Sherman Act.

Faced with the loss of lucrative cheap labor, the hospitals turned to Congress. In 2004, they were quietly given an exemption at the expense of residents. It happened without notice, without hearings, without public debate, without transparency, and without meaningful consideration of the harm that would result.

The exemption has now perpetuated the MATCH's harm for another 20 years. That harm, caused by a lack of competition, includes artificially suppressed wages for residents, long work hours dangerous to patients, wasted taxpayer funds, disadvantaged recruiting for rural programs, and a worsening nationwide physician shortage.

The *Jung* case did not stand alone in its conclusions. Independent experts and studies have corroborated our conclusions.

Repealing the 2004 exemption would not dismantle the MATCH or decide its legal merits, it would simply restore the authority of courts to examine those merits fully and fairly. The hospitals may present their justifications in court and attempt to prove them, or they may simply reform on their own when faced with standard antitrust liability.

In my view, this is a watershed opportunity for Congress to reaffirm core American values of free competition, individual opportunity, fiscal responsibility and legal accountability. Based on my experience in the *Jung* litigation, and my daily experience with the ongoing harm of the MATCH exemption, I strongly support repeal for the benefit of residents, patients, taxpayers, rural hospitals, and the general public. Thank you. I look forward to any questions you may have.

[The prepared statement of Mr. Marek follows:]



STATEMENT FOR THE RECORD

Submitted by
Sherman Marek, Esq.
Marek Health Law, LLC

“The MATCH Monopoly: Evaluating the Medical Residency Antitrust Exemption”
Hearing before the Subcommittee on the
Administrative State, Regulatory Reform, and Antitrust
Committee on the Judiciary
May 14, 2025

Dear Chairman Fitzgerald, Ranking Member Nadler, and Members of the Subcommittee:

Thank you for the opportunity to submit testimony today on the National Resident Matching Program (“MATCH”) monopoly and the medical residency antitrust exemption codified in 15 U.S.C. § 37b (2004). I support repeal of the exemption, not only because it targeted and extinguished an antitrust lawsuit originated by me and my clients in 2002, but also because I witness daily the exemption’s ongoing harm to medical residents, patients, taxpayers, rural hospitals, and the medically underserved public across the nation. In my view, it protects market distortions, undermines free-market principles, limits personal freedom and choice, prevents normal employment negotiations, shields wage suppression, and contributes to the nationwide physician shortage.

A. Introduction and Statement of Interest

My name is Sherman Marek, and I am the founder and principal attorney of Marek Health Law, a Chicago-based firm that focuses on representing medical residents in disputes with teaching hospitals through internal appeals, administrative proceedings, direct negotiations, mediation, and litigation when required. Over the past 25 years, my colleagues and I have represented more than one thousand residents nationwide. Our daily practice is dedicated to rescuing the careers of young physicians trapped in a monopolistic system that offers them no meaningful protections—and often no second chances.



In the late 1990s, I was hired by a group of medical residents whose teaching hospital had lost its accreditation due to negligence—costing my clients board-certification eligibility and jeopardizing their careers. Despite years of training and hundreds of thousands of dollars invested in their education, they had great difficulty transferring to another program. It soon became clear that their obstacles had nothing to do with their own personal academic or clinical shortcomings, but rather with anticompetitive restraints—chief among them, the National Resident Matching Program (NRMP or Match). These restraints held residents in place—and in doing so, shut my clients out.

The Match and related restraints, operated by teaching hospital associations and their affiliates, locked graduating medical students into a single position at a specific institution and program. Even in cases of unsafe working conditions, inadequate pay, incompatible supervisors, family or medical emergency, or simply changes in personal preference, the system offered no freedom or flexibility—no effective way for a resident to move to another program during his or her three- to five-year period of training, particularly without the consent of his or her assigned program.

I conducted a deeper investigation, which ultimately led to the filing of a federal antitrust class action in 2002: *Jung v. Association of American Medical Colleges*. Brought under Section 1 of the Sherman Act, 15 U.S.C. § 1, it challenged the Match system itself and related anticompetitive restraints. I served as co-lead counsel for the three named plaintiffs, who had courageously volunteered for that position at grave risk to their medical careers, and tens of thousands of putative class members.

The court upheld the viability of our claims in *Jung*, 300 F. Supp. 2d 119 (D.D.C. 2004), denying the defendants’ motions to dismiss. However, following that ruling, Congress enacted a statutory exemption as part of an unrelated pension bill—without hearings, debate, or public consultation. That exemption terminated the litigation and has shielded the Match and associated entities from antitrust scrutiny ever since. *See Jung*, 339 F. Supp. 2d 26 (D.D.C. 2004). The court described the Match as the “unifying element” of the overarching anticompetitive activity. *See Jung*, 226 F.R.D. 7, 10 (D.D.C. 2004). No court has retracted those legal conclusions, and the exemption has extended what was already 50 years of judicial avoidance into 75 years of complete immunity.



B. 2004 Exemption Harm to Residents and Patients

Residency training is essential for any graduating medical student who intends a career in medicine. All states require one or two years of such training to qualify for a medical license. Additionally, all specialty certification boards require three to five years of residency to become eligible for board certification. “General practitioners” who provide patient care without board certification have become largely anachronistic, as board certification has increasingly become essential for hospital admitting privileges, insurance reimbursement, participation in physician groups, and other critical aspects of medical practice.

The Match is the monopolistic gatekeeper of residency positions. Virtually all residency programs in the United States fill their first-year positions through the Match, which in turn compels virtually all graduating medical students and other applicants to participate as well. Once in an assigned position, the Match contract technically locks in the resident for only a portion of the training duration, but practicalities, inertia, and supplemental restraints generally bind residents to their assigned position for the entire three- to five-year period of training. Among other things, there is widespread “blacklisting” and refusal to hire any resident who attempts to transfer without the consent of his or her current program director.

The crucial nature of completing residency training, coupled with inability to transfer elsewhere, gives institutions, programs, and individual supervisors incredible leverage over residents. It is no level playing field. Residents must accept whatever low pay, burdensome working conditions, and bullying that are imposed on them and have little to no ability to improve their situations because they are unable to resign and resume training elsewhere.

One obvious harm to residents is compensation far below not only the value of services they provide on behalf of the hospital to patients, but also far below what Medicare pays the hospital to train that resident under the Indirect Medical Education (IME) and Graduate Medical Education (GME) funding programs. While the exact amount paid for any given resident is unique to each hospital based on a complicated formula, the average paid by Medicare is generally accepted to be \$150,000 to \$180,000 per resident annually. By contrast, the average resident in the United States is paid about \$65,000 annually.

In *Jung*, we provided the court with this information and much more. It subsequently denied the hospitals’ and associations’ motions to dismiss, ruling that “from these allegations, the Court concludes that plaintiffs adequately have alleged a common agreement to displace competition in the recruitment, hiring, employment and compensation of resident physicians and



to impose a scheme of restraints, which have the purpose and effect of fixing, artificially depressing, standardizing and stabilizing resident physician compensation and other terms of employment among a number of the named organizational defendants and those institutional defendants that participated in the Match Program.” *Jung*, 300 F. Supp. 2d at 162.

The harmful impact of the Match on resident compensation was also confirmed by detailed independent research and studies, including Bulow, J. and Levin, J., “Matching and Price Competition,” NBER Working Paper Series, National Bureau of Economic Research (2005). In that study, economic modeling showed that in the Match environment “salaries fall relative to any competitive equilibrium while profits rise by almost as much,” and that the best hospitals “gain the most from the system while wages become compressed.” *Id.*, p. 2 Abstract. This aligns directly with our position in *Jung*, which revealed an industry-wide agreement to fix compensation and eliminate individualized negotiation—conduct that would be illegal in any other labor market.

The *Jung* case also pointed out that lack of competition among hospitals “permits employers to exploit resident physicians by routinely requiring 60 to 100 hours of work per week, or more, often including 36-hour and 48-hour shifts.” Complaint pars. 96. Using exhausted residents to provide care obviously increases the risk of errors and corresponding danger to patients. This was reflected by the case of Libby Zion in New York, whose unfortunate death in connection with an overworked resident resulted in the adoption of a state law in 1989 that limited duty hours for residents. *See also*, Landrigan, C., et al., “Effect of Reducing Interns’ Work Hours on Serious Medical Errors in Intensive Care Units,” *The New England Journal of Medicine*, 35a:18 (2004).

Even though *Jung* was prematurely extinguished by the 2004 exemption, its filing in 2002 was followed closely by the decision of hospitals and their associations to “voluntarily” adopt 80-hour work week limits in 2003. In a competitive environment, however, the average number of work hours for residents would likely be reduced to even safer levels as hospitals sought to attract and keep residents who value that reduction. Many studies confirm that even the 80-hour limits put patients at risk and there is substantial room for improvement. *See, e.g.*, Ulmer, C., et al., “Resident Duty Hours: Enhancing Sleep, Supervision, and Safety,” *Institute of Medicine* (2009).

Burdened by low pay, long hours, and a lack of mobility due to the Match and structural impediments to transfer, residents are increasingly turning to collective bargaining to address workplace conditions. This trend reflects a growing desire for representation and recourse in a



system where residents have little power to negotiate independently. Since 2023 alone, several thousand residents have unionized at more than ten major academic medical centers—and early evidence suggests these efforts have advanced their interests.

C. 2004 Exemption Harm to Taxpayers, Rural Hospitals, and the Public

In addition to significantly harming residents and their patients, the Match and other mechanisms protected by the 2004 exemption also harm taxpayers, rural hospitals, and the physician workforce pipeline nationwide. Medicare pays hospitals about \$18 billion annually under the IME and GME funding programs, and many millions of that are wasted because no corresponding board-certified physician is ever produced as anticipated by the government. Rural hospitals have difficulty attracting medical school graduates to their residency programs, a difficulty exacerbated by the Match and related wage suppression that impedes unique incentive packages. The Match and related restraints also contribute significantly to the nationwide physician shortage, locking many partially-trained residents out of the system and preventing them from ever becoming board-certified.

When residents leave their current programs and are unable to transfer in elsewhere to complete their training, federal taxpayers lose their significant financial investment in that resident. More specifically, multiples of the \$150,000 to \$180,000 annual Medicare payment mentioned above. In my law practice, I have handled several cases in which a resident has been terminated as late as their fourth or fifth year of training for some reason having nothing to do with their academic knowledge, clinical skills, or other characteristics relevant to how they would perform as a board-certified physician. Instead, it was due to improper retaliation, or a minor infraction, or a personality conflict with an influential attending or program official. These residents, and the taxpayers who funded their advanced clinical training, deserve a pathway to continuation and completion at some other institution.

The Match also puts rural hospitals at a disadvantage in recruiting residents—a concern reflected in published data, even if not always recognized or stated publicly by those institutions themselves. Among other things, the Match reports “match rates” for each hospital; low match rates are commonly interpreted by candidates as reflecting poor program quality and thereby reduce applications; and rural hospitals have historically had lower match rates than urban hospitals. *See*, Longenecker, R., et al., “A Match Made in Rural: Interpreting Match Rates and Exploring Best Practices,” *Family Medicine*, Vol 55, Issue 7, 426-432 (2023).



Additionally, the Match and related restraints impede the flexibility of rural hospitals and prevent them from directly recruiting their preferred candidates with tailored incentives such as signing bonuses, relocation reimbursement, subsidized housing, or structured post-residency employment agreements designed to encourage longer-term commitment to the rural community. “Although rural family medicine programs are effective in preparing and placing trainees into rural practice, many struggle to recruit students to their programs.” *Id.*, at 426.

The Match and related anticompetitive restraints also exacerbate the nation's worsening physician shortage. According to reliable projections, the United States may face a shortfall of more than 100,000 physicians by 2034, with particularly acute deficits in primary care, rural medicine, and underserved urban communities. Each resident who exits the training pipeline prematurely and is unable to reenter due to structural impediments—rather than clinical inadequacy—represents a lost opportunity to address this national crisis. Each medical school graduate who does not complete residency equates to the loss of tens of thousands of future patient visits. The inability to transfer means that otherwise qualified and committed physicians are systematically excluded from completing their training, contributing to workforce gaps at a time when demand for care is surging due to population growth, aging demographics, and rising chronic disease burdens. The resulting shortages strain hospitals, delay treatment, increase provider burnout, and compromise patient outcomes.

D. The Remedy of Repeal and Conclusion

Repealing the 2004 exemption would not require Congress to decide the merits of any legal or factual claims. It could simply represent a return to consistency in federal law and a reaffirmation of sound legal and economic policy. Repeal may also have the salutary effect of prompting teaching hospitals and their associations to initiate systemic reforms on their own—as the adoption of work-hour limits shows they can do. If such voluntary changes prove insufficient to bring their practices into alignment with antitrust law, repeal will restore the courts’ ability to evaluate the facts and legal claims through established judicial procedures and apply more than 130 years of precedent under the Sherman Act.

If Congress ultimately disagrees with the outcome of court proceedings—or with voluntary reforms undertaken by hospitals and their associations—it retains full authority to remedy the matter through legislation. In doing so, it can ensure that its expectations are met with respect to all relevant stakeholders: residents, patients, hospitals, taxpayers, and the public. Unlike in 2004, however, such legislation would be grounded in a fully developed factual and legal record, shaped by open proceedings and judicial findings.



In my opinion, this is a watershed opportunity for Congress—and for this Subcommittee—to restore core American legal and economic values: fair competition, individual opportunity, and accountability under the law. Based on my role in the *Jung* litigation and years of firsthand experience with the Match system’s structural flaws and harmful consequences, I strongly support repeal of the 2004 antitrust exemption and the restoration of competition in residency training—for the benefit of all.

Sincerely,

/s/ Sherman Marek

Sherman Marek, Esq.

Mr. FITZGERALD. Thank you, Mr. Marek.
Mr. Miller, you may begin.

STATEMENT OF THOMAS MILLER

Mr. MILLER. Thank you, Chair Fitzgerald, Ranking Member Nadler, and Members of the Subcommittee for the opportunity to testify today on the medical residency antitrust exemption and, more generally, on competition policy considerations involving physician licensing.

One version or another of the so-called MATCH mechanism for assigning graduating medical students to resident physician programs has been around for over 70 years. Today's hearing considers whether to thaw what was essentially frozen in competition law terms over 20 years ago by virtue of an unusual legislative exemption from antitrust liability for the program amid ongoing litigation with no debate and little explanation.

Such exemptions are rarely granted. They are disfavored and construed narrowly by the courts. They usually reflect the efforts of power and privilege to gain or preserve special commercial advantages. Most limited antitrust exemptions also presume other regulatory mechanisms to monitor and police anticompetitive aspects of the activities otherwise protected.

Early discovery and initial rulings in an older class action litigation concerning the MATCH program provided evidence of serious problems. Absent the sweeping statutory exemption, further litigation under rule of reason analysis would have helped assess the net competitive effects of the MATCH program at that time or even later, as its practices evolved, and then assess its likelihood—the likelihood of less restrictive alternatives.

At a minimum, this Subcommittee and the current Congress should seriously consider ways to limit, if not repeal, the current antitrust exemption, and it certainly should review it extensively for the first time in over 20 years.

My written testimony recognizes that the likely competition problems come not from the mathematical elegance and ingenuity of the MATCH algorithm, per se, they derive, rather, from the programs related assembly of mutually reinforcing levers of market power that attach one-sided conditions to it.

The MATCH program may do an excellent job in solving the wrong problem. How to fix selection timing problems in a resident market monopsony that the program only strengthens. The matching process delivers efficient sorting of bounded preferences, finality, and fewer unfilled positions when it operates as described, but there's some question about that.

The main drawbacks, tied to older legal objections, appear to be the vastly unequal bargaining power, the wage suppression and compression, and onerous working conditions for residents that the program's interrelated rules and practices sustain.

Reduced labor market competition reduces the quality, availability, and value of healthcare services. I suggest an initial set of incremental changes, far from original on my part, that could improve competition within a reformed MATCH program, rather than displace it completely. They might have added conditions to retain

the current antitrust exemption inserted within a newly granted more narrow one or adopted to minimize new legal liabilities.

However, a singular focus on antitrust law will not solve all the problems of physician labor markets, let alone the larger issues of cost, quality, and access throughout our overall healthcare system.

Policymakers should consider a broader inventory of tools and levers that could shape not just the initial supply of new physicians, but also facilitate how all healthcare providers can deliver more assessable, effective, and affordable care.

Most policy interventions aimed at rebalancing competitive forces within physician labor markets face resistance not only from the powerful interest groups benefiting from the longstanding status quo; they also can trigger fears of disruption and timing mismatches in any transition toward alternative mechanisms.

A different set of policy conflicts may arise from federalism concerns. States have traditionally been viewed as the natural constitutional stewards of physician licensing as part of their traditional police powers.

Neither type of concerns are irreconcilable roadblocks to reasonable reforms that are calibrated and phased in carefully.

Although some States have led on this front, not enough have done so as rapidly and thoroughly as they might and should. Hence, arguments for an increased Federal Government role in at least providing stronger incentives to do so.

The MATCH program's nationwide competition for resident physicians was only an early sign of eroding geographical boundaries for healthcare labor markets. The issue is not whether Congress and the Federal Government have the power to be more assertive but whether they decide to do so absent more effective State-level actions.

The potential policy reforms and tools are available if the necessary political will to promote and adopt them develops. In the meantime, we should expect the more immediate resort of recent years: To leaving such matters to litigation, regulation, and other administrative actions, not coincidentally this Subcommittee's area of jurisdiction. Thank you.

[The prepared statement of Mr. Miller follows:]



Statement before the House Committee on the Judiciary

Subcommittee on the Administrative State, Regulatory Reform, and Antitrust

Hearing

The MATCH Monopoly:
Evaluating the Medical Residency Antitrust Exemption

Thomas Miller, J.D.

Resident Fellow in Health Policy Studies

American Enterprise Institute

May 14, 2025

Summary Points

- Projected problems of shortages and imbalances in physician labor markets; along with the chronically low wages and long working hours that most resident physicians still face, necessarily raise warning flags about the dangers of concentrated market power
- The likely competition problems come not from the mathematical elegance and ingenuity of the MATCH algorithm per se, but rather from the program's related powers and conditions attached to it.
- The MATCH program does an excellent job in solving the wrong problem --- how to fix the resident market monopsony that the program only strengthens.
- The matching process delivers efficient sorting of bounded preferences, finality, and fewer unfilled positions. The main drawbacks, tied to legal objections, appear to be the vastly unequal bargaining power, wage compression and suppression, and onerous working conditions for residents that the program's interrelated rules and practices sustain

- At a minimum, this subcommittee and the current Congress should indeed seriously consider ways to limit, if not repeal, the current antitrust exemption first awarded in 2004 to the MATCH program.
- Even a legal determination that the MATCH program increases output as a procompetitive restraint may not survive rule of reason analysis without careful consideration of other potentially “least restrictive” alternatives
- A narrow focus on antitrust law will not solve all of the problems in physician labor markets, let alone the larger issues of cost, quality, and access throughout our overall health care system.
- Policymakers should consider a broader inventory of tools and levers that can shape not just the initial supply of new physicians but also facilitate how all health care providers can deliver more accessible, effective, and affordable care

1.

Thank you, Chairman Jordan, Subcommittee Chairman Fitzgerald, Subcommittee Ranking Member Nadler, and Members of the Subcommittee, for the opportunity to testify today on The MATCH Monopoly: Evaluating the Medical Residency Antitrust Exemption, and more generally on competition policy considerations involving physician licensing .

I am testifying today as a health policy researcher and a resident fellow at the American Enterprise Institute (AEI). I also will draw upon previous experience as a senior lecturing fellow at Duke University School of Law, senior health economist at the Joint Economic Committee, member of the National Advisory Council for the Agency for Healthcare Research and Quality, and health policy researcher at several other Washington-based research organizations.

My remarks will focus first on the respective pros and cons of how the National Resident Matching Program (NRMP, or the “MATCH”) has shaped the evolution of the market for post-graduate medical education, resident physician training, and physician services over the last seven-plus decades. Of course, developments in how its practices are treated under antitrust law have essentially been frozen since Congress enacted a rare legislation exemption in 2004, amid pending litigation. Such a lack of further scrutiny and monitoring through the legal system makes today’s investigation by this subcommittee all the timelier and more overdue. Projected problems of shortages and imbalances in physician labor

markets; along with the chronically low wages and long working hours that most resident physicians still face, necessarily raise warning flags about the dangers of concentrated market power.

My testimony summarizes a number of potential legal remedies of different degrees and scales. Most of them presume reconsideration and modification, if not repeal, of the current statutory exemption. To be clear, the likely competition problems come not from the mathematical elegance and ingenuity of the MATCH algorithm per se, but rather from the program's related powers and conditions attached to it.

However, a narrow focus on antitrust law will not solve all of the problems in physician labor markets, let alone the larger issues of cost, quality, and access throughout our overall health care system. Policymakers should consider a broader inventory of tools and levers that can shape not just the initial supply of new physicians but also facilitate how all health care providers can deliver more accessible, effective, and affordable care. I will discuss a number of potential reforms that should rely more on reinvigorated competitive forces to do so.

How We Arrived at This Point (in Brief)

We are picking up on a previous trail of litigation that was frozen in time by congressional action. *Jung, Llerena, and Greene v. Association of American*

Medical Colleges (AAMC), National Resident Matching Program (NRMP), American Medical Association (AMA), American Hospital Association (AHA), American Board of Medical Specialties (ABMS), Council of Medical Specialty Services (CMSS), Accreditation Council for Graduate Medical Education (ACGME), and over two dozen individual medical schools, hospitals, medical centers, and universities, was filed pursuant to the Clayton Act in federal district court in June 2002, as a class action of resident physicians seeking compensation for violations of section 1 of the Sherman Act

The essential claims were tied to how the NRMP used to assign medical students and other applicants to ACGME-accredited residency programs artificially fixed, depressed, standardized and stabilized resident physician compensation and other terms of employment in an unlawful manner. The primary means alleged for accomplishing this involved exchanging competitively sensitive information regarding resident physician compensation and other terms of employment, eliminating competition in recruitment and employment of resident physicians by assigning them through the NRMP, and establishing and complying with anticompetitive accreditation standards and requirements through the ACGME.

As the initial litigation proceeded, a number of the original defendants were dismissed from the case, but early discovery revealed enough information to raise

the risk of substantial damages being awarded to the plaintiffs, as well as the need for changes in the NRMP's policies and practices. However, a rare exercise of congressional intervention to award a statutory exemption from antitrust liability essentially short circuited further proceedings in the lawsuit, as well as future efforts to revive such claims.

That did not deter further development of some robust academic literature debating the competitive advantages and disadvantages of the NRMP, as well as further modifications in some of its practices over the next two decades.

The MATCH Program's Pros & Cons

In broad terms, defenders of the MATCH portray it as a necessary remedy for previous market imperfections, and one that provides the maximum possible social benefit. They point to an older pre-MATCH period, mostly in the years just after World War II, and characterize it as a chaotic, "unraveling" market for resident physicians, plagued by increasingly earlier and earlier offers to medical students, exploding offer deadlines, and an "old boy" network of placement advantages for the most coveted positions. All of these practices were claimed to impose unreasonable uncertainties and pressures on young medical students. The

initial MATCH program was instituted in 1952, and it subsequently has been refined further.

The MATCH does deliver certain benefits in ensuring that a very high percentage of resident positions are filled. Most applicants succeed in gaining their (bounded) first or second choices. Defenders highlight overall consumer welfare benefits over the distributional disadvantages some individual applicants face when unable to negotiate their program participation terms more directly. The MATCH rules shift competition from the employment offer stage to the stage at which programs and applicants submit their respective lists of rank-order preferences. This later date of single-day competition can make use of all the information available in the market at that time.

Essential terms of employment for resident physicians such as starting salary and working hours lag well behind those of comparably skilled professionals, and they are offered essentially on a take it, or take it, basis. However, MATCH defenders point to the implicit tuition costs tied to training young residents, as well as program “prestige” factors, as part of the compensating differentials behind low resident salaries.

MATCH critics highlight the mutually reinforcing levers of market power tied to the program. The ACGME’s exclusive power over accreditation standards for graduate medical education means that it can limit the number of resident

positions available and determine which programs qualify for MATCH participation. MATCH program rules then make its process the nearly exclusive source for gaining acceptance to those resident positions. Those positions, in turn, represent the sole gateway not just to specialty board certification but even state licensure as a general practitioner.

Parties cannot negotiate and form “early contracts” that might better express their respective intensity preferences or assist transition planning for international medical school graduates. Meanwhile, comprehensive databases of salary, benefits, and other employment terms for resident programs are widely shared within the graduate medical education program community. This not surprisingly leads to a narrow convergence in compensation and working hours across resident programs by various measures, providing plausible indicators of buyers coordinating to create employer monopsony power over resident compensation. Those compressed wages also reflect the status of resident programs as the sole gateway to a future career as a licensed physician in the U.S., further distorting more fluid supply and demand responsiveness.

MATCH critics focus more on the program’s secondary conditions than on the efficiency of its final pairing algorithm. Indeed, some “concede” that the MATCH does an excellent job in solving the wrong problem --- how to fix the resident market monopsony that the program only strengthens. In other words,

once wage bargaining is taken off the table and price mechanisms cannot clear resident program markets, contract timing issues become both more important, and more problematic. A uniform matching date, and preference coordination, then “solves” the problems its other rules aggravate.

Further ground for skepticism is suggested by the absence of similar single-date, exclusive-mechanism matching rules for most other graduates entering labor markets (e.g. from law schools, business schools, colleges, or high schools), despite the many informational uncertainties and imperfect information sources faced by those other prospective employers and employees. Allowing price and wage flexibility to operate still can go a long way elsewhere in determining the optimal amount of information needed to enter a mutually agreeable transactions.

Counter-arguments emphasize that the market for graduating medical students is different. However, consider how recent developments in competition law for other highly skilled and perhaps even more highly valued students – those participating in certain major college sports – already have loosened or stripped away university restrictions on their labor mobility and compensation choices, primarily as a result of legal challenges under antitrust law.

In any case, MATCH defenders value streamlined, uniform selection procedures that are virtually mandatory for medical students seeking resident physician positions, at the expense of more individualized employment

negotiations and choices. The process delivers efficient sorting of bounded preferences, finality, and fewer unfilled positions. The main drawbacks, tied to legal objections, appear to be the vastly unequal bargaining power, wage compression and suppression, and onerous working conditions for residents that the program's interrelated rules and practices sustain.

The Limits of Antitrust Litigation, and Antitrust Exemptions

Standard methods for investigating the competitive effects on physician employment ordinarily would involve antitrust enforcement and private litigation. However, a unique congressional intervention with little advance notice and minimal explanation halted that process in April 2004, despite early discovery providing evidence of serious problems. Absent the sweeping antitrust exemption enacted under statutory law, further litigation under rule of reason analysis would have helped assess the net competitive effects of the MATCH program at that time, or even later as its practices evolved.

Such litigation and enforcement can often be blunt tools and not fully insulated from political factors either. Antitrust law and enforcement trends are subject to periodic swings of the legal pendulum, too. However, restoring that

avenue for challenging potentially anticompetitive policies can deter excesses, facilitate compromises, and stimulate alternative remedies.

In this case, the final result of reviving the older legal challenge to the MATCH program would be far from a sure thing in either direction. But the most revealing “tell” regarding the program’s legal vulnerabilities two decades ago was provided by the desperate scramble to cement such unusual legal immunity, by attaching it at the lastminute in conference committee to an unrelated piece of pork-barrel legislation, with no prior debate and little subsequent explanation.

Antitrust exemptions --- particularly through federal legislation -- are rarely provided. Those granted are viewed skeptically and narrowly by courts. They operate essentially as legalized monopolies, and they usually reflect the efforts of power and privilege to gain or preserve special commercial advantages. Most limited antitrust exemptions also presume other regulatory mechanisms to monitor and police anticompetitive aspects of the activities otherwise protected.

Hence, at a minimum, this subcommittee and the current Congress should indeed seriously consider ways to limit, if not repeal, the current antitrust exemption first awarded in 2004. Reliance interests and transition rules remain necessary, limiting considerations. The scope of potential financial liabilities for future defendants would extend only to post-exemption-repeal conduct. In all likelihood, substantial pressure to rebalance the competitive playing field for

resident physician selection and employment would lead to more nuanced adjustments, short of abandonment of all MATCH-like mechanisms.

We already have seen how working conditions such as maximum weekly hours and shift durations have been modified for residents in recent decades, but only to forestall the imminent likelihood of other federal regulation or legislation. Resident physicians employed at teaching hospitals and medical centers also have resorted more frequently to unionization as a means to collectively bargain for better work benefits and environments.

Potential Reforms to Head Off Future Legal Liabilities

What sort of modulated changes in MATCH program rules might head off future legal liabilities if the current exemption is repealed or limited? Even a determination that the MATCH program increases output as a procompetitive restraint may not survive rule of reason analysis if it is not seen as the “least restrictive” alternative.

More modest proposals to modify MATCH program practices include:

- Ensuring that all medical resident applicants have the opportunity to review the terms of their prospective contracts, with accurate and accessible information, before they must enter into any binding agreements,
- Imposing a date before which resident programs are prohibited from making offers (although this has been criticized as an insufficient remedy, the evidence is mostly based on much older history from more than 70 years ago),
- Setting mandatory minimum periods for holding offers open, to deter “exploding offer” abuses,
- Encouraging, if not mandating, opportunities for contingent contract negotiations between applicants and programs, before final rank-order preferences are submitted,
- Incorporating a separate early decision period for applications and acceptances, outside of the later MATCH process, to signal intensity preferences more effectively,
- Allowing applicants to receive two possible matches, with a set period of time to negotiate further, before making a final choice,
- Limiting the availability of comprehensive resident program compensation information to individual resident programs

All or some of the above would represent changes to improve competition within a reformed MATCH program, rather than displace it completely. They might be added as conditions to retain the current antitrust exemption, or inserted within a newly granted one.

Getting Beyond the Usual Tools and Stopping Points

This hearing is framed within the context of alleged monopoly insulated by an antitrust exemption. It makes for some good opening storylines. Legislative committee jurisdiction also is a factor. But from a broader policy reform vantage point, we should remain cautious in addressing complex problems, such as those in health care, too narrowly. The proverbial Law of the Hammer warns of cognitive bias in trying to fix many things with only the tools that are readily at hand. Overreliance in this case on a combined judicial and regulatory hammer of antitrust law as a familiar public policy tool follows from the saying, “If the only thing you have is a hammer, it is tempting to treat everything in the way as if it were a nail.” Antitrust enforcers certainly seem to see a lot of nails out there. But wild swings at the wrong targets not only might hit something else by mistake along the way. They might also miss some other targets.

Most policy interventions aimed at rebalancing competitive forces within physician labor markets face resistance not only from the powerful interest groups benefiting from the longstanding status quo. They also can trigger fear of disruption of well-established practices in the complex system used to train and select new physicians and timing mismatches in any transition toward alternative mechanisms. Long lead times are required to train each class of fully licensed and board-certified physicians – four years of medical school, and generally from three to seven years in internship and residency programs for specialty certification. Medical school and resident positions, along with the staff and facilities needed to train them, cannot be expanded (or reduced) substantially overnight. Unfilled positions are costly as well. However, older tales of excessive pressure by residency programs to fill slots as early as possible in the pre-MATCH era stem from more than 70 years ago, when the total number of positions exceeded applicants, unlike the opposite case in more recent years. Nevertheless, any significant policy changes should be calibrated and phased in carefully.

A different set of policy conflicts may arise from federalism concerns. States have traditionally been viewed as the natural constitutional stewards of physician licensing, as part of their traditional police powers. We should remember that any individual state already can step forward and reform its medical licensing system on its own, through various means:

- Maximizing scope of practice freedom for other licensed health care providers,
- Providing increased reciprocity or at least accelerated entry for out-of-state licensed practitioners,
- Reducing regulatory barriers to interstate telemedicine,
- Reducing hurdles to licensing of international medical graduates and foreign-licensed physicians,
- Supporting accelerated methods of medical training and licensing, such as assistant physician apprenticeships, or
- Considering new competing sources of accreditation for physician training and specialty certification.

More forward-looking initiatives recognize that the overall policy goal should not be construed as narrowly as just increasing the front-end production of young physicians newly trained at U.S. resident programs. They need to trigger nearer-term supply responses. This will require consideration of other policy tools to expand the entire health care workforce and provide greater flexibility to improve delivery of more valuable health care services and better health outcomes as soon as possible. One useful rationale for eroding rigid professional silos is to maximize

the use of the most highly skilled (but also the most expensive) medical professionals to the more challenging tasks and roles for which their extensive training and qualifications are best suited. That necessarily entails substituting other less-costly health care providers for some of those other tasks by practicing at the top of their own licenses, effectively but less expensively. Comparative advantage works in domestic markets, even as it faces renewed political challenges internationally.

Some states have led on this front, such as through interstate compacts to lessen barriers to their own markets, but not enough of them have done so as rapidly and thoroughly as they might. Hence, arguments for an increased federal government role in, at least, providing stronger incentives to do so. Federal and state governments still provide substantial financial support for graduate medical education and training. That funding could be retargeted to provide new incentives to ensure more competitive practices and policies, such as those suggested above.

The MATCH program's nationwide competition for resident positions was only an early sign of eroding geographic boundaries for health care labor markets. The modern digital era and early arrival of artificial intelligence tools will erode them further for more health care services. The continuing shift from physicians as independent business professionals to employees of larger health care companies will further transform health care labor market relationships.

We may wish to stop short of alternative federal licensing of physicians to provide different options, but that potential tool remains in the background as leverage. Impatience with the pace and depth of state-level reforms provides stronger temptations to nudge further with federal alternatives. Whether through more aggressive use of its commerce power, conditions of spending, or federal preemption, the issue is not whether Congress and the federal government has the power to be more assertive, but whether it decides it needs to do so absent more effective state-level actions. Even older legal immunities insulating state-government licensing from antitrust challenges, under the state action doctrine, have been carved back to some degree by clear articulation and close supervision requirements imposed in recent court cases. If state officials wish to preserve their own anti-competitive licensing regimes, they may at least have to speak more clearly.

In the event that Congress finds the will to do more in the physician licensing arena, it will have the ways to do so. For example, simply changing the rules of reimbursement for different types of physician services through federal health programs, particularly Medicare, could go a long way in redirecting young physicians toward primary care practices rather than specialties. But given the contemporary hurdles to overcome in finding sufficient resolve, compromise, and consensus to legislate on all but the most urgent issues, we still should expect the

more expedient resort to remain leaving such matters to litigation, regulation, and other administrative actions.

Of course, our broader chronic problems in health care policy go far beyond supply and demand for physicians' services, but that is an even larger topic for another day and another hearing.

Mr. FITZGERALD. Thank you, Mr. Miller.
Dr. Feldman, you may now begin.

STATEMENT OF DR. WILLIAM FELDMAN

Dr. FELDMAN. Chair Fitzgerald, Ranking Member Nadler, and the Members of the Subcommittee, I'm honored to talk with you all today about medical training in the United States and, more broadly, about ways of strengthening our healthcare system to improve outcomes for patients.

The MATCH, the subject of our hearing today, is the mechanism by which residency applicants are paired with hospitals for their training after medical school. For the past two decades, this mechanism has been protected by an exemption from antitrust violations. In March of this year, the Subcommittee sent letters to several stakeholders requesting information they consider as they considered the potential removal of this longstanding exemption.

The two central arguments of those letters are that the residency MATCH has created a bottleneck, resulting in physician shortages, and that it has depressed resident salaries. The goals of this Subcommittee, as expressed in those letters, of increasing physician workforce and ensuring adequate compensation for residents are laudable and ought to be pursued. The MATCH certainly has its downsides, but in my view, eliminating the MATCH would not necessarily accomplish the goals as set forth by this Committee.

Let's start with physician shortages, which are expected to increase from 37,000 in 2021 to over 80,000 in 2036. The problem is not that a large number of residency spots go unfilled each year. In fact, in 2024, 99.6 percent of the more than 40,000 advertised positions were filled. Instead, the problem is that more residency spots are needed. This, in turn, would require additional funding from Medicare and Medicaid and the hospitals themselves. The MATCH, per se, is not the bottleneck in the physician shortage.

Beyond creating and funding more positions, lawmakers should also identify new ways of bringing international medical graduates into our workforce, as many States are now doing. Numerous sectors in the U.S. economy, from tech to financial services, benefit from the infusion of highly skilled workers who train abroad. Why should medicine be different?

On the question of residency wages, I can tell you firsthand that living on a residency salary while trying to pay off student loans and start a family was challenging, but it's not clear that eliminating the MATCH would yield higher salaries across the board without disruption. There are certainly other ways of improving wages.

Resident unionization, Mr. Nadler mentioned, has accelerated in recent years, with 20 percent of all residents now unionized, including at my own institution. Through collective bargaining, residents have successfully negotiated wage increases, housing allowances, increased educational time, and numerous other benefits that help improve their quality of life and educational experience.

Residency programs can and should offer more, and Congress could facilitate this in any number of ways beyond actions to eliminate the MATCH, from increasing CMS funding of residency programs and supporting the right to unionize setting minimum sal-

ary floors and implementing more generous loan forgiveness programs.

I want to close by noting that some of the biggest threats to medical education and, indeed, to the very practice of medicine in the United States come not from the residency MATCH but from efforts by the current administration to undermine the very fabric of scientific discovery. Foundational research funded by the NIH and NSF form the core of what medical students and residents learn during their training.

Future groundbreaking cures that residents of today will prescribe to patients of tomorrow depend on a robust NIH and NSF for discovery, a well-staffed FDA for evaluation, and strong public players, including Medicare and Medicaid, for access. Yet, the current administration seems bent on gutting these institutions.

The administration's budget blueprint proposes cuts of 37 percent to the NIH and more than 50 percent to the NSF. Over 700 NIH grants, accounting for close to \$2 billion in funding, have been terminated this year, and more than half of these canceled grants are for medical schools and hospitals, a large number of which, by the way, are for clinical trials that are investigating diseases like cancer, psychiatric illness, HIV, and COVID.

At the FDA, more than 3,500 layoffs have already begun, slowing review times of new drugs. An entire office tasked with developing product-specific guidance and facilitating entry of low-cost generic drugs to keep prices down for patients was terminated. Proposed cuts to Medicaid, according to the CBO, will leave eight million beneficiaries uninsured, and these cuts will have disproportionate effects on hospitals that already struggle to cover the costs of uncompensated care.

This Committee has begun asking hard questions about medical training in the United States, which is good—

Mr. ISSA. Mr. Chair, can I have regular order, please?

Mr. FITZGERALD. Yes. Mr. Feldman, can you wrap up your comments, please.

Dr. FELDMAN. Yep. I would encourage you to widen the scope of assessment and consider an array of tools for addressing physician shortages, residency well-being, and larger threats to science in our healthcare system.

[The prepared statement of Dr. Feldman follows:]



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IMPROVING RESIDENCY SELECTION AND ADDRESSING THREATS TO SCIENCE AND THE US HEALTHCARE SYSTEM

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United States House of Representatives
Judiciary Committee
Wednesday, May 14, 2025
Washington, D.C.

1620 Tremont Street • Suite 3030 • Boston MA 02120

Chair Fitzgerald, Ranking Member Nadler, Chair Jordan, Ranking Member Raskin, and Members of the Committee:

My name is William Feldman. I am pulmonologist, ICU physician, and health services researcher at Harvard Medical School and Brigham and Women's Hospital, where I have joint appointments in the Division of Pulmonary and Critical Care Medicine and the Division of Pharmacoepidemiology and Pharmacoeconomics. My research focuses on pharmaceutical regulation and chronic respiratory disease and is funded by the National Institutes of Health (NIH), the Food and Drug Administration (FDA), and non-profit foundations. I am a faculty member in the Program On Regulation, Therapeutics, And Law (PORTAL), which is one of the largest non-industry funded research groups in the US devoted to the study of pharmaceutical pricing, regulation, policy, and outcomes. I also serve as co-chair of the Ethics Committee at Brigham and Women's Hospital, and I teach and mentor trainees from Harvard College, Harvard Medical School, and the residency and fellowship programs at the Harvard teaching hospitals. I am honored to talk with you all today about medical training in the US and, more broadly, about ways of strengthening our healthcare system to improve outcomes for patients.

1. Background on residency training and the match

Each year, more than 40,000 medical students take up residency positions in the US.¹ This phase of training is a vital component of medical education and is generally a prerequisite for practicing medicine in the US. During residency, newly minted physicians not only learn from more experienced doctors, but they also contribute in countless ways to patient care at academic teaching hospitals—from presenting on rounds and documenting treatment plans to communicating with nurses and covering hospitals overnight.

The National Resident Matching Program (NRMP, “the match”) is the mechanism by which residency applicants are paired with hospitals for training. Medical students select specialties, apply to programs, and then submit their preferences in rank-order. Each applicant matches to the highest-ranked program on his or her list among all programs that ranked the applicant with sufficient priority. The modern match was first launched in 1952, and the algorithm governing placement has undergone periodic refinement. But the match has long aimed to solve the twin problems of preserving student choice while ensuring that residency spots are filled in a time-sensitive fashion. In the absence of a match, students may face pressure to accept positions before having a chance to assess all programs (including with so-called “exploding offers”), and programs could struggle to fill slots when top-choice applicants accept positions elsewhere.² The match has sought to minimize these concerns while decreasing transaction costs and promoting applicant diversity.³

¹ National Resident Matching Program. NRMP Releases Results for the 2025 Main Residency Match. March 21, 2025. Available online at: <https://www.nrmp.org/match-data/2025/03/nrmp-releases-results-for-2025-main-residency-match/>. Accessed May 13, 2025.

² Chae SH. Is the match illegal? N Engl J Med. 2003 Jan 23;348(4):352-6. doi: 10.1056/NEJMs021241.

³ Ibid.

2. Challenges to the residency match

Although the match has become the dominant mode by which residency slots are allocated in the US, there are certainly downsides to the system. The binding nature of the match means that medical students may end up in less desired programs, although they can always choose to exclude such programs from their rank-lists. Applicants are also unable to negotiate individually for compensation packages before committing to programs on their list.⁴ A 2002 class-action lawsuit alleged that the match was anticompetitive for these reasons (and others), which, in turn, prompted Congress to pass a law specifically shielding residency programs from antitrust violations. Over the past two decades, the system has remained intact, and efforts to improve residency training have focused on collective bargaining for better salaries and benefits.

In March 2025, members of the House Judiciary Committee sent letters to the American Association of Medical Colleges (AAMC), the NRMP, and several hospitals seeking information as they explore potentially removing the match's antitrust exemption.⁵ The two central arguments of those letters are that the match has created a bottleneck resulting in physician shortages and that it has depressed resident salaries (which averaged \$66,712 in 2024).

Both goals—increasing the physician workforce and ensuring adequate compensation for residents—are laudable and ought to be pursued by policymakers. But the proposed solution of eliminating the match would not necessarily solve these problems. I would encourage the committee to think more broadly about how to deliver on these goals while strengthening innovation and competition across the healthcare system.

a. Physician shortages

The US has a shortage of physicians that is set to expand in the coming years. This shortage will likely increase from 37,000 in 2021 to as high as 86,000 by 2036, according to a recent AAMC report.⁶ The need for primary care doctors and those who care for marginalized patient populations in rural communities is especially pronounced. One concern raised by members of this committee is that, despite the need for more physicians, residency slots go unfilled each year in the match. For example, in the 2024 match, of the 41,503 positions advertised, 5.9% (2,562) went unfilled on the first round. Yet, all but 93 of the 2,562 unfilled positions were subsequently filled in the Supplemental Offer and Acceptance Program (SOAP)—a

⁴ Richman B. Now is the Time to Correct Residency Match and (Especially) Other Competition Issues in the Physician Market. Available online from: <https://ground.news/article/now-is-the-time-to-correct-residency-match-and-especially-other-competition-issues-in-the-physician-market>. Accessed May 13, 2025.

⁵ Scarcella M. US House panel launches antitrust probe of medical residency system. Reuters. March 17, 2025. Available online from: <https://www.reuters.com/legal/government/us-house-panel-launches-antitrust-probe-medical-residency-system-2025-03-17/>. Accessed May 13, 2025.

⁶ American Association of Medical Colleges. The Complexities of Physician Supply and Demand: Projections from 2021 to 2036. March 2024. Available online at: <https://www.aamc.org/media/75236/download>. Accessed May 13, 2025.

mechanism whereby unmatched applicants have a second chance to match to programs with unfilled spots.⁷ Together, the 2 rounds of matching resulted in 99.6% of positions being filled.

Recognizing that some of the unfilled spots may have been in less popular fields or locations, it is not clear how ending the match would address the physician shortage. If we continue to value residency training as a key step towards independent practice, the harder and more relevant question is: how do we fund and allocate more residency slots? The Centers for Medicare and Medicaid Services (CMS) contribute substantial sums each year to graduate medical education.⁸ One possibility would be for CMS to contribute more for newly created spots; hospitals could also share in this burden. Both approaches may be supplemented by efforts to grow the pool of students matriculating at US medical schools. But eliminating the match without creating a path for training more physicians would not seem to address the physician shortage.

Beyond efforts to increase the number of US medical residents, lawmakers should also identify new ways of bringing international medical graduates into the US workforce. In 2022, international medical graduates represented 23% of physicians practicing in the US.⁹ Several states have enacted legislation to streamline licensing requirements for these physicians.¹⁰ Rigorous standards to ensure quality are vital, but studies show that outcomes among patients cared for by international medical graduates in the US are comparable and, in some cases, superior to outcomes among patients cared for by US medical graduates.¹¹ Numerous sectors in the US economy, from technology companies and academic research centers to banks and engineering firms, have benefited from the infusion of highly skilled workers who train abroad. Lawmakers seeking to promote competition should welcome these efforts to build the physician workforce on behalf of patients.

b. Residency wages and quality of life

Recent letters from the House Judiciary Committee to different stakeholders in the match rightly note that residency salaries are low. But, as with the problem of physician shortages, eliminating the match could cause substantial disruption without delivering on the goal of improving outcomes. As it stands, residency salaries are typically uniform across specialties at a single hospital or institution, and these salaries are publicly available online. Residency

⁷ National Residency Matching Program. Results and Data: 2024 Main Residency Match. Available online at: <https://www.nrmp.org/match-data/2024/06/results-and-data-2024-main-residency-match/>. Accessed May 13, 2025.

⁸ Wagner MJ, Frazier HA, Berger JS. Navigating the Rapids: How Government Funds Flow to Graduate Medical Education. *J Grad Med Educ.* 2024 Jun;16(3):339-340. doi: 10.4300/JGME-D-24-00378.1. Epub 2024 Jun 13. See also: Congressional Research Service. Medicare Graduate Medical Education Payments: An Overview. Available online from: <https://www.congress.gov/crs-product/IF10960>. Accessed May 13, 2025.

⁹ Moyer DV, Erickson S, Opole IO. International Medical Graduates Are Integral to the Delivery of Patient Care in the United States. *Ann Intern Med.* 2025 Mar 4. doi: 10.7326/ANNALS-25-00847. Epub ahead of print.

¹⁰ Federation of State Medical Boards. States with Enacted and Proposed Additional Licensure Pathways: State-by-State Overview. Available online at: <http://www.fsmb.org/siteassets/advocacy/policies/states-with-enacted-and-proposed-additional-hmg-licensure-pathways-key-issue-chart.pdf>. Accessed May 13, 2025.

¹¹ Tsugawa Y, Jena AB, Orav EJ, Jha AK. Quality of care delivered by general internists in US hospitals who graduated from foreign versus US medical schools: observational study. *BMJ.* 2017 Feb 2;356:j273. doi: 10.1136/bmj.j273.

programs that offer more competitive compensation packages today may receive more applications and higher priority from applicants on match-lists. Compensation packages have improved in recent years as a growing proportion of residents have unionized (now 20% of the resident workforce).¹² Through collective bargaining, residents have successfully negotiated wage increases, housing allowances, increased educational time, and numerous other benefits that help improve their quality of life and educational experience.

Residency programs can and should continue to offer more, and Congress could facilitate this in any number of ways beyond eliminating the match, from increasing CMS funding of residency programs and supporting the right to unionize to setting minimum salary floors and implementing more generous loan forgiveness programs.

3. Other threats to American medicine

Some of the biggest threats to medical education—and indeed to the practice of medicine in the United States—come not from the residency match or challenges with medical training but from efforts by the current administration to undermine the very fabric of scientific discovery in the US. Foundational research funded by the National Institutes of Health (NIH) and National Science Foundation (NSF) form the core of what medical students and residents learn during their training. Future groundbreaking cures that residents of today will prescribe to patients of tomorrow depend on a robust NIH and NSF for discovering these therapies, a well-staffed Food and Drug Administration (FDA) for evaluating them, and strong public payers, including Medicare and Medicaid, to ensure access for patients. The current administration has proposed or enacted changes that will undermine our capacity to deliver high-quality care and will put patients at risk.

a. National Institutes of Health (NIH)

The Trump administration has proposed in its recent budget blueprint to cut funding at the NIH by 37% and at the NSF by 50%.¹³ Although now mired in lawsuits, the administration has announced cuts to indirect costs that would choke off scientific research at hospitals across the country.¹⁴ Many study sections, which review grant applications, have been cancelled or

¹² Mikolajczyk AE, Goodman C. Resident Labor Unions—Learning as We Go. *JAMA Netw Open*. 2024 Jul 1;7(7):e2421634. doi: 10.1001/jamanetworkopen.2024.21634. See also Ahmed A, Li X. Labor Unionization Among Physicians in Training. *JAMA*. 2023 Nov 21;330(19):1905-1906. doi: 10.1001/jama.2023.17494; Rosenbaum L. What Do Trainees Want? The Rise of House Staff Unions. *N Engl J Med*. 2024 Jan 18;390(3):279-283. doi: 10.1056/NEJMms2308224. Epub 2024 Jan 3; Committee of Interns and Residents (CIR). The National Voice of Residents. Available online from: <https://www.cirseiu.org/>. Accessed May 13, 2025; Ahmed AM, Kadakia K, Ahmed A, Shultz B, Li X. Trends in Labor Unionization Among US Health Care Workers, 2009-2021. *JAMA*. 2022 Dec 27;328(24):2404-2411.

¹³ Science. Trump's proposed budget would mean "disastrous" cuts to science. May 2, 2025. Available online from: <https://www.science.org/content/article/trump-s-proposed-budget-would-mean-disastrous-cuts-science>. Accessed May 13, 2025.

¹⁴ Wiley. Update: Federal Judge Blocks NIH Cap on Indirect Rates for Grants. March 6, 2025. Available online from: <https://www.wiley.com/alert-federal-judge-blocks-nih-cap-on-indirect-rates-for-grants>. Accessed May 13, 2025.

delayed.¹⁵ The NIH has been forced to lay off hundreds of employees.¹⁶ Seven hundred and seventy-seven NIH grants, accounting for \$1.9 billion in funding, have been terminated; more than half of the cancelled grants are from medical schools and hospitals, including clinical trials in disease-areas that represent significant threats to public health, from cancer and psychiatric illness to HIV and COVID-19.¹⁷ The 5 states hit the hardest (New York, North Carolina, California, Texas, and Florida) span the political spectrum.

These cuts at NIH threaten to undermine the prominent role of the US as a biotechnology leader. Nearly all 210 drugs approved by the FDA from 2010 to 2016 had funding contributions from the NIH.¹⁸ Members of our research group, PORTAL, have documented substantial NIH contributions to a wide range of new therapies, from cures for hepatitis C and vaccines for COVID-19 to cell and gene therapies for debilitating childhood diseases.¹⁹ Often, the riskiest research is performed in basic science laboratories at universities and medical centers before being commercialized by pharmaceutical firms. Delays and cuts at the NIH will deprive residents practicing today of the best tools available to care for patients once in independent practice.

b. Food and Drug Administration (FDA)

Attacks on foundational science at the NIH and NSF have been accompanied by layoffs at the FDA, which now number more than 3,500.²⁰ Staffing cuts have already led to delays in review

¹⁵ Molteni M, McFarling UL. Some NIH study sections will resume grant reviews, but final funding decisions are still in limbo. STAT. February 24, 2025. Available online from: <https://www.statnews.com/2025/02/24/some-nih-study-sections-to-resume-grant-funding-future-unclear/>. Accessed May 13, 2025.

¹⁶ Stein R, Noguchi Y, Lupkin S, et al. "Your RIF notice is not cancelled." Inside a chaotic week of massive layoffs at HHS. NPR. April 5, 2025. Available online from: <https://www.npr.org/sections/shots-health-news/2025/04/05/g-s1-58312/hhs-layoffs-rif-cdc-fda-nih>. Accessed May 13, 2025.

¹⁷ American Association of Medical Colleges. Impact of NIH Grant Terminations. May 6, 2025. Available online from: <https://www.aamc.org/media/83356/download>. Accessed May 13, 2025. See also Liu M, Kadakia KT, Patel VR, Krumholz HM. Characterization of Research Grant Terminations at the National Institutes of Health. *JAMA*. Published online May 08, 2025. doi:10.1001/jama.2025.7707

¹⁸ Galkina Cleary E, Beierlein JM, Khanuja NS, McNamee LM, Ledley FD. Contribution of NIH funding to new drug approvals 2010-2016. *Proc Natl Acad Sci U S A*. 2018 Mar 6;115(10):2329-2334. doi: 10.1073/pnas.1715368115. Epub 2018 Feb 12.

¹⁹ Kesselheim AS, Tan YT, Avorn J. The roles of academia, rare diseases, and repurposing in the development of the most transformative drugs. *Health Aff (Millwood)*. 2015;34(2):286-293. doi:10.1377/hlthaff.2014.1038; Nayak RK, Avorn J, Kesselheim AS. Public sector financial support for late stage discovery of new drugs in the United States: cohort study. *BMJ*. 2019;367:i5766. Published 2019 Oct 23. doi:10.1136/bmj.i5766; Nayak RK, Lee CC, Avorn J, Kesselheim AS. Public-sector Contributions to Novel Biologic Drugs. *JAMA Intern Med*. 2021;181(11):1522-1525. doi:10.1001/jamainternmed.2021.3720; Tessema FA, Barenie RE, Avorn J, Kesselheim AS. Federal Funding For Discovery And Development Of Costly HIV Drugs Was Far More Than Previously Estimated. *Health Aff (Millwood)*. 2023;42(5):642-649. doi:10.1377/hlthaff.2022.01134; Barenie RE, Avorn J, Tessema FA, Kesselheim AS. Public funding for transformative drugs: the case of sofosbuvir. *Drug Discov Today*. 2021;26(1):273-281. doi:10.1016/j.drudis.2020.09.024; Lalani HS, Nagar S, Sarpatwari A, et al. US public investment in development of mRNA covid-19 vaccines: retrospective cohort study. *BMJ*. 2023;380:e073747; Vokinger KN, Avorn J, Kesselheim AS. Sources of Innovation in Gene Therapies - Approaches to Achieving Affordable Prices. *N Engl J Med*. 2023;388(4):292-295. doi:10.1056/NEJMp2211729.

²⁰ Hopkins J. Drug Development is Slowing Down After Cuts at the FDA. *Wall Street Journal*. April 17, 2025. Available online from: <https://www.wsj.com/health/healthcare/drug-development-is-slowing-down-after-cuts-at-the->

times for new therapies; the FDA, for example, was unable to meet its deadline for assessing the biologic Nucala (mepolizumab) for chronic obstructive pulmonary disease (COPD).²¹ Peter Stein, who was terminated as director of the Office of New Drugs, likened the cuts to somebody walking onto a factory floor with no knowledge of the equipment and turning off different machines because they didn't look important.²² FDA staff have been unable to provide timely answers to pharmaceutical companies about clinical trial design or give sufficient scrutiny to inspection activities.²³ An entire division in the Office of Generic Drugs tasked with developing product-specific guidance and facilitating entry of low-cost generic drugs to keep prices down for patients was terminated.²⁴ Gutting the FDA undermines innovation and will reduce competition for pharmaceuticals in the US.

c. Medicaid

Patients can only access cutting-edge technologies in the US if they have insurance, and yet the administration's budget blueprint would leave more than 8 million Medicaid beneficiaries uninsured and would raise out-of-pocket costs for those who remain insured.²⁵ Cuts to Medicaid will have disproportionate effects for hospitals that already struggle to cover the costs of uncompensated care, including many safety-net hospitals; those systems need more funding, not less, to train the next generation of physicians. As the richest country in the world, we should be finding ways to ensure that more people have access to healthcare.

4. Conclusions

The House Judiciary Committee has begun asking hard questions about medical training in the US. How can we ensure a sufficient supply of physicians and improve the residency selection process? Ending the match is no guarantee for either goal and, in the absence of a well-constructed alternative, could result in a free-for-all that undermines both. I would encourage the committee to widen the scope of their assessment and consider other tools for addressing physician shortages, the residency experience, and larger threats to science in our healthcare system.

[fda-f22369cf](#). Accessed May 13, 2025. See also: Lawrence L, Herper M, Chen E. Crucial FDA reviews expected to be slowed by job cuts. STAT. April 10, 2025. Available online from: <https://www.statnews.com/2025/04/10/fda-layoffs-will-slow-down-drug-reviews-biotech-letter-cassidy/>. Accessed May 13, 2025.

²¹ Kansteiner F. FDA misses another approval decision target date, this time for GSK's Nucala in COPD. May 8, 2025. Available online from: <https://www.fiercepharma.com/pharma/fda-misses-another-approval-decision-deadline-time-gsk-nucala-copd>. Accessed May 13, 2025.

²² Lawrence L, Herper M, Chen E. Crucial FDA reviews expected to be slowed by job cuts. STAT. April 10, 2025. Available online from: <https://www.statnews.com/2025/04/10/fda-layoffs-will-slow-down-drug-reviews-biotech-letter-cassidy/>. Accessed May 13, 2025.

²³ Kansteiner F. FDA inspection operations face risk of further disruptions amid mass HHS layoffs: report. Fierce Pharma. Available online at: <https://www.fiercepharma.com/manufacturing/already-struggling-fda-inspections-face-risk-further-disruption-amid-mass-hhs-layoffs>. Accessed May 13, 2025.

²⁴ Lawrence L, Herper M, Chen E. Crucial FDA reviews expected to be slowed by job cuts. STAT. April 10, 2025. Available online from: <https://www.statnews.com/2025/04/10/fda-layoffs-will-slow-down-drug-reviews-biotech-letter-cassidy/>. Accessed May 13, 2025.

²⁵ Sanger-Katz M, Edmondson C. Republicans Propose Paring Medicaid Coverage but Steer Clear of Deeper Cuts. New York Times. May 12, 2025. Available online from: <https://www.nytimes.com/2025/05/12/us/politics/republicans-medicaid-cuts.html>. Accessed May 13, 2025.

Dr. FITZGERALD. Thank you, Dr. Feldman.

We will now proceed under the five-minute rule with questions. I'll recognize the gentleman from California, Mr. Issa, for five minutes.

Mr. ISSA. Thank you, Mr. Chair.

Dr. Feldman, I love it. You just had to go for a minute and 25 seconds on a rant against Trump for 100 days, as though what we're hearing about today had anything to do with it or that any real difference has occurred in 100 days to the root causes of not having enough physicians or that this didn't happen during the previous four years.

The least you could have done, of course, is talk about his first four years to give him at least a chance to have had some impact, but you chose not to.

I heard you say money, money, money. I think I'll go to Mr. Marek. You spend a fortune to become a doctor. Then, your system puts you into slave wages while the Federal Government is subsidizing the hospitals so they effectively have you for less than free. Is that a fair assessment of how we create residents? The Federal Government already pays more than you receive, isn't that true, if you're a resident?

Mr. MAREK. I agree with that. Yes, I agree with that. The government pays an average between \$150,000–\$180,000 a year per resident, and they convey about \$65,000 to each resident.

Mr. ISSA. OK. We've all heard about the rough hours that doctors go through and sort of part of this test, sort of like Navy SEALs and Rangers; you've got to stay up for a couple of days to prove you could in the future. I'm OK with that. I understand the stress.

What I don't understand is how we can have a projected shortage under a monopoly that was supposed to allocate and guarantee sufficiency, and then Dr. Feldman comes in and tells us the problem is that paying more to the hospital than they actually spend while getting a doctor for free, who they bill out is somehow the fault of an administration who has been here for 100 days. Mr. Miller, am I misunderstanding what I'm hearing?

Mr. MILLER. No. Let me add something else to this. I was wondering about this about 10 years ago. There's no correlation between the Federal funding and the supply of physicians. Now, we can change the rules and make it more targeted to incentivize the expansion of certain types of physicians or other areas, but the money goes in, and it goes to certain favorite parties over a period of time. It's not allocated on a need basis. It's just more sloshing around of funding, which is unrelated to what we say we're trying to accomplish.

Mr. ISSA. Dr. Lin, Dr. Feldman seemed to think that unions were the answer while maintaining an antitrust exemption. Do you see that as the answer, or do you see that a free market, or at least a partial free market being restored, could help with this problem?

Dr. LIN. I would say the latter, Congressman. I think union is not an answer for rural communities, especially small community hospitals. If you look at the current financial situation, we have hospitals closing, nursing homes closing because of financial stress. If you increase the wages artificially like that with union, that would be detrimental, and that would be a hindrance to our future.

Mr. ISSA. Now, Dr. Lin, I have also served over the years on the Immigration Subcommittee. One thing I understand is that we have a minuscule allocation to rural of foreigners able to get visas. Is that something that you would also seek to try to increase that number, since obviously there are more foreign-born doctors, some of whom have been U.S. educated, who are looking for those opportunities when they leave than we allocate slots? It's a quite small number, correct?

Dr. LIN. That's correct.

Mr. ISSA. OK.

Mr. Marek, your case was dismissed because Hillary Clinton and the late Senator Ted Kennedy got together and slipped it in there, and that's where we are. What, if any, improvement have you seen as a result of this antitrust exemption in any part of the process?

Mr. MAREK. Well, shortly after we filed the case, I believe that the hospitals saw the long, dangerous work hours as their Achilles' heel, and so they supposedly voluntarily adopted an 80-hour work week.

Mr. ISSA. OK. Well, Mr. Miller, let me—I'll take that as some good, only 80 hours. Mr. Miller, in my remaining time, antitrust exemption for the organization that does this work versus the effective antitrust that goes to the hospitals, should we make it clear that the selection process enjoys an antitrust, but all other aspects of the process should never have enjoyed antitrust exemption?

Mr. MILLER. Yes. It was a very sweeping exemption because basically it also prevented any evidence related to this from being used in collateral actions. Certainly, it should be set as narrowly as possible at a minimum.

Mr. ISSA. Thank you, Mr. Chair. I yield back.

Mr. FITZGERALD. The gentleman yields back. I now recognize the Ranking Member for five minutes.

Mr. NADLER. Thank you, Mr. Chair.

Dr. Feldman, since you've been attacked by several of the witnesses. Is there anything you would like to say in response?

Dr. FELDMAN. The one thing I would like to say is that my comment about more funding is about funding for more positions. If we're concerned about a residency shortage, if we're concerned about a physician shortage, we need more physicians, and the way to do that is by more funding.

Mr. NADLER. Thank you.

Dr. Feldman, in an April Executive Order, the Trump Administration once again took aim at institutions of higher education. This time it was focused on the administration's crusade against DEI. Can you explain whether there is a value in accounting for diversity in the provision of medical care?

Dr. FELDMAN. I do think there's value in accounting for diversity in the selection of medical students and residents. Having classes with a diverse set of interests and backgrounds can help strengthen the medical care that doctors provide and can strengthen residency classes.

Mr. NADLER. Thank you.

Dr. Feldman, you've seen the MATCH from both the applicant and program sides. What was the experience that you and your

peers had with the MATCH as applicants, and what concerns you about the prospect of eliminating the MATCH?

Dr. FELDMAN. The experience with the MATCH is that you apply to a bunch of programs. You interview. You rank the programs that you like the best, and you're placed into the one that also ranks you. The MATCH is not without its downsides, as I've said, but I would worry that eliminating the MATCH would create a kind of free-for-all that would make it harder for applicants.

This idea that you mentioned about exploiting offers and being pushed to commit early to one program without actually looking at all the programs would ultimately be problematic for residents—for applicants.

Mr. NADLER. Drawing on your experience, Dr. Feldman, with the FDA and pharmaceutical industry, what anticompetitive practices have you encountered that impacted most the public's health and well-being.

Dr. FELDMAN. I see lots of anticompetitive practices in the pharmaceutical industry. I'll give you one example that's very close to research that I've conducted with our team at Harvard Medical School. We see brand-name pharmaceutical companies obtaining patents that limit generic competition, that limit the entrance of low-cost generics onto the market. More competition is the way that we bring down drug prices.

Mr. NADLER. How could a patent—the patent limits the generic?

Dr. FELDMAN. Well, the companies list the patents with the FDA in what's called the Orange Book, and the generic entrants can't come onto the market until those patents expire, or they challenge them in court. We see anticompetitive practices all the time from pharmaceutical companies. We see anticompetitive practices from PBMs throughout the pharmaceutical supply chain. I would love for this Subcommittee to be focused on those issues.

Mr. NADLER. Thank you. Research funding is being cut for a variety of reasons, including administration concerns about a range of issues unrelated to the research itself. Against this indiscriminating approach to cost-cutting, for context, please explain the process by which these grants are made in the first place, Dr. Feldman.

Dr. FELDMAN. The process by which NIH grants are made?

Mr. NADLER. Yes.

Dr. FELDMAN. Well, we spend many, many hours writing grant applications. We submit them to the NIH. They go to study sections for evaluation, peer review, and the grants that have a certain score end up getting funded. It's an arduous process. It makes for good science because you get the best applications that are being selected, and I worry a lot about actions that are being taken now to cut funding from the NIH.

Mr. NADLER. Thank you. As a researcher who receives the NIH funding, what are your concerns about how freezing or terminating grants will affect the research enterprise and researcher choices?

Dr. FELDMAN. I have already seen the chilling effect that these cuts have had. I have had conversations with colleagues who are in academia and have thought about going into industry because of uncertainties around getting NIH funding. The NIH funds some of the riskiest research, also the highest reward research, in our

country, and I think these cuts are going to be devastating if they persist in breakthrough therapies.

Mr. NADLER. Thank you. Finally, the administration has been doing everything it can to deport foreign students and researchers. To what extent do you think what I just said is accurate, and how will this affect medical care?

Dr. FELDMAN. I'll come in on the latter question. I think that deporting international students, making it hard for international students to learn in the United States and practice in the United States will only contribute to the physician shortage.

Mr. NADLER. Thank you, I yield back.

Mr. FITZGERALD. The gentleman yields back. I now recognize the gentleman from Virginia for five minutes.

Mr. CLINE. Thank you. Dr. Lin, the ACGME leverages its accreditation monopoly to impose DEI hiring requirements on medical residency programs. According to ACGME program requirement IC, programs must hire a diverse and inclusive workforce. We heard Dr. Feldman try and justify that. Race-based hiring requirements are against Federal law. The Supreme Court was clear in *Students for Fair Admissions v. Harvard* that educational institutions cannot base admission on race either. American healthcare patients suffer when residency programs focus on gender or skin color instead of a resident's competency.

Do you think the ACGME should be in the business of forcing programs to hire residents based on race or gender instead of merit?

Dr. LIN. Congressman, I would tell you that, of course, personally I would think that they should not impose their will on individual programs. Some good news, as of May 9th, the ACGME has suspended their common standard for DEI practices, and—it remains to be seen how they're going to change their standard. We just got the email last week.

Mr. CLINE. That's good news.

Mr. Miller, the medical residency market is stagnant with low wages for residents and worse outcomes for patients. It also functions as a bottleneck that contributes to America's doctor shortage. Would removing the medical residency antitrust exemption make the market more competitive?

Mr. MILLER. We need to parse a couple of different parts to this. The supply line is a little more complex than just removing the antitrust exemption. It could create some opportunities, but primarily, in terms of improving the overall working conditions and the quality of the healthcare workforce we produce, there are a broader set of tools than that alone. There's some ambiguity over exactly what's driving the production line. I suggest we need a bigger basket than simply this tool alone. It will help, but I would not exaggerate its effects.

Mr. CLINE. Thank you. As you know, to receive a physician's license, doctors are required to participate in an ACGME accredited residency. Traditionally State licensing requirements that facilitate anticompetitive conduct are shielded from antitrust law under the State action immunity doctrine.

What do you see with State medical licensing boards rubber stamping monopolistic conduct like that of the ACGME?

Mr. MILLER. You're opening up a different basket. That's OK. Certainly, many State actions, there's real State action and then there's kind of periphery State action, certainly encourage an anti-competitive atmosphere in State physician markets.

In general, they are being clawed back but not as much as they should. We have eroded some of the excesses of the State action doctrine in terms of having a clear articulation of State policy and closer supervision. That's a process in which we're removing slower than we should on that front.

States certainly could do a better job in this regard, and there are, as I've suggested, other Federal levers to give them some encouragement to do so. Any individual State should be responsible for its medical markets and the result it produces. It's, the broad sense, fairly disappointing thus far.

Some States have led the way, but it's a handful. Whether it's licensing of foreign physicians, alternative ways to expand the workforce, we have to go a lot further on the front end there—reciprocity.

We had to have the extremes of the COVID situation to begin to find out how we can loosen things up when we're really desperate. We should do that more often as a general rule, and we have a long way to go to expand the overall supply of healthcare, not just the newly minted physicians.

Mr. CLINE. Staying with the ACGME, medical residency programs can only receive Federal funding through Medicare and Medicaid if they are accredited by the ACGME. As a result, the ACGME essentially controls the on-and-off switch for billions of dollars in Federal funding.

With that power, the ACGME has set accreditation requirements that are not consistent with the Federal Government's priorities, like radical DEI hiring requirements and wasteful administrative burdens.

How would creating an alternative certification process for Medicare and Medicaid funding loosen the ACGME's power over the medical residency market?

Mr. MILLER. There's always room for competition, even in government franchises, and certainly there are no ways to think of other forms of certification, independently driven through the private sector, which could be recognized as alternative sources of that supply. That would require the Federal Government to step forward, take more control of that situation, or States, also in their own determination of accreditation, decide they need additional sources.

When you have a shortage of supply and you only have one supplier, it suggests time to either find some alternatives or say to the person, "Let's make some adjustments."

Mr. CLINE. Thank you. Mr. Chair, I yield back.

Mr. FITZGERALD. The gentleman yields back. I now recognize the gentleman from Georgia for five minutes.

Mr. JOHNSON. Thank you, Mr. Chair. The medical MATCH is not perfect, but let's be honest about why we are having this hearing today. For House Republicans, this is a hearing—this hearing is an outgrowth of MAGA Republican ongoing attacks on science and research. President Trump and the Republican-controlled Congress

have made massive cuts to medical research programs at universities and at the Federal level, including research into things like women's health, racial disparities, and chronic diseases.

I'm proud that the Centers for Disease Control and Prevention is headquartered in my hometown of Atlanta, but the Trump Administration already cut 2,400 jobs from the CDC last month and ended programs on lead poisoning, smoking cessation, and reproductive health.

Now, that does not make America healthy again, does it, Dr. Lin? Yes or no.

Dr. LIN. Congressman—

Mr. JOHNSON. OK. So, yes or no? I'm running out of time. I'm going to move on. You don't want to answer that question.

President Trump's latest budget calls for cutting CDC's funding by half and eliminating its Chronic Disease Center entirely, wiping out programs aimed at preventing cancer, heart disease, diabetes, epilepsy, and Alzheimer's disease. That doesn't make America healthy again, does it, Mr. Marek? Yes or no?

Mr. MAREK. I don't have an answer for that.

Mr. JOHNSON. OK. Well, it's clear. It's abundantly clear to most Americans, exempting, of course, MAGA Republicans, I guess, would not understand.

Now, House Republicans are trying to jam through a spending bill that would make massive cuts to research, as well as massive cuts to Medicaid, ripping away eight million Americans' healthcare so that they can fund tax breaks for their billionaire buddies. Mr. Miller, that does not make America healthy again, does it?

Mr. MILLER. A lot of things don't make America healthy. We can talk about them if you wish to have a wide range—

Mr. JOHNSON. I'll reclaim my time.

Dr. Feldman, international medical graduates represent a substantial chunk of physicians practicing in the United States. You said 23 percent in your testimony. The Trump Administration and House Republicans are trying to make it harder for noncitizens to come work in the United States.

How would it impact care in this country if we lost those international medical graduates?

Dr. FELDMAN. It would be devastating. International medical graduates often serve in rural communities in primary care roles, and they help solve the physician shortage that we're here to talk about today.

Mr. JOHNSON. That would not make America healthy again, would it?

Dr. FELDMAN. It would not.

Mr. JOHNSON. Dr. Feldman, the Trump Administration and Republicans are trying to slash spending to Federal healthcare. Could you say more about why programs would be impacted if Congress increased funding for residency programs through the Centers for Medicare and Medicaid Services rather than trying to cut funding for those programs?

Dr. FELDMAN. We need to increase funding because we have a physician shortage, and the way to solve the physician shortage in part is through more physicians. The only way to have more physicians is more funding.

Mr. JOHNSON. That's commonsense. Mr. Miller, you're shaking your head no. I don't understand.

Back to Dr. Feldman, Republicans are floating an idea that would require doctors to work even longer to achieve public interest loan forgiveness because it would not count the years of their residency toward the 10-year requirement. Can you speak as to how this would impact on the availability of care, particularly in rural or underserved areas?

Mr. MILLER. If you ask the wrong question, you'll get the wrong answer.

Mr. JOHNSON. I'm asking Dr. Feldman.

Mr. MILLER. I thought you were asking me.

Dr. FELDMAN. I'll tell you, as somebody who is doing public service loan forgiveness and who started paying down my student loans during residency, there's no reason to push that out. It's a very good program, and it's a way to get physicians into the workforce, and it would be a bad idea.

Mr. JOHNSON. If Republicans were serious about making healthcare more affordable and more accessible to the American people, there are so many things that we could have hearings about other than this MATCH.

Mr. FITZGERALD. The gentleman's time has expired.

Mr. JOHNSON. I yield back the remainder of it.

Mr. FITZGERALD. The gentleman yields back. The gentlewoman from Wyoming is recognized.

Ms. HAGEMAN. Mr. Miller, you seemed as though you had something to say.

Mr. MILLER. Well, there's one view of the world which says simply, "Pour more resources in, and everything will work wonderfully." The problems with our healthcare system are what we're getting out of it, as well as what we're putting into it. A singular focus on just adding more dollars for more inputs says nothing about the quality of the care, its efficiency, its alternative delivery. We need to make lots of changes in a lot of things to get a better healthcare system. It should not be solely focused on "let's just have a lot more physicians, and everything will be great." We've tried that approach before; it doesn't produce the results.

Now, there are barriers to production of physicians, which we can talk about, but it isn't solved simply by increasing Federal funding.

Ms. HAGEMAN. OK. I appreciate that comment.

Several of you have testified that the MATCH system harms rural hospitals. I'm from Wyoming, which is a very rural State, dealing with many challenges in its ability to provide healthcare services with barriers related to financing, transportation, and access.

Dr. Lin, is it difficult for rural hospitals to meet ACGME's accreditation requirements?

Dr. LIN. It is challenging, Congresswoman.

Ms. HAGEMAN. What are those challenges?

Dr. LIN. Some of the challenges are some of the standards that they put in place, for example, distance radius. Obviously, if you look at rural America, there are 1,300 critical access hospitals, and by critical access hospitals, by definition, there are less than 25

beds. Given that, if you're training a physician, obviously scope and volume become a problem. When you're trying to train a rural program for residents, you have to send them to a distance away for training.

One of the barriers to that is that, for example, our orthopedic program got shut down because we have to send our residents to Cincinnati Children's Hospital, and we have a consortium model that we have partnership with them, and that was not acceptable to them. That creates a barrier where we're trying to increase quality and scope and volume for our residents, and they thought that was a negative. We got cited, and that was one of the reasons why they closed down our program.

Ms. HAGEMAN. Do you have some ideas of how to fix those kind of accreditation problems?

Dr. LIN. Yes. Absolutely. If you look at, prior to 2015, the merger of the ACGME and the AOA, there was alternative accreditation body, which is from the AOA, and if you look at, prior to the merger, we have most osteopathic institutions have a consortium model where we have a network of small community hospitals and/or community hospitals. We leverage each other's strength, and we put in the consortium model that we have a network of training sites that we can send our residents and collaborate. That model has worked out for many, many years. Millcreek Community Hospital, which is now—

Ms. HAGEMAN. Why was it changed?

Dr. LIN. It changed because of the merger.

Ms. HAGEMAN. Of the merger?

Dr. LIN. That's correct.

Ms. HAGEMAN. OK. Specifically, the issue that this Committee addressed to antitrust is focusing on, correct?

Dr. LIN. In my opinion, yes.

Ms. HAGEMAN. OK. Mr. Miller, there is a persistent and growing shortage of medical professionals in this country, and, again, representing a State like Wyoming, we seem to be hit harder than many others. Do you think placing qualifications on job positions that are not based on merits, such as the DEI requirements, exacerbates the challenges our Nation is facing in terms of providing care for our citizens?

Mr. MILLER. Well, it sounds like a euphemism. The goal is to have everything based on competition, quality, and merit. The rest of the distinctions are ancillary and can be distracting from that.

I don't want to overstate the magnitude of DEI. This is going to fight its way out through the courts. We've gotten rulings. They are going to be interpreted, and some games are going to be played in the educational system in general, not just for physicians.

The more we can focus on what physicians are doing at the point of care and what they're producing, that's what we want to measure as opposed to any other ancillary considerations. That's going to work itself out through further litigation, probably more so than random interventions.

Ms. HAGEMAN. OK. Mr. Marek, very quickly, this hearing focuses on the antitrust exemption granted by Congress, but you were hired in the 1990s as part of a lawsuit against the MATCH system. The National Resident Matching Program, also known as MATCH,

was founded in 1952. The ACGME was established in 1981. How far back does the harm for your clients and other medical students go?

Mr. MAREK. The harm goes all the way back to 1952, frankly.

Ms. HAGEMAN. From the beginning?

Mr. MAREK. Exactly.

Ms. HAGEMAN. It was created in the program itself?

Mr. MAREK. Exactly.

Ms. HAGEMAN. All right.

Mr. MAREK. People got their positions by telegrams back in 1952. The problems then have no relevance to today, in my view.

Ms. HAGEMAN. OK. Thank you. I yield back.

Mr. FITZGERALD. The gentlewoman yields back. The gentleman from Illinois is now recognized for five minutes.

Mr. GARCIA. Thank you, Chair Fitzgerald, and the Members and the witnesses that are here today.

We are here today because we are talking about the possibility of an antitrust exemption for the medical residency MATCH program. As a strong proponent of enforcing antitrust laws, I approach any exemption with skepticism. It seems to me that the exemption for the MATCH has pros and cons. In some ways, it does limit choice for candidates who are bound to the program they match with and cannot negotiate employment terms or benefits since they are matched. There are legitimate questions about how the system works and how it can be improved, but it's also true that repealing the antitrust exemption outright may have unintended consequences that worsen outcomes for medical residents.

Dr. Feldman, in your opinion, could repealing the exemption actually end up benefiting the most well-resourced hospitals, medical schools, and residency programs?

Dr. FELDMAN. It could because—what I would worry about is sort of insiderism where, outside of the match, you would have well-resourced applicants with well-resourced mentors who are connecting with well-resourced institutions, and some of the fairness that the MATCH engenders would be lost.

Mr. GARCIA. Thank you. Clearly, this is a nuanced issue, and Congress should be taking a nuanced approach to it as well.

One relevant factor here is that most medical residencies are at least partially funded by Federal dollars. If we want to fix some of the issues created by the MATCH, like compensation and shortages of internal medicine residents, Congress can act to solve them.

Dr. Feldman, would you agree that Federal funding can be used to address these issues?

Dr. FELDMAN. I would agree.

Mr. GARCIA. Thank you. I also want to join my colleagues here in pointing out how absurd it is that Republicans are portraying themselves as champions of physicians, patients, and healthcare more broadly when their policies are actively destroying access to affordable healthcare. My colleagues have addressed that, and they've also brought up the devastating cuts to the NIH and the FDA, which will jeopardize the research that residents and physicians rely on to treat their patients.

There are also significant antitrust issues in healthcare that are driving up costs for patients. If Republicans cared about solving the

root causes of those problems, we would be talking about hospital mergers, price gouging, or consolidation in the pharmaceutical industry.

Dr. Feldman, let me ask you about the last issue, since your research has focused on it. How is vertical integration in the pharmaceutical industry driving up the cost for consumers?

Dr. FELDMAN. At the center of vertical integration in the pharmaceutical industry are PBMs, pharmacy benefit managers, and PBMs distort the incentives for lower cost drugs. PBMs are after large confidential discounts, which can keep list prices high, and patients don't see the benefits of those discounts. In fact, their out-of-pocket costs are tied more to list prices. The PBMs have been in part responsible for driving some of the high out-of-pocket costs that we see. Vertical integration, when PBMs and pharmacies and payers are all owned by the same company, can lead to reduced choices at the pharmacy and bad outcomes for patients.

Mr. GARCIA. Thank you. This exchange illustrates why we need a serious, principled approach to antitrust enforcement and why we need antitrust enforcers at the FTC and the DOJ who are willing to fight for workers, for consumers and patients, instead of bending the knee to billionaires and corporate interests.

Thank you, and I yield back.

Mr. FITZGERALD. The gentleman yields back. I'm now going to recognize myself for five minutes and yield my time to the gentleman from Missouri for five minutes who waived on to the Committee.

Mr. ONDER. Thank you, Mr. Chair, and thanks for all the witnesses here today.

Dr. Lin, in your testimony, you touched a little bit on some of the residency closures that—were those ones at your institution specifically or around the country or—

Dr. LIN. In my written testimony and my oral testimony, it's a combination of our LECOM system hospitals.

Mr. ONDER. OK. I was reading earlier in your written testimony that there was a general surgery program—let's see—the termination—oh, it was of the director due to noncompliance with COVID-19 vaccination—

Dr. LIN. Yes. That was in our Elmira campus and our regional campus. My understanding of that case is that it was the height of COVID, and the program director didn't want to get a vaccination, and because of that—there was a mandate from ACGME that required the program directors to have vaccinations. The program director resigned from the position, and because of that, there was no program director, and they shut down the program.

Mr. ONDER. Oh, that was my question. The program did end up getting shut down?

Dr. LIN. Yes.

Mr. ONDER. OK. Do you have an estimate of how many residency programs have been shut down over the years because of ACGME?

Dr. LIN. I just have general statistics where, after the merger of the ACGME and the AOA, there are approximately 670-some programs that have closed. More recently, it's an ongoing process where there are new programs that are trying to get started, and then there are programs getting shut down.

If you look at it, disproportionately, it's always the smaller community program that is not as resourced as the tertiary care center or university-based center that can't meet the standards that are getting shut down.

Mr. ONDER. Right. Yes. That's what it seems to me, that it's a matter of resources. You're not going to see a program at Harvard Medical School getting shut down, but, in rural America, where we have the most acute shortage of primary care doctors and of specialists with fewer resources, that's where they get shut down.

Dr. LIN. Correct. I would say that Dr. Feldman and my job are probably very different. His environment and my environment are very different. I work in a Critical Access Hospital with 25 beds in Corry, Pennsylvania, where the population is probably less than 6,000 in that town, but there's absolutely no resources. From that perspective, I'm not saying ACGME is bad.

Mr. ONDER. Right.

Dr. LIN. I'm just saying that there needs to be an alternative way to focus on different venues so we can create different types of physicians.

Mr. ONDER. Nor, I'm sure, are you saying that every residency program in the country is good, that there isn't—

Dr. LIN. Correct. There has to be a standard.

Mr. ONDER. There has to be a standard.

Dr. LIN. Absolutely.

Mr. ONDER. It seems to me that, at a time when over 8,800 medical school graduates per year go unmatched—that it's a tragedy that a bureaucratic organization with a monopoly is shutting down programs.

Dr. LIN. Correct.

Mr. ONDER. I believe there was a question earlier in this about DEI and maybe ACGME backing away from DEI requirements. Did one of the witnesses address that?

Dr. LIN. Yes. That was me.

Mr. ONDER. That was you.

Dr. LIN. We did receive an email notifying all the programs that, as of May 9th, they are suspending the DEI requirements. That used to be an institutional and common program requirement for every sponsoring institution as well as programs.

Mr. ONDER. Did many of those programs have DEI officers or someone employed to monitor these mandates?

Dr. LIN. Well, yes.

Mr. ONDER. Yes.

Dr. LIN. Because it was in the standards.

Mr. ONDER. Right.

Dr. LIN. If they want to maintain the program, the individual program institution would have to suspend resources to meet that requirement.

Mr. ONDER. Yes. My concern there, of course, is that, even if the requirement goes away, all these institutions have hired people to do something. Those people are going to—unless they relieve them of their jobs, these same people embedded in the system driven by ACGME requirements over the years will continue to engage in pernicious discrimination based on race in violation of both moral

principle and Federal law, but that's something ACGME has given us over the years.

Well, thank you for your testimony. I yield back.

Mr. FITZGERALD. The gentleman yields back. I now recognize the Ranking Member of the Full Committee for five minutes.

Mr. RASKIN. Thank you very much, Mr. Chair.

Dr. Feldman, President Trump and Secretary Kennedy want to cut \$18 billion from NIH. They want to cut \$3.5 billion dollars from CDC, the Centers for Disease Control. They want to cut \$4.7 billion from the National Science Foundation. These unprecedented, proposed reductions in America's healthcare research spending would come at a time when we have overwhelming needs in the American public for medical and scientific breakthroughs, and, also, they come at a time when we have the opportunity to make big breakthroughs in scientific research related to everything from multiple sclerosis to cystic fibrosis to breast cancer to malignant narcissistic personality disorder. You name it.

What would be the direct effects of such drastic budget reductions on healthcare delivery and on the progress of healthcare research?

Dr. FELDMAN. The effects would be dramatic. When you look at FDA-approved drugs, nearly every single drug that gets approved by the FDA is traced back to some funding through the NIH. The NIH funding has contributed to cures for hepatitis C, to treatments for HIV, and to COVID-19 vaccines. Cutting NIH funding will absolutely reduce the number of breakthrough therapies of game-changing therapies that patients would see in the future. It's a bad idea.

Mr. RASKIN. It sounds like we would be essentially destroying the wellspring for research across the board?

Dr. FELDMAN. That's right. What you have to remember is that the NIH is funding the highest risk, highest reward research that pharmaceutical companies then take to market. It's hard to know what's going to work and what doesn't, and that's why you need broad funding, and NIH has been incredibly successful in funding new cares.

Mr. RASKIN. What are some of the next-generation breakthroughs that might be lost if Robert F. Kennedy, Jr. and Donald Trump have their way in dismantling so much scientific health research?

Dr. FELDMAN. What's hard about this is we can't know until we actually do the research, and we can't do the research until the funding comes.

You mentioned some key disease areas that are vital for public health. Cancer. We've had breakthroughs in cancer therapy over the last 10-30 years. Checkpoint inhibitors treat a variety of different malignancies, Alzheimer's, dementia. There are numerous untreated diseases. In my area of pulmonology, COPD, asthma. These are diseases that have had some recent breakthroughs, but I would love to see more therapies available for patients.

Mr. RASKIN. My guest at the Joint Session of Congress, Dr. Lauren McGee, a constituent of mine, was the chief biologist on a pediatric cancer unit at NIH, and she got sacked on February 14th, because she made the mistake of being on probation. Not because

she had done anything wrong, but because she had been promoted after serial superior evaluations by the people reviewing her. Then, we heard President Trump at the State of the Union saying that attacking childhood cancer was one of his key priorities.

Do we have any chance of making progress on childhood cancer if we are dismantling the basic research that's going on at NIH about it?

Dr. FELDMAN. The way to make progress on childhood cancer and other diseases of childhood is through funding the research enterprise that finds new cures.

Mr. RASKIN. The administration is also proposing a massive cut to Medicaid, which the CBO estimates would result in 8.5 million people losing healthcare access over the next decade. What population groups and what parts of the country are most affected by these Medicaid cuts?

Dr. FELDMAN. These cuts will affect the most disadvantaged members of society in rural communities and urban communities in cities. It will lead to very bad health outcomes.

Mr. RASKIN. All right. My time is up, but thank you, Mr. Chair.

Mr. FITZGERALD. The gentleman yields back. We're now going to recognize the gentleman from California for five minutes.

Mr. CORREA. Thank you, Mr. Chair.

First, I want to welcome the witnesses here today. My wife is a medical doc, and this subject brings back a lot of memories of some kind of nightmarish residences, an OB resident putting in all those hours, 90 hours a week. The pay was challenging, but we all knew it was part of the education process to become a good medical doctor, a good specialist in the area of practice. I've spoken to her about this issue, and she concurs with me. A lot of nightmares, a lot of challenges, and a tight budget. It worked out.

My question would be—Dr. Feldman, I'm going to ask you—if it ain't broke, why fix it? What is wrong right now with the MATCH system or the program?

Dr. FELDMAN. The downsides have been spelled out by other witnesses and, to an extent, in my testimony. The current system does not allow individuals to negotiate salaries or benefits directly with institutions.

Mr. CORREA. So, let me ask you. It's an issue of money, so to speak, like everything else. How much can you pay? We're looking at possible Medicaid cuts. Where do most of the MATCH—where is that funded? You've got medical schools that are growing. We have a doctor shortage, and you have people like Kaiser Permanente back home in California—they have a doctor shortage. They started their own medical school. They are moving on their own to try to alleviate the challenges they have.

If you want to have more docs and expand the MATCH, what does it take? More money?

Dr. FELDMAN. We need more residency positions, and, as you said, the funding for residency positions comes largely from Medicare and Medicaid. Cuts to Medicaid are counterproductive. It's also worth noting that hospitals that serve disadvantaged patient populations, including patients with Medicaid, will be hurt by these cuts to Medicaid—

Mr. CORREA. Inner city, rural areas, farms, and Midwest? Is that what you're talking about?

Dr. FELDMAN. All of what you just mentioned.

Mr. CORREA. My spouse usually gets very interesting offers to go work as an OB in the middle of somewhere in this country, and they're not very lucrative. If it wasn't for the fact that we had family established in Southern California, we may have taken some of them. There's not much money to be made as a doc in the middle of nowhere.

Dr. FELDMAN. I would love to see more incentives for primary care doctors in these underserved communities, including rural communities.

Mr. CORREA. Give me an example of an incentive. Higher pay? Loan forgiveness? What are we talking about?

Dr. FELDMAN. We could debate what incentives would work best. Loan forgiveness is a good example of a way in which the system might be able to entice physicians into areas that they might otherwise not be considering.

Mr. CORREA. Well, I remember, again, speaking to my spouse and some of her colleagues. The new brand-spanking-new docs that are hitting the market, half a million dollars in debt or something like that. An unbelievable amount of money.

How does a doc like that coming out of medical school residency balance their checkbook?

Dr. FELDMAN. Those numbers are right. I can tell you, coming out of residency, I had over \$300,000 in medical school debt. That's just the cost of going to medical school now. There are programs in place—

Mr. CORREA. We are looking at we just—we need more money. The testimony that we need to pay residents a whole lot more is probably correct. I wish you would have been there 40 years ago when my wife was going through residency. We would have appreciated your efforts. Today, here we are.

You're looking at some public policies by the administration to cut Medicaid, possibly Medicare, when we're trying to expand the field of doctors available to take care of Americans. It seems to me it's contradictory here. What am I missing?

Dr. FELDMAN. I don't think you're missing anything. I agree.

Mr. CORREA. We all have got to get on the same page. We need more docs. We need more residents. We need a better matching program. We need more money, but it seems like the public policy is going the other way.

Dr. FELDMAN. I agree. If the focus is on solving the goals set by this Subcommittee of addressing physician shortages and improving resident salaries, there are numerous, countless ways to do that are worth discussing.

Mr. CORREA. Thank you very much, and I thank the witnesses all for their time and interest in this issue.

Mr. Chair, I yield.

Mr. FITZGERALD. The gentleman yields back. I recognize Mr. Nadler for some unanimous consent requests.

Mr. NADLER. Thank you, Mr. Chair. I ask unanimous consent to submit for the record this statement from the Association of American Colleges, dated May 14, 2024.

I ask unanimous consent to enter into the record an article titled “More Medicare-supported GME slots needed to curb doctor shortages,” from the *AMA Journal*, dated October 4, 2024.

Mr. FITZGERALD. Without objection.

Mr. NADLER. Thank you, Mr. Chair.

Mr. FITZGERALD. I ask unanimous consent to enter into the record the following statements: A statement from Dr. Jon Ward, a double board-certified dermatologist practicing in Florida; a statement from Dr. Caleb Atkins, a current resident practicing family medicine in rural New York; a statement from National Board of Physicians and Surgeons calling for antitrust scrutiny of the medical residency market; and a statement from Dr. Jeffrey Singer, a Senior Fellow at the Cato Institute.

With no objection.

Mr. FITZGERALD. At this time, that would conclude today’s hearing. We thank our witnesses for appearing before the Committee today.

Without objection, all members will have five legislative days to submit additional written questions for the witnesses or additional materials for the record.

[Whereupon, at 11:26 a.m., the Subcommittee was adjourned.]

All materials submitted for the record by Members of the Subcommittee on the Administrative State, Regulatory Reform, and Antitrust can be found at: <https://docs.house.gov/Committee/Calendar/ByEvent.aspx?EventID=118236>.

